
# Musician Benefit Plans

# Musicians Benefit Plan

## MONTHLY RATES

### MEDICAL

| | | Southern CA | Northern CA |
|---|---|---|---|
| **KAISER RATES VALID 10/1/2023 - 9/30/2024** | | | |
| **Kaiser HMO - High Option** | Subscriber | $975.52 | $1,490.17 |
| | Subscriber + Spouse | $2,075.58 | $2,695.60 |
| | Subscriber + Child(ren) | $1,764.06 | $3,171.81 |
| | Subscriber + Family | $3,263.27 | $4,987.40 |
| **Kaiser HMO - Low Option** | Subscriber | $759.93 | $1,064.47 |
| *HSA Compatible Plan* | Subscriber + Spouse | $1,669.45 | $2,265.08 |
| | Subscriber + Child(ren) | $1,517.86 | $1,925.09 |
| | Subscriber + Family | $2,275.80 | $3,561.30 |
| **Kaiser HMO - Senior Advantage** | Subscriber (age 65+) | $255.00 | $272.00 |

### DENTAL

| | | |
|---|---|---|
| **PREMIER ACCESS RATES VALID 1/1/2024 - 12/31/2024** | | |
| **Premier Access Dental HMO** | Subscriber | $18.76 |
| | Subscriber + Spouse | $27.77 |
| | Subscriber + Child(ren) | $30.86 |
| | Subscriber + Family | $39.78 |
| **Premier Access Dental PPO** | Subscriber | $59.42 |
| | Subscriber + Spouse | $104.44 |
| | Subscriber + Child(ren) | $119.48 |
| | Subscriber + Family | $168.11 |

**PARTICIPATION RULES FOR LOCALS (except Local 47)**

-Each local will be a separate billing entity.
-Bills are due to French Cormany Insurance Services Inc. by the 15th of the month PRIOR to coverage period.
-In order to maintain group status, each local must collect premium from its enrolled members and submit one check to French Cormany Insurance Services Inc.

**PARTICIPATION RULES FOR MEMBERS (except Local 47)**

-Must be a member of the Local
-Must make initial premium payment for first and last month's premiums
-Must make subsequent monthly payments to the Local by the 1st of the month PRIOR to coverage month (i.e., March premiums are due by March 1st)
-Late payers will be terminated effective 1st of the month following late payment (no exceptions)
-Premium checks are payable to Local and sent to Local directly.
-Pre-existing Conditions are all covered.
-For dental enrollment, you must select either Premier Access Dental HMO or Premier Access Dental PPO. If Dental HMO is selected, enrollee must select a dental office. Dental providers can be found online at www.premierlife.com.

**HOW TO ENROLL FOR MEMBERS (except Local 47)**

Submit the following items:

1. Completed Enrollment Form(s)
2. Check payable to Local for first and last month's premium.

# LOCAL 47

## PARTICIPATION RULES FOR MEMBERS – LOCAL 47 ONLY

-Must be a member of the Local
-Must make initial premium payment for first and last month's premiums
-Must make subsequent monthly payments to French Cormany Insurance Services by the 15th of the month PRIOR to coverage month (i.e., March premiums are due by February 15th)
-Late payers will be terminated effective 1st of the month following late payment (no exceptions)
-Pre-existing Conditions are all covered.
-For dental enrollment, you must select either Premier Access Dental HMO or Premier Access Dental PPO. If Dental HMO is selected, enrollee must select a dental office. Dental providers can be found online at www.premierlife.com.

## HOW TO ENROLL FOR MEMBERS – LOCAL 47 ONLY

Submit the following items:

1. Completed Enrollment Form(s)
2. Check payable to French Cormany Insurance Services for first and last month's premium.

**For Local 47, all paperwork and payments can be mailed to:**

**French Cormany Insurance Services**
**Attn: Mark Cormany**
**1422 Edinger Ave #200**
**Tustin, CA 92780**


OREGON
Del Norte
Siskiyou
Modoc
KAISER
NORTH
SOUTH
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
NEVADA
Lake
Colusa
Sutter
Yuba
Nevada
Placer
Sonoma
Yolo
El Dorado
Napa
Sacramento
Amador
Alpine
Solano
Marin
Calaveras
San Francisco
Contra Costa
San Joaquin
Tuolumne
Mono
Alameda
San Mateo
Stanislaus
Mariposa
Santa Clara
Merced
Madera
Santa Cruz
San Benito
Fresno
Inyo
Tulare
Monterey
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Orange
Riverside
San Diego
Imperial
PACIFIC OCEAN
MEXICO

# KAISER HMO

| | Kaiser High Option | | Kaiser Low Option (HSA Compatible) | |
|---|---|---|---|---|
| **Monthly Premium effective 10/1/23** | Southern CA | Northern CA | Southern CA | Northern CA |
| **Subscriber** | **$975.52** | **$1,490.17** | **$759.93** | **$1,064.47** |
| **Subscriber + Spouse** | **$2,075.58** | **$2,695.60** | **$1,669.45** | **$2,265.08** |
| **Subscriber + Child(ren)** | **$1,764.06** | **$3,171.81** | **$1,517.86** | **$1,925.09** |
| **Subscriber + Family** | **$3,263.27** | **$4,987.40** | **$2,275.80** | **$3,561.30** |
| ***MEDICAL SERVICES*** | | | | |
| **Calendar Year Deductible** | | | | |
| ~ One Member | Not Applicable | | $2,000 | |
| ~ Two Members or more | Not Applicable | | $4,000 | |
| **Physician Services (Office Visits)** | | | | |
| ~ Office Visits | $40 Co-pay | | $30 after Deductible | |
| ~ Specialist Visits | $40 Co-pay | | $30 after Deductible | |
| ~ Physical & Occupational Therapy | $40 Co-pay | | $30 after Deductible | |
| ~ Lab & X-ray | $10 Co-pay | | $10 after Deductible | |
| **Maternity Care** | | | | |
| ~ Prenatal & Postnatal Care | $10 Co-pay | | No charge (Deductible doesn't apply) | |
| ~ Normal Delivery | $250 per admission | | $250 per admission after Deductible | |
| **Preventive Care** | | | | |
| ~ Well Women Exam | $40 Co-pay | | No charge (Deductible doesn't apply) | |
| ~ Well Baby Care | $10 Co-pay | | No charge (Deductible doesn't apply) | |
| ~ Periodic Health Exam | $40 Co-pay | | No charge (Deductible doesn't apply) | |
| **Hospital Services** | | | | |
| ~ Inpatient Care | $250 per admission | | $250 per admission after Deductible | |
| ~ Outpatient Care | $250 per procedure | | $150 per procedure after Deductible | |
| ~ Emergency Care | | | | |
| Ambulance | $150 Co-pay | | $100 per trip after Deductible | |
| ER | $150 Co-pay | | $100 per visit after Deductible | |
| If admitted | Waived | | Waived after Deductible is met | |
| **Psychiatric Services** | | | | |
| ~ Inpatient Care (30 days/yr max) | $250 per admission | | $250 per admission after Deductible | |
| ~ Outpatient Care - Crises Intervention | $40 Co-pay | | $30 after Deductible | |
| **Alcohol/Chemical Dependency** | | | | |
| ~ Inpatient Care ( Detox Only ) | $250 per admission | | $250 per admission after Deductible | |
| ~ Outpatient Care | $40 Co-pay | | $30 after Deductible | |
| **Prescription Drugs** | | | | |
| ~ Generic (Pharmacy up to 30 day supply) | $15 | | $10 after Deductible | |
| ~ Brand Name (Pharmacy up to 30 day supply) | $30 | | $30 after Deductible | |
| **Additional Benefits** | | | | |
| ~ Durable Medical Equipment | 50% Coinsurance | | 20% after Deductible | |
| **Out of Pocket Maximums (Includes Deductible)** | | | | |
| ~ One Member | $3,000 | | $3,000 | |
| ~ Two Members or more | $6,000 | | $6,000 | |
| **Preexisiting Conditions** | Covered | | Covered | |

*This is only a summary of benefits. Please consult contract for complete descriptions of benefits, exclusions, and participating requirements.*

Revised 6/12/2023

# California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

**TO BE COMPLETED BY EMPLOYER**

| Company name | | Hire date (mm/dd/yyyy) |
|---|---|---|
| Group number | Enrollment unit | Effective enrollment/ change date (mm/dd/yyyy) |

**A. ENROLLMENT/CHANGE REASON** *(see Change Table for assistance)* New group: ❑ Yes ❑ No

❑ New Hire *(complete sections A, B, C, D)* ❑ Open Enrollment *(complete sections A, B, C, D)*

Health Plan *(Check one)* ❑ HMO Plan ❑ Deductible Plan ❑ Other _____

❑ Loss of Other Coverage *(complete sections A, B, C, D)* ❑ Other *(please specify)* _____

❑ Name Change *(complete sections A, B, C, D)* From: _____ To: _____

Event Date (mm/dd/yyyy) _____

**B. EMPLOYEE** Have you ever been a Kaiser Permanente member? ❑ Yes ❑ No

Medical Record No. *(if known)* _____ Social Security No. _____

Name (Last, First, MI) _____ Birth Date (mm/dd/yyyy) _____ Gender ❑ M ❑ F

Home Address _____ City _____ State _____ ZIP _____

Work Phone _____ Home Phone _____ Email _____

Ethnicity _____ Preferred Language _____

**C. FAMILY** For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

| | |
|---|---|
| ❑ Add ❑ Delete ❑ Spouse ❑ Domestic partner Gender ❑ M ❑ F<br>Spouse/domestic partner name:<br>Former last name *(if any)*: | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F<br>Dependent name:<br>Relationship: | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F<br>Dependent name:<br>Relationship: | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F<br>Dependent name:<br>Relationship: | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |

Do any of dependents above live at another address? ❑ Yes ❑ No If yes, complete the following:

Name (Last, First, MI): Address:

**D. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement***

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage* and in the *Certificate of Insurance.*

**Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2) the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3) the KPIC Dental plans.*

_____ _____

Signature Required for all Kaiser Permanente Plans (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans) Date

KAISER PERMANENTE®

# KAISER HMO - Medicare

| | Kaiser HMO - Senior Advantage | |
|---|---|---|
| **Monthly Premium effective 10/1/23** | Southern CA | Northern CA |
| **Medicare (ages 65+)** | **$255.00** | **$272.00** |
| ***MEDICAL SERVICES*** | | |
| **Deductible** | | |
| ~ Calendar Year Deductible | Not Applicable | |
| **Physician Services (Office Visits)** | | |
| ~ Office Visits | $20 Co-pay | |
| ~ Specialist Visits | $20 Co-pay | |
| ~ Eye Exams for Refraction | $20 Co-pay | |
| ~ Hearing Exams | $20 Co-pay | |
| ~ Physical & Occupational Therapy | $20 Co-pay | |
| ~ Lab & X-ray | No Charge | |
| **Preventive Care** | | |
| ~ Annual Wellness Visit | No Charge | |
| **Hospital Services** | | |
| ~ Inpatient Care | No Charge | |
| ~ Outpatient Care | $20 Co-pay | |
| ~ Urgent Care | $20 Co-pay | |
| ~ Emergency Care | | |
| Ambulance | No Charge | |
| ER | $20 Co-pay | |
| If admitted | Waived | |
| **Psychiatric Services** | | |
| ~ Inpatient Care | No Charge | |
| ~ Outpatient Care - Crises Intervention | $20 Co-pay | |
| **Alcohol/Chemical Dependency** | | |
| ~ Inpatient Care ( Detox Only ) | No Charge | |
| ~ Outpatient Care | $20 Co-pay | |
| **Prescription Drugs** | | |
| ~ Formulary | $10 for up to 100 day supply | |
| **Additional Benefits** | | |
| ~ Durable Medical Equipment | No Charge | |
| ~ Eyewear purchased at Plan Medical Office | $150 allowance per 24 months | |
| **Out of Pocket Maximums** | | |
| ~ One Member | $1,500 | |
| ~ Two Members or more | $3,000 | |
| **Preexisiting Conditions** | Covered | |

*This is only a summary of benefits. Please consult contract for complete descriptions of benefits, exclusions, and participating requirements.*

Start here - Tear and separate pages along the perforated edge before completing

Kaiser Permanente Senior Advantage (HMO)

# GROUP ELECTION REQUEST FORM

KAISER PERMANENTE®

Northern California or Southern California Region

## IMPORTANT INFO – Read all pages before signing this form

Completing and returning this form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, you'll each need to complete a separate form. For help completing this form, call **1-800-443-0815**, toll free (TTY **711**), seven days a week, 8 a.m. to 8 p.m.

- You're entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this form signifies that you've read, understand, and agree to these provisions. Kaiser Permanente is a health plan with a Medicare contract.
- You must be enrolled in Medicare Part B, however some employer groups require both Parts A and B. To join a Kaiser Permanente Medicare Health Plan, you must reside in the Kaiser Permanente Senior Advantage service area in which you enroll. Please check your enrollment materials to be sure you qualify for enrollment.

### ABOUT THE ENROLLMENT PROCESS - Submitting your form

- **Begin by tearing along the perforated edge to separate the form pages before completing the form.**
- Fill out the form completely then mail the top, original signed form in the enclosed postage-paid envelope to:
  Kaiser Permanente – Medicare Unit
  P.O. Box 232400
  San Diego, CA 92193-2400
- Keep the bottom copy for your own records. If required, also send a copy to your employer group or union/trust fund.
- We'll review your form for completeness and required signatures and then contact you by mail that we have received it.
- We'll notify Medicare that you've applied to join Senior Advantage.
- Within 10 calendar days after Medicare confirms your eligibility, we'll confirm the effective date of your coverage. We'll send you a Kaiser Permanente ID card and information for new members.

Top white original signed copy – Kaiser Permanente
Yellow copy - Employer group/union/trust fund
Bottom white copy - Keep for your records

SKU 60093624 (09/2012)

**Employer Group Use Only**
**Optional Group Stamp Area:**

Employer Group #: _____ Employer Receipt Date: _____

Authorized Rep: _____

Please contact Kaiser Permanente if you need information in another language or format (Braille).

**To enroll in Kaiser Permanente Senior Advantage, please provide the following information:**

| | | | |
|---|---|---|---|
| Employer or Union Name | | | Group # |
| Last Name First Name Middle Initial | | | ☐ Mr. ☐ Mrs. ☐ Ms. |
| Birth Date (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) | Sex ☐ M ☐ F | Home Phone Number ( ) | Alternate Phone Number ( ) |
| Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No<br>If yes: ☐ Current ☐ Former<br>Kaiser Permanente Medical/Health Record Number _____ | | | |
| Permanent Residence Street Address (P.O. Box is not allowed) | | | |
| City | County | State | ZIP Code |
| **Mailing Address** (only if different from your Permanent Residence Address)<br>Street Address City State ZIP Code | | | |
| **E-mail Address** | | | |

**Please Provide Your Medicare Insurance Information**

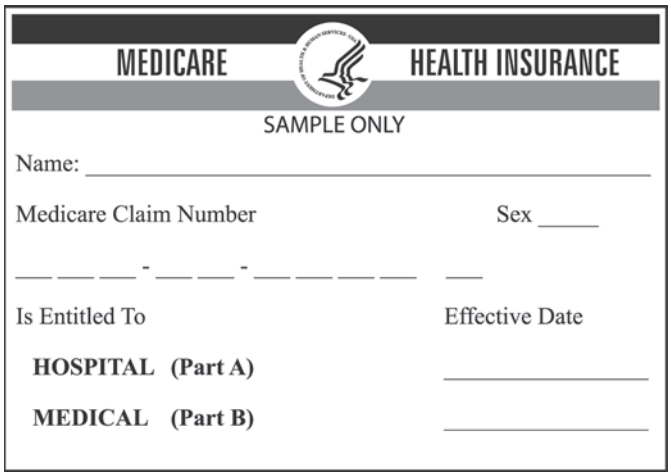
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part B, however some employer groups require both Parts A and B to join a Medicare Advantage plan.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex _____

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Last Name _____ First Name _____

**Please read and answer these important questions:**

1. Are you the retiree? ☐ Yes ☐ No
   If yes, retirement date (month/date/year) _____
   If no, name of retiree _____
2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse _____
   Name of dependents _____
3. Do you or your spouse work? ☐ Yes ☐ No
4. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to Kaiser Permanente? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage.
   Name of other coverage ID # for this coverage
   _____ _____
6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes", please provide the following information:
   Name of institution _____
   Address & phone number of institution (number and street) _____
7. Requested effective date (subject to CMS approval) _____/_____/_____

Please check one of the boxes below if you would prefer for us to send you information in a language other than English or in another format:

☐ Spanish

This information is available for free in other languages. Please contact Member Services at **1-800-443-0815** (TTY **711**) for additional information (seven days a week, 8 a.m. to 8 p.m.).

Se puede obtener esta información gratis en otros idiomas. Si desea información adicional, por favor llame a Servicios a los Miembros al **1-800-443-0815** (TTY **711**) (los siete días de la semana, de 8 a.m. a 8 p.m.).

Last Name _____ First Name _____

**Please complete the information below.**
If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name _____

Employer Group/Union/Trust Fund ID# _____ Subgroup _____

Requested effective date (subject to CMS approval) _____

## Please Read and Sign Below

**KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT**
**I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, claims that cannot be subject to binding arbitration under governing law), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.**

**By completing this enrollment application, I agree to the following:**
Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however some employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE** (**1-800-633-4227** or TTY **1-877-486-2048**), 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Senior Advantage plan.

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Senior Advantage Evidence of Coverage* document from Kaiser Permanente when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Last Name _____ First Name _____

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Kaiser Permanente and other services contained in my Senior Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES**.

If I am a Kaiser Permanente Medicare Cost member enrolling in Senior Advantage, I understand that the Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

**Signature** _____ **Today's Date** _____

If you are the authorized representative, you must sign above and provide the following information:

**Name** _____

**Address** _____

**Phone Number (_____) _____- _____**

**Relationship to Enrollee** _____

**Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment) _____

Plan ID # _____ Effective Date of Coverage _____

ICEP/IEP _____ AEP _____ SEP (type) _____ Not Eligible _____

# PREMIER ACCESS DENTAL

| | Dental HMO | Dental PPO | |
|---|---|---|---|
| **Plan Name** | Plan 500 | PPO Plus Plan 6 Enhanced | |
| **Annual Maximum** | None | $1,500 | $1,500 |
| **Deductible** | None | $50 / 3x family | $50 / 3x family |
| **Waiting Period for Services** | None | None | None |
| **Out of Network Payment** | Not Covered | Fee Schedule | |
| | **IN NETWORK** | **IN NETWORK** | **OUT OF NETWORK** |
| **Preventive** | | | |
| 210: X-rays, full mouth | No Charge | No Charge | No Charge |
| 1110: Teeth Cleaning | No Charge | No Charge | No Charge |
| 1203: Topical Fluoride (child) | No Charge | No Charge | No Charge |
| **Restorative** | | | |
| 2140: Amalgam filling - one tooth | No Charge | You pay 20% | You pay 20% |
| 2330: Resin based filling | No Charge | You pay 20% | You pay 20% |
| **Endodontics** | | | |
| 3310: Root canal - anterior | $55 | You pay 20% | You pay 20% |
| 3320: Root canal - bicuspid | $120 | You pay 20% | You pay 20% |
| 3330: Root canal - molar | $250 | You pay 20% | You pay 20% |
| **Oral Surgery** | | | |
| 7111: Extraction - coronal remnants | No Charge | You pay 20% | You pay 20% |
| 7210: Surgical removal of erupted tooth | $25 | You pay 20% | You pay 20% |
| 7240: Removal of impacted tooth | $90 | You pay 20% | You pay 20% |
| **Major** | | | |
| 2750: Crown procelin + precious metal | $165 | You pay 50% | You pay 50% |
| 2790: Crown full cast precious metal | $165 | You pay 50% | You pay 50% |
| 5110: Complete Denture (Lower or Upper) | $140 | You pay 50% | You pay 50% |
| 6000: Implants | Not Covered | You pay 50% | You pay 50% |
| **Orthodontia** | | | |
| 8080: Comprehensive Ortho Child (to age 19) | $1,975 | You pay 50% | You pay 50% |
| 8090: Comprehensive Ortho Adult | $2,175 | Not Covered | Not Covered |
| **MONTHLY RATES** **Rates valid 1/1/2024 - 12/31/2024** | | | |
| Employee Only | $18.76 | $59.42 | |
| Employee + Spouse | $27.77 | $104.44 | |
| Employee + Child(ren) | $30.86 | $119.48 | |
| Family | $39.78 | $168.11 | |

*This is only a summary of benefits. Please consult contract for complete descriptions of benefits, exclusions, and participating requirements.*

**Premier Access Provider Search**:

Go to: https://www.premierlife.com

Click on the green "Find a Dentist" icon at the top right of the page.

Click on the grey "Advanced Search" tab to specify various options such as Provider Name, Zip Code, etc.

FOR DENTAL HMO: Under "Select a Plan" choose "Dental HMO" under the drop down list for Commercial Plans

FOR DENTAL PPO: Under "Select a Plan" choose "Dental PPO" under the drop down list for Commercial Plans; the Network is "PCN & PPO"

Click on "Search" to get your results

PREMIER ACCESS
Dental and Vision

# EMPLOYEE ENROLLMENT/CHANGE FORM

**Use this form for a new enrollment or a change to an existing enrollment. Please complete in blue or black ink.**
**Mail to: Premier Access Membership Accounting, P.O. Box 659020, Sacramento, CA 95865-9020 or fax to: 877.648.7748**

Group Number:_____ Coverage Type: ❑ PPO ❑ DHMO

Effective Date of Enrollment/Change:_____

**Reason for Enrollment Form**

❑ New Enrollment/New Hire
- ❑ Qualifying Event *(Attach supporting documentation)*
- ❑ Late Enrollee *(Subject to Late Enrollee Waiting Period)*

❑ Add Dependent (including spouse and registered domestic partner)
Qualifying Event: _____
Date of Qualifying Event: _____

❑ Change of Address
❑ Terminate Dental Coverage, Subscriber & Dependent(s)
❑ Terminate Dental Coverage, Dependent(s) Only
❑ Change in Other Dental Insurance *(Please see reverse side)*
❑ Other (*Specify:* _____)

**Subscriber (Employee) Information**

Social Security Number: _____ Date of Hire: _____
Last Name: _____ First Name: _____ MI: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ E-mail Address: _____
Date of Birth: _____ Sex: ❑ M ❑ F Married? ❑ Yes ❑ No Children? ❑ Yes ❑ No
Employer (Company) Name: _____
Job Title: _____ Division/Class: _____ Hours Worked Per Week: _____
Preferred Spoken Language: _____ Preferred Written Language: _____
Ethnicity (optional): _____ Race (optional): _____

*Managed Care Only: Please select a Primary Care Dentist (PCD) from the provider directory for yourself and each of your family members. Fill in the Provider ID number and Office ID number in the appropriate areas. If a selection is not made, a PCD will be assigned for you.*

Primary Care Dentist No. _____ Primary Care Dentist Office No. _____

**Dependent Information**

*New Enrollment/New Hire:* Complete this section for all dependents you are choosing to enroll.
*Add Dependent:* Complete this section only for the dependents you are adding to your existing enrollment.
*Terminate Dependent Coverage Only:* Complete this section only for dependent(s) you are choosing to terminate.

| Relation to Subscriber | Last Name | First Name & MI | Date of Birth** | Sex (M/F) | Primary Care Dentist Office ID # | Primary Care Dentist ID # |
|---|---|---|---|---|---|---|
| **Spouse/ or Reg. Domestic Partner** | | | | | | |
| **Child** | | | | | | |
| **Child** | | | | | | |
| **Child** | | | | | | |
| **Child** | | | | | | |
| **Child** | | | | | | |

** Dependent child eligibility requirements are defined by the Employer Group Policy. Supporting documentation of dependent eligible status must be submitted with this form for dependent children age 19 or over for the enrollment to be processed and claims paid.

*To the best of my knowledge or belief, I have answered truthfully and completely the information requested on this application, including the information on the back of this application. I understand that Premier Access Insurance Company reserves the right to rescind or terminate coverage if any material misrepresentation is made in this enrollment application. I have read and agree to the notice on the back of this form.*

**MANDATORY BINDING ARBITRATION:** Premier Access Insurance Company uses binding arbitration to settle disputes, including to settle claims of dental malpractice. The insured understands and agrees that if a dispute arises in connection with this policy, the parties waive the right to a jury trial and must settle the dispute through binding arbitration. The Premier Certificate of Insurance contains a provision that further addresses this issue Premier Access Insurance Company does not use binding arbitration in connection with any dispute that an insured's life insurance coverage.

**Employee Signature:** _____ **Date:** _____

# EMPLOYEE ENROLLMENT/CHANGE FORM

**Other Dental Coverage**

Do you or your dependents have other dental coverage? ❑ Yes ❑ No *(If yes, complete the information below.)*

**Other Dental Coverage Information**

Name of Insured: _____ Social Security Number: _____

Insured's Employer: _____ Name of Insurance Carrier: _____

Employer's Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Are your dependent children enrolled under your spouse's (or registered domestic partner) dental plan? ❑ Yes ❑ No

**CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE. THEREFORE, PREMIER ACCESS INSURANCE COMPANY WILL NOT REQUIRE THAT AN HIV TEST BE REQUIRED AS A CONDITION OF OBTAINING COVERAGE. IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFETY CODE SECTION 120980, PREMIER ACCESS INSURANCE COMPANY COMPLIES IN ALL RESPECTS WITH THE PROHIBITION AGAINST THE UNAUTHORIZED DISCLOSURES OF AN HIV TEST.**

I, on my behalf and on behalf of my dependent(s) on this enrollment application, hereby (1) request coverage for the group insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance, or agree that the contributions be added to my dues; (3) state that I became a full-time employee on the date stated on the reverse, and do currently work the number of hours per week stated on the reverse, (4) agree to be bound by benefits, copayments, deductibles, exclusions, limitations, and other terms and conditions of the Premier* Certificate of Insurance, (5) agree that if I or my dependents receive dental services after my coverage is terminated or lapses, that I am responsible to reimburse Premier for any unrecovered payments made by Premier for such services, and (6) understand that verification of eligibility by Premier does not guarantee payment of claims and that retroactive eligibility changes supercede verifications of eligibility.

**DENTAL RELEASE:** I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby authorize Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. If you request, Premier will provide a copy to you of any information it discloses to third parties regarding your dental information. This Dental Release authorization shall remain in effect thirty months from the date the application is signed. This Dental Release authorization solely provides authorization of Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. The dental information is being collected by Premier solely for the specific purpose of premium underwriting..

**RIGHT OF REIMBURSEMENT:** I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage , I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided

**NOTICE:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.