

# 2024

# Open Enrollment

# Live Meeting Retirees



## Benefit Period:

**Medical:** January 1<sup>st</sup> – September 30<sup>th</sup>

**Dental & Vision:** January 1<sup>st</sup> – December 31<sup>st</sup>

# Presenters

- **SISC** – Nicole Henry, Frank Impastato
- **Navitus** – Jeff Bogardus, Chris Mead, Athena Eggers
- **VCCCD Benefits** – Katy Lyon, Janice Endo
- **Burnham Benefits** – Maggie Lepore, Christian Hariot,  
Sheridan Eaddy, Laurine Wood

# Layout

## PART 1

### Presentation

- Burnham
- SISC
- Navitus

## PART 2

### Q&A Session

- **Indicate your question through the Zoom Chat Feature**  
*“Kaiser – Do I have to switch my doctors, and will my member ID stay the same under SISC?”*

# Content

## Agenda

1. Important Dates
2. Benefit Information Resources
3. Steps to Enroll
4. Overview of the *new* Benefit Options
  - Medical
5. Transition of Care
6. What's Next?

# Important Updates

## Benefit Changes

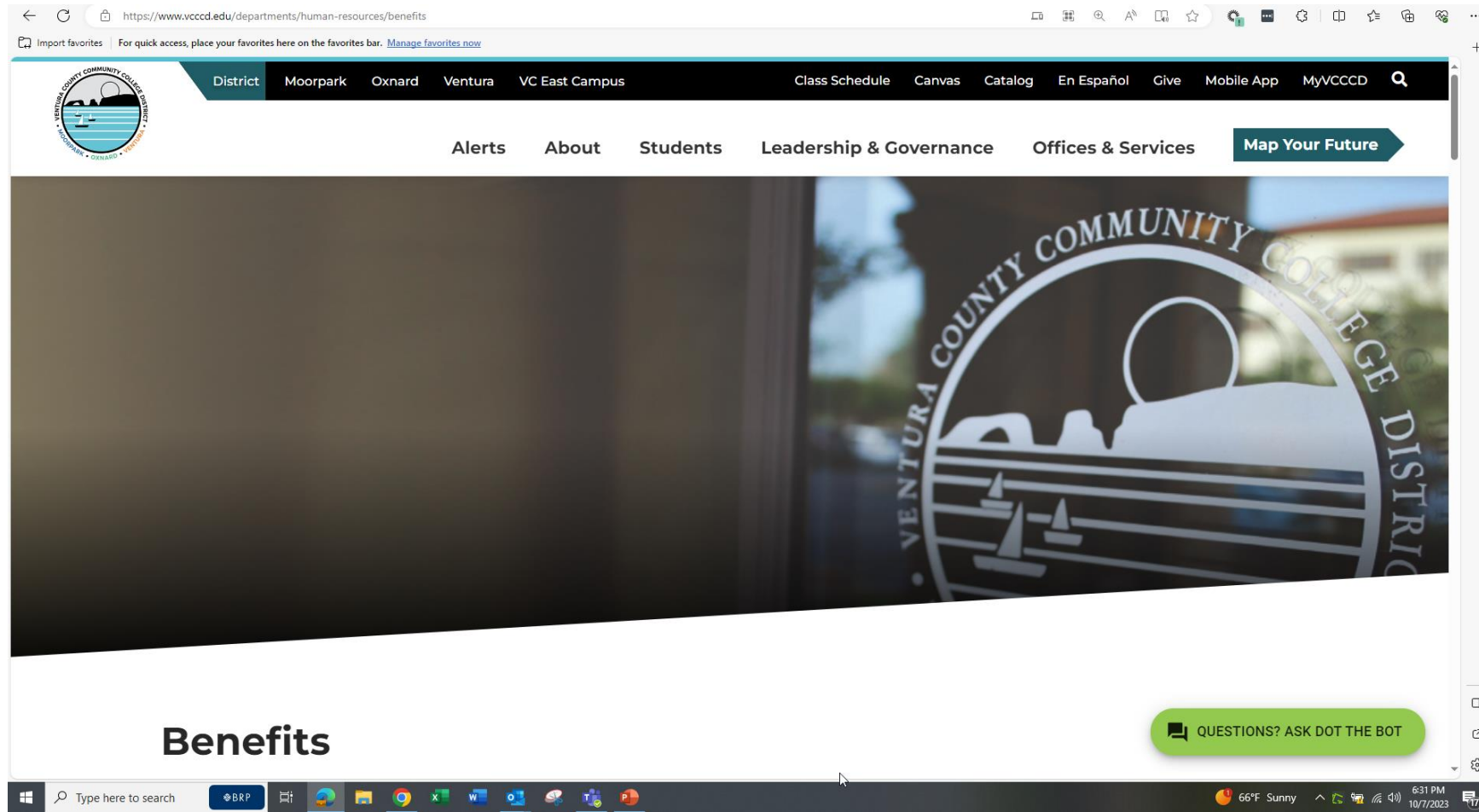
### Medical Plan Changes effective January 1, 2024

- **All CalPERS plans will terminate effective December 31, 2023**
- All medical plans will move to SISC (Self Insured Schools of California)
  - **Completed SISC enrollment forms are required to continue with medical plans through VCCCD.**
  - Plan year will run from **January 1<sup>st</sup> through September 30<sup>th</sup>**
  - Networks **will remain the same** if you are currently enrolled in Anthem, Kaiser (living in California) or a Medicare Supplement plan, with **an option for an expanded network.**
- ✓ **Dental will remain with Delta Dental** *No Action Required*
- ✓ **Vision Plans will remain with EyeMed** *No Action Required*

# Enrollment Information



# Benefits Information Resources

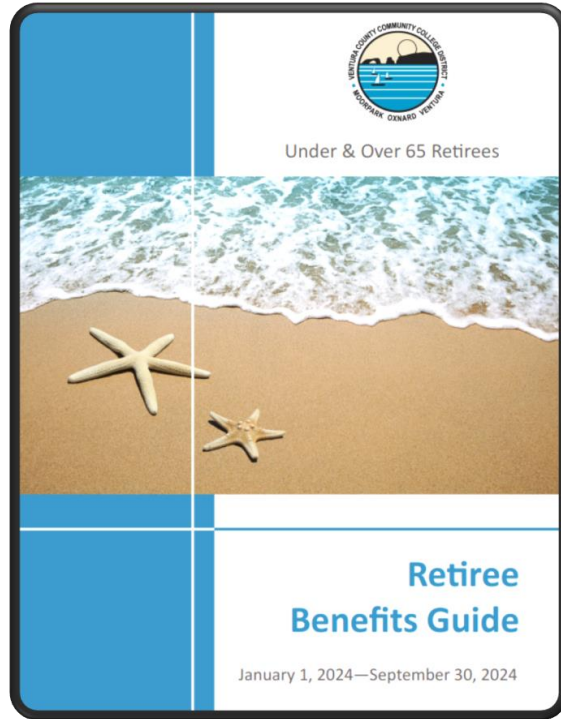


**VCCCD Benefits Website**

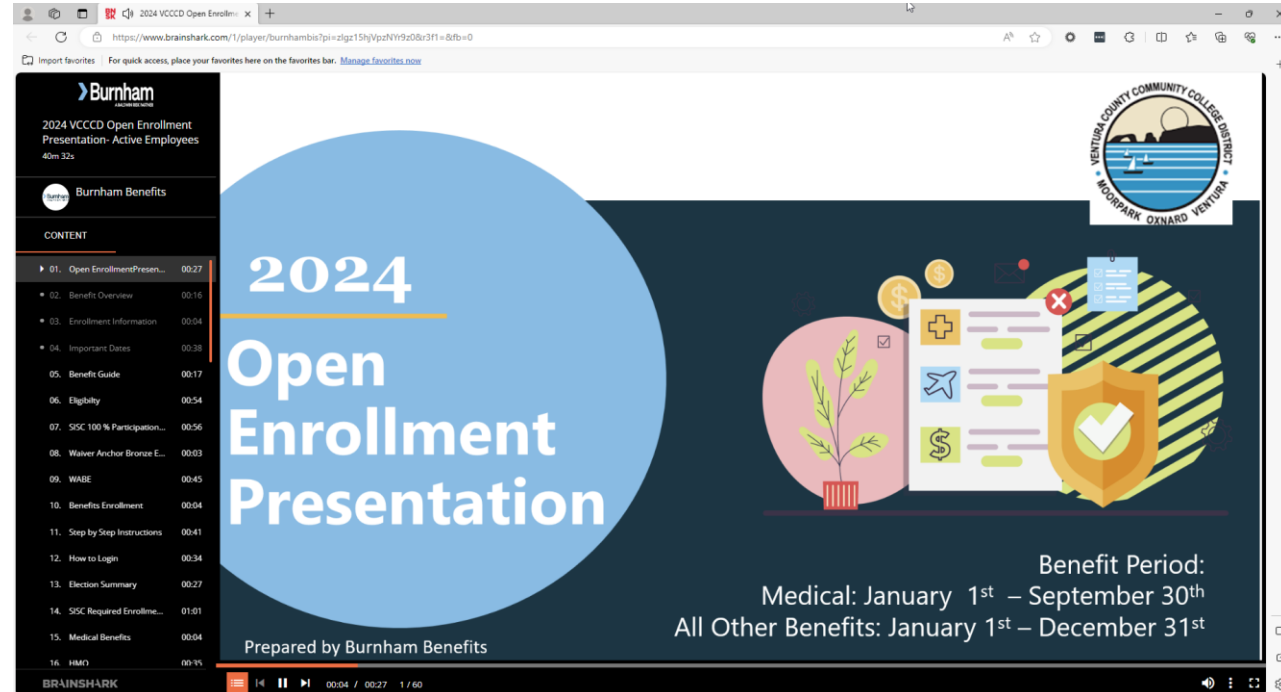
<https://www.vcccd.edu/departments/human-resources/benefits>

# Benefits Information Resources

## Benefits Guide



## Pre-Recorded Open Enrollment Presentation



- How to Enroll
- Benefits Overview
- Resources and Contacts



# Important Dates

Action must be taken before November 1<sup>st</sup> to have medical benefits in 2024

## October / November 2023

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1			

## Plan Year

January 1, 2024  
through  
September 30, 2024

**Open Enrollment:** October 11, 2023 through November 1, 2023

**Plan Year:** January 1, 2024 through September 30, 2024

Medical annual deductible and out-of-pocket maximums are based on a calendar year (January 1<sup>st</sup> – December 31<sup>st</sup>)

# Eligibility

## Eligible Dependents

- Legally married spouse
- Dependent children under age 26
- Domestic partners

## Qualifying Events

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- Loss of dependent coverage from another health plan

**Notify the Benefits Team within 30 days of a qualifying event: [Benefits@vcccd.edu](mailto:Benefits@vcccd.edu)**

**Retirees who decline medical coverage will not be eligible to enroll in SISC medical coverage in the future**



# Enrolling Dependents

## Documentation Required

- **To Enroll a Spouse**
  - ✓ **Prior year's 1040 Federal Tax form** (face page only) that shows the couple was married (financial information may be blocked out). If taxes were not filed jointly, you can complete an Affidavit of Marriage with a copy of the **marriage certificate**. A marriage certificate will be accepted for newly married couples (within 1 year) where prior year tax return is unavailable.
- **To Enroll a Domestic Partner**
  - ✓ **Certificate of Registered Domestic Partnership** issued by the State of California
- **To Enroll a Child**
  - ✓ **Legal Birth Certificate or Hospital Birth Certificate** (to include full name of child, Parent(s) name, and child's date of birth)
  - ✓ **Legal Adoption Documentation**
- **To Enroll a Child of which you are Legal Guardian (up to age 18)**
  - ✓ **Legal U.S. Court Documentation** establishing Guardianship
- **To Enroll a Unmarried Disabled Dependent (over age 26)**
  - ✓ Anthem
    - ✓ **Legal Birth Certificate or Hospital Birth Certificate** (to include full name of child, Parent(s) name, and child's date of birth)
    - ✓ **Prior year's Federal Tax Form** that shows child is claimed as an IRS dependent (First page only, financials can be blocked out)
    - ✓ **Proof of 6 months prior creditable coverage** under the retiree's plan. There can be no break in coverage.
    - ✓ **Completed Anthem Disabled Dependent Certification Form**
  - ✓ Kaiser
    - ✓ **Legal Birth Certificate or Hospital Birth Certificate** (to include full name of child, Parent(s) name, and child's date of birth)
    - ✓ **Prior year's Federal Tax Form** that shows child is claimed as an IRS dependent (First page only, financials can be blocked out)
    - ✓ **Proof of 6 months prior creditable coverage** under the retiree's plan. There can be no break in coverage.

# Eligibility

**Retirees who decline medical coverage will not be eligible to enroll in SISC medical coverage in the future.**

SISC will make a one-time exception for any retiree that have currently opted out. This will be a one-time opportunity to enroll at this open enrollment. If you waive coverage at this open enrollment or in the future, you will not be eligible to enroll back into a SISC plan in the future.



# Eligibility

## Important Medicare Guidelines

Retirees and their spouses/domestic partners that are age 65 or older are required to **provide proof of Medicare Parts A and B.**

- A **copy of the Medicare card** for the retiree and the spouse/domestic partner must be sent to SISC prior to the first of the month in which they turn 65 (or the first of the prior month if the birthdate falls on the first of the month), **or when first enrolled in a SISC plan.**
- Retirees must have **continuous enrollment in Medicare** while enrolled in a SISC retiree plan.
- Medicare will continue to be the **primary insurance for those enrolled that are age 65 or older.**



# Eligibility

## Important Medicare Guidelines

If proof of Medicare is not provided to SISC, a penalty surcharge will be applied to the monthly premium. The surcharge will be applied the first of the month in which the member turns 65 until the Medicare card is produced.

### 2024 Missing Medicare Surcharge

Missing Part A	\$625
Missing Part B	\$625
Missing Parts A and B	\$1,250

Retirees who are ineligible for Free Part A, and currently enrolled in a Basic plan with CalPERS, may remain without Medicare and enroll in an 'under age 65' plan through SISC.



# Plan Options & Contributions

If you are a Tier I, Tier II, or Tier III retiree who is currently eligible for the district contribution towards health coverage, the district will **cover the cost of premiums, in full**, for the plans listed below.

- ✓ SISC/Anthem PPO 90-C Under 65
- ✓ SISC/Anthem PPO 80-G Under 65
- ✓ SISC/Anthem HMO Traditional and Select Under 65
- ✓ Kaiser HMO \$10 Under 65
- ✓ SISC/Anthem PPO 100-A (EGWP) 65+
- ✓ CompanionCare Medicare Supplement 65+
- ✓ Kaiser Senior Advantage Plan (KSPA) 65+



# Options for Retirees & Dependents

You have the option to **Combine Plans** if you and your dependents fall under different categories.

- **Retiree or spouse is over 65 and the other is under age 65:**
  - Both members remain enrolled on the Retiree **under age 65** until both parties turn 65
  - or the **over age 65 person** with both parts of Medicare can enroll in any of the Retiree **over 65 plans** and the **under age 65 person** can remain on the Retiree **under age 65 plan**.
- **Both retiree and spouse are over age 65:**
  - Both members enroll in a Retiree **over 65 plan**
- **Both retiree and spouse are over age 65 and there is a dependent under age 65:**
  - All members remain enrolled on the Retiree **under age 65** until all parties turn 65 and the under 65 dependent drops off
  - Or one parent that is **over age 65** with both parts of Medicare can enroll in any of the Retiree **over 65 plans** and **the other parent and the dependents** can enroll on the Retiree **under age 65 retiree plan**.
    - *Dependent children cannot be on a plan on their own*



# Options for Retirees & Dependents

	Retiree Under 65 Plans available if anyone enrolled is under age 65	Retiree Over 65 Plans available if <u>everyone</u> enrolled is over age 65
<b>Medical Benefits</b>		
SISC Anthem PPO 90-C \$20 5/20 RX Plan	Eligible	N/A
SISC Anthem PPO 80-G \$20 5/20 RX Plan	Eligible	N/A
SISC Kaiser Traditional HMO \$10 10 RX Plan	Eligible	N/A
SISC Anthem HMO Premier Full Network 10 5/20 RX	Eligible	N/A
SISC Anthem HMO Premier Select Network 10 5/20 RX	Eligible	N/A
SISC Anthem Blue Cross PPO 100-A Plan 0/20 RX	N/A	Eligible
Kaiser Permanente Senior Advantage (KPSA)	N/A	Eligible
CompanionCare Medicare Supplement Plan	N/A	Eligible
<b>Dental Benefits</b>		
Delta Dental PPO Plus Premier	Eligible	Eligible
Delta Dental HMO	Eligible	Eligible
<b>Vision Benefits</b>		
EyeMed Vision Plan	Eligible	Eligible

# Transition of Care

## Medical

### New insurance ID cards will be sent by mail

- ✓ **Anthem PPO subscribers and spouses** will receive new cards by mail. ID cards for **Dependent children**, the subscriber must call to request in if they want one.
- ✓ **Anthem HMO members** will all receive new cards. It will be critical that the card is reviewed for medical group/PCP selection. If it is not correct, members must call to have it updated.
- ✓ **Kaiser members** only receive a new card if they haven't gotten one **in the past year**.

# Transition of Care

## Medical

- ✓ When you **seek care after 1/1/24**, make sure to let your providers know that you are covered under a **new insurance policy** and provide them with your new ID card
- ✓ If you are **currently undergoing treatment or have a surgery/procedure scheduled**, **contact your provider** and let them know you will be insured through a new policy
- ✓ If necessary, your provider will **submit the paperwork needed** to transition your care under your new policy

# Transition of Care

## Prescriptions

- ✓ All members will receive new insurance ID cards by mail, which indicate **pertinent Rx coverage information**
- ✓ If you are on a **regular maintenance medication**, you may request a transition of these prescriptions to the new plan by contacting one of the following;
  - Navitus – (866) 333-2757
  - Your Doctor
  - Your Pharmacy
  - *Any one of these, can facilitate the transition of your approved medication to the new plan*
- ✓ If you are taking a prescription that requires a **Prior Authorization**
  - **Fill your Rx** as close to the end of your current plan as possible prior to December 31<sup>st</sup>.
  - **Once the new plan becomes active**, you may either
    - Ask your **doctor** to submit the Prior Authorization to Navitus
    - OR you may call **Navitus\*** to initiate the Prior Authorization and they will contact your doctor on your behalf

You will be notified in writing once your authorization has been approved

\*Navitus Customer Service: (866) 333-2757

# Transition of Care

## Prescriptions

If you have questions regarding if your medication is covered before you are enrolled:

- ✓ Call Navitus Health Solutions at 1-866-333-2757
- ✓ Tell Customer Care you are “New to SISC but not active in the system”
- ✓ Provide Navitus with this code:
  - **100-A EGWP** - Anthem Group number **4R001A (0X20)**
  - **CompanionCare**- Anthem Group number **4R003C (CompanionCare 9X35)**
  - **Under 65 Plans** - **RXPID 5x20, SISC Formulary G**. Make sure you mention “SISC”

# Medical Benefits



# Medical Plan Comparison



## Under 65

	<b>Anthem Blue Cross HMO</b> <b>Full (California Care) Network Only</b>	<b>Anthem Blue Cross HMO</b> <b>Select HMO In-Network Only</b>	<b>Kaiser HMO</b> <b>Kaiser In-Network Only</b>
Calendar Year Deductible - Individual - Family	None None	None None	None None
Calendar Year Out-of-Pocket Max - Individual - Family	\$1,000 \$2,000	\$1,000 \$2,000	\$1,500 \$3,000
Office Visits - PCP - Specialist - Urgent Care	\$10 Copay \$10 Copay \$10 Copay	\$10 Copay \$10 Copay \$10 Copay	\$10 Copay \$10 Copay \$10 Copay
Hospitalization -Inpatient / Outpatient	No Charge / \$10 Copay	No Charge / \$10 Copay	No Charge / \$10 Copay
Emergency Room Waived if Admitted	\$100 Copay	\$100 Copay	\$100 Copay
Prescription Drugs Generic/Brand/Specialty	\$5 / \$20 / \$20	\$5 / \$20 / \$20	\$10 / \$10 / \$10

# Medical Plan Comparison



## Under 65

	Anthem Blue Cross 90-C PPO		Anthem Blue Cross 80-G PPO	
	Prudent Buyer	Non-Network	Prudent Buyer	Non-Network
Calendar Year Deductible - Individual - Family	\$200 \$500		\$500 \$1,000	
Calendar Year Out-of-Pocket Maximum - Individual - Family	\$1,000 \$3,000		\$2,000 \$4,000	
Office Visits - PCP - Specialist - Urgent Care	\$20 Copay \$20 Copay \$20 Copay		\$20 Copay \$20 Copay \$20 Copay	
Hospitalization	Ded, 90%		Ded, 80%	
Emergency Room Waived if Admitted	\$100 Copay + Ded then 10%		\$100 Copay + Ded then 20%	
Prescription Drugs Generic/Brand/Specialty	\$5 / \$20 / \$20 Copay + 50%		\$5 / \$20 / \$20 Copay + 50%	



# Medical Plan Comparison



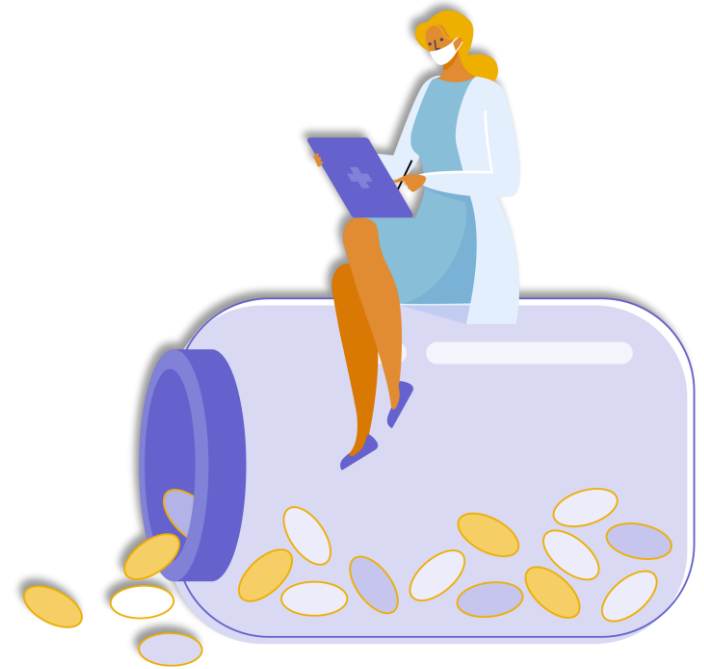
65+

	Anthem PPO 100-A \$0	Anthem COMPANIONCARE	Kaiser Senior Advantage \$10 KPSA
	In-Network	In-Network	In-Network
<b>Calendar Year Deductible</b> <ul style="list-style-type: none"><li>- Individual</li><li>- Family</li></ul>	\$0 \$0	\$0 \$0	\$0 \$0
<b>Calendar Year Out-of-Pocket Maximum</b> <ul style="list-style-type: none"><li>- Individual</li><li>- Family</li></ul>	\$1,000 \$3,000	\$0 \$0	\$1,000 per individual
<b>Office Visits</b> <ul style="list-style-type: none"><li>- PCP</li><li>- Specialist</li><li>- Urgent Care</li></ul>	\$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay \$0 copay	\$10 copay \$10 copay \$10 copay
<b>Inpatient Hospital</b>	Covered 100%	Covered 100%	Covered 100%
<b>Emergency Room</b> Waived if Admitted	\$100 copay	\$0 copay	\$50 copay
<b>Prescription Drugs - Retail</b> Generic/Brand	\$0 / \$20 / \$20	\$9 / \$35	\$10 / \$20 / \$20

Enrollment in Medicare Parts A & B is REQUIRED

# Medical – Prescriptions for PPO Plans

- The Pharmacy Benefit Manager for SISC PPO plans is Navitus Health Solutions
- Mail Order is through Costco Mail Order
- Most pharmacies are in-network with the exception of Walgreen's
- Kaiser members will use Kaiser Pharmacies
- Members may use the mail order pharmacy for their maintenance medications. A member can order a 90-day supply and have the convenience of having the medications shipped directly to their home (or alternate address).



# Reminder:

Everyone must have their enrollment forms and other required documents back to the district office by November 1<sup>st</sup>. Benefits will not rollover from your CalPERS plan.



# Benefits Enrollment



# Benefits Enrollment

All Retirees will receive a packet mailed to their home which includes:

- **Open Enrollment Letter**
- **Benefit Summaries**
- **Enrollment Forms**



# Enrollment Forms - Under 65 or over 65 not enrolled in parts A & B of Medicare

Anthem Plan (PPO or HMO)

Kaiser HMO \$10

Use or print clearly in black ink.

**SECTION I: SELECTED COVERAGE - REQUIRED (DISTRICT USE ONLY)**

ENROLLMENT REASON: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE ☐ COBRA

QUALIFYING DATE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_ HIRE DATE: \_\_\_\_\_ DISTRICT APPROVED INITIALS: \_\_\_\_\_

DISTRICT NAME (DO NOT ABBREVIATE): \_\_\_\_\_ EMPLOYEE GROUP (BARGAINING UNIT): ☐ Certified ☐ Classified ☐ Management EMPLOYEE TYPE: ☐ Full-Time ☐ Part-Time ☐ Variable/Temporary/Seasonal

MEDICAL GROUP NO. \_\_\_\_\_ DENTAL GROUP NO. \_\_\_\_\_ VISION GROUP NO. \_\_\_\_\_ LIFE GROUP NO. \_\_\_\_\_

**SECTION II: EMPLOYEE / APPLICANT INFORMATION - REQUIRED**

SOCIAL SECURITY NO. \_\_\_\_\_ LAST NAME (PRINT) \_\_\_\_\_ FIRST NAME (PRINT) \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ ☐ MALE ☐ FEMALE

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE NO. \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_ IPA (HMO ONLY-REQUIRED) \_\_\_\_\_ PCP (HMO ONLY-REQUIRED) \_\_\_\_\_ CURRENT PROVIDER? ☐ YES ☐ NO

**MEDICARE COVERAGE** If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.

ARE YOU RETIRED? ☐ YES ☐ NO IF YES, DO YOU HAVE MEDICARE? ☐ YES ☐ NO (Copy of Medicare card required) DO ANY OF YOUR DEPENDENTS HAVE MEDICARE? ☐ YES ☐ NO (Copy of Medicare card required)

**SECTION III: DEPENDENT INFORMATION** Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

☐ SPOUSE LAST NAME (PRINT) \_\_\_\_\_ FIRST NAME (PRINT) \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

☐ DOMESTIC PARTNER GENDER: ☐ M ☐ F ☐ DU

☐ SPOUSE/OTHER HEALTH PLAN? ☐ YES ☐ NO ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO DATE OF BIRTH: \_\_\_\_\_ TOTALLY DISABLED? ☐ YES ☐ NO IPA (HMO ONLY-REQUIRED) \_\_\_\_\_ PCP (HMO ONLY-REQUIRED) \_\_\_\_\_ IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ SON LAST NAME (PRINT) \_\_\_\_\_ FIRST NAME (PRINT) \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

☐ DAUGHTER GENDER: ☐ M ☐ F ☐ DU

☐ SPOUSE/OTHER HEALTH PLAN? ☐ YES ☐ NO ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO DATE OF BIRTH: \_\_\_\_\_ TOTALLY DISABLED? ☐ YES ☐ NO IPA (HMO ONLY-REQUIRED) \_\_\_\_\_ PCP (HMO ONLY-REQUIRED) \_\_\_\_\_ IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ SON LAST NAME (PRINT) \_\_\_\_\_ FIRST NAME (PRINT) \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

☐ DAUGHTER GENDER: ☐ M ☐ F ☐ DU

☐ SPOUSE/OTHER HEALTH PLAN? ☐ YES ☐ NO ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO DATE OF BIRTH: \_\_\_\_\_ TOTALLY DISABLED? ☐ YES ☐ NO IPA (HMO ONLY-REQUIRED) \_\_\_\_\_ PCP (HMO ONLY-REQUIRED) \_\_\_\_\_ IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to SISC. If claims were paid on behalf of non-eligible individuals.

**DEDUCTION AUTHORIZATION:** If applicable, I authorize my school district to deduct from my wages the required contribution.

**NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

**HIV Testing Prohibited:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

**EFFECTIVE DATE:** The effective date of coverage is subject to SISC III approval.

Any complaints regarding the exemption due to the Affordable Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

**SECTION IV: SIGNATURE OF UNDERSTANDING - APPLICANT MUST SIGN**

After reading and understanding the provisions outlined on this form, All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under it. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your file. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or other service providers, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

**ARBITRATION AGREEMENT:** I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

**California Region Kaiser Permanente Group Enrollment Form**

Please print or type in black ink only. Make a copy for your records.

**TO BE COMPLETED BY EMPLOYER:**

District Name: \_\_\_\_\_ Hire Date (mm/dd/yyyy): \_\_\_\_\_

Medical Group Number: \_\_\_\_\_ Enrollment Unit: \_\_\_\_\_ Effective Enrollment Date (mm/dd/yyyy): \_\_\_\_\_

Complete this section **ONLY** if dental, vision and/or life insurance is offered through SISC:

Delta Dental Group#: \_\_\_\_\_ Vision Group#: \_\_\_\_\_ SISC Life Ins Group#: Employee Only: \_\_\_\_\_

**A. ENROLLMENT:** New group: Yes ☐ No ☐

☐ New Hire (complete sections A, B, C, D) ☐ Full-Time ☐ Part-Time ☐ Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) ☐ HMO Plan ☐ Deductible Plan ☐ Other \_\_\_\_\_

☐ Loss of Other Coverage (complete sections A, B, C, D) ☐ Other (please specify) \_\_\_\_\_

☐ Event Date (mm/dd/yyyy): \_\_\_\_\_

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

Medical Record No. (if known) \_\_\_\_\_ Social Security No. \_\_\_\_\_ Gender: ☐ M ☐ F

Name (Last, First, MI) \_\_\_\_\_ Birth Date (mm/dd/yyyy) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Ethnicity \_\_\_\_\_ Preferred Language \_\_\_\_\_

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

☐ Add ☐ Spouse ☐ Domestic partner ☐ Med ☐ Den ☐ Vision

Spouse/domestic partner name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Gender: Male ☐ Female ☐ Birth Date (mm/dd/yyyy) \_\_\_\_\_

☐ Add ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision

Dependent name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Birth Date (mm/dd/yyyy) \_\_\_\_\_

☐ Add ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision

Dependent name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Birth Date (mm/dd/yyyy) \_\_\_\_\_

☐ Add ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision

Dependent name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Birth Date (mm/dd/yyyy) \_\_\_\_\_

☐ Add ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision

Dependent name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Birth Date (mm/dd/yyyy) \_\_\_\_\_

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

Name (Last, First, MI): \_\_\_\_\_ Address: \_\_\_\_\_

**D. Kaiser Foundation Health Plan 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 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.

Signature required for all Kaiser Permanente Plans (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans) \_\_\_\_\_ Date: \_\_\_\_\_

\*Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration; the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point of Service (POS) plans; 3) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.


**KAISER PERMANENTE**



# Enrollment Forms - 65+ Enrolled in parts A & B of Medicare

100-A Anthem or CompanionCare Medicare Supplement

Kaiser (KPSA)

 **SISC**  
Self-Insured Schools of California  
Schools Helping Schools

SISC Enrollment Form for following plans:

- ☐ PPO Retiree 65+ with Medicare A&B (EGWP Rx)
- ☐ CompanionCare – Medicare A&B Supplement (Part D Rx)

Please choose one:

- ☐ I am the Retiree
- ☐ I am the Spouse or Domestic Partner (provide name and SSN of the retiree). Separate enrollment form required.

REQUIRED INFORMATION District Use Only	
District Name:	
<input type="checkbox"/> SISC bills District	<input type="checkbox"/> SISC bills Retiree
Medical Group No.	Effective Date
Dental Group No.	Vision Group No.
Bargaining Unit:	

Retiree name	Retiree SSN

Applicant Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(MM / DD / YYYY)

☐ Male ☐ Female

Email address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street, Apt. No., Suite No. City State Zip

I am currently covered under Medicare for:

- ☐ Hospital Part A (Date): \_\_\_\_\_ ☐ Medical Part B (Date): \_\_\_\_\_

I am not currently covered under Medicare Parts A&B. It will be effective on the following dates:

- ☐ Hospital Part A (Date): \_\_\_\_\_ ☐ Medical Part B (Date): \_\_\_\_\_

Medicare Beneficiary Identifier (MBI) Required: \_\_\_\_\_  
(Please attach a photocopy of your Medicare card)

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**Important Note:**  
Each individual must complete their own application, e.g. Retiree and Spouse

**Senior Advantage - Group** Page 1 of 5

**Employer Group Use Only**  
Please provide receipt date of form in this section when submitting on behalf of employee/retiree.

Employer Group #: \_\_\_\_\_ Employer Receipt Date: \_\_\_\_\_

Authorized Rep: \_\_\_\_\_

To Enroll in Kaiser Permanente Senior Advantage, Please Provide the Following Information

Employer or Union Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Ventura County Community College District

LAST Name: \_\_\_\_\_

FIRST Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former Kaiser Permanente Medical/Health Record Number: \_\_\_\_\_

Permanent Residence Street Address (P.O. Box is not allowed): \_\_\_\_\_

City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Mobile Phone Number: \_\_\_\_\_ Birth Date: (mm/dd/yyyy) \_\_\_\_\_

**Mailing Address** (only if different from your Permanent Residence Address)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

926636244 (10/2022)

# What's Next

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## Open Enrollment Action Items:

**All employees are required** to complete their enrollment forms and required documentation by **November 1<sup>st</sup>** if they wish to have medical coverage. **If you do not elect a medical plan during this Open Enrollment, you will not have an opportunity to enroll in a SISC medical plan in the future.**

## Plan Year:

Your coverage period will be *January 1, 2024 - September 30, 2024*

## Questions?

Contact the VCCCD Benefits Department at [benefits@vcccd.edu](mailto:benefits@vcccd.edu)