

Kaiser Permanente Senior Advantage (HMO)

Election form

Northern California or Southern California Region Group Plan

Filling out and returning the enrollment form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, call our Member Services Contact Center at **1-800-443-0815 (TTY 711)**, seven days a week, 8 a.m. to 8 p.m.

How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign the form on page 5 and date it. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:
Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400
4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Senior Advantage.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

Last Name [] First Name []

6. Are you a resident in a long-term care facility, such as a nursing home? [] Yes [] No

If yes, please provide the following information:

Name of institution: []

Address of institution (number and street): [] Phone Number: [] - [] - []

7. Requested effective date (subject to CMS approval): [] / [] / []

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

[] Spanish [] Large Print [] Braille [] CD

Please contact Kaiser Permanente at 1-800-443-0815 if you need information in an accessible format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 711.

Please complete the information below

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name: []

Employer Group/Union/Trust Fund ID #: [] Subgroup: [] Requested effective date (subject to CMS approval): [] / [] / []

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however some employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't 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. 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.

I understand that 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 union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Senior Advantage plan.

Last Name

First Name

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Senior Advantage **Evidence of Coverage** document from Kaiser Permanente when I receive it in order to know which rules I must follow to get coverage with this Medicare Advantage plan. 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.

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency, urgently needed services or out-of-area dialysis services.

Services authorized by Kaiser Permanente and other services contained in my 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.**

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.

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 necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including my 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 enrollment 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.

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 application means that I have read and understand the contents of this application. 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 from Medicare.

Last Name [] First Name []

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that, if I select a health insurance plan ("health plan") that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the health plan (except for Small Claims Court cases, claims governed by the ERISA claims procedure regulation, and other claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the 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 in the health plan's coverage document, which is available for my review.

Signature: []

Today's Date: [] / [] / []

If you are the authorized representative, you must sign above and provide the following information:

Name: []

Address: []

Phone Number: [] - [] - [] Relationship to Enrollee: []

Office Use Only: Name of staff member/agent/broker (if assisted in enrollment): [] Plan ID #: [] Effective Date of Coverage: [] / [] / [] ICEP/IEP: [] AEP: [] SEP (type): [] Not Eligible: []

Kaiser Permanente Senior Advantage (HMO)

Formulario de elección

Plan de Grupo de la Región del Norte de California o del Sur de California

Completar y enviar el formulario de inscripción es su primer paso para convertirse en miembro de Kaiser Permanente Senior Advantage. Si tanto usted como su cónyuge están solicitando afiliarse, cada uno de ustedes necesitará llenar un formulario por separado. Si desea ayuda para completar el formulario de inscripción, llame a nuestra Central de Llamadas de Servicio a los Miembros al **1-800-443-0815 (TTY 711)**, los siete días de la semana, de 8 a. m. a 8 p. m.

Cómo llenar este formulario

1. Responda todas las preguntas y escriba sus respuestas con pluma de tinta negra o azul. Marque las casillas con una X.
2. Firme en la página 5 del formulario e incluya la fecha. **Asegúrese de leer todas las páginas antes de firmar.**
3. Envíe por correo el formulario original firmado a:
Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400
4. Saque una copia para sus archivos. Si se le solicita, envíe una copia al grupo del empleador, al sindicato o al fondo fiduciario.

Siguientes pasos

- Revisaremos su formulario para asegurarnos de que esté completo. Luego, le informaremos por correo que lo recibimos.
- Informaremos a Medicare que usted solicitó inscribirse a Senior Advantage.
- En un plazo de 10 días calendario después de que Medicare confirme su inscripción, le informaremos la fecha de inicio de su cobertura. Luego, le enviaremos una tarjeta de identificación de Kaiser Permanente y su paquete de nuevo miembro en un plazo de 10 días a partir de su fecha de inicio.

Kaiser Permanente es un plan de una HMO con un contrato de Medicare. La inscripción en Kaiser Permanente depende de la renovación del contrato.

Employer Group Use Only (Para Uso Exclusivo del Grupo del Empleador)

Please, provide receipt date of form in this section when submitting on behalf of employee/retiree.

Employer Group #:

Employer Receipt Date: / /

Authorized Rep:

Comuníquese con Kaiser Permanente si necesita información en otro idioma o en algún formato accesible (Braille).

Para Inscribirse en Kaiser Permanente Senior Advantage, Proporcione la Siguiete Información

Nombre del Empleador o Sindicato:

N.º de Grupo:

APELLIDO:

Sr. Sra. Srita.

NOMBRE:

Inicial del Segundo Nombre: Sexo: Hombre Mujer

¿Actualmente es miembro de algún plan de salud de Kaiser Permanente, o lo fue anteriormente? Sí No Si marcó "Sí": Actual Antiguo

Número de Historia Clínica de Kaiser Permanente:

Dirección de la Residencia Permanente (no se permiten los Apartados Postales):

Ciudad:

Condado:

Estado: Código Postal:

Número de Teléfono de su Casa: - -

Número de Teléfono Alternativo: - -

Fecha de Nacimiento: (mm/dd/aaaa) / /

Dirección Postal (solo si es diferente a su Dirección de Residencia Permanente)

Dirección:

Ciudad:

Estado: Código Postal:

Dirección de Correo Electrónico:



Apellido Nombre

Proporcione la Información de Su Seguro de Medicare

Saque su tarjeta roja, blanca y azul de Medicare para llenar esta sección.

- Llene esta información como aparece en su tarjeta de Medicare.

- O BIEN -

- Adjunte una copia de su tarjeta de Medicare o su carta del Seguro Social o de la Junta de Jubilación de Empleados Ferroviarios.

Nombre (como aparece en su tarjeta de Medicare):

Número de Medicare:

Tiene Derecho a: Fecha de Vigencia:

HOSPITAL (Parte A) / /

MÉDICO (Parte B) / /

Debe tener Medicare Parte B; sin embargo, algunos grupos de empleadores requieren tanto la Parte A como la Parte B para poder afiliarse a un plan Medicare Advantage.

Lea y Responda Estas Preguntas Importantes

1. ¿Trabaja usted o su cónyuge? Sí No

2. Si su empleador brinda cobertura para jubilados, ¿usted es la persona jubilada? Sí No N/C

Si la respuesta es "sí", fecha de jubilación (mm/dd/aaaa): / /

Fecha de jubilación (mm/dd/aaaa):

 / /

Si la respuesta es "no", nombre de la persona jubilada:

3. ¿La cobertura de este plan del empleador o sindicato incluye al cónyuge o a dependientes? Sí No

Si la respuesta es "sí", nombre del cónyuge:

Nombres de los dependientes:

4. ¿Tiene Insuficiencia Renal Terminal (IRT)? Sí No

Si le hicieron un trasplante de riñón con éxito o ya no necesita hacerse diálisis de forma regular, **incluya una nota o los registros** de su médico que indiquen que le hicieron un trasplante de riñón con éxito o que ya no necesita diálisis; de lo contrario, es posible que necesitemos comunicarnos con usted para obtener información adicional.

5. Es posible que algunas personas tengan otra cobertura de medicamentos, incluidos otro seguro privado, compensación del trabajador, beneficios por parte de VA o programas de asistencia farmacéutica del Estado.

¿Tendrá usted cobertura adicional para medicamentos de venta con receta aparte de la de Kaiser Permanente? Sí No

Si la respuesta es "sí", anote su cobertura adicional y sus números de identificación para dicha cobertura.

Nombre de la cobertura adicional:

N.º de identificación de la cobertura adicional:

Apellido Nombre

6. ¿Vive en un centro de cuidados a largo plazo, como un hogar para ancianos? Sí No

Si la respuesta es "sí", proporcione la siguiente información:

Nombre de la institución:

Dirección de la institución (número y calle): Número de Teléfono: - -

7. Fecha de vigencia solicitada (sujeta a la aprobación de los CMS): / /

Marque una de las casillas que aparecen a continuación si preferiría que le enviáramos la información en un idioma que no sea inglés o en otro formato accesible:

Español Letra Grande Braille CD

Llame a Kaiser Permanente al **1-800-443-0815** si necesita información en un formato accesible u otro idioma diferente al que se mencionó anteriormente. Nuestro horario de atención es de 8 a. m. a 8 p. m., los siete días de la semana. Los usuarios de TTY deben llamar al **711**.

Llene la siguiente información

Si actualmente cuenta con cobertura de Kaiser Permanente a través de más de un empleador o sindicato/fondo fiduciario, debe elegir UN empleador o sindicato/fondo fiduciario a través del cual recibir su cobertura Senior Advantage. Llene la información de ese empleador o sindicato/fondo fiduciario a continuación.

Nombre del Grupo/Sindicato/Fondo Fiduciario del Empleador:

N.º de Identificación del Grupo/Sindicato/
Fondo Fiduciario del Empleador: Subgrupo: Fecha de vigencia solicitada (sujeta a la aprobación de los CMS): / /

Lea y Firme a Continuación

Al completar este formulario de inscripción, acepto los siguiente:

Kaiser Permanente es un plan de Medicare Advantage y tiene un contrato con el gobierno Federal. Tendré que conservar mi cobertura de Medicare Parte B; sin embargo, algunos grupos de empleadores requieren tanto la Parte A como la Parte B. Solo puedo estar afiliado a un plan de Medicare Advantage a la vez y entiendo que mi inscripción en este plan pondrá fin a mi inscripción en otro plan de salud de Medicare automáticamente. Es mi responsabilidad informarles de cualquier cobertura para medicamentos de venta con receta que tenga o pudiera obtener en el futuro. Entiendo que si no tengo cobertura de medicamentos de venta con receta de Medicare o una cobertura de medicamentos de venta con receta acreditada (tan buena como la de Medicare), es posible que deba pagar una penalización por inscripción tardía, si me inscribo en la cobertura para medicamentos de venta con receta de Medicare más adelante. Puedo abandonar este plan en cualquier momento enviando una solicitud a Kaiser Permanente o llamando al **1-800-MEDICARE (1-800-633-4227 o TTY 1-877-486-2048)**, las 24 horas del día, los 7 días de la semana. Sin embargo, antes de solicitar la cancelación de la afiliación, consultaré a mi grupo o sindicato/fondo fiduciario para determinar si puedo continuar como miembro del grupo.

Entiendo que si actualmente tengo cobertura de Kaiser Permanente a través de más de un empleador o sindicato/fondo fiduciario, debo elegir una de estas opciones de cobertura para mi plan Senior Advantage porque solo puedo estar inscrito en un plan Senior Advantage a la vez. Es posible que mi otro empleador o sindicato/fondo fiduciario me permita inscribirme también en uno de sus planes que no pertenecen a Medicare. Me comunicaré con los administradores de beneficios de cada empleador o sindicato/fondo fiduciario para comprender la cobertura a la que tengo derecho antes de tomar una decisión acerca de qué plan de empleador o sindicato/fondo fiduciario elegiré para mi plan Senior Advantage.

Apellido Nombre

Kaiser Permanente brinda sus servicios en un área de servicio específica. Si me mudo del área donde brinda sus servicios Kaiser Permanente, necesito notificárselo al plan para poder cancelar mi afiliación y encontrar otro plan en mi nueva área. Una vez que sea miembro de Kaiser Permanente, tengo derecho a apelar las decisiones del plan sobre los pagos o servicios con los que no esté de acuerdo. Leeré el documento **Evidencia de Cobertura** de Senior Advantage de Kaiser Permanente cuando lo reciba para informarme de las reglas que debo seguir para obtener cobertura por medio de este plan de Medicare Advantage. Entiendo que las personas que tienen Medicare generalmente no tienen la cobertura de Medicare cuando están fuera del país, a excepción de una cobertura limitada cerca de la frontera de los Estados Unidos.

Entiendo que a partir de la fecha en la que inicie la cobertura de Senior Advantage, debo recibir toda mi atención médica por parte de Kaiser Permanente, excepto los servicios de emergencia o de urgencia, o los servicios de diálisis fuera del área.

Se cubrirán los servicios autorizados por Kaiser Permanente y otros servicios que se incluyan en el documento **Evidencia de Cobertura** (conocido también como un contrato de membresía o un acuerdo de suscripción) de Senior Advantage. **NI MEDICARE NI KAISER PERMANENTE PAGARÁN LOS SERVICIOS** si no se tiene autorización.

Entiendo que si recibo asistencia por parte de un representante o agente de ventas, u otro individuo que trabaje o tenga contrato con Kaiser Permanente, es posible que se pague a dicha persona con base en mi inscripción en Kaiser Permanente.

Divulgación de Información

Al afiliarme a este plan de salud de Medicare, reconozco que el plan de salud de Medicare divulgará mi información a Medicare y a otros planes según se requiera para operaciones de tratamiento, pago y atención médica. También reconozco que Kaiser Permanente divulgará mi información, incluidos mis datos de incidencias de medicamentos de venta con receta, a Medicare, el cual a su vez la divulgará para investigaciones y otros fines que se apeguen a todas las leyes y reglamentos Federales correspondientes. La información de este formulario de inscripción es correcta según mi leal saber y entender. Entiendo que si doy información falsa en este formulario intencionalmente, se cancelará mi afiliación en el plan.

Entiendo que mi firma (o la firma de la persona autorizada para representarme conforme a las leyes del Estado donde resido) en esta solicitud significa que he leído y entiendo el contenido de la misma. Si una persona autorizada (como se describe anteriormente) firma, esta firma certifica que: 1) esta persona está autorizada conforme a las leyes estatales para completar esta inscripción y 2) los documentos de esta autorización están a disposición de Medicare si los solicita.

Apellido Nombre

CONVENIO DE ARBITRAJE DE KAISER FOUNDATION HEALTH PLAN

Entiendo que si selecciono un plan de seguro de salud ("plan de salud") que está sujeto al arbitraje obligatorio requerido para resolver las disputas, estoy aceptando que se arbitren las reclamaciones relacionadas con mi membresía o la de un dependiente en el plan de salud (a excepción de los casos del Tribunal para Reclamaciones Menores, que están regulados por la reglamentación del procedimiento de reclamación de la ERISA, y otras reclamaciones que no puedan estar sujetas al arbitraje obligatorio conforme a la ley vigente). Entiendo que cualquier disputa entre mi persona, mis herederos, familiares o partes asociadas, por un lado, y el plan de salud, cualquier proveedor de beneficios de atención médica contratado, administradores u otras partes asociadas, por el otro, por la supuesta violación de cualquier obligación derivada de o relacionada con la membresía en el plan de salud, incluida toda reclamación por negligencia médica u hospitalaria (reclamación según la cual los servicios médicos fueron innecesarios o no autorizados o prestados de forma indebida, negligente o incompetente), por responsabilidad civil de las instalaciones o en relación con la cobertura o la prestación de servicios o artículos, independientemente de lo que disponga la doctrina jurídica, no deberá resolverse en un pleito o procedimiento judicial, sino mediante arbitraje obligatorio conforme a la legislación de California, salvo que las normas pertinentes dispongan la revisión judicial de los procedimientos de arbitraje. Acepto renunciar a nuestro derecho a un juicio con jurado y acepto el uso del arbitraje obligatorio. Entiendo que todas las disposiciones del arbitraje se incluyen en el documento de cobertura del plan de salud, al cual tengo acceso para su revisión.

Firma:

Fecha de Hoy: / /

Si usted es el representante autorizado, debe firmar en la línea anterior y proporcionar la siguiente información:

Nombre:

Dirección:

Número de Teléfono: - -

Relación con la Persona Inscrita:

Office Use Only (Para Uso Exclusivo del Consultorio):			
Name of staff member/agent/broker (if assisted in enrollment):	<input type="text"/>		
Plan ID #:	<input type="text"/>	Effective Date of Coverage:	<input type="text"/> / <input type="text"/> / <input type="text"/>
ICEP/IEP:	<input type="text"/>	AEP:	<input type="text"/>
SEP (type):	<input type="text"/>	Not Eligible:	<input type="text"/>

January 1–December 31, 2019

2019 Summary of Benefits

Kaiser Permanente Senior Advantage (HMO) for Federal Members
High, Standard, & Basic Options

With Medicare Part D prescription drug coverage

About this Summary of Benefits

Thank you for considering Kaiser Permanente Senior Advantage. You can use this **Summary of Benefits** to learn more about our plan. It includes information about:

- Benefits and costs
- Part D prescription drugs
- Who can enroll
- Coverage rules
- Getting care

For definitions of some of the terms used in this booklet, see the glossary at the end.

For more details

This document is a summary of four Kaiser Permanente Senior Advantage plans for Federal members, High, Standard, and Basic Options. It doesn't include everything about what's covered and not covered or all the plan rules. For details, see both your FEHB brochure (RI 73-003) and Senior Advantage **Evidence of Coverage (EOC)**, which we'll send you after you enroll. If you'd like to see it before you enroll, you can view it online at kp.org/feds or request a copy from Member Services by calling **1-800-443-0815**, 7 days a week, 8 a.m. to 8 p.m. (TTY 711).

To receive the Senior Advantage benefits described in this Summary of Benefits, you must be enrolled in Kaiser Permanente through the FEHB Program and meet the eligibility requirements described in your FEHB brochure (RI 73-003). As a member of Kaiser Permanente Senior Advantage (HMO) for Federal members, you are still entitled to coverage under the FEHB Program. For a complete statement of your FEHB benefits, including any limitations and exclusions, please refer to your FEHB brochure (RI 73-003). All FEHB benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB brochure.

If you are already enrolled in one of our Senior Advantage plans and wish to switch to a different Senior Advantage plan, you may do so during the annual open season or you may also be able to change your enrollment when you have a life event (for example, you become eligible for Medicare). Please refer directly to opm.gov and your employing agency or retirement office for more information about when you can make plan changes outside of the open season.

Have questions?

- Please call Member Services at **1-800-443-0815** (TTY 711).
- 7 days a week, 8 a.m. to 8 p.m.

What's covered and what it costs

*Your plan provider may need to provide a referral

†Prior authorization may be required

Benefits and premiums	Senior Advantage 1 High Option	Senior Advantage 2 High Option	Senior Advantage Standard Option	Senior Advantage Basic Option
Plan premium	You must pay your FEHB monthly contribution. There is no increase in your FEHB premiums for Senior Advantage membership.	You must pay your FEHB monthly contribution. There is no increase in your FEHB premiums for Senior Advantage membership.	You must pay your FEHB monthly contribution. There is no increase in your FEHB premiums for Senior Advantage membership.	You must pay your FEHB monthly contribution. There is no increase in your FEHB premiums for Senior Advantage membership.
Deductible	None	None	None	None
Your maximum out-of-pocket responsibility	\$2,000	\$2,000	\$2,000	2,000
Inpatient hospital coverage*† There's no limit to the number of medically necessary inpatient hospital days.	\$100 per admission	\$250 per admission	\$250 per admission	\$250 per day, for days 1 through 4 of a hospital stay. You pay nothing for the rest of the hospital stay
Outpatient hospital coverage	\$5 per surgery	\$50 per surgery	\$15 per surgery	\$25 per surgery
Doctor's visits Primary care providers and specialists	\$5 per visit	\$10 per visit	\$15 per visit	\$25 per visit
Preventive care* See the EOC for details.	\$0	\$0	\$0	\$0

Benefits and premiums	Senior Advantage 1 High Option	Senior Advantage 2 High Option	Senior Advantage Standard Option	Senior Advantage Basic Option
Emergency care We cover emergency care anywhere in the world.	\$75 per Emergency Department visit	\$75 per Emergency Department visit	\$75 per Emergency Department visit	\$75 per Emergency Department visit
Urgently needed services We cover urgent care anywhere in the world.	\$5 per office visit	\$10 per office visit	\$15 per office visit	\$25 per office visit
Diagnostic services, lab, and imaging <ul style="list-style-type: none"> • Lab tests • Diagnostic tests and procedures (like EKG) • X-rays 	\$0	\$0	\$10 per encounter	\$0
<ul style="list-style-type: none"> • Other imaging procedures (like MRI, CT, and PET) 	\$0	\$0	\$50 per procedure (\$10 for ultrasounds)	\$50 per procedure (\$0 for ultrasounds)
Hearing services <ul style="list-style-type: none"> • Evaluations to diagnose medical conditions 	\$0	\$0	\$0	\$0
<ul style="list-style-type: none"> • Hearing aids 	Not covered	\$500 allowance per hearing aid, per ear. (If the hearing aid you purchase costs more than \$500 per ear, you pay the difference.)	Not covered	Not covered

Benefits and premiums	Senior Advantage 1 High Option	Senior Advantage 2 High Option	Senior Advantage Standard Option	Senior Advantage Basic Option
Dental services Preventive and comprehensive dental coverage	Refer to your Senior Advantage Evidence of Coverage for a description of your dental coverage provided to you as a Senior Advantage Federal Member.	Not covered	Refer to your Senior Advantage Evidence of Coverage for a description of your dental coverage provided to you as a Senior Advantage Federal Member.	Not covered
Vision services* <ul style="list-style-type: none"> • Visits to diagnose and treat eye diseases and conditions 	\$5 per visit	\$10 per visit	\$15 per visit	\$25 per visit
<ul style="list-style-type: none"> • Routine eye exams • Preventive glaucoma screening and yearly diabetic retinopathy exam 	\$0	\$0	\$0	\$0
<ul style="list-style-type: none"> • Eyeglasses or contact lenses after cataract surgery 	\$0 up to Medicare's limit, but you pay any amounts beyond that limit.	\$0 up to Medicare's limit, but you pay any amounts beyond that limit.	\$0 up to Medicare's limit, but you pay any amounts beyond that limit.	\$0 up to Medicare's limit, but you pay any amounts beyond that limit.
<ul style="list-style-type: none"> • Other eyeglasses or contact lenses (covered once every 24 months) 	If your eyewear costs more than \$200, you pay the difference.	Not covered	If your eyewear costs more than \$150, you pay the difference.	If your eyewear costs more than \$150, you pay the difference.

Benefits and premiums	Senior Advantage 1 High Option	Senior Advantage 2 High Option	Senior Advantage Standard Option	Senior Advantage Basic Option
Mental health services <ul style="list-style-type: none"> • Outpatient group therapy 	\$2 per visit	\$5 per visit	\$7 per visit	\$12 per visit
<ul style="list-style-type: none"> • Outpatient individual therapy 	\$5 per visit	\$10 per visit	\$15 per visit	\$25 per visit
Skilled nursing facility† Our plan covers up to 100 days per benefit period.	\$0	\$0	\$0	\$0
Physical therapy*	\$5 per visit	\$10 per visit	\$15 per visit	\$25 per visit
Ambulance	\$50 per one-way trip	\$50 per one-way trip	\$125 per one-way trip	\$150 per one-way trip
Transportation	Not covered	Not covered	Not covered	Not covered
Medicare Part B drugs† A limited number of Medicare Part B drugs are covered when you get them from a plan provider. See the EOC for details. <ul style="list-style-type: none"> • Drugs that must be administered by a health care professional 	\$0	\$0	\$0	\$0
<ul style="list-style-type: none"> • Up to a 30-day supply from a plan pharmacy 	<ul style="list-style-type: none"> • \$10 for generic drugs • \$30 for brand-name drugs 	<ul style="list-style-type: none"> • \$10 for generic drugs • \$40 for brand-name drugs 	<ul style="list-style-type: none"> • \$10 for generic drugs • \$40 for brand-name drugs 	<ul style="list-style-type: none"> • \$10 for generic drugs • \$47 for brand-name drugs

Benefits and premiums	Senior Advantage 1 High Option	Senior Advantage 2 High Option	Senior Advantage Standard Option	Senior Advantage Basic Option
Chiropractic <ul style="list-style-type: none"> Manual manipulation of the spine* 	\$5 per visit	\$10 per visit	\$15 per visit	\$25 per visit
<ul style="list-style-type: none"> Covered chiropractic services from any American Specialty Health Plans of California, Inc. (ASH Plans) participating chiropractor 	\$15 per visit for up to a total of 20 chiropractic office visits per calendar year. Our plan pays \$50 each calendar year toward the chiropractic ASH Plans fee schedule price for covered chiropractic appliances.	\$15 per visit for up to a total of 20 chiropractic office visits per calendar year. Our plan pays \$50 each calendar year toward the chiropractic ASH Plans fee schedule price for covered chiropractic appliances.	\$15 per visit for up to a total of 20 chiropractic office visits per calendar year. Our plan pays \$50 each calendar year toward the chiropractic ASH Plans fee schedule price for covered chiropractic appliances.	\$15 per visit for up to a total of 20 chiropractic office visits per calendar year. Our plan pays \$50 each calendar year toward the chiropractic ASH Plans fee schedule price for covered chiropractic appliances.
Fitness benefit Silver&Fit® fitness programs, including a basic facility membership	Not covered	\$0	Not covered	Not covered

Medicare Part D prescription drug coverage†

The amount you pay for drugs will be different depending on:

- The Senior Advantage plan you enroll in (High, Standard, or Basic).
- The tier your drug is in. To find out which of the 6 tiers your drug is in, see our Part D formulary at kp.org/seniorrx or call Member Services to ask for a copy at **1-800-443-0815**, 7 days a week, 8 a.m. to 8 p.m. (TTY **711**).
- Your drug quantity (like a 30-day or 100-day supply). Note: A supply greater than a 30-day supply isn't available for all drugs.

- When you get a 31 to 100-day supply, whether you get your prescription filled by one of our retail plan pharmacies or our mail-order pharmacy. Note: Not all drugs can be mailed.
- The coverage stage you're in (initial or catastrophic coverage stage).

Initial coverage stage

You pay the copays and coinsurance shown in the chart below until your total yearly drug costs reach **\$5,100**. (Total yearly drug costs are the amounts paid by both you and any Part D plan during a calendar year.) If you reach the \$5,100 limit, you move on to the coverage gap stage and your coverage changes.

Drug tier	Senior Advantage 1 High Option	Senior Advantage 2 High Option	Senior Advantage Standard Option	Senior Advantage Basic Option
Tiers 1 (Preferred Generic) and 2 (Generic)	\$10 (up to a 100-day supply)	\$10 (up to a 30-day supply)	\$10 (up to a 30-day supply)	\$10 (up to a 30-day supply)
Tiers 3 (Preferred Brand) and 4 (Nonpreferred Brand)	\$30 (up to a 100-day supply)	\$40 (up to a 30-day supply)	\$40 (up to a 30-day supply)	\$47 (up to a 30-day supply)
Tier 5 (Specialty)	\$100 (up to a 100-day supply)	\$100 (up to a 30-day supply)	\$150 (up to a 30-day supply)	\$200 (up to a 30-day supply)
Tier 6 (Vaccines)	\$0	\$0	\$0	\$0

For members enrolled in the **Senior Advantage 2 High, Standard, and Basic Options**, when you get a 31- to 100-day supply, you will pay the following for drugs in Tiers 1-5:

- If you get a 31- to 60-day supply from any plan pharmacy (retail or mail order), you pay 2 copays.
- If you get a 61- to 100-day supply from our mail-order pharmacy, you pay 2 copays.
- If you get a 61- to 100-day supply from one of our retail pharmacies, you pay 3 copays.

Catastrophic coverage stage

If you spend **\$5,100** on your Part D prescription drug costs in 2019, you'll enter the catastrophic coverage stage. Most people never reach this stage, but if you do, your copays and coinsurance will change for the rest of the year. To find out what you would pay during this stage, see the Senior Advantage **Evidence of Coverage**.

Long-term care and non-plan pharmacies

If you live in a long-term care facility and get your drugs from their pharmacy, you pay the same as at a plan pharmacy and you can get up to a 31-day supply. If you get covered Part D drugs from a non-plan pharmacy, you pay the same as at a plan pharmacy and you can get up to a 30-day supply.

Generally, we cover drugs filled at a non-plan pharmacy only when you can't use a network pharmacy, like during a disaster. See the Senior Advantage **Evidence of Coverage** for details.

Who can enroll

You can sign up for this plan if:

- Must be enrolled in Kaiser Permanente through the FEHB Program and meet the eligibility requirements described in your FEHB brochure (RI 73-003).
- You have both Medicare Part A and Part B. (To get and keep Medicare, most people must pay Medicare premiums directly to Medicare.)
- You're a citizen or lawfully present in the United States.
- You don't have end-stage renal disease (ESRD) unless you got ESRD when you were already a member of one of our plans or you were a member of a different plan that ended.
- You live in the service area for this plan, which includes all of **Alameda, Contra Costa, Marin, Napa, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Cruz, Solano, and Stanislaus**. It also includes and parts of these **counties** in these ZIP codes only:
 - **Amador County:** 95640 and 95669
 - **El Dorado County:** 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, and 95762
 - **Fresno County:** 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, and 93888
 - **Kings County:** 93230, 93232, 93242, 93631, and 93656

- **Madera County:** 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, and 93720
- **Mariposa County:** 93601, 93623, and 93653
- **Placer County:** 95602–04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95703, 95722, 95736, 95746–47, and 95765
- **Santa Clara County:** 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, and 95196
- **Sonoma County:** 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, and 95492
- **Sutter County:** 95626, 95645, 95659, 95668, 95674, 95676, 95692, and 95836–37
- **Tulare County:** 93238, 93261, 93618, 93631, 93646, 93654, 93666, and 93673
- **Yolo County:** 95605, 95607, 95612, 95615–18, 95645, 95691, 95694–95, 95697–98, 95776, and 95798–99
- **Yuba County:** 95692, 95903, and 95961

Coverage rules

We cover the services and items listed in this document and the Senior Advantage **Evidence of Coverage**, if:

- The services or items are medically necessary.
- The services and items are considered reasonable and necessary according to Original Medicare’s standards.
- You get all covered services and items from plan providers listed in our **Provider Directory** and **Pharmacy Directory**.

But there are exceptions to this rule. We also cover:

- Care from plan providers in another Kaiser Permanente Region
- Emergency care
- Out-of-area dialysis care
- Out-of-area urgent care (covered inside the service area from plan providers and in rare situations from non-plan providers)
- Referrals to non-plan providers if you got approval in advance (prior authorization) from our plan in writing

Note: You pay the same plan copays and coinsurance when you get covered care listed above from non-plan providers.

For details about coverage rules, including services that aren’t covered (exclusions), see the Senior Advantage **Evidence of Coverage**.

Getting care

At most of our plan facilities, you can usually get all the covered services you need, including specialty care, pharmacy, and lab work. You aren't restricted to a particular plan facility or pharmacy, and we encourage you to use the plan facility or pharmacy that will be most convenient for you. To find our provider locations, see our **Provider Directory** or **Pharmacy Directory** at **kp.org/directory** or ask us to mail you a copy by calling Member Services at **1-800-443-0815**, 7 days a week, 8 a.m. to 8 p.m. (TTY 711).

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Your personal doctor

Your personal doctor (also called a primary care physician) will give you primary care and will help coordinate your care, including hospital stays, referrals to specialists, and prior authorizations. Most personal doctors are in internal medicine or family practice. You may choose any available plan provider to be your personal doctor. You can change your doctor at any time and for any reason. You can choose or change your doctor by calling Member Services or at **kp.org/mydoctor/connect**.

Help managing conditions

If you have more than 1 ongoing health condition and need help managing your care, we can help. Our case management programs bring together nurses, social workers, and your personal doctor to help you manage your conditions. The program provides education and teaches self-care skills. If you're interested, please ask your personal doctor for more information.

Notices

Appeals and grievances

You can ask us to provide or pay for an item or service you think should be covered. If we say no, you can ask us to reconsider our decision. This is called an appeal. You can ask for a fast decision if you think waiting could put your health at risk. If your doctor agrees, we'll speed up our decision.

If you have a complaint that's not about coverage, you can file a grievance with us. See the Senior Advantage **Evidence of Coverage** for details.

Kaiser Foundation Health Plan

Kaiser Foundation Health Plan, Inc., Northern California Region is a nonprofit corporation and a Medicare Advantage plan called Kaiser Permanente Senior Advantage (HMO).

Privacy

We protect your privacy. See the **Evidence of Coverage** or view our **Notice of Privacy Practices** on kp.org/privacy to learn more.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal. This contract is renewed annually by the Centers for Medicare & Medicaid Services (CMS). By law, our plan or CMS can choose not to renew our Medicare contract.

This information is not a complete description of benefits. Call **1-800-443-0815** (TTY **711**) for more information. For information about Original Medicare, refer to your “**Medicare & You**” handbook. You can view it online at medicare.gov or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-800-443-0815** (TTY: **711**).

ATENCIÓN: Si habla español, tenemos a su disposición servicios gratuitos de asistencia con el idioma. Llame al **1-800-443-0815** (los usuarios de la línea TTY deben llamar al: **711**).

Helpful definitions (glossary)

Allowance

A dollar amount you can use toward the purchase of an item. If the price of the item is more than the allowance, you pay the excess.

Benefit period

The way our plan measures your use of skilled nursing facility services. A benefit period starts the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't gotten any inpatient hospital care or skilled care in an SNF for 60 days in a row. The benefit period isn't tied to a calendar year. There's no limit to how many benefit periods you can have or how long a benefit period can be.

Calendar year

The year that starts on January 1 and ends on December 31.

Coinsurance

A percentage you pay of our plan's total charges for certain services or prescription drugs. For example, a 20% coinsurance for a \$200 item means you pay \$40.

Copay

The set amount you pay for covered services — for example, a \$20 copay for an office visit.

Evidence of Coverage

A document that explains in detail your plan benefits and how your plan works.

Maximum out-of-pocket responsibility

The most you'll pay in copays or coinsurance each calendar year for services that are subject to the maximum. If you reach the maximum, you won't have to pay any more copays or coinsurance for services subject to the maximum for the rest of the year.

Medically necessary

Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Non-plan provider

A provider or facility that doesn't have an agreement with Kaiser Permanente to deliver care to our members.

Plan

Kaiser Permanente Senior Advantage.

Plan premium

The amount you pay for your Senior Advantage health care and prescription drug coverage.

Plan provider

A plan or network provider can be a facility, like a hospital or pharmacy, or a health care professional, like a doctor or nurse.

Prior authorization

Some services or items are covered only if your plan provider gets approval in advance from our plan (sometimes called prior authorization). Services or items subject to prior authorization are flagged with a † symbol in this document.

Region

A Kaiser Foundation Health Plan organization. We have Kaiser Permanente Regions located in Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

Retail plan pharmacy

A plan pharmacy where you can get prescriptions. These pharmacies are usually located at plan medical offices.

Service area

The geographic area where we offer Senior Advantage plans. To enroll and remain a member of our plan, you must live in our Senior Advantage plan service area.

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - ◆ Qualified sign language interpreters.
 - ◆ Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
 - ◆ Qualified interpreters.
 - ◆ Information written in other languages.

If you need these services, call Member Services at **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Multi-language Interpreter Services

English

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-443-0815** (TTY: **711**).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-443-0815** (TTY: **711**).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-443-0815** (TTY : **711**) 。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-443-0815** (TTY: **711**).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-443-0815** (TTY: **711**).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-443-0815** (TTY: **711**)번으로 전화해 주십시오.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-800-443-0815** (TTY (հեռատիպ) **711**):

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-443-0815** (телетайп: **711**).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-443-0815 (TTY:711) まで、お電話にてご連絡ください。

Punjabi

ਸਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-443-0815 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-443-0815 (TTY: 711)។

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-443-0815 (TTY: 711).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-443-0815 (TTY: 711) पर कॉल करें।

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-443-0815 (TTY: 711).

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-443-0815 (TTY: 711) تماس بگیرید.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-443-0815 (رقم هاتف الصم والبكم: 711).

kp.org/feds

Kaiser Foundation Health Plan, Inc.
393 E. Walnut St.
Pasadena, CA 91188

Kaiser Foundation Health Plan, Inc., Northern California Region.
A nonprofit corporation and Health Maintenance Organization (HMO)

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