RETIREE OPEN ENROLLMENT 2011

The month of August 2011 is open enrollment for all eligible retirees who are currently enrolled in SRJC's health plans. This renewal period there are some exciting changes to our coverage!

Effective October 1, 2011 all of the Districts active, early retiree, and over age 65 coverage will be contracted with Self Insured Schools of California (SISC).

The SISC Blue Shield and Kaiser plans available to retirees under age 65 are renewing with no significant changes to the coverage.

- SISC/Blue Shield: No changes at this time
- SISC/Kaiser: Chiropractic copayment reduced to $ 10.00 per visit

The District's over age 65 plans SISC/Companion Care/Medco and SISC/Kaiser Senior Advantage have been renewed with some changes. The changes listed below were designed to reduce the monthly premium while maintaining a very rich plan design.

- SISC/Companion Care/Medco Rx plan changes effective January 1, 2012 are the following:

Generic 30 day supply	$ 9.00
Brand 30 day supply	$ 35.00

- SISC/Kaiser Senior Advantage changes effective October 1, 2011 are the following:

Office Visits reduced to	$ 10.00 Copayment
Outpatient Surgery reduced to	$ 10.00 Copayment
Brand Name Rx reduced to	$ 20.00 Copayment
Hospitalization Admission increased	$200.00 per stay
Durable Medical Equipment increased	20% cost sharing

Enrollment forms and complete summary plan descriptions are available from Louise Burke in Human Resources. This information will also be available on line at www.santarosa.edu/hr in mid August.

If you would like to remain with your current coverage no action on your part is necessary. If you are choosing to switch your medical coverage, enrollment forms must be completed and returned to Human Resources by August 31, 2011. The coverage you elect will remain in effect October 1, 2011 through September 30, 2012.

The rates listed below are the full monthly premium and are not offset by retiree stipends or Early Retirement Option provisions. Once open enrollment concludes you will receive a letter confirming your coverage and any premium amount due from you.

If you have any questions please contact Louise Burke, in the Human Resources Department at (707) 527-4304 or lburke@santarosa.edu.

RETIREE RATES

KAISER

Single Kaiser	(1) under 65	$ 453.00
Double Kaiser	(2) under 65	$ 973.00
Family Kaiser	(3) or more under 65	$1,335.00
Single Sr. Advantage	(1) over 65	$ 309.00
Double Sr. Advantage	(2) over 65	$ 618.00
Senior Advantage + 1	(1) over 65(1) under 65	$ 760.00

SISC/BLUE SHIELD & COMPANION CARE

Single Blue Shield	(1) under 65	$ 567.00
Double Blue Shield	(2) under 65	$ 1,227.00
Family Blue Shield	(3) or more under 65	$1,704.00
Single Companion Care	(1) over 65	$ 427.00
Double Companion Care	(2) over 65	$ 854.00
Companion Care + 1	(1) over 65(1) under 65	$ 994.00

SRJC DENTAL – NO INCREASE TO PREMIUMS FOR NEW PLAN YEAR

Single	(1)	$ 78.60
Double	(2)	$ 169.00
Family	(3) or more	$ 235.85

Although August 2011 is not an open enrollment year for our dental plan, a small change to our dental coverage and annual benefit maximum will become effective October 1, 2011.

Once the changes have been finalized an updated Summary Plan Description will be posted to the Human Resources website at www.santarosa.edu/hr.

Proposed Benefit Summary
600115 SISC-Self Insured Schools of California

Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (10/1/11—9/30/12)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary and in accord with Medicare guidelines
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area, except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*)

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Deductible or Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$10 per visit
Routine physical exams	$10 per visit
Eye exams for refraction	$10 per visit
Hearing exams	$10 per visit
Urgent care consultations, exams, and treatment	$10 per visit
Physical, occupational, and speech therapy	$10 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most X-rays, annual mammograms, and laboratory tests	No charge
Manual manipulation of the spine	$10 per visit
Health education:	
Most individual health education counseling	$10 per visit
Covered health educational programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$200 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
Note: This Cost Sharing does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition for covered Services (see "Hospitalization Services" for inpatient Cost Sharing)	
Ambulance Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	$10 for up to a 100-day supply
Most brand-name items	$20 for up to a 100-day supply
Durable Medical Equipment	**You Pay**
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20 percent Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$200 per admission
Individual outpatient mental health evaluation and treatment	$10 per individual visit
Group outpatient mental health treatment	$5 per group visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$200 per admission
Individual outpatient chemical dependency evaluation and treatment	$10 per visit
Group outpatient chemical dependency treatment	$5 per visit

continues

continued

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge
Other	**You Pay**
Eyewear purchased at Plan Medical Offices or plan optical sales offices every 24 months	Amount in excess of $150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	20 percent Coinsurance

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For an explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

COMPANIONCARE/Medicare Supplement Plan
BENEFIT SUMMARY
(Based on Calender Year)

SERVICES	MEDICARE 2011 Benefits	COMPANIONCARE Based on 2011 Medicare Benefits
Inpatient Hospital (Part A)	*Pays all but first **$1132** for 1st 60 days*	*Pays $1132*
	*Pays all but **$283** a day for the 61st to 90th day*	*Pays $283 a day*
	*Pays all but **$566** a day Lifetime Reserve for 91st to 150th day*	*Pays $566 a day*
	Pays nothing after Lifetime Reserve is used	*Pays 100% for 151st day to 515th day*
Skilled Nursing Facilities (Must be approved by Medicare)	*Pays 100% for 1st 20 days*	*Pays nothing*
	*Pays all but **$141.50** a day for 21st to 100th day*	*Pays $141.50 a day for 21st to 100th day*
	Pays nothing after 100th day	*Pays nothing after 100th day*
Deductible (Part B)	***$162** Part B deductible per year*	*Pays $162*
Basis of Payment (Part B)	*80% Medicare Approved (MA) charges after Part B deductible*	*20% MA charges including 100% of Medicare Part B deductible*
Medical Services (Part B) Doctor, x-ray, appliances & ambulance	*80% MA charges*	*20% MA charges*
Lab	*100% MA charges*	*Pays nothing*
Physical/Speech Therapy (Part B)	*80% MA charges up to the Medicare annual benefit amount.*	*20% MA charges up to the Medicare annual benefit amount. (PT & STh Combined)*
Blood (Part B)	*80% MA charges after 3 pints*	*Pays 1st 3 pints unreplaced blood and 20% MA charges*
Travel Coverage (when outside the US for less than 6 consecutive months)	*Not covered*	*Pays 80% inpatient hospital, surgery, anesthetist and in hospital visits for medically necessary services for 90 days of treatment per lifetime*

Outpatient Prescription Drugs	**Rx drug plan enhanced through Medco Health Effective 10/1/2011 thru 12/31/2011**		**Rx drug plan enhanced through Medco Health Effective January 1, 2012**	
Due to Medicare restrictions the following programs are not available with CompanionCare:	**Retail Pharmacy:** 30 day supply	$7 Generic co-pay $25 Brand co-pay	**Retail Pharmacy:** 30 day supply	$9 Generic co-pay $35 Brand co-pay
Costco & Prilosec $0 co-pay; Diabetic Supplies for Generic co-pay	**Mail Order:** 90 day supply	$14 Generic co-pay $60 Brand co-pay	**Mail Order:** 90 day supply	$18 Generic co-pay $90 Brand co-pay

COMPANIONCARE is a Medicare Supplement plan that pays for medically necessary services and procedures that are considered a Medicare Approved Expense. SISC will atuomatically enroll CompanionCare Members into Medicare Part D. No additional premium required. SISC plans are NOT subject to the 'doughnut hole'.

Notation: The standard Medicare Part B monthly premium is $115.40 for 2011.

Eligibility: Member must be retired and enrolled in Medicare Part A (hospital) and Medicare Part B (medical) coverage. Retirees under age 65 with Medicare for the disabled (Parts A&B) may enroll in CompanionCare.

Enrollment: Enrollment forms and a copy of the Medicare card must be received by SISC 45 days in advance of requested effective date - NO exceptions. SISC will automatically enroll members in Medicare Part D for outpatient prescription medications. Members already enrolled in non-SISC Medicare Part D plans will be automatically disenrolled from those plans.

Disenrollment: Members can enroll into Medicare Part D plans outside of SISC with a January 1 effective date. Please note they will lose SISC medical coverage at the same time. SISC requires that members be enrolled in both medical and prescription drug (Medicare Part D) coverage. Members can not enroll into a Medicare Part D plan outside of SISC and retain SISC medical coverage.

Provider Network: Physicians who accept Medicare Assignment.

For additional Medicare benefit information, please go to www.medicare.gov or call 1-800-medicare.

For additional Medco prescription drug information, please go to www.medco.com or call 1-800-596-7986.

Rate Effective October 1, 2011	**Total Cost Per Person**
Retirees with Medicare A & B **(SISC will enroll members in part D)**	**$427.00**

Kaiser Permanente Senior Advantage (HMO)
ELECTION FORM
Northern California Region or Southern California Region Group Plan

IMPORTANT INFO – Read *all* pages before signing this form

Complete and return this form to become a Kaiser Permanente Senior Advantage (HMO) member. If you and your spouse are both applying, you'll each need to complete a separate form. For help completing this form, call **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

- You're entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this election form signifies that you've read, understand, and agree to these provisions. Kaiser Permanente is a health plan with a Medicare contract.
- You must be enrolled in Medicare Part B. You must live inside our Senior Advantage service area to enroll. Check the ZIP codes/counties listed in the *Evidence of Coverage* to be sure you qualify for enrollment.
- If you have end-stage renal (kidney) disease (ESRD), you may not become a member of Senior Advantage unless one of the following is also true:
  - You were diagnosed with ESRD while you were already a Kaiser Permanente member in the Northern California region or the Southern California region, and you are enrolling during an allowable election period. To be eligible, there must be no break in coverage between your current Kaiser Permanente coverage and the start of your coverage in our Senior Advantage plan.
  - You were in a Medicare Advantage (or Medicare+Choice) plan that left the Medicare program or stopped providing coverage in your area on or after December 31, 1998, and you have not yet used your one-time enrollment exception to enroll in a Medicare health plan.
  - You've had a successful kidney transplant and you attach a note or records from your doctor showing that you've had a kidney transplant and no longer need regular dialysis.
  - You belong to an employer group or union/trust fund plan who terminated their contract with another insurer and selected Kaiser Permanente as a plan option for their employees.

ABOUT THE ELECTION PROCESS - Submitting your form

- After completing pages 1-3, read the sections titled "Release of Information" and "Conditions of Election" at the end of this form. Then sign and date page 3.
- Keep the bottom white copy of this form. If required, send the middle yellow copy to your employer group or union/trust fund. Return the top, signed white copy in the enclosed postage-paid envelope to:

  Kaiser Permanente – Medicare Unit
  P.O. Box 232400
  San Diego, CA 92193-2400

- We'll review your form for completeness and required signatures and then contact you by mail that we have received it.
- We'll notify Medicare that you've applied to join Senior Advantage.
- Within 10 calendar days after Medicare confirms your eligibility, we'll confirm the effective date of your coverage. We'll send you a Kaiser Permanente ID card and information for new members.

Top white original signed copy – Kaiser Permanente
Yellow copy - Employer group/union/trust fund
Bottom white copy – Keep for your records

COMPLETE THE REQUIRED FIELDS BELOW

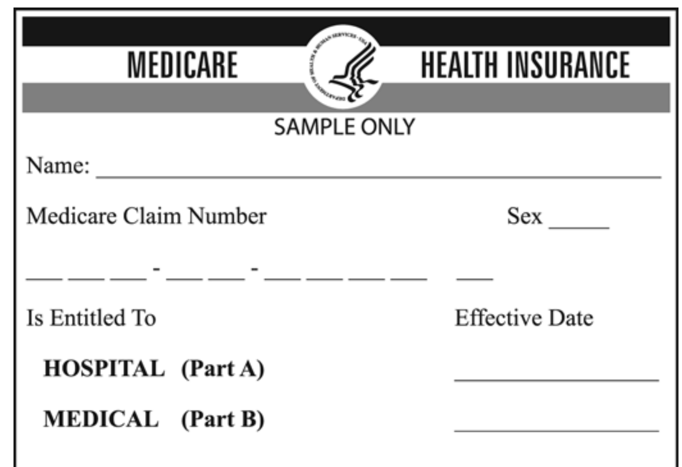
Last Name	First Name	Middle Initial	Gender ☐ M ☐ F
Permanent residence street address (Street Address ONLY – No P.O. Box)			Apt #
County	City	State	ZIP
Mailing address (if different from permanent residence)			Apt #
County	City	State	ZIP
Daytime phone number	Evening phone number		Date of Birth
Providing the following information is optional:			
E-mail address			
Other contact: Name		Phone number	

MEDICARE HEALTH INSURANCE CARD (REQUIRED INFO)

Complete this sample Medicare Health Insurance card with the information found on your own Medicare card. Copy each line exactly as it appears.

If you prefer, you may include a photocopy of your Medicare verification letter (Letter of Award from Social Security or the Railroad Retirement Board) that provides the same information.

You must have Medicare Part B to join a Medicare Advantage plan.



MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: ______________________________

Medicare Claim Number Sex ____

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To Effective Date

HOSPITAL (Part A) ____________

MEDICAL (Part B) ____________

Last Name: ______________________ First Name: ______________________

ADDITIONAL REQUIRED INFORMATION

1. Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No
   If yes: ☐ Current ☐ Former Kaiser Permanente Medical Record Number ______________
2. Do you currently have end-stage renal (kidney) disease? ☐ Yes ☐ No
   If yes, provide: Diagnosis date (mm/dd/yyyy) ____ / ____ / ______
   Transplant date ____ / ____ / ______
   See the section titled "Important info" on the cover page for more information about enrolling with ESRD.
3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If yes, provide: Date of admission ____ / ____ / ______
   Name of institution ______________________ Phone ______________
   Address ______________________ City ______________ State ____ ZIP ________

4a. Are you actively working for an employer with 20 or more employees who provides employee group health insurance coverage for you? ☐ Yes ☐ No
   If no, are you retired? ☐ Yes Retirement date ____ / ____ / ______

4b. Is your spouse actively working for an employer with 20 or more employees who provides employee group health insurance for you? ☐ Yes ☐ No
   If yes, provide name of spouse's employer ______________________

5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Workers' Compensation, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Senior Advantage? ☐ Yes ☐ No
   If yes, list other coverage and ID number(s) for this coverage:
   Name of other coverage ______________________
   ID# for this coverage ______________________ Group # for this coverage ______________
6. Requested effective date (subject to CMS approval) ____ / ____ / ______

☐ Check here if you prefer to receive info in Spanish

This information is available in a different format or in Spanish by calling **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

Puede obtener esta información en un formato diferente o en español llamando al **1-800-443-0815** (TTY **1-800-777-1370**), los siete días de la semana, de 8 a.m. a 8 p.m.

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose one coverage option for your Senior Advantage plan and complete the information below.

Employer Group/Union/Trust Fund Name ______________________

Employer Group/Union/Trust Fund ID# ______________________ Subgroup ______________

Requested effective date (subject to CMS approval) ____ / ____ / ______

Last Name: ______________________ First Name: ______________________

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 1560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (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*.

RELEASE OF INFORMATION

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Kaiser Permanente will release my information, including any prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

READ "CONDITIONS OF ELECTION" BEFORE SIGNING AND DATING BELOW (REQUIRED INFO)

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this election form means that I have read and understand the contents of this election form. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment; and 2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

Signature of applicant *or* signature of authorized representative ______________________ Date ____ / ____ / ______

Authorized representative name (please print) ______________________ Relationship ______________

Address ______________________ Phone ______________

Signature of any person who assisted in completing this form ______________________ Date ____ / ____ / ______

INTERNAL USE ONLY

Date ______________ Lang Pref ______________

Rep ______________ ☐ IEP ☐ ICEP ☐ AEP ☐ SEP

CONDITIONS OF ELECTION – By completing this form, I agree to the following:

1. I will read the Senior Advantage *Evidence of Coverage (EOC)* when I get it to know which rules I must follow in order to get coverage in this Medicare Advantage plan. If I don't receive a copy of the *EOC*, I may call Kaiser Permanente at **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.
2. I understand that Kaiser Permanente is a health plan with a Medicare contract.
3. I must maintain my enrollment in Medicare Part B.
4. I can be in only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.
5. If I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Senior Advantage plan.
6. It's my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
7. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
8. I understand that I must enroll in the Senior Advantage service area in which I reside. I understand that it's my obligation to notify Kaiser Permanente if I permanently move or leave the service area for more than six months in a row.
9. I may leave this plan at any time by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE** (**1-800-633-4227** or TTY **1-877-486-2048**), 24 hours a day / 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.
10. I understand that starting on the effective date of my coverage, I must receive all of my covered health care from Kaiser Permanente, except for emergency care, out-of-area urgent care when our network is not available, dialysis care while temporarily outside the service area, or authorized referrals. If I obtain routine care from non-Plan providers, neither Kaiser Permanente nor Medicare will be responsible for the costs. I will refer to the Senior Advantage *EOC* for more information about covered benefits and services. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. Services authorized by Kaiser Permanente and other services contained in my Kaiser Permanente Senior Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.
11. Once I become a member of Senior Advantage, I have the right to appeal plan decisions about payment/services.
12. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.
13. Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
14. If I am a Kaiser Permanente Medicare Cost member enrolling in Senior Advantage, I understand that the Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

If you currently have health coverage from an employer or union/trust fund, joining Senior Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Senior Advantage. Read the communications your employer or union/trust fund sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any info on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read carefully before you sign this form.

For District Use Only
Medical Group No.
Effective Date

SISC Medicare Supplemental Coverage CompanionCare Application Form

Application Information – Applicant must complete this section.

Name ________________________________ Social Security Number ______________
(Last) (First) (M)

❑ Male ❑ Female Date of Birth (Month/Day/Year) _____/_____/_____

Home Address ____
Street, Apt. No., Suite No. City State Zip

Care of/Attention ____________________________ Home Telephone Number ______________

Billing Address ____
(if different from home address)

If transferring from another group or plan, indicate:
I am covered under Medicare for: ❑ Hospital Part A
❑ Medical Part B

I am not currently covered under Medicare Parts A & B ❑ I will be covered effective on ____/____/____

Medicare Beneficiary ID Number Required ______________________(Please attach a photocopy of your Medicare ID card)

I understand that the following conditions apply as a part of this coverage:

1. Health conditions which you may presently have (pre-existing conditions) will be covered immediately.
2. If a retiree transfers to a SISC Medicare Supplemental Plan the retiree may not transfer back to a regular SISC plan.
3. If your doctor does not accept Medicare Assignment, you will be responsible for the difference between the Medicare allowable charge and the doctor's billed charges.
4. Coverage under this policy will be effective on the first day of the month following a period of 45 days after the application and initial premium payment are received.
5. If you cancel your CompanionCare coverage, it is the member's responsibility to notify their local Medicare office or Medicare at 1-800-Medicare (1-800-633-4227) within 63 days after coverage ends to select a new Medicare Part D plan.

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 ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

Employee Signature ______________________________ ***Date*** ______________________

NOTICE OF PRIVACY PRACTICES

FOR THE USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 3, 2006

Anyone has the right to ask for a paper copy of this Notice at any time.

Q. Why are you providing this Notice to me?

A. The SISC Health Benefits Plan is required by federal law, the Health Insurance Portability and Accountability Act (HIPAA), to make sure that your Protected Health Information (PHI) is kept private. This law applies to the health benefits offered through SISC, including SISC Flex, the Health Reimbursement Arrangements (SISC HRA) and the Health Savings Account (SISC HSA). We must give you this Notice of our legal duties and Privacy Practices with respect to your PHI. We are also required to follow the terms of the Notice that is currently in effect. PHI includes information that we have created or received about your past, present, or future health or medical condition that could be used to identify you. It also includes information about medical treatment you have received and about payment for health care you have received. We are required to tell you how, when, and why we use and/or share your Protected Health Information (PHI).

Q. How and when can you use or disclose my PHI?

A. HIPAA and other laws allow or require us to use or disclose your PHI for many different reasons. We can use or disclose your PHI for some reasons without your written agreement. For other reasons, we need you to agree in writing that we can use or disclose your PHI. We describe in this Notice the reasons we may use your PHI without getting your permission. Not every use or disclosure is listed, but the ways we can use and disclose information fall within one of the descriptions below.

So you can receive treatment. We may use and disclose your PHI to those who provide you with health care services or who are involved in your care. These people may be doctors, nurses, and other health care professionals. For example, if you are being treated for a knee injury, we may give your PHI to the people providing your physical therapy. We may also use your PHI so that health care can be offered or provided to you by a home health agency.

To get payment for your treatment. We may use and disclose your PHI in order to bill and get paid for treatment and services you receive. For example, we may give parts of your PHI to our billing or claims department or others who do these things for us. They can use it to make sure your health care providers are paid correctly for the health care services you received under a health plan.

To operate our business. We may use and disclose your PHI in order to administer our health plans. For example, we may use your PHI in order to review and improve the quality of health care services you receive. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are obeying the laws that affect us. Another time when we may provide PHI to other organizations is when we ask them to tell us about the quality of our health plans and how we operate our business. Before we share PHI with other organizations, they must agree to keep your PHI private.

To meet legal requirements. We share PHI with government or law enforcement agencies when federal, state, or local laws require us to do so. We also share PHI when we are required to in a court or other legal proceeding. For example, if a law says we must report private information about people who have been abused, neglected, or are victims of domestic violence, we share PHI.

To report public health activities. We share PHI with government officials in charge of collecting certain public health information. For example, we may share PHI about births, deaths, and some diseases. We may provide coroners, medical examiners, and funeral directors information that relates to a person's death.

For health oversight activities. We may share PHI if a government agency is investigating or inspecting a health care provider or organization.

For purposes of organ donation. Even though the law permits it, we do not share PHI with organizations that help find organs, eyes, and tissue to be donated or transplanted.

For research purposes. We do not use or disclose your PHI in order to conduct medical research.

To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement or people who may be able to stop or lessen the harm.

For specific government functions. We may share PHI for national security reasons. For example, we may share PHI to protect the president of the United States. In some situations, we may share the PHI of veterans and people in the military when required by law.

For workers' compensation purposes. We may share PHI to obey workers' compensation laws.

For information about health-related benefits or services. We may use PHI to give you information about other health care treatment services, or benefits.

A plan amendment has been adopted to protect your PHI as required by law. The plan amendment allows PHI to be shared with the plan sponsor (SISC III Board of Directors) for purposes of treatment, payment, health care operations and for other reasons related to the administration of the SISC Health Benefits Plan.

Other Uses and Disclosures Require Your Prior Written Agreement. In other situations, we will ask for your written permission before we use or disclose your PHI. You may decide later that you no longer want to agree to a certain use of your PHI for which we received your permission. If so, you may tell us that in writing. We will then stop using your PHI for that certain situation. However, we may have already used your PHI. If we had your permission to use your PHI when we used it, you cannot take back your agreement for those past situations.

Q. Will you give my PHI to my family, friends, or others?

A. We may share medical information about you with a friend or family member who is involved in or who helps pay for your medical care when you are present. For example, if one of our home health nurses or case managers visits you at your home or in the hospital and your mother is with you, we may discuss your PHI with you in front of her. We will not discuss your PHI with you when others are present if you tell us not to.

In order to enroll you in a health plan, we may share limited PHI with your employer or other organizations that help pay for your membership in the plan. However, if your employer or another organization that pays for your membership asks for specific PHI about you, we will get your permission before we disclose your PHI to them.

There may be a situation in which you are not present or you are unable to make health care decisions for yourself. Then we may use or share your PHI if professional judgment says that doing so is in your best interests. For example, if you are unconscious and a friend is with you, we may share your PHI with your friend so you can receive care.

Q. What are my rights with respect to my PHI?

A. You have the right to ask that we limit how we use and give out your PHI. You also have the right to request a limit on the PHI we give to someone who is involved in your care or helping pay for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had. We will consider your request. However, we are not required to agree to the request. If we accept your request, we will put any limits in writing. We will honor these limits except in emergency situations. You may not limit the ways we use and disclose PHI when we are required to make the use or disclosure.

You have the right to ask that we send your PHI to you at an address of your choice or to communicate with you in a certain way if you tell us that this is necessary to protect you from danger. You must tell us in writing what you want and that the reason is you could be put in danger if we do not meet your request. For example, you may ask us to send PHI to your work address instead of your home address. You may ask that we send your PHI by e-mail rather than regular mail.

You have the right to look at or get copies of your PHI that we have. You must make that request in writing. You can get a form to request copies or look at your PHI by calling the SISC Privacy Officer. If we do not have your PHI, we will tell you how you may be able to get it. We will respond to you within 30 days after we receive your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, the reasons we are denying your request. We will also explain your right to have our denial reviewed.

If you ask for a copy of your PHI, we will charge you a reasonable fee based on the cost of copying and postage. We can send you all your PHI, or if you request, we may send you a summary or general explanation of your PHI if you agree to the cost of preparing and sending it.

You have the right to get a list of instances in which we have given out your PHI. The list will not include: a) disclosures we made so you could get treatment; b) disclosures we made so we could receive payment for your treatment; c) disclosures we made in order to operate the Plan; d) disclosures made directly to you or to people you designated; e) disclosures made for national security purposes f) disclosures made to corrections or law enforcement personnel; g) disclosures we made before we sent you this Notice; or h) disclosures we made when we had your written permission.

We will respond within 60 days of receiving your written request. The list we give you can only include disclosures made after April 14, 2003, the date this Notice became effective. We cannot provide you a list of disclosures made before this date. You may request a list of disclosures made the six years (or fewer) preceding the date of your request. The list will include a) the date of the disclosure; b) the person to whom PHI was disclosed (including their address, if known); c) a description of the information disclosed; and d) the reason for the disclosure. We will give you one list of disclosures per year for free. If you ask for another list in the same year, we will send you one if you agree to pay the reasonable fee we will charge for the additional list.

You have the right to ask us to correct your PHI or add missing information if you think there is a mistake in your PHI. You must send us your request in writing and give the reason for your request. You can get a form for making your request by calling the SISC Privacy Officer. We will respond within 60 days of receiving your written request. If we approve your request, we will make the change to your PHI. We will tell you that we have made the change. We will also tell others who need to know about the change to your PHI.

We may deny your request if your PHI is a) correct and complete, b) not created by us, c) not allowed to be disclosed, or d) not part of our records. If we deny your request, we will tell you the reasons in writing. Our written denial will also explain your right to file a written statement of disagreement. You have the right to ask that your written request, our written denial, and your statement of disagreement be attached to your PHI anytime we give it out in the future.

Q. How may I complain about your Privacy Practices?

A. If you think that we may have violated your Privacy rights, you may send your written complaint to the address shown at the bottom of this notice. You also may make a complaint to the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint about our Privacy Practices.

Q. How will I know if my rights described in this Notice change?

A. We reserve the right to change the terms of this Notice and our Privacy Policies at any time. Then the new Notice will apply to all your PHI. If we change this Notice, we will put the new Notice on our website at and mail a copy of the new Notice to our subscribers (but not to dependents).

Q. Who should I contact to get more information or to get a copy of this Notice?

A. For more information about your Privacy rights described in this notice, or if you want another copy of the Notice, please visit our website where you can download the Notice. You may also write us at Self-Insured Schools of California, 1300 17th Street, Bakersfield, CA 93301. Further information may also be obtained by calling SISC's Privacy Officer at (661) 636-4887.

ANNUAL NOTICE: Women's Health and Cancer Rights Act (WHCRA)

Your Plan is required to provide you annually with the following notice, which applies to breast cancer patients who elect to have reconstructive surgery in connection with a mastectomy.

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for reconstructive surgery, in a manner determined in consultation with the attending physician and the patient, for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to a plan's deductibles, coinsurance or copayment provisions.

If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact your Plan Administrator.