District Use Only	
District Name:	
Medical Group No.	**Effective Date**
40003A	
Dental Group No.	**Vision Group No.**
❑ **SISC bills District**	❑ **SISC bills Retiree**

SISC CompanionCare
Medicare Supplemental Coverage Application for Medical and Prescription Drug Benefits

(Continuous enrollment in Medicare A&B required)

Applicant Name: ____
(Last) (First) (MI)

Social Security Number: ____________________ Date of Birth: _______________
(MM / DD / YYYY)

❑ Male ❑ Female Email address: _______________________________________

Home Address:

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

Care of/Attention: ______________________________ Home Phone 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 and/or ❑ Medical Part B

I am not currently covered under Medicare Parts A & B ❑ I will be covered effective ________________

Medicare ID Number Required: ________________________________
(Please attach a photocopy of your Medicare card)

SISC CompanionCare – Medicare Supplemental Coverage Application
For Medical and Prescription Drug Benefits
(Continuous enrollment in Medicare A&B required)

Applicant Name: ____
(Last) (First) (MI)

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/spouse/domestic partner transfers to a SISC Medicare Supplemental Plan, they **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. This application form and a copy of the applicant's Medicare card **MUST** be received by SISC **45 calendar days** in advance of the requested effective date.
5. Since CompanionCare is single coverage a **separate** application and/or disenrollment form **MUST** be completed by **EACH** applicant.
6. To CANCEL this coverage, the SISC Disenrollment form **MUST** be completed and received by SISC **45 calendar days** in advance of the requested termination date. Both Medical and Prescription drug benefits will be canceled.
7. It will also be your responsibility as the applicant to notify **Medicare at 1-800-Medicare (1-800-633-4227)** within 63 days after coverage ends to select a new Medicare Part D plan.
8. Application and/or Disenrollment forms must be completed signed and returned to SISC 45 calendar days in advance of the requested effective date. **No Exceptions.**

Please Read and Sign Below

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.)

Applicant Signature Required: ____Date: ___________________

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date: ________________________

Member Name: ____

Address: ____

____

Phone: ____

Member ID: <Member ID>

Medicare Health Insurance Claim #: ____

(From red, white and blue Medicare card)

Name of Medicare Prescription Drug Plan: __________________________________

Please check all boxes that apply to you.	Dates of Coverage (month/year)
I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP). Name: __________________________________	From: __________________ To: __________________
I had creditable* prescription drug coverage from Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state. Name of SPAP: ___________________________ If you are in an SPAP, what state do you live in: _______________________________________	From: __________________ To: __________________
I had prescription drug coverage through my VA benefits (veterans, survivor, or dependent benefits).	From: __________________ To: __________________

I had prescription drug coverage through my TRICARE or other military coverage.	From: __________________ To: __________________
I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage.	From: __________________ To: __________________
I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U).	From: __________________ To: __________________
I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly).	From: __________________ To: __________________
I had creditable* prescription drug coverage from a different source not listed above. Name of other source: _____________________	From: __________________ To: __________________
I have/had extra help from Medicare to pay for my prescription drug coverage.	From: __________________ To: __________________
I lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) and I joined a Medicare prescription drug plan before December 31, 2006. Name of Parish: __________________________	From: __________________ To: __________________
I never had creditable* drug coverage	

* “Creditable” means that your prior coverage met Medicare’s minimum standards.

Please complete this section:

“To the best of my knowledge, the information on this form is true and correct. I understand that if I didn’t have creditable coverage and/or don’t give proof of creditable prescription drug coverage if asked, my premium may be higher.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this document means that I have read and understand the contents of this declaration. 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 Navitus MedicareRx (PDP) by Medicare.”

Signature: ____

Date: *(month/day/year):* ____________________________________

If you are the representative, you must provide the following information:

Name: ____

Address: ____

____

City: ___________________________ State: _______ ZIP: ________

Phone Number: (______) _________- ______________

Relationship to Member: ____

This plan, Navitus MedicareRx (PDP), is offered by Navitus Health Solutions and underwritten by Dean Health Insurance, Inc., a Federally-Qualified Medicare Contracting Prescription Drug Plan

Navitus MedicareRx (PDP) is offered by Navitus Health Solutions
P.O. Box 1039■ Appleton, WI 54912-1039
Navitus MedicareRx Customer Care: 1-866-270-3877 ■ TTY: 711
Hours of Operation: 24 hours a day/7 days a week (Except Thanksgiving and Christmas)
■ Website: https://www.medicarerx.navitus.com

S9701_801_2016_ALL_LEP10_V01

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 manager's 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 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, 2000 K 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.

COMPANIONCARE/Medicare Supplement Plan
BENEFIT SUMMARY
As of January 1, 2018

(Based on Calendar Year)

SERVICES	MEDICARE 2018 Benefits	COMPANIONCARE Based on 2018 Medicare Benefits
Inpatient Hospital (Part A)	Pays all but first **$1340** for 1st 60 days	Pays **$1340**
	Pays all but **$335** a day for the 61st to 90th day	Pays **$335** a day
	Pays all but **$670** a day Lifetime Reserve for 91st to 150th day	Pays **$670** a day
	Pays nothing after Lifetime Reserve is used (refer to Evidence of Coverage)	Pays 100% after Medicare and Lifetime reserve are Exhausted up to 365 days per lifetime
Skilled Nursing Facilities (Must be approved by Medicare)	Pays 100% for 1st 20 days	Pays nothing
	Pays all but **$167.50** a day for 21st to 100th day	Pays **$167.50** a day for 21st to 100th day
	Pays nothing after 100th day	Pays nothing after 100th day
Deductible (Part B)	**$183** Part B deductible per year	Pays **$183**
Basis of Payment (Part B)	80% Medicare Approved (MA) charges after Part B deductible	Pays 20% MA charges including 100% of Medicare Part B deductible
Medical Services (Part B) Doctor, x-ray, appliances & ambulance	80% MA charges	Pays 20% MA charges
Lab	100% MA charges	Pays nothing
Physical/Speech Therapy (Part B)	80% MA charges up to the Medicare annual benefit amount.	Pays 20% MA charges up to the Medicare annual benefit amount. (PT & ST Combined)
Blood (Part B)	80% MA charges after 3 pints	Pays 1st 3 pints un-replaced 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. For details call Anthem customer service 1-800-825-5541.

Outpatient Prescription Drugs	Medicare Part D Prescription drug plan through Navitus Health Solutions			
Due to Medicare restrictions the following programs are not available with CompanionCare: $0 generic copay at Costco & Diabetic Supplies for Generic co-pay	**Retail Pharmacy:**	30 day supply	$9 Generic co-pay	$35 Brand co-pay
	Mail Order:	90 day supply	$18 Generic co-pay	$90 Brand co-pay
	Pharmacy benefits are administered through Navitus Health Solutions MedicareRx using a Med D formulary. Some exclusions and prior authorizations may apply. Members that have questions regarding their medication coverage can call Navitus Health Solutions MedicareRx at 1-866-270-3877 or TYY users please call 711.			

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

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 calendar 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: Disenrollment throughout the year requires submission of a disenrollment form to SISC with a 45 calendar day advance notice of requested effective date. During the annual Med D Open Enrollment members can enroll into Medicare Part D plans outside of SISC with a January 1 effective date. Enrollment in a Med D plan outside of SISC will terminate the SISC medical and Rx benefits.

Provider Network: Physicians who accept Medicare Assignment.

For additional Medicare benefit information, please go to www.medicare.gov or call 1-800-medicare (1-800-633-4227).
For additional Navitus Medicare Rx prescription drug information, please go to www.navitus.com or call 1-866-270-3877.

BENEFIT MATRIX

NAVITUS MEDICARERX (PDP) PRESCRIPTION DRUG PLAN FOR THE SELF-INSURED SCHOOLS OF CALIFORNIA

BENEFIT STRUCTURE	Retail Network Pharmacy (up to 31 day Supply)	Navitus 90 Day Retail Network Pharmacy (up to 90 day Supply)	Network Mail Order Pharmacy (up to 90 day Supply)
Tier 1 Consists of formulary preferred generics and certain low-cost brand name drugs	$9 copayment	$27 copayment	$18 copayment
Tier 2 Consists of formulary preferred brand name drugs and certain higher-cost generic drugs	$35 copayment	$105 copayment	$90 copayment

Prior Authorization
We cover prescribed drugs and medication according to a drug formulary. Certain prescription drugs included in the formulary require prior authorization. The drug prior authorization process can be initiated by your primary care provider or treating physician by filling out and submitting a Drug Prior Authorization Request form. Notification of a determination will then be mailed to both you and the prescribing physician. If prior authorization is required to obtain a prescription but it is not obtained, then no benefits are available for that prescription. For information on a particular drug, you may contact your prescriber or contact our Navitus MedicareRx Customer Care Center at 1-866-270-3877.