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: Santa Monica-Malibu Unified School District		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	Home 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 Spouse/domestic partner name: Gender: Male ☐ Female ☐	☐ Med ☐ Den ☐ Vision	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter Dependent name:	☐ Med ☐ Den ☐ Vision	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter Dependent name:	☐ Med ☐ Den ☐ Vision	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter Dependent name:	☐ Med ☐ Den ☐ Vision	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

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 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.

Signature required for all Kaiser Permanente Plans **Date**

(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

**Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

KAISER PERMANENTE®

Santa Monica-Malibu Unified School District

Plan Comparison & ***Kaiser*** Summary

2022-2023	Kaiser HMO
Plan Description Name	**Trad HMO $15**
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**
Individual/Family Deductibles	**$0**
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	**$1,500/$3,000**
PROFESSIONAL SERVICES	
Office Visit (OV) co-pay	$15
Urgent Care co-pay	$15
Specialists/Consultants co-pay	$15
Prenatal, postnatal office visit co-pay	$0
Scans: CT, CAT, MRI, PET etc.	$0
Diagnostic X-ray & Laboratory Procedures	$0
Infertility (Refer to Plan Document)	Co-pay applies
Preventive Care (includes physical exams & screenings)	$0
HOSPITAL & SKILLED NURSING FACILITY SERVICES	
Emergency Room visit (copay waived if admitted)	$100
Inpatient Hospital (preauthorization required) - limits may apply	$0
Outpatient Hospital	$15
Surgery, Outpatient (performed in Surgery Center)	$15
Surgery, Outpatient (performed in a Hospital) - limits may apply	$15
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT	
INPATIENT: Facility Based Care (preauth required)	$0
OUTPATIENT: Facility Based Care (preauth required)	$15
OTHER SERVICES	
Ambulance (Ground or Air)	$50
Acupuncture - Limits apply - Must use ASH Network	$10/30 visits combined w/chiro
Chiropractic - Limits apply - Must use ASH Network	$10/30 visits combined w/acu
Durable Medical Equipment (DME)	no charge
Physical and Occupational Therapy - Limits apply	$15
Hearing Aids	Amount in excess of $500 allowance every 36 months
PHARMACY BENEFITS	**Custom $5-$20 (30 day)**
Pharmacy Benefit Manager	**Kaiser**
Individual/Family Brand & Specialty Rx Deductibles	**none**
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	**Included w/ Med OOP Max**
Generic co-pay/30 days supply	$5 up to 30 day supply
Brand co-pay/30 days supply	$20 up to 30 day supply
Specialty co-pay/up to 30 days supply	$20 up to 30 day supply
Mail Order (Generic-Brand co-pay/90 days supply)	$10-$40/up to 100 day supply
Mail Order Pharmacy	Kaiser Mail Order Pharmacy

Please initial in the box under the plan you wish to enroll in

Initial

PRINT YOUR NAME CLEARLY

DATE

I understand the only time I may change from one Medical Plan to another Medical Plan is during the district's designated Open Enrollment Period for an effective date of October 1. if I gain a new dependent (marriage, birth or adoption) I can add those dependents by completing a Change Form but I cannot change my Medical Plan except during Open Enrollment.

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the district.

ELIGIBILITY DOCUMENTATION CHECKLIST

The following verification documents are required to enroll a subscriber or dependent in health benefit plans. SISC requires the Social Security Numbers for all members to be covered on the plans and reserves the right to request additional documentation to substantiate eligibility.

Dependent Type	Required Documentation
Spouse	• Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out). • For newly married couples where prior year tax return is not available a marriage certificate will be accepted.
Domestic Partner	• Certificate of Registered Domestic Partnership issued by State of California (Enrolling a Domestic Partner may cause the employer contribution to become taxable).
Children, Stepchildren, and/or Adopted Children up to age 26	• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name, and child's DOB) • Legal Adoption Documentation
Legal Guardianship up to age 18	• Legal U.S. Court Documentation establishing Guardianship
Disabled Dependents over age 26 (requires enrollment in a SISC medical plan)	**Anthem Blue Cross (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Anthem Disabled Dependent Certification Form **Blue Shield (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage. • Completed Declaration of Disability for Overage Dependent Child **Kaiser (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Disabled Dependent Enrollment Application • Most recent Kaiser Certification notice (if available)
Retirees and/or Dependents on a Retiree Plan Age 65 or Over	• Proof of enrollment in Medicare Part A & Part B (copy of current Medicare card or Medicare enrollment confirmation letter showing effective dates of Part A and Part B)