District Council 16 Health and Welfare
Enrollment Booklet

DISTRICT COUNCIL 16 NORTHERN CALIFORNIA HEALTH AND WELFARE PLAN
1640 South Loop Road * Alameda, CA 94502
Mailing Address: P.O. Box 24454, Oakland CA 94623
PHONE NUMBER: (510) 864-6444 * TOLL FREE: (800) 922-9902 * FAX: (510) 337-3080

ENROLLMENT INSTRUCTIONS

PLEASE READ THESE INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE ATTACHED ENROLLMENT FORMS. In order to enroll yourself and your eligible dependents into the District Council 16 Northern California Health & Welfare Plan, you must complete all of the required Enrollment Forms which are attached hereto. Be sure to completely and accurately provide all of the required information requested on the Enrollment Forms.

Use the enclosed envelope to mail this completed booklet to the Fund Office. The address for the Fund Office is: District Council 16 Health and Welfare Trust Fund PO Box 24454 Oakland CA, 94623. Contact the Fund Office at (510) 864-6444 if you have questions. You may also make a copy of this booklet for your records. The Trust Fund Office is required to safeguard the privacy of all participants' individually identifiable health information as required by federal regulations. The Union and Employers cannot access member's individual health information.

TO ADD OR CHANGE A DEPENDENT, THE FOLLOWING DOCUMENTS ARE REQUIRED AND MUST BE SUBMITTED WITH YOUR ENROLLMENT FORMS:

- COPIES OF MARRIAGE CERTIFICATE OR DIVORCE PAPERS
- CERTIFICATE OF DOMESTIC PARTNERSHIP ISSUED BY GOVERNMENTAL AGENCY & DOMESTIC PARTNERSHIP AFFIDAVIT
- COPIES OF BIRTH CERTIFICATES FOR DEPENDENT CHILDREN
- FOSTER & ADOPTED CHILDREN: LEGAL GUARDIANSHIP OR COURT ADOPTION PAPERS

DEPENDENT ELIGIBILITY AND ENROLLMENT – WHO IS ELIGIBLE:
If YOU qualify for benefits, the following dependents may also be covered:

- **Your Legal spouse or registered domestic partner**
- **Children who are less than 26 years of age:**
  - Natural children
  - Step-children who reside with you and are dependent on you for support
  - Legally adopted children
  - Children for whom you have been legally appointed guardian

Please refer to the SPD for further dependant eligibility qualifications and rules.

Trust Fund Website: For additional information please visit https://www.dc16trustfund.org where you will find access to all of your Health and Welfare Plan documents including the Summary Plan Description, forms and news. Enrollment Forms are also provided electronically on our website for your convenience. We have created an electronic working draft of the SPD that is regularly revised to keep you up to date with the latest changes to the Plan. On the home screen under "Useful Links" you will also find direct links to your personnel provider websites such as: Kaiser, Anthem Blue Cross, & Delta Dental.

OFFICE USE ONLY
DATE PROCESSED: _____
PROCESSOR: _____

☐ NEW MEMBER ☐ OPEN ENROLLMENT CHANGE OF: ☐NAME ☐MARITAL STATUS ☐PLAN ☐BENEFICIARY ☐DEPENDENTS ☐BIRTH ☐ MARRIAGE ☐ DIVORCE ☐OTHER EVENT DATE: _____

PARTICIPANT DATA

LAST NAME	FIRST NAME	MI	DATE OF BIRTH / /
ADDRESS	CITY / STATE / ZIP / SEX		SOCIAL SECURITY # - -
EMAIL ADDRESS	TELEPHONE # ( )	KIDNEY TRANSPLANT ☐ OR/ DIALYSIS ☐	RECEIVING MEDICARE PART A ☐ PART B ☐
MARITAL STATUS ☐ SINGLE ☐MARRIED ☐DIVORCED ☐DOMESTIC PARTNER	DATE OF MARRIAGE or DIVORCE / /	**EMPLOYER/LOCAL#**	DATE OF HIRE / /

STATUS:

- ☐ ACTIVE
- ☐ RETIREE WITH MEDICARE
- ☐ RETIREE WITHOUT MEDICARE

CHOICE OF PLANS:
MEDICAL PLAN SELECTION – CHOOSE ONE:

- ☐ BLUE CROSS NETWORK (PPO)
- ☐ *BLUE CROSS NETWORK/SMART CHOICES (APPO)
- ☐ KAISER (DHMO)
- ☐ *KAISER/SMART CHOICES (HMO)

CHOICE OF PLANS:
DENTAL PLAN SELECTION – CHOOSE ONE:

- ☐ DELTA DENTAL #0308
- ☐ DELTACARE #6123
- ☐ UNITED HEALTHCARE/PUD #712019

If you choose to opt out of the dental plan and/or vision plan benefits, there is no incentive, reward, or financial gain provided to you or your dependents.

OPT OUT OF DENTAL ☐ AND OR VISION ☐

*ADDITIONAL STEPS ARE REQUIRED TO ENROLL INTO THE SMART CHOICES PROGRAM; See "Smart Choices/Healthy Rewards Enrollment Instructions for Members and Spouses" starting on page 4. FAILURE TO COMPLETE ALL SMART CHOICES ENROLLMENT REQUIREMENTS WILL RESULT IN BEING ENROLLED IN THE CORRESPONDING "BLUE CROSS NETWORK (PPO)" OR "KAISER (HMO)".

IF YOU SELECT THE KAISER PLAN AND HAVE PREVIOUSLY BEEN COVERED BY KAISER PERMANENTE, PLEASE PROVIDE YOUR ORIGINAL KAISER MEDICAL RECORD NUMBER:

#_____

DEPENDENT DATA

YOU MUST COMPLETE IF YOU OR YOUR SPOUSE ARE RECEIVING MEDICARE OR YOU CHECKED YES TO KIDNEY TRANSPLANT OR DIALYSIS

FULL NAME	RELATION	SEX	DATE OF BIRTH	SOCIAL SECURITY#	RECEIVING MEDICARE PART A OR B	KIDNEY TRANSPLANT OR DIALYSIS
SPOUSE OR DOMESTIC PARTNER: (Attach copy of MC or DP Certificate)						
DEPENDENT: (Attach copy of Birth Certificate)						
DEPENDENT: (Attach copy of Birth Certificate)						
DEPENDENT: (Attach copy of Birth Certificate)						
DEPENDENT: (Attach copy of Birth Certificate)						
DEPENDENT: (Attach copy of Birth Certificate)						

PERSONAL & DEPENDENT DATA CONTINUED

COMPLETE THE SECTION BELOW AND ENCLOSE A COPY OF THE MEDICARE CARD IF YOU OR A DEPENDENT ARE ENROLLED IN MEDICARE:		
PLEASE LIST THE INDIVIDUAL RECEIVING MEDICARE: _____	RECEIVING PART A: YES ☐ NO ☐ RECEIVING PART B: YES ☐ NO ☐	EFFECTIVE DATE A: _____ EFFECTIVE DATE B: _____
PLEASE LIST THE INDIVIDUAL RECEIVING MEDICARE: _____	RECEIVING PART A: YES ☐ NO ☐ RECEIVING PART B: YES ☐ NO ☐	EFFECTIVE DATE A: _____ EFFECTIVE DATE B: _____
PLEASE LIST THE INDIVIDUAL RECEIVING DIALYSIS: _____	RECIVED KIDNEY TRANSPLANT: YES ☐ NO ☐ RECEIVING DIALYSIS: YES ☐ NO ☐	DATE OF TRANSPLANT: _____ DATE OF FIRST TREATMENT: _____

ADDITIONAL ADDRESS & INSURANCE INFORMATION

PLEASE LIST ANY DEPENDENT WITH AN ADDRESS DIFFERENT THAN THE MEMBERS ADDRESS:

DEPENDENT: _____ ADDRESS: _____CITY:_____ST:_____ZIP:_____

DEPENDENT: _____ ADDRESS: _____CITY:_____ST:_____ZIP:_____

PLEASE LIST ANY DEPENDENT WHO IS ENTITLED TO BENEFITS FROM ANOTHER GROUP HEALTH CARE, INSURANCE, OR PRE-PAID MEDICAL PLAN:

DEPENDENT: _____ ADDRESS: _____CITY:_____ST:_____ZIP:_____

DEPENDENT: _____ ADDRESS: _____CITY:_____ST:_____ZIP:_____

Kaiser Permanente Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Kaiser Permanente 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, 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 my 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.

Name: _____ Signature: _____ Date: _____

YOU MUST SIGN IN ORDER TO PROCESS YOUR "KAISER" ENROLLMENT SELECTION. FAILURE TO SIGN ABOVE WILL RESULT IN BEING ENROLLED IN THE "BLUE CROSS NETWORK (PPO)"

BENEFICIARY OF DEATH BENEFIT

BENEFICIARYS FULL NAME & ADDRESS	SOCIAL SECURITY #:	DATE OF BIRTH	%:
BENEFICIARYS FULL NAME & ADDRESS	SOCIAL SECURITY #:	DATE OF BIRTH	%:
BENEFICIARYS FULL NAME & ADDRESS	SOCIAL SECURITY #:	DATE OF BIRTH	%:

YOUR FULL NAME: _____ **SIGNATURE:** _____ **DATE:** _____

YOU MUST SIGN IN ORDER TO PROCESS YOUR ENROLLMENT APPLICATION.

DC 16 Smart Choices HEALTHY REWARDS

Smart Choices/Healthy Rewards Enrollment Instructions for Members and Spouses

We Want Everyone to Have a Chance to Make the SMART CHOICE!

The Trustees are pleased to offer continuing enrollment in the Smart Choices/Healthy Rewards Program. If you are just now enrolling for benefits for the first time or if you have not changed your medical plan selection in the last 12 months, you are eligible to enroll in the Smart Choices/Healthy Rewards Program. By enrolling, you can avoid the $1,000 deductible and begin receiving Healthy Rewards. This generally takes place the first of the month following the month in which you complete the Smart Choices/Healthy Rewards enrollment process.

The Smart Choices/Healthy Rewards Program is designed to deliver high quality health care to Participants while reducing the overall costs that all Participants share. An important part of this Program includes making the Smart Choices Promise, which requires Participants and spouses/domestic partners to commit to taking simple steps in order to be eligible for Healthy Rewards. Healthy Rewards include doubling your Cash Bank to cover up to six months worth of eligibility and funding a personal medical expense debit card that you can use to pay some of your out-of-pocket medical expenses that are not paid by your insurance.

What are my HEALTHY REWARDS?

By enrolling in the Smart Choices/Healthy Rewards Program and completing the requirements of the Smart Choices Promise, you will begin receiving Healthy Rewards:

- You avoid the $1,000 deductible in the Blue Cross Network (PPO) and the Kaiser (HMO).
- You will be eligible to earn up to an additional 3 months (six months total) worth of eligibility in your Cash Bank.
- After reaching your maximum Cash Bank, you will begin receiving 20% of your Health & Welfare contributions that are in excess of 130 hours per month which will accrue to your personal Health Reimbursement Arrangement (HRA) debit card. You can use your HRA debit card funds to pay for eligible health care expenses.

What is my SMART CHOICE Promise?

If you elect the Blue Cross Network/Smart Choices (APPO)…

You and all your covered family members agree to use the Anthem Blue Cross Advantage APPO Providers, otherwise non-PPO Provider coverage shall apply.

Note: **Most Sutter-affiliated providers are not part of the Advantage PPO network.** Visit www.anthem.com/ca to see if your provider participates in the APPO network, or call the Fund Office. You can also request an exemption from the Fund Office if you live more than 30 miles from an APPO facility. The Smart Choices **(APPO)** network is significantly different than the non-Smart Choices (PPO) network.
You agree to call Care Counseling before you receive outpatient care. Call Care Counselors and the Nurse Line at 1-855-754-7271.

You agree to remain in the Smart Choices Program for at least twelve months. If you opt out of the Smart Choices Program at any time you immediately lose all accumulated Healthy Rewards.

If you elect the Kaiser/Smart Choices (HMO)…

If you elect the Kaiser/Smart Choices (HMO) Plan the Co Pay is $20.00, if you choose NOT to participate and enroll into the Kaiser (DHMO) Plan the Co Pay is $30.00.

You agree to remain in the Smart Choices Program for at least twelve months. If you opt out of the Smart Choices Program at any time you immediately lose all accumulated Healthy Rewards.

If I elect the Smart Choices Program, what am I agreeing to do?

Participants agree to:

- Get a free biometric health screening.
- Keep your contact information up to date.
- Provide an email address or cell phone number as a supplemental way for the Fund to contact you with general information about the Smart Choices/Healthy Rewards and other Trust Fund programs.
- Provide the name and contact information for your primary care doctor where indicated on the Smart Choices Promise and Election Form for Members and Spouses.

Make the SMART CHOICES Promise today!

- Carefully read and follow these Smart Choices/Healthy Rewards Enrollment Instructions for Members and Spouses.
- Complete the enclosed Smart Choices Promise and Election Form for Members and Spouses and mail it to the Fund Office.
- Complete your free biometric screening. Refer to the instructions below for details.
- Start enjoying Healthy Rewards the month after you have completed all the Smart Choices enrollment requirements.
- Please contact the Fund Office at (510) 864-6444 if you have any questions.

Instructions on how to enroll in the SMART CHOICES/HEALTHY REWARDS Program.

Step 1: Complete the attached SMART CHOICES Promise and Election Form for Members and Spouses and mail it to the Fund Office. Note: that your spouse/domestic partner must also complete and sign the Promise and Election form.
Step 2: Get a free biometric health screening. As part of the SMART CHOICES Promise, you (and your covered spouse/domestic partner) must complete the required free biometric health screening. The requirement to complete a biometric health screening does not apply to your children.

Here's what to do for Step 2 if you elect the BLUE CROSS NETWORK/SMART CHOICES (APPO):

You can get your biometric health screening through Quest Diagnostics® Patient Service Center (PSC) or through your doctor. To schedule a Blueprint for Wellness® biometric health screening with Quest Diagnostics, call (866) 908-9440 or go online at My.BlueprintForWellness.com. Note: When you go online to the Quest Diagnostics Blueprint for Wellness scheduling tool, you will need to enter the registration key: DC16. Your Unique ID # is your last name plus the last four digits of your Social Security Number (for example, johnson1234). Your spouse's/domestic partner's Unique ID is your last name + last four digits of your Social Security Number + an "S" (for example, johnson1234S). ***When you go to your doctor for your screening**, be sure to bring the Physician Result Form *(included with this packet on page 9)* with you. Your doctor will need to fill it out and send it to Quest Diagnostics.

Here's what to do for Step 2 if you elect the KAISER/SMART CHOICES (HMO):

You can get your biometric health screening through Kaiser On-the-Job® Center (also called Occupational Health Centers). To schedule a screening with your doctor, call Kaiser at (888) KOJ-WORK (888) 565-9675. Be sure to bring the Kaiser Proof of Biometric Screening Form *(included with this packet on page 7-8)* with you. You will need to send it to the Trust Fund with your completed Enrollment Forms. If you already had your annual screenings please send in verification with your enrollment form.

Your personal health information will not be shared with the Trust Fund, Trustees, Union or your Employer—only the fact that you (and your covered spouse/domestic partner) completed a screening will be communicated to the Fund Office.

SMART CHOICES Promise:

To participate in the SMART CHOICES/HEALTHY REWARDS Program, you and your covered spouse or domestic partner promise to take the following actions:

1. I/we shall complete a biometric health screening. In doing so, I/we authorize the Trust Fund to receive notification that I/we completed the screening; no individual results will be provided to the Trust Fund.
2. I/we shall provide complete contact information as requested on this form and also agree to keep my/our contact information up to date with the Trust Fund Office by calling (510) 864-6444. I/we hereby authorize the Trust Fund to communicate general information about Smart Choices/Healthy Rewards and other Trust Fund programs via my/our mobile phone number or email address provided on this form.
3. I/we shall provide my/our primary doctor's complete contact information as requested below.
4. I agree to remain in the Smart Choices Plan for at least 12 months and through any subsequent plan year end.

Complete the following steps to be eligible for the Smart Choices/Healthy Rewards Plan:

- Complete your biometric health screening.
- Return all completed & signed Forms to the Fund Office.

DISTRICT COUNCIL 16 NORTHERN CALIFORNIA HEALTH AND WELFARE PLAN

Smart Choices Promise and Election Form for Members and Spouses

If you complete all requirements, you will be enrolled in the Smart Choices/Healthy Rewards Program effective the first of the month after the month in which you complete all enrollment requirements. If you fail to complete all the enrollment requirements for the Smart Choices Healthy Rewards Program, you will automatically be enrolled in the corresponding non-Smart Choice Medical Plan, both of which include a $1,000 deductible.

Authorization: (check box below to agree to the terms, and complete each of the required fields and sign below)

- ❑ Yes, I agree to the terms of the Smart Choices Promise and understand that I only become eligible to receive Healthy Rewards (additional cash bank accumulation and contributions to an HRA) when I complete all Smart Choices enrollment requirements.

By signing below, I/we agree to complete the Smart Choices Promise. **Note: BOTH you and your spouse/domestic partner must complete & sign this form; otherwise, you will not be enrolled.**

MEMBER INFORMATION

LAST NAME	FIRST NAME	MI
EMAIL ADDRESS	CELL PHONE # ( )	
DOCTORS NAME	DOCTORS ADDRESS	
DOCTORS CITY/ST/ZIP	DOCTORS PHONE ( )	

MEMBERS FULL NAME: _____ **SIGNATURE:** _____ **DATE:** _____

YOU MUST COMPLETE THE ABOVE INFORMATION & SIGN IN ORDER TO PROCESS YOUR SMART CHOICES ENROLLMENT APPLICATION.

SPOUSE/ DOMESTIC PARTNER INFORMATION

LAST NAME	FIRST NAME	MI
EMAIL ADDRESS	CELL PHONE # ( )	
DOCTORS NAME	DOCTORS ADDRESS	
DOCTORS CITY/ST/ZIP	DOCTORS PHONE ( )	

SPOUSE'S FULL NAME: _____ **SIGNATURE:** _____ **DATE:** _____

YOU MUST COMPLETE THE ABOVE INFORMATION & SIGN IN ORDER TO PROCESS YOUR SMART CHOICES ENROLLMENT APPLICATION.

Dear District Council 16 Active Hourly Participants:

KAISER PERMANENTE®

In order to qualify for THE KAISER Smart Choices/Healthy Rewards program, you must submit proof that you have received your biometric screening tests.

Both you and your spouse are required to sign and date and also have your provider sign and date this form and return a copy of the completed document to The Trust Fund Office with your Enrollment Forms.

PLEASE NOTE: In order to ensure the accuracy of your fasting glucose and fasting lipid tests DO NOT consume any food or liquids other than water for at least 10-12 hours prior to when blood is drawn.

I authorize the provider performing biometric screening tests described above to disclose to the Trust Fund and to KFHP, Inc. Account Management staff my name, social security, and the Biometric Screening Confirmation Form. I understand that KFHP, Inc. Account Management staff will gather and send aggregate information to the Trust Fund confirming that I have satisfied the eligibility requirements for the Trust Fund's Wellness Incentive Program by completing the biometric screening tests. I understand that neither the Trust Fund, KFHP Inc. nor any treating provider will condition treatment, payment, enrollment, or eligibility for benefits on providing or refusing to provide this authorization.

I am over 18, and I am authorized to sign this release and consent on behalf of myself:

MEMBER FULL NAME	**SSN** - -	**KAISER MEDICAL RECORD #**
ADDRESS		**PHONE NUMBER**
SIGNATURE		**DATE**

SPOUSE FULL NAME	**SSN** - -	**KAISER MEDICAL RECORD #**
ADDRESS		**PHONE NUMBER**
SIGNATURE		**DATE**

This authorization is effective immediately and remains effective until January 1, 2020. I understand that I may revoke this authorization in writing at any time. My written revocation is effective upon receipt, except to the extent that the disclosing party or others have relied on this authorization in taking any actions. I understand that by signing this authorization, the disclosed information is no longer subject to the HIPAA privacy rules and that information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal privacy law.

DC 16 Smart Choices HEALTHY REWARDS

Dear TPMG/SCPMG Provider:

Your patient is required to complete certain biometric screening tests in order to participate in a Wellness Incentive Program offered by his or her group health plan. **Please complete Section 2 below by filling in the date that the following tests were administered.**

1. Fasting Lipid Panel (Total Cholesterol, Triglycerides, HDL and LDL-Cholesterol) and Fasting Glucose test
2. Body Mass Index, and Blood Pressure Screening

Authorization for Use and Disclosure of Protected Health Information with KFHP, Inc. Account Management Staff: (KP # 602697)

Section 2: TO BE COMPLETED BY A PERMANENTE MEDICAL GROUP OR KOJ PROVIDER

Patient(s) have completed:

(1) A Lipid profile (Total Cholesterol, Triglycerides, HDL, and LDL-Cholesterol)	MEMBER_____ SPOUSE_____
(2) Fasting Blood Glucose	MEMBER _____ SPOUSE_____
(3) Body Mass Index	MEMBER _____ SPOUSE_____
(4) Blood Pressure Screening	MEMBER _____ SPOUSE_____

TPMG/SCPMG Provider Name: _____

Location: _____

Provider Signature: _____ Date: _____

Blueprint for Wellness®

Quest Diagnostics

Physician Results Form

Completed form must be faxed to 855-794-1391

Patient's Employer Wellness Program Information	
Account District Council No. 16 N. California	**QLS Number (provided by Quest)** 97561320

Wellness Participant Completes		
Wellness Participant Name (Last, First, Middle Initial)	**Email Address**	
Employee SSN + E / Spouse: Employee SSN + S	**Date of Birth (MM/DD/YYYY)**	**Phone**
Address		
City	**State**	**Zip Code**
Wellness Participant Signature		**Date**

The information provided on this form will be kept confidential.

Physician Office Completes					
Date of Test (Required)	**Testing and measurements must have been completed between these dates:**				
Biometric Screening Measurement	**Screening Values** Enter NG for any result not available for reporting.				
Height (feet)		**Height (inches)**		**Weight (lbs)**	
	Systolic	**Diastolic**			
Glucose mg/dL			**Total Cholesterol mg/dL**		
Triglycerides mg/dL			**LDL Cholesterol mg/dL**		
HDL Cholesterol mg/dL					
Tobacco Status (Required)	☐ **Tobacco User**	☐ **Tobacco Free**	Please mark the box "Tobacco User" if the individual reports when asked that they currently use tobacco in any amount. Examples of tobacco include: Cigarettes, cigars, chewing, pipe, etc.		

Physician Office – Below Information Must Be Complete to Process		
Physician or Physician Designee's Signature		**Date**
Physician's Name (please print)	**UPIN/NPI**	**Phone Number**

Wellness Participant Information:

- Physician Results Form option is available for those participants who cannot participate at an on-site event or Patient Service Center. By submitting this form, you are requesting your physician to report laboratory and biometric results to Quest Diagnostics for your Health Risk Screening.
- You are responsible for ensuring your doctor returns this form by the deadline. Your results will not be processed if your form is received after
- For an individual participant only **one** physician form can be submitted.
- Physician results **cannot** be combined with or used to override any actual measured results by Quest Diagnostics.

For questions please contact the Blueprint for Wellness Customer Support Center by email at Wellness@QuestDiagnostics.com or by calling 866-908-9440 available (Monday – Friday 7 a.m. – 8:30 p.m. CST and Saturday 7:30 a.m. – 4 p.m. CST).