

California Employers Alliance

Benefit Plans

Offered through the
United Industrial, Services Workers of America
Health & Welfare Trust

LOCAL 47

ABOUT CEA

The California Employers Alliance (CEA) was created by the United Industrial, Services Workers of America, NFIU, LIUNA, and AFL-CIO to allow the smaller employer to join the Union's Health & Welfare Trust and to take advantage of large group, fully insured health plans.

There are no additional fees to join. Premiums are composite rated so they are easy to understand. Monthly billing is provided by Musicians Benefit Administrators, a Third Party Administrator.

Trust participation does not provide the enrollees with representation by the Union. Also, the Union will not have access to the enrollment information of the local or the enrollees.

With the continuous premium increases seen in the small group market, the CEA is providing a viable option for California's small employers.

PARTICIPATION RULES FOR MEMBERS

- Must be a member of the Local
- Must make initial premium payment for first and next month's premiums
- Must make subsequent monthly payments to Musicians Benefit Administrators 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)
- Pre-existing Conditions:
 - Kaiser HMO – all conditions are covered from the 1st day of coverage

HOW TO ENROLL FOR MEMBERS

Submit the following items:

1. Signed CEA Participation Joiner Agreement
2. Completed Enrollment Form
3. Check payable to Musicians Benefit Administrators for first and next month's premium.

All paperwork and payments can be mailed to:

Musician Benefit Administrators
Attn: Mark Cormany
20 Corporate Park, Suite 110
Irvine, CA 92606

CALIFORNIA EMPLOYERS ALLIANCE

UISWA WELFARE BENEFITS TRUST FUND

And

BARGAINING UNIT AGENCY PARTICIPATION IN UISWA

PARTICIPANT JOINER AGREEMENT

PARTICIPANT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE _____ FAX _____ Email _____

CITY, STATE, ZIP CODE _____

SINGLE _____ MARRIED _____ JOB TITLE _____ PLAN SPONSOR _____

I am applying for participation in the UISWA Welfare Benefits Trust Fund. I understand that participation in the Welfare Benefits Trust Fund requires membership in the UISWA established by an agreement between my Plan Sponsor and the UISWA.

I hereby give my Plan Sponsor authorization to deduct from my wages and transmit to UISWA, such amount as may be lawful and properly adopted in the current agreement as the agency fees. This authorization shall be irrevocable for the period of one year following the date it is signed or until the current agreement expires between the U.I.S.W.A. Trust and the C.E.A., whichever occurs first. This authorization shall automatically renew from year to year. If I cancel my participation in the Trust benefit offering, this authorization will also be considered as terminated.

PARTICIPANT: _____ DATE: _____

CEA/UISWA REPRESENTATIVE: _____ DATE: _____



KAISER Rates - Local 47 for 10/1/08 only

	Kaiser HMO	
2008 Monthly Premium	Southern CA	Northern CA
Subscriber	\$402.00	\$452.00
Subscriber + Spouse	\$822.00	\$927.00
Subscriber + Child(ren)	\$702.00	\$792.00
Subscriber + Family	\$1,277.00	\$1,447.00
MEDICAL SERVICES		
Deductible		
~ Calendar Year Deductible	Not Applicable	
Physician Services (Office Visits)		
~ Office Visits	\$30 Co-pay	
~ Specialist Visits	\$30 Co-pay	
~ Physical & Occupational Therapy	\$30 Co-pay	
~ Lab & X-ray	No Charge	
Maternity Care		
~ Prenatal & Postnatal Care	No Charge	
~ Normal Delivery	\$250 per admission	
~ Complications (Includes C Sections)	No Charge	
Preventive Care		
~ Well Women Exam	\$30 Co-pay	
~ Well Baby Care	\$30 Co-pay	
~ Periodic Health Exam	\$30 Co-pay	
Hospital Services		
~ Inpatient Care	\$250 per admission	
~ Outpatient Care	\$30 per procedure	
~ Emergency Care		
Ambulance	\$50 Co-pay	
ER	\$50 Co-pay	
If admitted	Waived	
Psychiatric Services		
~ Inpatient Care (30 days/yr max)	\$250 per admission	
~ Outpatient Care - Crises Intervention	\$30 / 20 visits	
Alcohol/Chemical Dependency		
~ Inpatient Care (Detox Only)	\$250 per admission	
~ Outpatient Care	\$30 / 20 visits	
Prescription Drugs		
~ Generic	\$10 for up to a 100 day supply	
~ Brand Name	\$20 for up to a 100 day supply	
Additional Benefits		
~ Durable Medical Equipment	20% Coinsurance	
Out of Pocket Maximums		
~ One Member	\$1,500	
~ Two Members or more	\$3,000	
Preexisting Conditions		
	Covered	

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

KAISER Rates - Local 47 effective 11/1/08*

	Kaiser HMO	
Estimated Monthly Premium*	Southern CA	Northern CA
Subscriber	\$462.30	\$519.80
Subscriber + Spouse	\$945.30	\$1,066.05
Subscriber + Child(ren)	\$807.30	\$910.80
Subscriber + Family	\$1,468.55	\$1,664.05
MEDICAL SERVICES		
Deductible		
~ Calendar Year Deductible	Not Applicable	
Physician Services (Office Visits)		
~ Office Visits	\$30 Co-pay	
~ Specialist Visits	\$30 Co-pay	
~ Physical & Occupational Therapy	\$30 Co-pay	
~ Lab & X-ray	No Charge	
Maternity Care		
~ Prenatal & Postnatal Care	No Charge	
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* The rates for November are estimates and subject to change.

Please print or type in black ink only. See instructions on reverse before completing this form. Retain last copy for your records and use as a temporary ID after the effective date. (See * footnote on reverse.)

TO BE COMPLETED BY EMPLOYER			
Company name _____		Date of hire _____	
Group number _____	Enrollment unit _____	Effective date of enrollment or coverage _____	
NEW ENROLLMENT Check one:			
<input type="checkbox"/> New purchaser	<input type="checkbox"/> Open enrollment (complete sections A, B, C, D)		
<input type="checkbox"/> New hire (complete sections A, B, C, D)	<input type="checkbox"/> Other (please specify) _____		
<input type="checkbox"/> Loss of other coverage (complete sections A, B, C, D)	Date of event _____		
PLAN Check one: <input type="checkbox"/> HMO <input type="checkbox"/> Deductible Plan			
IF MAKING A CHANGE, COMPLETE THE FOLLOWING:			
<input type="checkbox"/> Add dependents (complete sections A, B, D)		<input type="checkbox"/> Delete dependents (complete sections A, B, D)	
*Reason: _____ (see Change Reason Table) Event date: _____			
<input type="checkbox"/> Name change (complete sections A, B, D) From: _____ To: _____			
<input type="checkbox"/> Address (complete section A) _____			
<input type="checkbox"/> Telephone (complete section A) _____			
A. EMPLOYEE INFORMATION			
Name (Last, First, MI) _____		Former last name (if any) _____	
Home address _____	Apt. no. _____	City _____	State _____ ZIP _____
Home phone _____	Work phone _____	Medical Record no. (if known) _____	
<input type="checkbox"/> M <input type="checkbox"/> F	Gender _____		Social Security no. _____
E-mail _____	Date of birth _____ Preferred spoken or written language (optional) _____ Ethnicity (optional) _____		
B. FAMILY INFORMATION For additional dependents, attach a separate sheet and please put the employee's name at the top. (Last, First, MI)			
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number _____	
Spouse/Domestic partner name: _____		Date of birth _____	Medical Record number _____
Former last name (if any): _____			
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number _____	
Dependent name: _____		Date of birth _____	Medical Record number _____
Relationship: _____			
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number _____	
Dependent name: _____		Date of birth _____	Medical Record number _____
Relationship: _____			
Do any of your dependents above live at another address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:			
Name(s) (Last, First, MI): _____		Address: _____	
C. OTHER COVERAGE INFORMATION:			
Including yourself, do any of the persons listed above have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name _____	Insurance carrier name _____	Policy no./Effective date _____	Phone no. _____
D. Kaiser Foundation 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 Employee Retirement Income Security Act regarding certain benefit related disputes) any dispute between myself, my heirs, 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, 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.			
Employee/Applicant signature _____		Date _____	Employer signature _____ Date _____

*Additional documentation may be required.