

2024
OPEN
ENROLLMENT



STEP-BY-STEP INSTRUCTIONS

Follow these easy step-by-step instructions below to assist you in completing either your Dependent Verification, Enrollment Steps, Wellness Steps, or both for the 2024 Plan Year. Some users may see both or only see Enrollment Steps or Wellness Steps.

This year Open Enrollment has 3 sections:
Dependent Verification, Enrollment Steps, and Wellness Steps

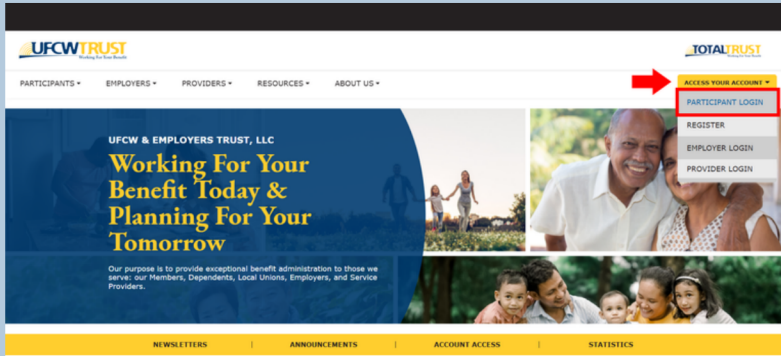
First, watch a quick video overview to learn what's new for 2024 Open Enrollment!

[CLICK HERE TO WATCH VIDEO](#)



DEPENDENT VERIFICATION

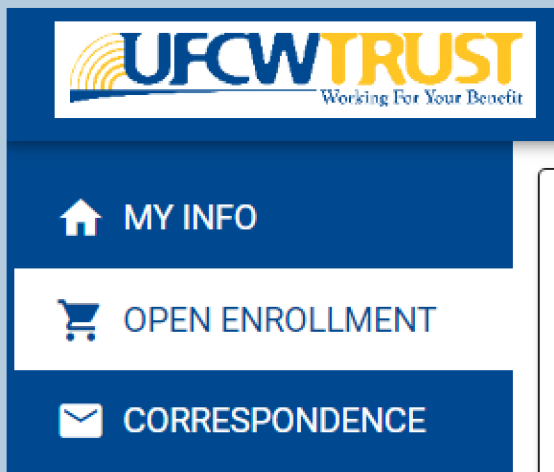
- 1 Visit ucfwtrust.com and click "**Participant Login**" under the Access Your Account section.



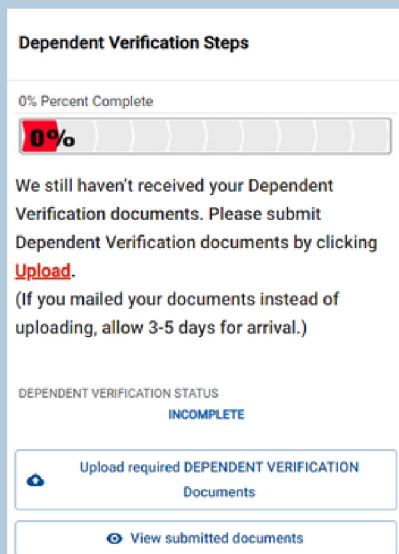
- 2 Log in or register on the site.



- 3 Select the "**Open Enrollment**" tab on the top left side.



- 4 The Open Enrollment page displays your Dependent Verification Action Items and progress bar (if applicable). Your progress bar will update automatically once the TFO reviews and approves your submitted documentation (5-7 business days).



5 Select "Upload required DEPENDENT VERIFICATION Documents," and then select the scanned PDF or image from your device. Select "2024 Dependent Verification Proof" for the question "What is this for?" Select "Upload."

Upload DEPENDENT VERIFICATION Documents

Click to upload, or drag and drop files here.

To be uploaded	What is this for?	Description
SAMPLE PDF 1 0.03MB pdf	2024 Dependent Verification ...	

DIRECTIONS:

1. Upload a Household bill or the first page of your most recent Tax return. The household bill must be within 60 days or less and either document must show that your Spouse or your Domestic Partner currently resides at your place of residence. Samples below.
2. When uploading your proof document, choose the **2024 Dependent Verification Proof** document type. Your document will be processed within 5-10 business days during the Open Enrollment period of October 2nd - December 1st.

Cancel Upload



Upload any of the following documents dated within the last 60 days. Spouse's name and Member's address must be listed on the document, and must be a recurring statement. For privacy, financial information can be covered before sending to the TFO.

- ◆ Utility Bill: Electric, Gas, Water, Phone, Cable, Internet, Cellular
- ◆ Mortgage or Rent Statement
- ◆ Car Payment Statement
- ◆ Bank Statement
- ◆ Credit Card Statement
- ◆ Most Recent Tax Return (page 1) or acknowledgement of your tax extension (Form 4868)

6 Your Dependent Verification Status will update to "Complete" once the TFO reviews and approves your submitted documentation (5-7 business days).

Dependent Verification Steps

100% Percent Complete

100%

DEPENDENT VERIFICATION STATUS
COMPLETE

View submitted documents



You can also submit your Dependent Verification documentation through postal mail, fax, or drop it off in-person to one of our offices:

- Mail: PO Box 4100, Concord, CA 94524-4100
- Fax: Health & Welfare Services Department at (925) 746-7549
- Concord Drop Off: 1000 Burnett Ave, Suite 110, Concord, CA 94520
- Roseville Drop Off: 2200 Professional Drive, Suite 200, Roseville, CA 95661

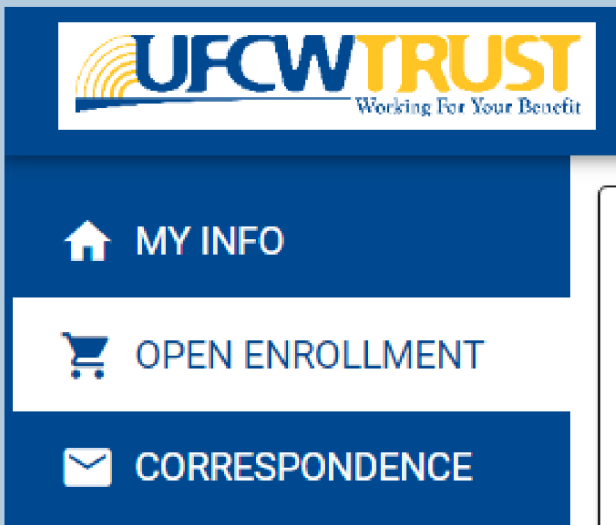
ENROLLMENT STEPS

NEED HELP WITH ENROLLMENT?
Watch a quick video tutorial!

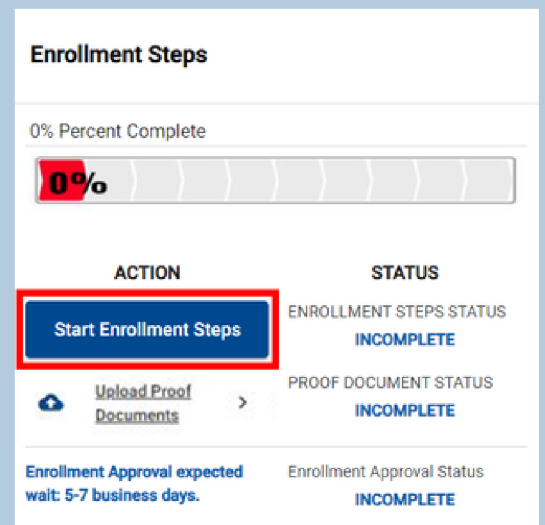
[CLICK HERE TO WATCH VIDEO](#)



7 Select the **“Open Enrollment”** tab on the top left side.



8 The Open Enrollment page displays your Enrollment Steps Action Items and progress bar. Your progress bar will update automatically as you complete Action Items, or once the TFO reviews and approves your submitted documents (5-7 business days)



Select **“Start Enrollment Steps,”** to choose your Carriers and Dependents for Plan Year 2024.

9

Click the Open Enrollment event option.

Enrollment Steps

Please select the event applicable to you...

- **Annual Verification** is for members without current coverage that do not have a qualifying Life Event.
- **Life Events** include: Marriage, Birth, Adoption, Divorce, Separation, Loss or Gain of Insurance, etc.
- **Open Enrollment** is for members making their 2024 Plan Year elections. [2024](#)

OPEN ENROLLMENT (ANNUAL)

10

Review listed dependents that may or may not be currently enrolled on your plan and add any new dependents not yet listed.

Member-Dependent Info
Add any new dependent(s) you want to enroll in your plan. The dependent(s), if any listed may or may not be currently enrolled.

Add a new Dependent +

Employee Details

First Name	Last Name	Date of Birth	SSN
TOM	TESTGUY	03/03/1960	XXX-XX-2222

Spouse / Domestic Partner Details

First Name	SSN
PETUNIA	
Last Name	Gender
TESTGUY	Female
Date of Birth	Relation
12/25/1964	Spouse

Child(ren) Details

First Name	SSN
WILLIAM	
Last Name	Gender
TESTGUY	Male
Date of Birth	Relation
03/23/2018	Natural Child

Student YES NO Student From Date

First Name: SSN:

100% completed

The next steps will allow you to choose these dependents for your 2024 Elections.

11

Review your current enrollment elections, then select "Next" to proceed.

Enrollment Steps ✕

Please click the below box to proceed
 The box shows your current enrollment elections. The next steps will allow you to add or remove dependents and make carrier changes, if needed.

CURRENTLY ENROLLED

UEBT

Kaiser (Medical): Member Only

12

Please select your preferred medical carrier.

Enrollment Steps

Please specify plan details
Below you can choose from a list of available plans as well as update the corresponding coverage effective date.

Coverage Effective Date
01/01/2024

Blue Shield of California (Medical)

Kaiser (Medical)



13

Select a Tier indicating how many covered individuals you want to enroll. You can also click the link to review costs per person at each plan level.

Enrollment Steps

Please select the tier you would like to enroll with. [Click or tap here](#) for detailed premium costs by person and plan level.
The document is called "Dependent Premium Reference Table."

Tier

- Member Only
- Member + Spouse
- Member + Spouse + Child
- Member + Spouse + 2 Children
- Member + Spouse + 3 Children or more
- Member + Domestic Partner
- Member + Domestic Partner + Child
- Member + Domestic Partner + 2 Child
- Member + Domestic Partner + 3 Children or more
- Member + Child
- Member + 2 Children
- Member + 3 Children or more



14

Select the dependents you want to cover on your plan next year.

Enrollment Steps

Please select who is covered under each of your benefits

Name	Relation	Age
<input checked="" type="checkbox"/> TESTGUY, TOM G	Member	62
<input checked="" type="checkbox"/> TESTGUY, MINNIE	Natural Child	0
<input checked="" type="checkbox"/> TEST, JOSH	Natural Child	2
<input checked="" type="checkbox"/> TESTGUY, WILLIAM	Natural Child	4
<input checked="" type="checkbox"/> TESTGUY, TINA	Natural Child	10
<input checked="" type="checkbox"/> TESTGUY, MICHEAL J	Natural Child	16



15

Review your premiums and select your dental carrier. Then fill out any other health insurance information your household may have.

Enrollment Steps

Premium	Amount
Wellness Weekly Premium	\$30.00
Non Wellness Wkly Premium	\$45.00

Please answer some additional questions that may impact your coverage

Coverage

Carrier Election
 Select Dental Carrier *
 Cypress Dental

Select Vision Carrier *
 VSP

Select Hearing Carrier *
 Kaiser

Select Prescription Carrier *
 Elavix Rx

Select Podiatry Carrier *
 Kaiser

Select Mental Health Carrier *
 Kaiser

Other Insurance Information - Medical
 Do you have a Spouse or a Domestic Partner and are they employed? *
 Yes, I have a Spouse/Domestic Partner, but no they are not employed

Does anyone being covered under this Plan, including yourself, have other insurance to report, including Medicare? *
 No, everything looks correct, and/or I have no other insurance to report

16

Review the Weekly Premium Disclosure, and select "Agree and Proceed"

Weekly Premium Disclosure

Active Member: [Name]

I hereby request the Trust Fund (Plan) election coverage for the Dependents I am enrolling under the (DBP Plan Part), as listed on the next page and on my Confirmation Statement.

I understand and agree that I must pay the required weekly premium amount shown on the next page, and as provided in the Collective Bargaining Agreement based on my selection, and authorize my employer to withhold such required weekly premium amount from my paycheck and to remit such amount directly to the Plan.

If I qualify for participation in the Wellness Program, sometimes referred to as Health Care Performance (or HCP) by Wellness Program (WCP) premium amount for coverage of my enrolled Dependents that my Employer is authorized to reduce will be the Trust Fund (Plan) (DBP) Health Care Performance (HCP) premium amount. I acknowledge and agree that if I am not covered under the Wellness Plan, my required weekly premium amount based on the next page for coverage of my enrolled Dependents from my enrolled Dependents. If I am not covered under the Wellness Program, my required weekly premium amount will be the Trust Fund (Plan) (DBP) Health Care Performance (HCP) premium amount. I understand that at any time my Employer cannot deduct the required premium amount from my paycheck, the Trust Fund (Plan) (DBP) will be the required premium amount and I will be responsible to make those payments for the Plan to the applicable due date or coverage of my Dependents may be suspended.

Employer to authorize the required premium amount for coverage of my enrolled Dependents, except for my new health work. I understand that at any time my Employer cannot deduct the required premium amount from my paycheck, the Trust Fund (Plan) (DBP) will be the required premium amount and I will be responsible to make those payments for the Plan to the applicable due date or coverage of my Dependents may be suspended.

I understand that if my employer increases a health care plan under Internal Revenue Code Section 125, the required premium amount will be defined as a pre-tax basis unless otherwise defined in the plan document. I understand that the required premium amount will be defined as a pre-tax basis and I understand that the contribution will not be paid for the plan part if I do not make my election on time and if the premium amount for coverage under the plan is not paid.

I understand that I will be responsible for coverage of my Dependents. I will be responsible for the Plan's eligibility rules, including the health requirements for dependent coverage and I must pay the required premium amount for the month in advance of the month of coverage.

By clicking on the "Agree and Proceed" button, you certify that you have read and agree to the above information. If you do not accept this agreement, click the "Cancel" button to change your election.

Event Approval Disclaimer

Detailed information regarding your health benefit elections is outlined in your Confirmation Statement. These elections are NOT that unit of necessary documentation and details of the enrollment event has been reviewed and subsequently approved by CIGNA/Blue Cross. The enrollment event is subject to change based on Plan Rules.

Please be aware and understand that your health benefit elections are subject to change based on Plan Rules. If you are not covered under the Wellness Program, you must submit your Confirmation Statement to the Trust Fund (Plan) (DBP) Health Care Performance (HCP) premium amount for coverage of my enrolled Dependents from my enrolled Dependents. If I am not covered under the Wellness Program, my required weekly premium amount will be the Trust Fund (Plan) (DBP) Health Care Performance (HCP) premium amount. I understand that at any time my Employer cannot deduct the required premium amount from my paycheck, the Trust Fund (Plan) (DBP) will be the required premium amount and I will be responsible to make those payments for the Plan to the applicable due date or coverage of my Dependents may be suspended.

Kaiser HIPAA Acknowledgment

The Kaiser HIPAA Acknowledgment and Attribution language only applies to those who have elected Kaiser as their Medical plan.

Kaiser HIPAA Disclosure and Acknowledgment

UFCW 6945 Health Plan: Trust Health Reimbursement Account (HRA) Disclosure and Acknowledgment for Kaiser HRA Participants

DISCLOSURE

As a participant in the DBP Health Care Performance Plan (HCP) (Plan), you are a participant in the DBP Health Care Performance Plan (HCP) (Plan). You may use funds in your HRA to pay for eligible expenses.

Cancel Agree and Proceed

17

Confirm your Enrollment and carefully review all details. Select "Authorize"

Confirm Enrollment

By Confirming and Authorizing this enrollment, I understand that I am authorizing my employer to collect dependent premiums, as applicable.

Review and Authorize Enrollment

Click Please Note: Premium costs may not reflect accurately during trial service enrollment. The new costs reflected on your Confirmation Statement document is approximate these listed rates.

Member	Premium Cost
Wellness Plan	\$30.00
Non Wellness Plan	\$45.00
Wellness Plan	\$30.00
Non Wellness Plan	\$45.00

Additional Plan

You are enrolling in a Kaiser (Wellness) plan. Your selected coverage is Member + 3 Dependents or more, and it will be effective starting 01/01/2025.

Coverage Information

Coverage

Carrier Election
 Select Dental Carrier *
 Cypress Dental

Select Vision Carrier *
 VSP

Select Hearing Carrier *
 Kaiser

Select Prescription Carrier *
 Elavix Rx

Select Podiatry Carrier *
 Kaiser

Select Mental Health Carrier *
 Kaiser

Cancel Authorize



ATTENTION: If you have newly added Dependents, don't forget to upload proof documents to complete enrollment steps. More info on page 8.

UPLOAD PROOF DOCUMENTS FOR NEWLY ADDED DEPENDENTS

18 If you are enrolling a new dependent, click **“Upload Proof Documents”** to complete this step of the Enrollment process.

Enrollment Steps

50% Half-Way and In Processing

50%

ACTION	STATUS
Start Enrollment Steps	ENROLLMENT STEPS STATUS COMPLETE
Upload Proof Documents	PROOF DOCUMENT STATUS INCOMPLETE
Enrollment Approval expected wait: 5-7 business days.	Enrollment Approval Status INCOMPLETE

19 If you have already provided a proof document, you will see a received timestamp next to that specific document name.

Coverage Proof Documents

The following Documents are needed in order for us to successfully process your enrollment. If you do not have these documents ready, you may still exit, and we will pend your enrollment until you submit them.

If there is an **Accepted Date** for the document, then we have one on file already. There is no need to upload a new one

Proof Document	Owner	
County issued Birth Certificate	TESTGUY, TINA	Change
Not loaded	Natural Child	
Received Date	Accepted Date	

[Cancel](#) [Save](#)

If you are still missing the document, click **“Change”** to attach and browse on your computer or device to upload your scanned document, and then click **“Save”**.

20 Your enrollment steps have been submitted. Please review your preliminary election statement to ensure your elections are accurate for the 2024 Plan Year. Once your elections and proof documents have been reviewed and accepted by the Trust Fund Office (TFO), return to this page to see your Enrollment Approval. Your status bar will automatically update to 100% complete.

Enrollment Materials

[2024 MY FUND AND PLAN LEVEL Guide >](#)

[View my 2024 Open Enrollment Cover Letter](#)

[View my Enrollment Steps Confirmation Statement](#)

Enrollment Steps

100% Percent Complete

100%

ACTION	STATUS
Start Enrollment Steps	ENROLLMENT STEPS STATUS COMPLETE
Upload Proof Documents	PROOF DOCUMENT STATUS COMPLETE
Enrollment Approval expected wait: 5-7 business days.	Enrollment Approval Status COMPLETE

Enrollments are approved on a first come, first served basis and may take between 5-7 business days to be final approved.

You can also submit your documentation through postal mail, fax, or drop it off in-person to one of our offices:

- Mail: PO Box 4100, Concord, CA 94524-4100
- Fax: Health & Welfare Services Department at (925) 746-7549
- Concord Drop Off: 1000 Burnett Ave, Suite 110, Concord, CA 94520
- Roseville Drop Off: 2200 Professional Drive, Suite 200, Roseville, CA 95661

WELLNESS STEPS

NOTE: UCBT Standard will only see HRQ under Wellness. See page 12. Retirees do not have Wellness Steps unless they are DUAL Retirees.

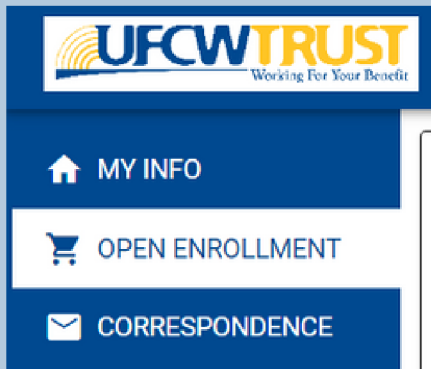
21 Visit ufcwtrust.com and click "**Participant Login**" under the Access Your Account section.



22 Log in or register on the site.

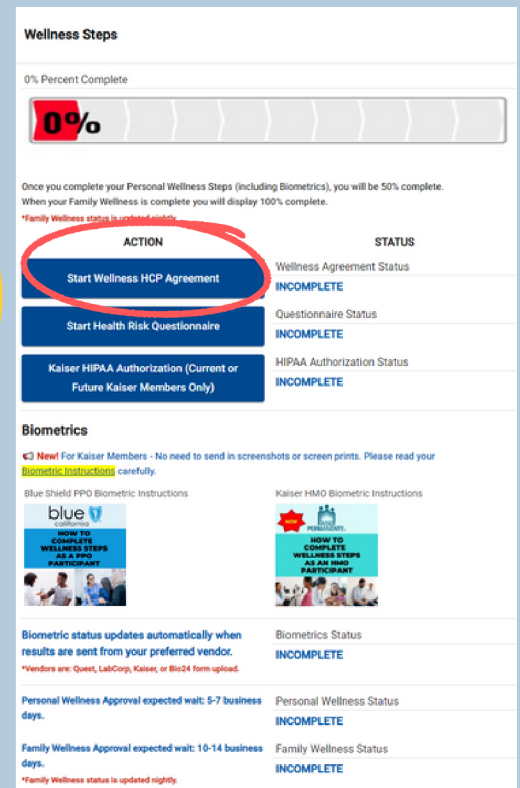


23 Click or tap the "**Open Enrollment**" tab on the top left side.



Your progress bar will update automatically as you complete Action Items, or once the TFO reviews and approves your submitted documents (5-7 business days).

24 You will see your Wellness Steps Action Items and Progress bar.



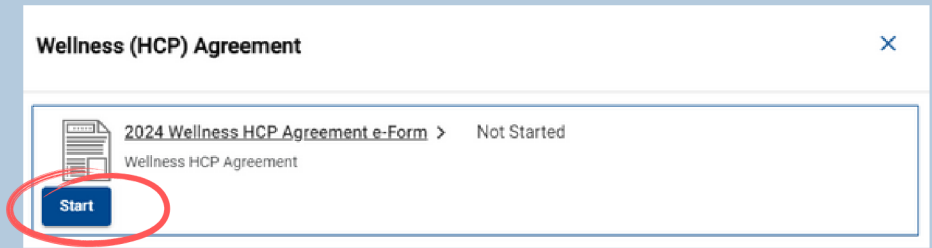
NOTE: Some Participants will not see all Wellness Steps displayed in the example picture. Your Open Enrollment tab will only display Wellness Steps applicable to you.

To get started, click on the "Wellness(HCP) Agreement"

WELLNESS STEPS (CONTINUED) HCP AGREEMENT

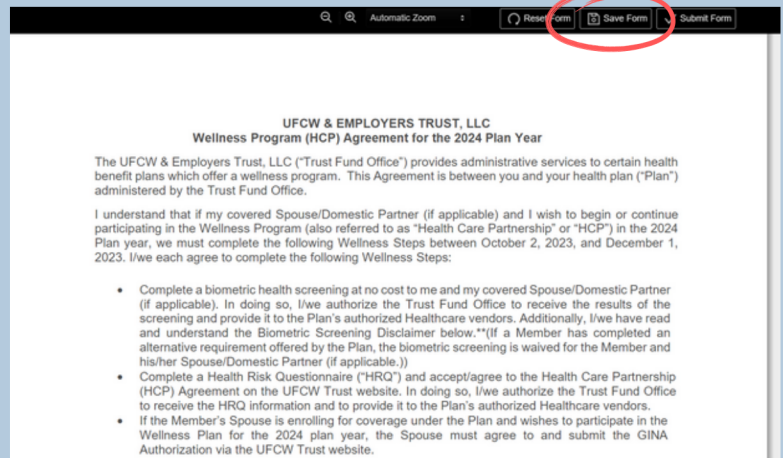
25

The HCP Agreement window will appear. Select "Start"



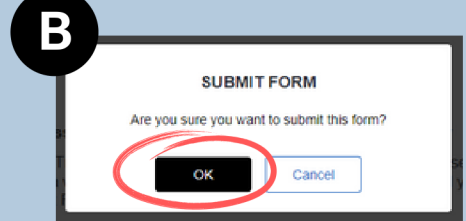
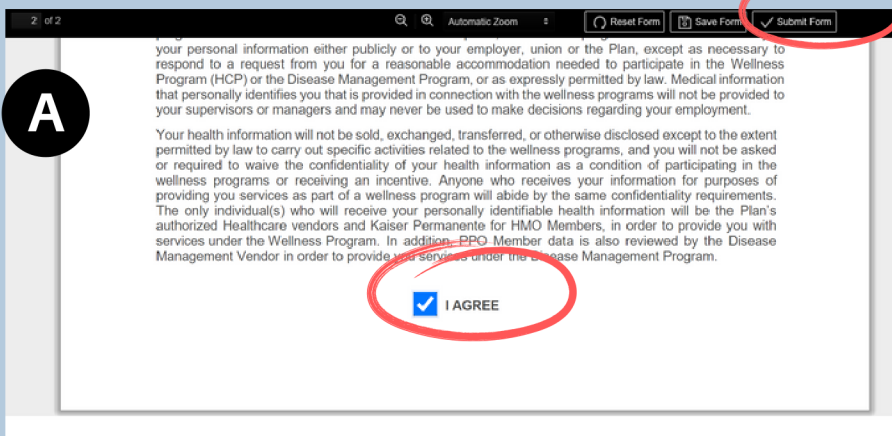
26

You will be directed to the electronic form. Please read the Agreement. You have the option to "save" in the top right corner, and return to it later if necessary.



27

Select the "I Agree" check box at the bottom of the form then select "Submit Form" in the top right corner. Then say "Ok" and click "Finish Form".



GINA AUTHORIZATION (IF APPLICABLE)

Complete your GINA Authorization (only applicable to an enrolled Spouse, the Member will not see this step).

! WARNING: The GINA Authorization is only applicable to an enrolled Spouse completing Wellness Steps. The GINA Agreement must be completed by the Spouse prior to submitting Proof of the Completed Biometrics.

28 To get started, click on the "Start GINA Authorization" under Wellness Steps

Wellness Steps

0% Percent Complete

0%

Once you complete your Personal Wellness Steps (including Biometrics), you will be 50% complete. When your Family Wellness is complete you will display 100% complete. *Family Wellness status is updated nightly.

ACTION	STATUS
Start GINA Authorization	GINA Authorization Status INCOMPLETE
Start Wellness HCP Agreement	Wellness Agreement Status INCOMPLETE
Start Health Risk Questionnaire	Questionnaire Status INCOMPLETE
Kaiser HIPAA Authorization (Current or Future Kaiser Participants Only)	HIPAA Authorization Status INCOMPLETE

The GINA Authorization window will appear. Select "Start"

2024 GINA Agreement

2024 GINA Agreement > Not Started

Wellness GINA Agreement

Start

29 You will be directed to the electronic form. Please read the Authorization. You have the option to "save" in the top right corner, and return to it later if necessary.

UFCW & EMPLOYERS TRUST, LLC
GINA SPOUSE AUTHORIZATION

Important Information Regarding Participation in the Wellness Program. A federal law (the Genetic Information Nondiscrimination Act of 2008 or "GINA") generally prohibits employers from requesting or requiring genetic information of an individual or that individual's family members. However, final rules issued by the Equal Employment Opportunity Commission (EEOC) provide that employers and sponsors of health plans may offer limited financial inducements (also called incentives or rewards) in exchange for an employee and his/her spouse providing information about his or her current or past health status as part of a wellness program, if certain conditions are met. The rules for spouses are somewhat different than for employees, in that the employee only needs to be informed of his/her rights with regard to the collection of genetic information, but for spouses, additional requirements need to be met. Therefore, your health plan ("Plan") requests information about the current or past health status of a member's spouse who is completing the Health Risk Questionnaire (HRQ), conditioned on: (i) the spouse providing prior, knowing, written and voluntary authorization for the Plan to collect such genetic information, and (ii) inducements in exchange for this information being limited. Therefore, if you are a spouse of a member, you will be asked to authorize the Plan to collect the information requested in the HRQ.

Save Form

30 Select the "I Agree" check box at the bottom of the form then select "Submit Form" in the top right corner. Click "ok" and then click "Finish Form".

2 of 2

Reset Form Save Form Submit Form

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness programs, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness programs or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of a wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information will be the Plan's authorized Healthcare vendors and Kaiser Permanente for HMO Members in order to provide you with services under the Wellness Program. Both PPO and HMO Member data is also reviewed by the Disease Management vendor (if applicable) in order to provide you services under the Disease Management Program.

For more information regarding this form or your other upcoming Wellness Steps, please visit ufcwtrust.com or call 1 (800) 552-2400.

If you have questions about the HRQ, eligibility or enrollment in medical plan benefits, please contact the Trust Fund Office. Receipt of this notice does not constitute a determination of your eligibility for benefits.

I AGREE

HEALTH RISK QUESTIONNAIRE (HRQ)

Complete your Health Risk Questionnaire. This questionnaire is comprised of 24 questions to help you identify healthier life habits and recommendations. It takes between 5-10 minutes to complete.

31a

To get started, under Wellness Steps, click on the "Start Health Risk Questionnaire (HRQ)"

ACTION	STATUS
Start Wellness HCP Agreement	Wellness Agreement Status INCOMPLETE
Start Health Risk Questionnaire	Questionnaire Status INCOMPLETE
Kaiser Health Plan Authorization (Current or Future Kaiser Members Only)	HIPAA Authorization Status INCOMPLETE

31B

The HRQ window will appear. Select "Start"

32

You will be directed to the electronic HRQ . Please fill out all 24 questions. You have the option to "save" in the top right corner, and return to it later if necessary.

33

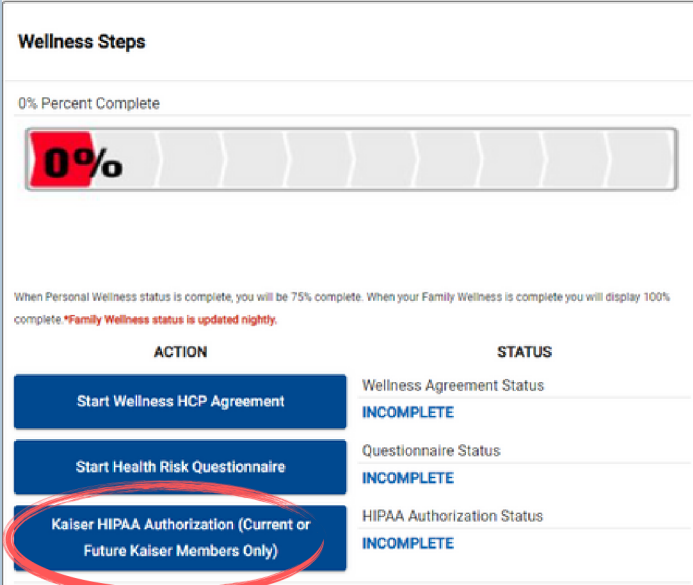
When the form is complete select the "Submit Form" button on the top right corner. Click "ok" and then "Finish Form".

KAISER HIPAA (IF APPLICABLE)

If you are a current or future Kaiser Participant (Member, or Spouse or Domestic Partner), review and agree to the Kaiser HIPAA Authorization.

34 You can access the Kaiser HIPAA Authorization form by selecting "Kaiser HIPAA" under your Enrollment Steps. You will then be directed to the Kaiser HIPAA Authorizations page.

A



Wellness Steps

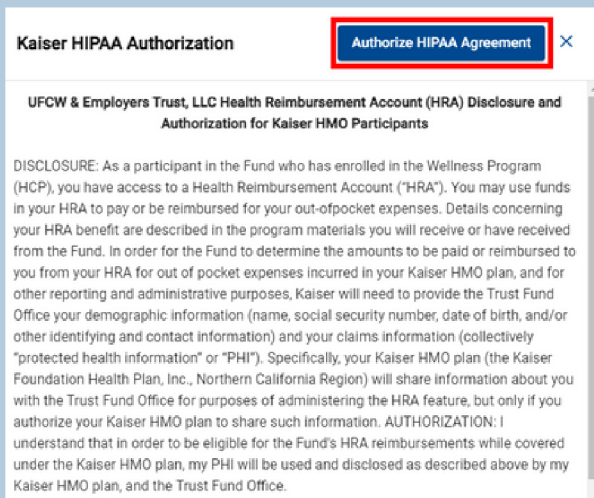
0% Percent Complete

0%

When Personal Wellness status is complete, you will be 75% complete. When your Family Wellness is complete you will display 100% complete. **Family Wellness status is updated nightly.**

ACTION	STATUS
Start Wellness HCP Agreement	Wellness Agreement Status INCOMPLETE
Start Health Risk Questionnaire	Questionnaire Status INCOMPLETE
Kaiser HIPAA Authorization (Current or Future Kaiser Members Only)	HIPAA Authorization Status INCOMPLETE

B After reviewing the agreement select "Authorize HIPAA Agreement."



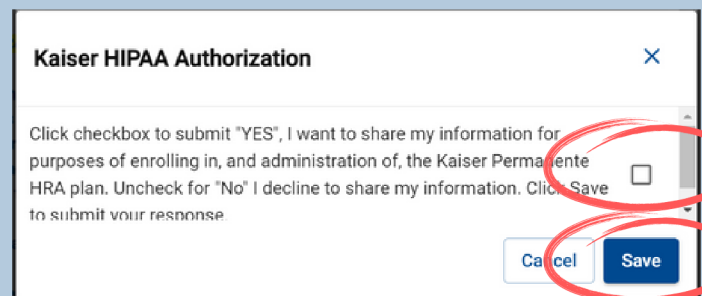
Kaiser HIPAA Authorization

Authorize HIPAA Agreement

UFCW & Employers Trust, LLC Health Reimbursement Account (HRA) Disclosure and Authorization for Kaiser HMO Participants

DISCLOSURE: As a participant in the Fund who has enrolled in the Wellness Program (HCP), you have access to a Health Reimbursement Account ("HRA"). You may use funds in your HRA to pay or be reimbursed for your out-of-pocket expenses. Details concerning your HRA benefit are described in the program materials you will receive or have received from the Fund. In order for the Fund to determine the amounts to be paid or reimbursed to you from your HRA for out of pocket expenses incurred in your Kaiser HMO plan, and for other reporting and administrative purposes, Kaiser will need to provide the Trust Fund Office your demographic information (name, social security number, date of birth, and/or other identifying and contact information) and your claims information (collectively "protected health information" or "PHI"). Specifically, your Kaiser HMO plan (the Kaiser Foundation Health Plan, Inc., Northern California Region) will share information about you with the Trust Fund Office for purposes of administering the HRA feature, but only if you authorize your Kaiser HMO plan to share such information. AUTHORIZATION: I understand that in order to be eligible for the Fund's HRA reimbursements while covered under the Kaiser HMO plan, my PHI will be used and disclosed as described above by my Kaiser HMO plan, and the Trust Fund Office.

C Select the checkbox to submit "Yes" to authorize the Agreement. Then, select "Save."



Kaiser HIPAA Authorization

Click checkbox to submit "YES", I want to share my information for purposes of enrolling in, and administration of, the Kaiser Permanent HRA plan. Uncheck for "No" I decline to share my information. Click Save to submit your response.

Save

Cancel Save

KAISER HIPAA FOR DEPENDENT CHILD AGE 18+ (IF APPLICABLE)

Your Children turning age 18 on or before January 2024 must sign a paper form. You may download a copy of the Kaiser HIPAA Authorization Form from the Open Enrollment website, or by logging into your Participant Account online at ufcwtrust.com. You can then upload a scanned JPG or PDF copy of the signed form to your Participant Account.

35A

Select "Download Kaiser HIPAA Authorization Form" in the "Kaiser HIPAA for Dependent Child (age 18+)" section, and download and print the form. Have the Dependent Child sign and date the Authorization. Scan or take a clear photograph of the complete form.

Kaiser HIPAA for Dependent Child (age 18 +)

Enrolled Dependent Children (age 18+) must complete a paper HIPAA Authorization. Use the buttons below to download a blank Kaiser HIPAA Authorization and upload the signed, scanned copy to the TFO.

Members and Spouse/Domestic Partners that will participating in the Wellness Program (HCP) should each complete their own Kaiser HIPAA Authorization in the Wellness Steps section of their own Open Enrollment tab.

[Download Kaiser HIPAA Authorization Form](#)

[Upload Kaiser HIPAA Authorization Form](#)

35B

Select "Upload Kaiser HIPAA Authorization," and select the scanned PDF or image from your device.

Kaiser HIPAA for Dependent Child (age 18 +)

Enrolled Dependent Children (age 18+) must complete a paper HIPAA Authorization. Use the buttons below to download a blank Kaiser HIPAA Authorization and upload the signed, scanned copy to the TFO.

Members and Spouse/Domestic Partners that will participating in the Wellness Program (HCP) should each complete their own Kaiser HIPAA Authorization in the Wellness Steps section of their own Open Enrollment tab.

[Download Kaiser HIPAA Authorization Form](#)

[Upload Kaiser HIPAA Authorization Form](#)

35C

Select "Kaiser HIPAA Authorization Form" for the question "What is this for?" then click "Upload."

Upload Dependent (age 18+) Kaiser HIPAA Authorization for HRA Funding

Click to upload, or drag and drop files here.

SAMPLE PDF 1
0.03MB pdf

To be uploaded

What is this for?
Kaiser HIPAA Authorization F...

Description

Please Note: Your Member or Spouse Kaiser HIPAA Authorization for HRA reimbursement is completed by you electronically in the Wellness Steps section of your Open Enrollment tab.

- For the 2024 Plan Year if your family will be enrolled in Kaiser and you have enrolled dependent children, age 18+, please download the Kaiser HIPAA Authorization form, and have them sign and date.
- Scan or take a photo of the signed form.
- Upload the scanned photo to the Kaiser HIPAA Authorization document type.

Cancel Upload

You can also submit your form through postal mail, fax, or drop it off in-person to one of our offices:

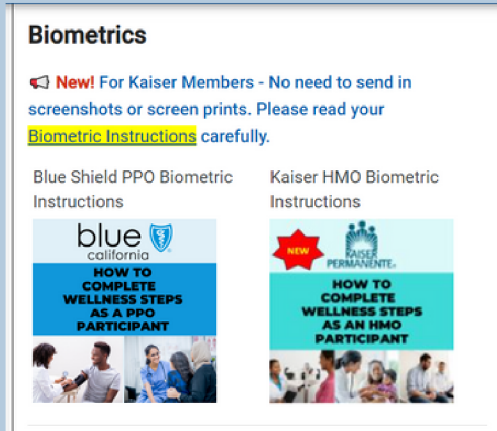
- **Mail:** PO Box 4100, Concord, CA 94524-4100
- **Fax:** Health & Welfare Services Department at (925) 746-7549
- **Concord Drop Off:** 1000 Burnett Ave, Suite 110, Concord, CA 94520
- **Roseville Drop Off:** 2200 Professional Drive, Suite 200, Roseville, CA 95661

Please allow 5-7 business days for the TFO to review and approve your submitted form.

BIOMETRICS

36

Both the Member and the enrolled Spouse or Domestic Partner must each complete their own proof of Biometrics. Click the following "How to Complete Your Biometrics" image and it will direct you to the Instructions section.



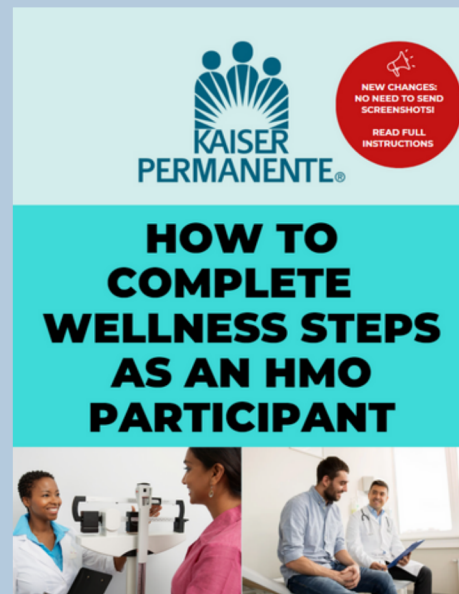
Click or tap on the instructions that pertain to you.

(For example: if you are currently a Blue Shield PPO participant, please use the "Blue Shield PPO Biometric Instructions."

Kaiser HMO Participants would select the Kaiser HMO Biometric Instructions.)

37

Once you've selected the instructions that pertain to you, follow the instructions and to complete your Biometrics.



WARNING: Proof of COVID-19 vaccination will not be accepted in place of a Wellness Step for 2024 Wellness Program participation. You must complete the biometrics as a Wellness Step if you want to participate in the Wellness Program in 2024.

FOR BLUE SHIELD PARTICIPANTS ONLY: QUEST

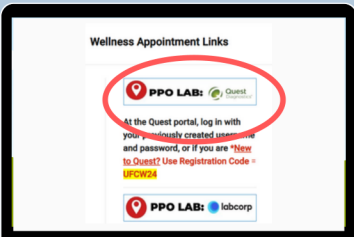


[CLICK HERE FOR BIOMETRICS PPO INSTRUCTIONS](#)

Current Blue Shield participants may make an appointment at a Quest Diagnostics to complete Biometrics, instead of their primary care doctor, without cost.

Members can go to Quest to complete Biometrics instead of their primary care doctor, without cost.

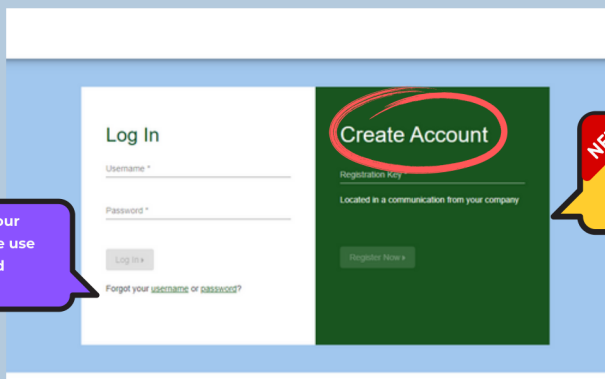
A



Log into your ufcwtrust.com Participant Account. Click on the **"PPO Lab: Quest"** button under Wellness Appointment Links.

You will be directed to my.questforhealth.com If you already have a Quest account, please log in with your Username and Password.

If you don't remember your Login information, please use the [Forgot username and password link here](#)



NEW NEW USERS ONLY: If you are new to Quest, create an account. For the Registration Key please enter "UFCW24"

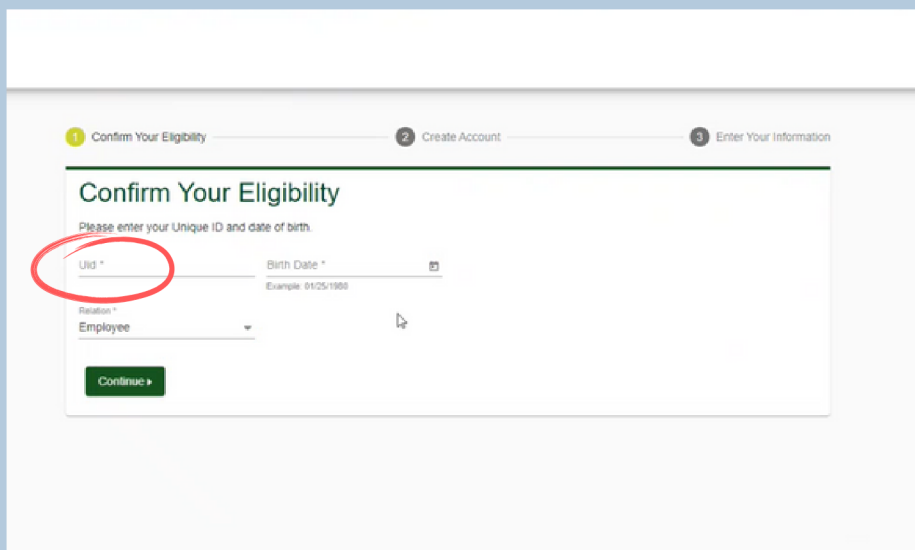
B

If you are creating an account you will see the Confirm your Eligibility page.

For Members: the "UID" will be the 9 digits of your **SSN** + **8 digit Date of Birth**. (EXAMPLE: **12345678901011970**)

For Spouses, the "UID" will be the **Member's SSN** + **Member's 8 digit DOB** (NOT your own) with an "S" (EXAMPLE: **12345678901011970S**)

NEW USERS ONLY

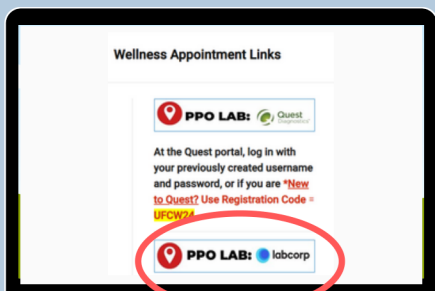


Continue to fill out your information. Once your account is created, continue to fill out your information in each step. You will be prompted to make an appointment.

LABCORP INSTRUCTIONS

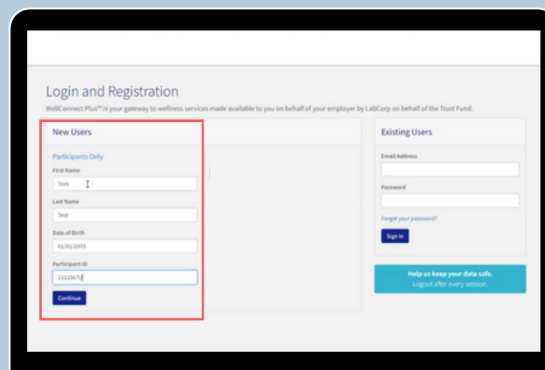
Alternatively, Members can also go to LabCorp to complete Biometrics.

- A** Log into your ufcwtrust.com Participant Account, and select the Open Enrollment tab.



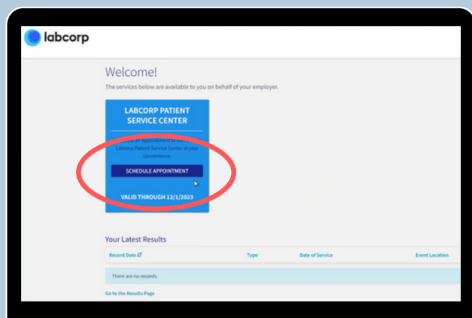
Click on the “**PPO Lab: LabCorp**” button under Wellness Appointment Links.

- B** Under “New Users” please fill out your information in the following fields, then click “Continue”.



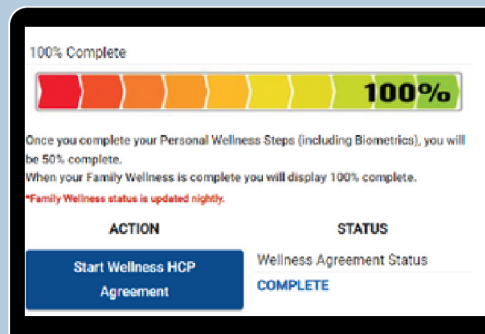
Continue to follow the prompts and fill out your information to register for an account.

- C** Once your account is created, you will be prompted to make an appointment, where you can find a location and schedule a time.



You will be provided a test requisition form, please bring a paper or digital copy with you to the LabCorp facility.

- D** Within 2-3 weeks after your test, go to your ufcwtrust.com Participant Account to view your results.

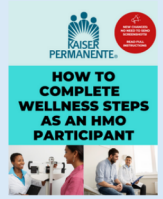


FOR KAISER PARTICIPANTS ONLY:



CLICK HERE FOR BIOMETRICS HMO INSTRUCTIONS

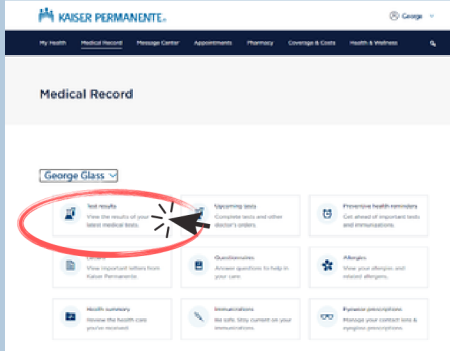
For Kaiser Members - No need to send in screenshots or screen prints.
Please read your Biometric Instructions carefully.



VERIFY GLUCOSE AND CHOLESTROL

A

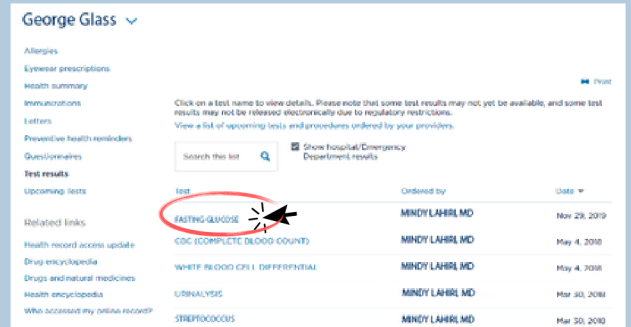
Go to kp.org and log in with your username and password.



Under the Medical Record tab, select the box labeled "Test Results."

B

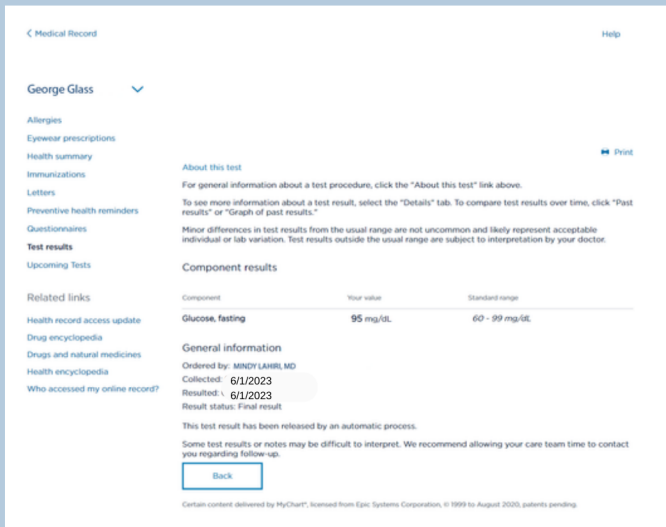
Review your list of previously completed Medical tests and compare the completed tests to the Biometric requirements on page 4 of full instructions.



If you have completed any of the required tests in the specific time period, click on the name of the test to show additional details.

C

Verify the information displayed is the correct test and the test was administered within the correct time frame.



D

Complete any missing tests or labs at a Kaiser Facility. See full instructions for more details.



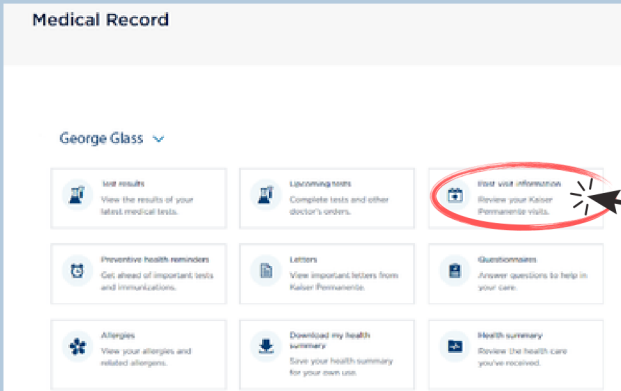
FOR KAISER PARTICIPANTS ONLY: (CONTINUED)

***Your BMI is a combination of your Height and Weight*

TO VERIFY PAST VISITS, BLOOD PRESSURE, & BODY MASS INDEX (BMI)

E

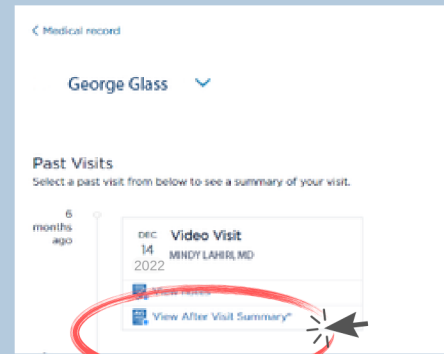
Go to kp.org and log in with your username and password.



Under the Medical Record tab, select the box labeled "Past Visit Information."

F

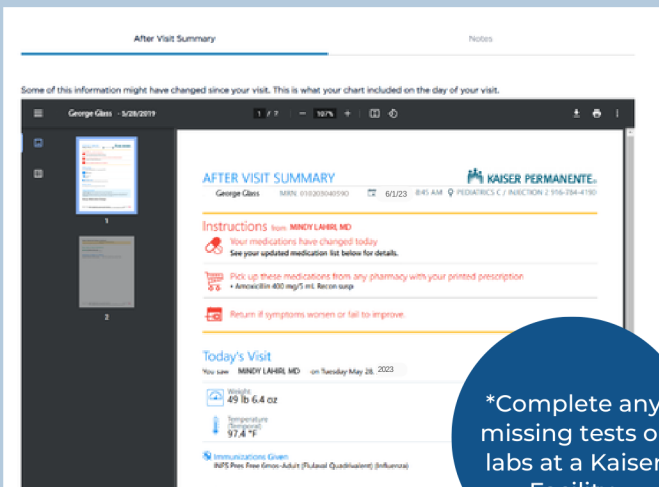
Click "View After Visit Summary". Once the summary is open you'll find your blood pressure, height and weight in this report under the section titled "Today's Visit".



**Hint: if you don't see this information, go back and look in a different in-person visit.*

G

Verify the information displayed is correct and the date is within the stated time frame on page 4 of the full HMO Instructions.



**Complete any missing tests or labs at a Kaiser Facility.*



KAISER PARTICIPANTS SHOULD NO LONGER SEND SCREEN PRINTS. After you've reviewed and completed all Biometric Screenings, you will need to make sure your Kaiser HIPAA Authorization is signed.

The Kaiser HIPAA Authorization must be electronically signed by both you and your Spouse in the Wellness Section under your individual logins. This step allows Kaiser to send the Trust Fund Office your Biometric information, and Reimburse claims with your HRA dollars.

See Kaiser HIPAA instructions on page 13 for more information.

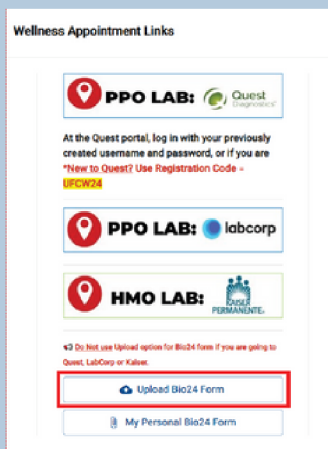
BIOMETRIC UPLOAD



Quest, Labcorp, and Kaiser results are sent to the TFO automatically. You will only need to upload your Proof of Biometrics if you complete your biometrics tests with your physician (the BIO24 form must be signed by your authorized medical provider.)

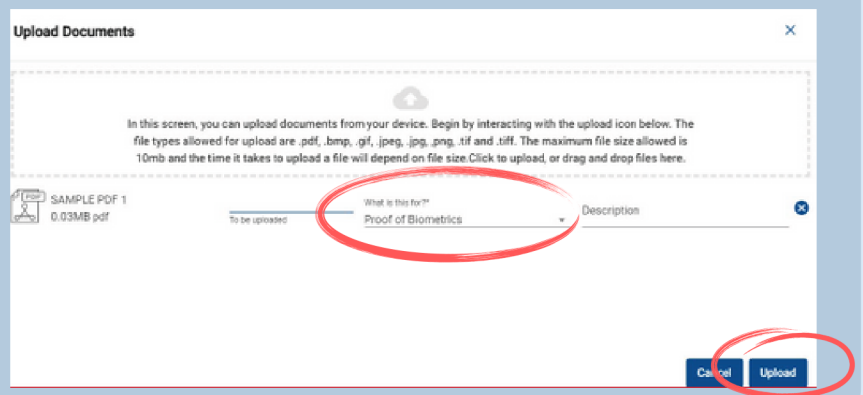
38

Select the "Upload Bio24 Form" button in your Wellness Appointment Links section.



39

Select the scanned BIO24 form on your device. Select "Proof of Biometrics" for the question "What is this for?" and select "Upload."



WELLNESS APPROVAL

40

Once you and your Spouse/Domestic Partner (if applicable) have both completed all Wellness Steps, your Family Wellness status will update, and your status bar will automatically update to 100% complete.

WARNING: Both the Member and the enrolled Spouse or Domestic Partner (if applicable) must individually complete their own Wellness Steps for a household to be complete and participate in the Wellness (HCP) Program for 2024 Plan Year. If you are dropping your Spouse/Domestic Partner from your plan for the 2024 Plan Year, they must still complete Wellness Steps for your household to participate in the 2024 Wellness Program.

