Otium Agency

1588 North Batavia Street, Suite 1B
Orange, California 92867
Office (714) 770-8207
Fax (714) 770-8208

- Adding new health plan options!
- Adding dental plans!
- Adding voluntary life and critical illness plans!

It is Open Enrollment time for benefits! This is the time of year that you can make changes to your benefits such as enrolling, adding dependents, or changing plan choices. Please read this letter carefully and respond promptly.

You are required by law to have health coverage or face penalties on your tax return. TWS offers an affordable health insurance plan to its full time employees. You have the option to enroll in this plan or obtain coverage on your own. Medi-Cal and Medicare count as valid coverage as well. ***Please note that, since you are offered coverage through your employer, you are NOT eligible to receive a subsidy (help paying for insurance) through the exchange.***

Enclosed are the following for your review:

1. Summary of Benefits for health insurance plan offered by TWS.
2. Dental and Voluntary Benefits summary.
3. Personalized quote for health insurance.
4. Health insurance application.
5. Dental insurance applications (HMO and PPO).
6. Waiver form (only if you choose not to enroll).
7. Return envelope.

Please complete and return either the application or the waiver form and return to us.

Coverage will be effective on: March 1, 2017

Application or Waiver due by: February 20, 2017

If you do not enroll now, you will not have another opportunity to enroll until open enrollment.

If you have any questions, please feel free to contact our office. Thank you!

The Otium Agency Inc.
info@otiumagency.com
(714) 770-8207

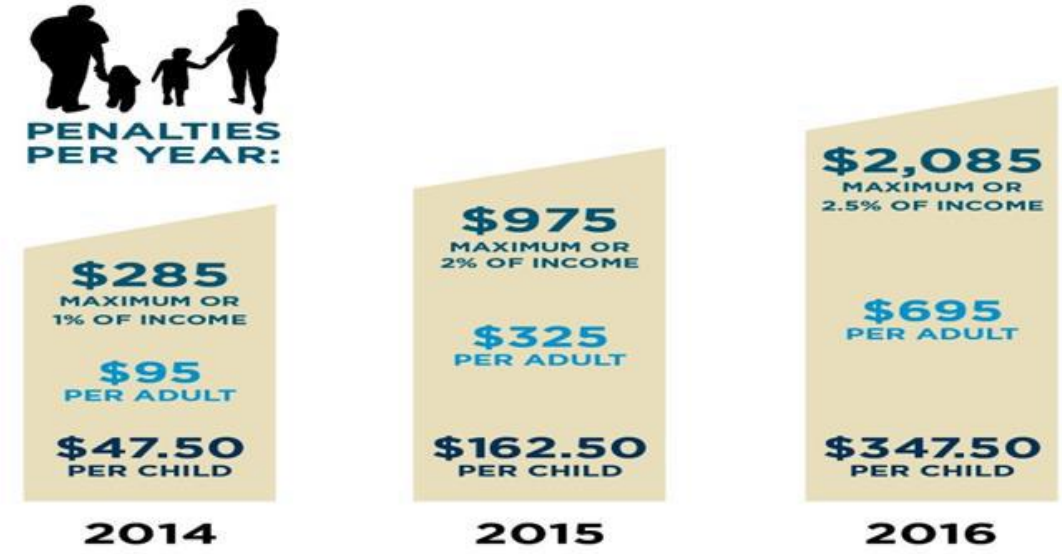
TWS Benefits Summary *Effective 03/01/2017*

MEDICAL	**Member Pays**			
Plan Name	**Bronze 60 HDHP HMO 4800/40%**	**Silver 70 HDHP HMO 2000/20%**	**Gold 80 HMO 0/30**	**Bronze PPO 6300/75**
Deductible	$4800 Ind. $9600 Family	Self-only $2000 If enrolling dep: $2600 Ind. $4000 Family	$0	$6300 Indiv. $12600 Family
Deductible (Out of Network)	N/A	N/A	N/A	$12600 Indiv. $25200 Family
Out-of-Pocket Maximum	$6550 Ind. $13100 Family	$6550 Ind. $13100 Family	$6720 Ind. $13500 Family	$6800 Indiv. $13600 Family
Out-of-Pocket Max (Out of Network)	N/A	N/A	N/A	$13600 Indiv. $27200 Family
Hospital Care	40% (after ded.)	20% (after ded.)	$655 per day up to 5 days per admission	100% Up to OOP
Primary Care Visits	40% (after ded.)	20% (after ded.)	$30	$75 (after ded.)
Primary Care Visits (Out of Network)	N/A	N/A	N/A	100% Up to OOP
Generic Rx	40% up to $500 mx (after ded.)	20% up to $250 max (after plan ded.)	$15	100% up to $500 max (after $500 drug ded.)
Brand Rx	40% up to $500 mx (after ded.)	20% up to $250 max (after plan ded.)	$55	100% up to $500 max (after $500 drug ded.)
Specialty Rx	40% up to $500 mx (after ded.)	20% up to $250 max (after plan ded.)	20% up to $250 maximum	100% up to $500 max (after $500 drug ded.)

Disclaimer – Must Read!

If you choose not to enroll in one of the health (medical) plans offered by your employer during this Open Enrollment period you are REQUIRED BY LAW to obtain health coverage from an outside vendor or your spouse's employer coverage.

Please note that if you go through Covered California you WILL NOT be eligible to receive a subsidy/tax credit, you will be responsible for 100% of the cost.
If you DO NOT enroll yourself and your dependents in a health plan, you will be liable to pay a PENALTY to the government for not having health coverage.
The penalty fee schedule is as follows –
If you don't have coverage in 2016, you'll pay the **higher** of these two amounts



How you pay the fee
You'll pay the fee on the federal income tax return you file for the year you don't have coverage.
Example: If you do not have coverage in 2016, you will be penalized on your tax returns you file in early 2017.

KAISER PERMANENTE®

Small Business
EMPLOYEE ENROLLMENT

INSTRUCTIONS

Please print neatly.

Be sure to fill in the enrollment form completely. Missing or inaccurate information will delay enrollment processing.

Employer

1. Complete section 1 on the enrollment forms.

   1A. If enrollment reason is loss of coverage or other, the event must be one of the special enrollment triggering events listed below:
   - Increase in an employee's hours so that he or she meets your requirement for medical plan eligibility
   - Return from a leave of absence
   - Involuntary termination or loss of other group coverage
   - A dependent loses coverage elsewhere
   - Marriage or addition of a domestic partner
   - Birth
   - Adoption of a child or placement for adoption
   - Court order
   - Death of a spouse, domestic partner, or dependent

2. Give each enrolling employee an enrollment form to complete.
3. Confirm that the information provided by employees on their enrollment forms is complete and accurate.
4. Return the completed enrollment forms to your broker or Kaiser Permanente.

Employee

1. Complete sections 2 through 4.
2. Sign and date the form.
3. Make a copy of the form for your records.

This form serves as your temporary Kaiser Permanente member ID.
Please make a copy and keep it until you receive your official member ID.

KAISER PERMANENTE®

Small Business
EMPLOYEE ENROLLMENT

See instructions on page 1 before completing this form. Make a copy for your records.

1 TO BE COMPLETED BY EMPLOYER

☐ New group account ☐ Existing account

Company name	Customer ID (if assigned)	Date of coverage to be effective (mm/dd/yyyy)

Plan selection	Employee classification (if applicable)

Employee last name	Employee first name	MI

Enrollment reason (Please check 1) ☐ New group account ☐ New hire ☐ Open enrollment ☐ Part-time to full-time ☐ Loss of coverage ☐ Other:

If you have an **existing** account, please fax this form to **858-614-3345** (SCAL), **858-614-3344** (NCAL), or email **csc-sd-sba@kp.org**.

2 TO BE COMPLETED BY EMPLOYEE

Have you ever been a member of, or received care from, Kaiser Permanente in California? ☐ Yes ☐ No

If so, under what medical record number (if known)	Social Security number	Former/Maiden name

Last name	First name	MI	Preferred language (optional)

Home address (no P.O. boxes)

City	State	ZIP	County

Date of birth	Gender ☐ M ☐ F	Day phone	Evening phone

If you decline coverage for yourself or an eligible dependent, you can only enroll or change your coverage during an annual open enrollment period established by your employer, or during a special enrollment period if you have experienced a triggering event. You must request coverage within 60 days of a triggering event. Special enrollment triggering events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court orders that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

3 FAMILY INFORMATION (Please list only those family members to be enrolled.)

☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	

Do any of your dependents listed above live at another address? ☐ Yes ☐ No If Yes, complete the following:

Name (Last, First, MI)	Address

4 SIGNATURE

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other 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 Kaiser Foundation Health Plan, Inc. (KFHP), 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, 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*.

Employee name (please print)	Title (please print)
Employee signature X	Date

** Disputes arising from fully insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration: 1) Preferred Provider Organization (PPO) plans and 2) KPIC Dental plans.*

PPO ONLY

110

Principal Life Insurance Company

Mailing Address
Des Moines, IA
50392-0002

Employee Enrollment & Waiver-CA

Company name	Division level	Account number/unit number
Motivational Marketing, Inc.	All Members Electing EPO	

Employee Information

Name		Social security number	
Mailing address (street)		Birth date	☐ male ☐ female
(city)	(state)		(ZIP code)

Do you have an eligible spouse or state registered domestic partner or nonregistered domestic partner or child(ren)? ☐ yes ☐ no

Date employed full-time	Hours worked per week	Job occupation/class	Location

Email address	Phone number

What is your payroll mode?	Employer ZIP	Employer county
☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly	91708	SAN BERNARDINO

Eligible Dependent Information (Complete if you are electing benefits for your spouse or state registered domestic partner or nonregistered domestic partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ spouse ☐ state registered domestic partner ☐ nonregistered domestic partner
		☐ male ☐ female		☐ child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ child ☐ foster child* ☐ disabled child**

* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court? ☐ yes ☐ no

** When your child, who is developmentally or physically disabled, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

Is your spouse or state registered domestic partner or nonregistered domestic partner employed by this company? ☐ yes ☐ no

Coverage	Employee	Spouse or State Registered Domestic Partner or Nonregistered Domestic Partner*	Child(ren)
Dental	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

Important: You must elect Employee coverage in order to elect the coverage for your dependent(s).

* If enrolling a Nonregistered Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60603).

Declining Coverage

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

☐ spouse's or state registered domestic partner or nonregistered domestic partner's group coverage

☐ individual insurance

☐ other coverage offered by my employer

☐ other _____

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- If I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any false statement made on this form will not bar the right to recovery under the group policy(ies) unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Principal Life.
- Explanation of Benefits reflecting claims payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and/or my dependents will be used by Principal Life only as allowed by law.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life, disability and critical illness coverage. Information will not be used for any purposes prohibited by law.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X_____ **Date Signed** _____

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

California DENTAL
A DENTAL HEALTH PLAN

THE NO PROBLEM PLAN!

- ***No*** *Deductibles!*
- ***No*** *Claim Forms!*
- ***No*** *Annual Maximums!*
- ***No*** *Limitations on Most Pre-Existing Conditions!*
- ***No*** *Waiting Periods to See a Dentist!*

SEE YOUR SAVINGS!

Compare your costs with **California Dental Network's** ADVANTAGE PLAN 75 to average dental fees:

Sample Treatment Plan	Avg. Fee*	With ADV 75	Your Savings
Exams	$88.00	No Charge	$88.00
Cleanings	$93.00	No Charge	$93.00
Full Mouth X-Rays	$136.00	No Charge	$136.00
Filling, 1 surface	$142.00	No Charge	$142.00
Root Canal, single	$762.00	$ 50.00	$712.00
Crown, PFM	$1152.00	$ 75.00	$1077.00
	$2,373.00	$125.00	$2,248.00

*2012 National Dental Advisory Service for 92653

CHOOSE FROM HUNDREDS OF DENTISTS!

California Dental Network offers comprehensive dental benefits through hundreds of independently owned and operated dental offices conveniently located throughout California.

SPECIALTY COVERAGE!

All general dentists may not be capable of performing each of the services listed herein and, based upon a Member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such a case, the general dentist will refer the Member to a **California Dental Network** participating dental specialist. Your costs for the services of a dental specialist may vary, based upon the coverage option selected by your group.

Summary of Benefits and Copayments
Advantage Plan 75

*The following dental services are covered benefits for the specified copayment, **only** when provided by a participating **California Dental Network** general dentist, which may be found online at **www.caldental.net***

I. PREVENTIVE SERVICES

	Your Copayment
Office visit	No Charge
Oral examination	No Charge
Intraoral x-rays, complete series	No Charge
Bitewing x-rays, single film	No Charge
Panoramic x-ray	No Charge
Prophylaxis (teeth cleaning)	No Charge
Topical fluoride (child)	No Charge
Oral hygiene instruction	No Charge

II. ROUTINE SERVICES

	Your Copayment
RESTORATIONS	
Amalgam, one surface	No Charge
Amalgam, two surfaces	No Charge
Amalgam, three surfaces	No Charge
Resin, one surface anterior	No Charge
Resin, two surface anterior	No Charge
ORAL SURGERY	
Extraction, single tooth	No Charge
Surgical removal of erupted tooth	No Charge
Removal of impacted tooth, soft tissue	No Charge
Removal of impacted tooth, partially bony	No Charge
Surgical incision with drainage of abscess, intraoral soft tissue	No Charge
ENDODONTICS	
Pulp cap, direct	No Charge
Pulp cap, indirect	No Charge
Therapeutic pulpotomy	No Charge
Root canal, anterior	$50.00
Root canal, bicuspid	$70.00
Root canal, molar	$150.00
PERIODONTICS	
Gingivectomy or gingivoplasty, 4 or more contiguous teeth, per quadrant	$40.00
Scaling & root planing, per quadrant	$20.00

III. MAJOR SERVICES

	Your Copayment
CROWNS	
Porcelain fused to base metal (not for molars)	$75.00
Porcelain fused to base metal (for molars)	$150.00
Full cast base metal	$75.00
3/4 cast metallic	$75.00
Prefabricated stainless steel, permanent tooth	No Charge
DENTURES & PROSTHODONTICS	
Complete upper or lower denture	$90.00
Upper or lower partial denture, resin base	$125.00
Upper or lower partial denture, cast metal base with resin saddles	$125.00
Adjust complete denture	No Charge
Repair broken complete denture base	$10.00
Replace missing or broken teeth, complete denture, each tooth	$10.00
Reline complete or partial upper or lower denture, chairside	$25.00
Reline complete or partial upper or lower denture, laboratory	$25.00

Advantage Plan 75 covers many of the name brand crowns and dentures. See evidence of coverage for details.

IV. ORTHODONTICS

STANDARD 24-MONTH CASE	
Phase one interceptive treatment	$1,150.00
Full-banded, upper and lower, to age 19	$1,775.00
Full-banded, upper and lower, adults	$1,975.00
Banded, upper *or* lower, children & adults	$1,000.00
Consultation	No Charge

V. COSMETIC BENEFITS

Tooth colored fillings, one surface, back tooth	$65.00
Bleaching, per arch	$125.00
Labial veneer (porcelain laminate), laboratory	$250.00
Night guards, soft, includes lab fee	$150.00

The ratio of premium costs to health services paid, for plan contracts with individuals and groups of 25 or fewer members, during the preceding fiscal year was 65%.

Detach and Return

ENROLLMENT APPLICATION

Please print or type.

Group # _____ Eff. Date _____

Social Security No. _____ Last Name _____ First _____ Initial _____ Birthday ___/___/___ Home Phone (___) _____ *Language _____

Address _____ City _____ State _____ Zip _____ Work Telephone (___) _____

Employer's Name _____

Dependents to be covered: *Please indicate Preferred Language other than English for Communications with Plan.

	First	Birthday	*Language	Last Name (if different)	First	Birthday	*Language
Spouse:		___/___/___		Child:		___/___/___	
Child:		___/___/___		Child:		___/___/___	
Child:		___/___/___		Child:		___/___/___	

Plan A75

Dental Office # _____

On behalf of the above named individuals, I hereby apply for enrollment in CDN and certify that the above information is true and correct.
NOTICE: BY SIGNING THIS APPLICATION YOU ARE AGREEING TO HAVE ANY DISPUTE WITH THE PLAN, INCLUDING MEDICAL MALPRACTICE, DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL. SEE THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM FOR DETAILS.

_____ Applicant's Signature

Date _____

TWS FACILITY SERVICES BENEFITS **Effective 03/01/2017**

DENTAL

POS (Point of Service) Dental Benefits: Includes PPO Network, EPO Network and Out-of-Network

	Calendar Year Deductible			Coinsurance (Policy Pays)			Calendar Year Maximum Benefit		
	EPO	PPO	Non-Networ	EPO	PPO	Non-Network	EPO	PPO	Non-Network
Preventive	$0	$0	$50	100%	100%	100%	$1,500	$1,500	$1,500
Basic	$50	$50	$50	80%	80%	80%	$1,500	$1,500	$1,500
Major	$50	$50	$50	50%	50%	50%	$1,500	$1,500	$1,500

HMO Option will assign member to a dental office for all services, which have set copays. Unlimited benefits.

Plan	Employee	Employee +Spouse	Employee +Child(ren)	Family
POS	$16.66	$34.21	$39.23	$59.49
HMO	$5.30	$9.41	$10.59	$14.71

Rates are per pay period

VOLUNTARY LIFE AND CRITICAL ILLNESS

* Rates based on age, available on request.

* Term Life for Employee and Spouse
* Critical Illness for Employee and Spouse (Cancer, Heart Attack, Major Organ Failure, Stroke)

I have been offered the following benefits by my employer and have declined to enroll in coverage for:

____ Medical

____ Dental

____ Voluntary Benefits

I understand that I will not be eligible to enroll in coverage until the next open enrollment period.

Signature: _____

Printed Name: _____

Date: _____

I have been offered the following benefits by my employer and would like to enroll in coverage for:

_____ Medical

_____ Dental

_____ Voluntary Benefits

I understand that I must contact Sandi at The Otium Agency Inc. (657) 284-5222 by Wednesday, February 22nd, 2017 to inform them of my decision to enroll.

Signature: _____

Printed Name: _____

Date: _____