California's Valued Trust

Dear California School Employees Association Retiree:

California's Valued Trust (CVT) is proud to partner with your union, California School Employees Association (CSEA) to offer Medicare insurance plan options to eligible members. If you are retired and eligible for Medicare Part A & B or are age 65 and still working, needing insurance coverage, our program may be for you. Enclosed is a comprehensive packet of the plan choices and rates available through Anthem Blue Cross (PPO and Medicare Advantage) with SilverScript Part D drug coverage and Kaiser Permanente Senior Advantage.

Also included are the guidelines for our retiree benefit program, enrollment procedures, required forms and payment instructions needed to enroll. CVT requires a deposit equal to one month of premium as a deposit in addition to your first month's premium paid by check. After the first month of enrollment, your insurance payment going forward is required to be funded through our Automatic Clearing House (ACH) authorization of funds. The form is included, and your enrollment cannot be processed if the ACH paperwork is not received. Enrollment must be completed no later than one month prior to your coverage effective date.

CVT's Member Services Representatives are available Monday-Friday 8:00am-5:00pm via phone or video conferencing to walk you through the program and plans as well as assisting with the enrollment paperwork. Contact us at 800-288-9870 CSEAMedicare@cvtrust.org. Please reference that you are a **CSEA Retiree Unit Member** to direct you to the appropriate representative.

We look forward to the opportunity to serve you for your medical insurance needs.

Sincerely,
CVT Member Services Department

California's Valued Trust

Medicare Program Guidelines for CSEA Retirees

California's Valued Trust

Healthcare Benefits for the Education Community

MEDICARE PROGRAM GUIDELINES FOR CSEA RETIREES

ELIGIBILITY REQUIREMENTS

CVT Medicare Requirements

For retiree coverage under all health plans, Medicare requirements are as follows: If the retiree is age 65 or over, or otherwise eligible for Medicare, they **must** be enrolled in both Medicare Part A and B. Dependents of retired employees must also enroll in enrolled Medicare Parts A and B, or are otherwise eligible for Medicare if under age 65.

CVT REQUIRES A PHOTOCOPY OF THE MEDICARE CARD FOR BOTH RETIREE AND/OR DEPENDENTS

If not enrolled in both Medicare Parts A and B this will result in the disqualification from eligibility to participate in CVT health plans.

The following dependents are eligible if enrolled in both Medicare Part A & B:

- **Spouse of Retiree:** A spouse of an enrolled retiree is eligible for coverage. **(Marriage Certificate is required for enrollment.)**

- **State Registered Domestic Partner of Retiree:** A state registered domestic partner of an enrolled retiree is eligible for coverage. **(State Registration Certificate is required for enrollment.)**

- **Surviving Spouse/Partner of Retiree:** A surviving spouse/partner of an enrolled retiree, or retiree eligible, is eligible for coverage; however, the surviving spouse/partner is not permitted to add a new partner.

- **Child:**

  Child of an enrolled retiree, spouse or domestic partner *under 26 years of age:*

  - Natural child – **(Birth Certificate is required for enrollment.)**
  - Adopted child – **(Final Adoption Papers are required for enrollment.)**
  - Step child – **(Birth Certificate is required for enrollment.)**
  - Child of an eligible, covered domestic partner – **(Birth Certificate is required for enrollment.)**
  - Unmarried child under legal guardianship - A dependent child under a court ordered legal guardianship of the retiree is eligible for coverage, provided they meet all other eligibility requirements. Please note: eligibility ends on the date of expiration of the court awarded guardianship or upon the 18th birthday of the child, whichever comes first. **(Legal Guardianship Papers are required for enrollment.)**

ENROLLMENT

An enrollment form is required to be completed and submitted to the Trust for every eligible retiree and dependent for whom coverage is requested through CVT. Eligible dependents for whom coverage is sought when the retiree initially enrolls, should be included on the enrollment form. Enrollment must be applied for within 31 days of first becoming eligible for coverage or during the Medicare open enrollment period.

Annual Open Enrollment Period for Current Enrollees
The month of September is the annual open enrollment period for CVT. Any changes made during the annual open enrollment period will be effective October 1. Plan year information will be mailed to you prior to open enrollment.

During the month of September:

- A retiree may elect to change his or her plan selection and participate in a different plan
- A retiree may terminate or add eligible dependents to their medical coverage

Annual Open Enrollment Period for New Enrollees
October through December is the annual open enrollment period for Medicare retirees that wish to enroll in CVT coverage. Plan enrollment will be effective January 1st.

Plan Selection or Coverage Changes
Plan selection changes will not be allowed at any time other than the annual open enrollment period, or unless the retiree experiences a qualifying event listed below:

- Joins the CSEA retiree unit
- A marriage
- A divorce
- The birth of a child
- The adoption of a child
- Court ordered guardianship of a minor child
- The requirements of domestic partnership are met
- Dissolution of domestic partnership
- 25% increase in the employer/employee contribution to the benefit package
- Involuntary termination of a plan covering the employee or employee's dependent
- A change in the employee's employment status
- A change in an employee's dependent's employment status when the employee's dependent is covered
- The cessation of an employer's contribution toward an employee's or employee's dependent's coverage
- Acquiring coverage
- Gaining Medicare
- Death of subscriber or covered spouse

Written application for additions, terminations, and coverage changes must be made within 31 days of the qualifying event. If application is not made within 31 days, a retiree will have to wait until the next annual open enrollment period to make any changes.

Additions, terminations, or coverage changes will be effective on the first day of the month following the qualifying event, after the receipt of a timely request for the change. Documentation is required for any changes based on the events listed above. However, upon re-marriage surviving spouses may not add a new partner.

MEDICAL PLAN OPTIONS

Anthem Blue Cross Preferred Provider Organization (PPO) Plans

CVT provides the best-of-the-best in healthcare. Being a member of CVT brings you many different partners who are leading carriers in the healthcare industry. By doing so, CVT can provide members the best products and services available at the most affordable prices. Multiple health plan options are available from CVT to meet the needs of our retirees. As a result, you may see many different products and provider names associated with your benefits, but it is important to note they are your partners through CVT.

Retirees who enroll in a CVT PPO plan, will receive their prescription benefits from SilverScript (a division of CVS/caremark providing Medicare D prescription coverage). If you are currently enrolled in another Medicare D program you will **not** be able to participate in CVT's medical and prescription drug coverage.
Your key CVT **PPO** partners

- **Anthem Blue Cross** – Provides members access to contracted providers, and a variety of Health and Wellness resources
- **SilverScript Medicare Part D Prescription Coverage** – Members receive their prescription drugs through the SilverScript network of providers and mail order
- **Accordant® Health Management Program** – Support for members with rare, complex health conditions
- **Beacon Health Options** – Employee Assistance Program (EAP)
- **TruHearing** - TruHearing Select discount hearing aid program

Kaiser Permanente Senior Advantage HMO Plan

Your CVT health care plan through Kaiser Permanente is more than just coverage – it is a partnership in health. It connects you to a group of physicians, services, and online tools for a total approach to care.

Retirees and/or their dependents who are Medicare eligible are required to enroll in the Kaiser Permanente Senior Advantage Program. You may not enroll in Senior Advantage if you reside outside of the Kaiser service area or the State of California. A Kaiser Permanente Senior Advantage Disenrollment Form is required to be completed and submitted to the Trust to terminate Senior Advantage coverage. The termination date will be effective the last day of the month that the Trust receives the completed form.

TERMINATION OF BENEFITS

CVT requires advance written notice to discontinue any/or all coverage(s). The termination date will be effective the last day of the month that CVT receives written notification. CVT requires advance written notice to discontinue any/or all coverage(s). The termination date will be effective the last day of the month that CVT receives written notification.

BILLING INFORMATION

Deposit Requirements

Under a direct medical plan arrangement with the Trust, CSEA retirees are required to pay one month's premium plus a "deposit" in the same amount. The deposit is held in your account as a safeguard against cancellation for late payment of premium. Should you decide to leave the Trust in the future, the deposit is fully refundable or may be used as your last month's premium. Please note that the deposit must always equal one month's total premium and is adjusted annually in October to correspond with current rates.

Monthly Payments

CVT requires Automated Clearing House (ACH) payments. Once enrolled in ACH, payment withdrawal notifications are through your bank statement. ACH payments for retiree accounts can be set up on the 1st – 5th of the month.

Delinquent Payments

Failure to keep your account current will result in cancellation**.** Please note that payments are always due during the current month of coverage. If your ACH is returned to CVT, you will be notified to send payment to maintain coverage eligibility. If payment is not received timely your account may be terminated for non- payment. Your deposit will be used to pay your last month of coverage and you will receive a termination notification.

If your coverage is terminated, you will be held responsible for all claims incurred after the date of termination.

QUESTIONS?

Please contact CVT Member Services Department.

California's Valued Trust
520 E. Herndon Avenue
Fresno, CA 93720
Email: CSEAMedicare@cvtrust.org
P 559.437.2960 / 800.288.9870
(Reference you are a CSEA Retiree Unit Member)

www.CVTrust.org/CSEAMedicarePlans

CVT complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1- 800-288-9870.

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 1-800-288-9870.

California's Valued Trust
Healthcare Benefits for the Education Community

CSEA
AFL-CIO

CSEA Retiree Enrollment Checklist

Required items to be returned to CVT for enrollment:	✓
Completed CVT Enrollment Form	
Completed Automatic Payment Authorization (ACH) Form & Voided Check	
Payment for Deposit and First Month of Coverage Premium (ACH cannot be used for this; automatic payments will begin after the first month)	
Required Documents: • Copy of Medicare Card for each enrollee • Completed SilverScript Medicare Part D Opt-In Form (if enrolling in a PPO Plan 1C) • Completed Medicare Advantage PPO Opt-In Form (if enrolling in the Medicare Advantage PPO plans) • Completed Senior Advantage Form (if enrolling in a Kaiser Permanente Plan)	
Copy of Marriage Certificate or Birth Certificate (if adding a spouse or a dependent not currently enrolled in a plan)	

Your enrollment will not be processed unless all items are returned

California's Valued Trust
520 E Herndon Ave Fresno CA 93720
800-288-9870
559-437-2965 (fax)
CSEAMedicare@cvtrust.org

CSEA Medicare Retiree Membership Enrollment Form

AUTOMATIC ELECTRONIC PAYMENT FORM ALSO REQUIRED

CALIFORNIA'S VALUED TRUST
Healthcare Benefits for the Education Community
520 E. Herndon Ave., Fresno, CA 93720
(800) 288-9870 FAX (559) 437-2965
www.cvtrust.org

School District Retired From:
Chapter Number:
Effective Date:

CVT USE ONLY-
DATE RECEIVED

RETIREE INFORMATION

NAME: _____ ☐ MALE ☐ FEMALE
(Last, First, Middle Initial)

SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____ AGE: _____

MAILING ADDRESS _____CITY_____STATE_____ZIP_____

STREET ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)_____CITY_____STATE_____ZIP_____

HOME PHONE ( )_____CELL PHONE ( )_____EMAIL ADDRESS_____

☐ MARRIED* DATE OF MARRIAGE_____(REQUIRED) ☐ SINGLE ☐ DIVORCED ☐ WIDOW / WIDOWER

☐ DOMESTIC PARTNER* DATE OF REGISTRATION_____(REQUIRED)

BENEFIT PLAN SELECTION

ANTHEM BLUE CROSS PPO PLAN : ☐ MEDICARE ADVANTAGE PPO PLAN, RX-UV ☐ MEDICARE ADVANTAGE PPO PLAN, RX-C ☐ PPO PLAN 1, RX-C

KAISER PERMANENTE SENIOR ADVANTAGE HMO PLAN: ☐ ESSENTIAL PLAN ☐ PLAN 4 ☐ PLAN 1

DEPENDENT CODES

SP=Spouse DP=Domestic Partner*	CH=Child* SC=Step Child*	DD=Dependent of Domestic Partner* LG=Legal Guardianship*	AD=Adoption*

List Dependent(s) To Add or Delete - All dependents must have Medicare Part A&B — M=Medical (Circle)

Dep Code*	Last Name, First name and Middle Initial	Gender	Social Security	Date of Birth	Age	M	Enroll Status
						M	add / delete
						M	add / delete

Reason for Deleting Dependent(s)_____(Required)

MEDICARE INFORMATION – Medicare Part A&B is required for all enrolled in the plan

Are you eligible for Medicare? ☐YES ☐NO Do any of your dependents have Medicare? ☐YES ☐NO

A COPY OF RETIREE'S / DEPENDENT'S MEDICARE CARD IS REQUIRED. IF NOT INCLUDED, IT WILL DELAY ENROLLMENT

AUTHORIZATION - PLEASE READ CAREFULLY

Authorizations - If I have chosen a Preferred Provider Plan or an HMO Plan, I understand that I am responsible for a greater portion of my medical costs when I use a Non-Participating Provider.

I hereby authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of CVT any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter or purpose of review, investigation, or evaluation of any application or a claim.

I also authorize CVT or its agents, designees, or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim.

This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable CVT to process claims.

Email Address - The information you are asked to provide to CVT is used for technical and member administration only and is not shared with anyone outside the confines of your health coverage.

You are entitled to a copy of this signed authorization for your files, if requested.

I declare, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

CVT USE ONLY
DATE COMPLETED

Signature _____ Date Signed_____

*Additional Forms Required

CALIFORNIA'S VALUED TRUST

Automatic Payment Plan Authorization Form-Required

Please note an automatic payment plan authorization form is required in order to have coverage through CVT. Complete the authorization form on the other side of this page and return with the following information:

- Enrollment form
- Medicare Card copies (if applicable)
- Payment for deposit and first month of coverage premium

Your enrollment may be delayed without the completed automatic payment authorization form.

CALIFORNIA'S VALUED TRUST
Automatic Payment Plan Authorization (ACH)-Required

This form authorizes the automatic withdrawal of your insurance minimum monthly payment from a financial institution.

To apply. Please complete this form, **attach a voided check,** and return it with your payment.

Please continue to pay your bill until you receive notification by mail of enrollment.

Questions? Please call 1-800-288-9870 during regular business hours.

First name _____ MI_____

Last name _____

Daytime phone _____

E-Mail_____

This form is for (check one box only)

□ New Automatic Payment enrollment

Premium Payment Date:
Circle the day of the month below for automatic payment of your premium

1 2 3 4 5

Payment Information

Financial Institution Name _____

□ Checking □ Savings

Name on account _____

Routing # _____

Account # _____

Jim Smith 215
1800 Place Dr. 90-8105/1222
Fresno, Ca 93710

SAMPLE CHECK

Pay to the
Order of _____ **VOID**_____ $
_____Dollars
XYZBank
Costa Mesa, CA 92626
For _____ _____

⑈122281057⑈2010000225588⑈215
ROUTING# ACCOUNT#

I agree to the Pre-Authorized Automatic Payment Plan Terms and Conditions mentioned below.

Signature _____

Date _____

Please attach a voided check to this form and return it with your insurance payment, or mail to:

California's Valued Trust
520 E. Herndon Ave
Fresno, CA 93720

PRE-AUTHORIZED AUTOMATIC PAYMENT PLAN TERMS AND CONDITIONS

1. By submitting the Automatic Payment Authorization Form to CVT, I authorized my bank or credit union (financial institution) to honor CVT's electronic funds transfer/ACH request for the policies selected on the form.
2. My authorization will remain in effect until 6-8 weeks after I notify CVT in writing that I wish to terminate my authorization.
3. Submission of an Automatic Payment Authorization Form to CVT is not effective unless accepted by CVT. I acknowledge that CVT may decide not to accept my Automatic Payment Authorization form for any reason or for no reason.
4. CVT reserves the right to terminate my Automatic Payment plan without notice if payment requests are refused by my financial institution for any reason. CVT also reserves the right to terminate my Automatic Payment plan for any other reason upon 30 days notice.
5. CVT reserves the rights to change these Terms and Conditions at any time so long as I am given at least 30 days notice of change.
6. Payment is considered made only if CVT actually receives funds. In addition, CVT will charge $15.00 for a dishonored payment. I acknowledge that some financial institutions treat a dishonored payment much like a dishonored check and charge fees accordingly.
7. I acknowledge that, if I change my financial institution I must complete a new Automatic Payment Authorization Form.
8. If CVT or my financial institution is prevented from processing a payment due to catastrophes or other causes beyond the control of CVT or my financial institution, the payment will be processed at the earliest opportunity when services are restored.

California's Valued Trust

Anthem

CSEA AFL-CIO

Complete this form if you are enrolling in either:

- Medicare Advantage with Rx UV
  or
- Medicare Advantage with Rx C

Important information regarding your Medicare Advantage plan

- I understand that the effective date of coverage is when I can begin using the plan services, and the Medicare Advantage plan will send me written notification of the effective date of my enrollment in the plan. I understand that this Medicare Advantage plan is offered under a contract with the Centers for Medicare & Medicaid Services (CMS) and CMS' review of its benefits. I understand that my coverage will come into effect only if this enrollment is approved by the plan and CMS.
- I understand that I need to keep my Medicare Parts A & B. I must maintain my Medicare Part B insurance by continuing to pay the Part B premium, if applicable.
- I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by CMS from any other Medicare Advantage plan of which I am currently a member. **I can only be in one Medicare Advantage plan at a time.** 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 enroll in a Medicare Part D Prescription Drug plan, it also must be a group sponsored plan. If I enroll in an individual Medicare Part D Prescription Drug plan, it will disenroll me from this group sponsored Medicare Advantage plan.
- I understand that enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year if an enrollment period is available, or under certain special circumstances. I may disenroll from this Medicare Advantage plan by sending a written request to my group sponsor. Prior to sending a written request, I will discuss my disenrollment with my group sponsor to ensure that my retiree benefits are not jeopardized. I understand that if I don't have 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 will read the Evidence of Coverage document for this Medicare Advantage plan to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.
- This Medicare Advantage plan serves a specific service area, which includes all 50 states, Washington, DC, American Samoa, Guam, Northern Mariana Islands, US Virgin Islands, and Puerto Rico. If I move out of the area the plan 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 this Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree.
- I understand that as a member of this plan, I have the right to ask about the plan's decision about payments or coverage for services I receive, if I disagree.
- **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 this Medicare Advantage plan will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. I understand that if false enrollment information is provided, I will be disenrolled from this Medicare Advantage plan.

Anthem

Anthem BC Health Insurance Company Group Sponsored Health Plan Enrollment Election Form

To enroll in Anthem Medicare Preferred (PPO), please provide the following information:	
Group sponsor name California's Valued Trust (CVT)	Group # CAEGR029
Check the box below to select the plan in which you want to enroll ☐ Anthem Medicare Preferred (PPO)	Requested effective date of coverage (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) Generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.

Last name	First name	Middle initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birthdate (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex ☐ M ☐ F	Home phone number ( ) Alternate phone number ( )

Permanent residence street address (P.O. Box is not allowed)

City	State	ZIP code

Mailing address (only if different from your permanent residence address)

City	State	ZIP code

Email address
Your email address will be used for communications only from Anthem BC Health Insurance Company. We will not share your email address.

Please provide your Medicare insurance information		
Please take out your red, white and blue Medicare card to complete this section. • Please fill out this information as it appears on your Medicare card. - OR - • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan. You will need to keep Medicare Parts A and B.	Name (as it appears on your Medicare card):	
	Medicare Number:	
	Is Entitled To:	Effective Date:
	HOSPITAL (Part A)	
	MEDICAL (Part B)	

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

If "yes," retirement date (month/date/year) _____

If "no," name of retiree _____ Retiree Medicare ID #_____

2. Do you have end-stage renal disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.

3. Do you have other medical insurance? ☐ Yes ☐ No

If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____

What are the effective dates of coverage? _____

4. Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or coverage from state pharmaceutical assistance programs.

Will you have other prescription drug coverage? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage _____ ID number for coverage _____

5. 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 (number and street) and phone number of institution _____

_____

This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team number listed in this document for additional information.

Please read and sign below

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

Anthem Medicare Preferred (PPO) is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare 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 Anthem Medicare Preferred (PPO) of any prescription drug coverage that I have or may get in the future. If my plan does not include prescription drug coverage, I understand that if I don't have other 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. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (example: Annual Election Period from October 15 – December 7) or under certain special circumstances.

Anthem Medicare Preferred (PPO) serves a specific service area. If I move out of the area that Anthem Medicare Preferred (PPO) 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 Anthem Medicare Preferred (PPO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Anthem BC Health Insurance Company when I get it to know which rules I must follow in order 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 generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed. Beginning on the date Anthem BC Health Insurance Company coverage begins, I must get all of my health care from Anthem BC Health Insurance Company, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Anthem BC Health Insurance Company and other services contained in my Anthem Medicare Preferred (PPO) *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR ANTHEM BC HEALTH INSURANCE COMPANY WILL PAY FOR THE SERVICES.

Release of information: By joining this Medicare health plan, I acknowledge that Anthem BC Health Insurance Company will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem BC Health Insurance Company 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.

Signature required to process your application

Applicant signature	**Today's date**

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

Name _____

Address _____

City _____ State _____ ZIP code _____

Phone number (____) ____ – _____

Relationship to enrollee _____

Anthem

HIPAA authorization

If you would like to authorize an individual to have the ability to speak with us and/or obtain protected health information (PHI) on your account, please select "yes" below and complete the HIPAA (Health Insurance Portability and Accountability Act) Member Authorization Form form on the next page and return it with your application. This form is valid for one year from the signature date.* If you select "no," a future request for this form can be made by contacting Member Services at the telephone number on the back of your membership card.

☐ Yes ☐ No

Applicant signature _____ Date _____

* If you wish to continue having the authorized representative on your account, a new form is required annually.

Please return this application to:

California's Valued Trust (CVT)
Attn: Member Services Department
520 E. Herndon Ave.
Fresno, CA 93720

Please refer to the Anthem BC Health Insurance Company *Evidence of Coverage* for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions number listed in this document to request interpreter services.

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.

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Instructions for completing the *Member Authorization Form*

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

Part A: Member information

This section applies to the member who is asking for the release of his or her information to another person or company.

1. Print your last name, first name, and middle initial.
2. Write your date of birth in this format: mm/dd/yyyy. (If you were born on October 5, 1960, you would write 10/05/1960.)
3. Write your full street address, city, state, and ZIP code.
4. Write your daytime phone number (including area code.)
5. Write your cell/mobile number (including area code).
6. **Identification number**
   You will find this number on your member identification card.
7. **Group number**
   You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

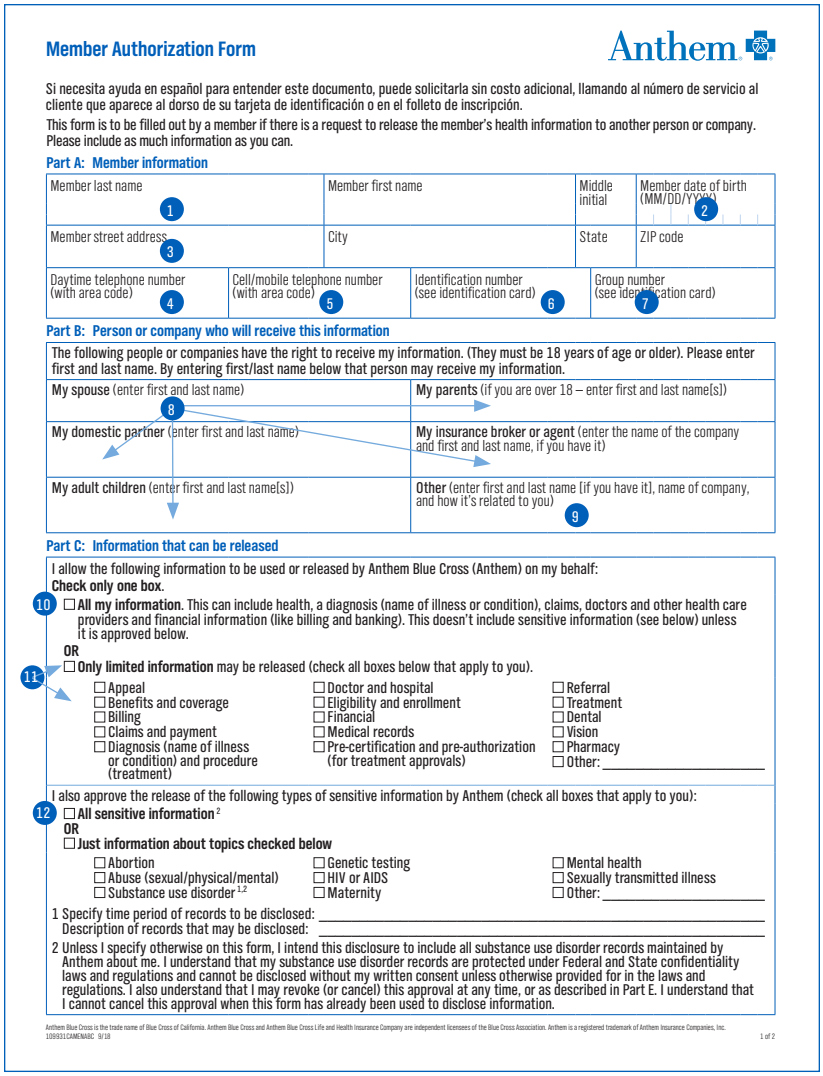
Part B: Person or company who will receive this information

8. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like “my daughter” or “my son” as it will not be accepted. You need to be specific.
9. If you check “Other,” give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

Part C: Information that can be released

This section tells us what information you would like us to release: all or just some.

10. For “all of your information,” check the first box.
11. For “limited information,” check the second box and the boxes that apply to you.
12. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.



Member Authorization Form

Anthem

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name 1	Member first name	Middle initial	Member date of birth (MM/DD/YYYY) 2
Member street address 3	City	State	ZIP code
Daytime telephone number (with area code) 4	Cell/mobile telephone number (with area code) 5	Identification number (see identification card) 6	Group number (see identification card) 7

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

My spouse (enter first and last name) 8	**My parents** (if you are over 18 – enter first and last name(s))
My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name(s))	**Other** (enter first and last name [if you have it], name of company, and how it's related to you) 9

Part C: Information that can be released

I allow the following information to be used or released by Anthem Blue Cross (Anthem) on my behalf:
Check only one box.

10 ☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

11 ☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

12 ☐ **All sensitive information**[2]

OR

☐ **Just information about topics checked below**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder[1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

1 Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Please read the following for help completing page two of the form.

Part D: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

1. Check the first box to let us know to give out this information as shown on this form.
2. Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: Date your approval expires

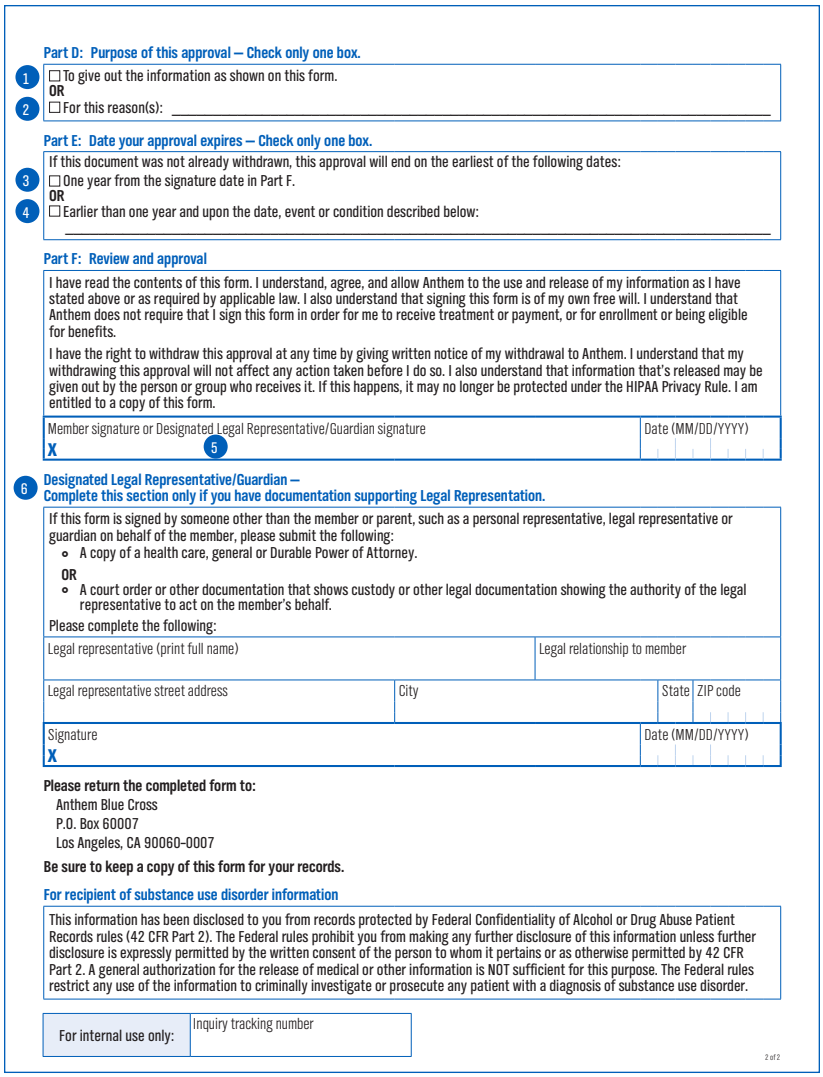
You have two choices of when you would like this approval to end.

3. Check the first box for the standard one year that it will end.
4. Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

Part F: Review and approval

5. **Sign your name and put the date on the form.** Your name and signature ***must*** match the information in Part A.
6. **If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:**
   - You must complete the Designated Legal Representative/Guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Part D: Purpose of this approval – Check only one box.

1 ☐ To give out the information as shown on this form.
OR
2 ☐ For this reason(s): _____

Part E: Date your approval expires – Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:
3 ☐ One year from the signature date in Part F.
OR
4 ☐ Earlier than one year and upon the date, event or condition described below:
_____

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow Anthem to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature 5	Date (MM/DD/YYYY)
X	

6 **Designated Legal Representative/Guardian – Complete this section only if you have documentation supporting Legal Representation.**

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:
- A copy of a health care, general or Durable Power of Attorney.

OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member

Legal representative street address	City	State	ZIP code

Signature	Date (MM/DD/YYYY)
X	

Please return the completed form to:
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

For internal use only:	Inquiry tracking number

2 of 2

Examples of legal documents:

- **Health Care, General or Durable Power of Attorney**. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship**. This is when the court appoints someone to care for another person.
- **Conservatorship**. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of estate**. This type of document would be used when the person who is being represented has died.

Member Authorization Form

Anthem

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This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name	Member first name	Middle initial	Member date of birth (MM/DD/YYYY)
Member street address	City	State	ZIP code

Daytime telephone number (with area code)	Cell/mobile telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)

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My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	**Other** (enter first and last name [if you have it], name of company, and how it's related to you)

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OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

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- ☐ Benefits and coverage
- ☐ Billing
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- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

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☐ **All sensitive information** [2]

OR

☐ **Just information about topics checked below**

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- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder [1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

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Description of records that may be disclosed: _____

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☐ To give out the information as shown on this form.
OR
☐ For this reason(s): _____

Part E: Date your approval expires – Check only one box.

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OR
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I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date (MM/DD/YYYY)
X	

Designated Legal Representative/Guardian – Complete this section only if you have documentation supporting Legal Representation.

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member

Legal representative street address	City	State	ZIP code

Signature	Date (MM/DD/YYYY)
X	

Please return the completed form to:

Anthem Blue Cross
PO Box 110
Fond du Lac WI 54936-0110

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

For internal use only:	Inquiry tracking number

California's Valued Trust

SilverScript®

CSEA AFL-CIO

Complete this form if enrolling in one of the following plans:

- Medicare Advantage with Rx UV
- Medicare Advantage with Rx C
- PPO Plan 1 with Rx C

California's Valued Trust
Healthcare Benefits for the Education Community

Medicare Part D Opt-In Form

If you enroll in a California's Valued Trust (CVT) retiree health care plan, you will automatically be enrolled in SilverScript Employer PDP sponsored by California's Valued Trust (SilverScript) for your prescription drug coverage when you are eligible for Medicare. SilverScript combines a standard Medicare Part D plan with additional coverage provided by CVT. To enroll in the plan, you must complete the information below.

Please **read and check the box** if you choose CVT-sponsored SilverScript prescription drug plan. **Provide any additional information needed** below and **sign the form** before returning to CVT.

☐ I choose to receive prescription drug benefits from CVT through SilverScript, along with my enrollment for medical coverage. CVT will automatically enroll me in Medicare Part D prescription drug coverage. I understand that I must enroll in Medicare Part A and/or Medicare Part B in order to be enrolled in Medicare Part D. The premium is included in the monthly CVT health insurance premium payment.

I understand that if I am later disenrolled from the plan due to failure to pay Part B or because I enroll in a non-CVT Medicare Part D plan, I will lose both my CVT medical and prescription drug coverage. I will not be able to re-enroll in the medical or prescription drug plan in the future. If I am the retiree, I also understand that my covered spouse/dependent(s) will also lose their CVT medical and prescription drug coverage.

By agreeing to be enrolled in a CVT-sponsored Medicare Part D plan, I acknowledge that SilverScript will release my information to Medicare as is necessary for treatment, payment and health care operations. I also acknowledge that the plan will release my information, including my prescription drug data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. My personal health information will be protected as required by federal and state laws.

The information provided on this form is correct to the best of my knowledge. I understand that I may be disenrolled from the plan if I intentionally provide false information as part of my enrollment.

_____

Retiree Name (please print)

_____

Spouse/Partner/Dependent Name, if applicant, as it appears on your Medicare ID card (please print)

(*please continue on page 2*)

Medicare Number (from red, white and blue Medicare card) Home Telephone Number

Mailing Address

City State ZIP Code

Medicare does not accept P.O. Boxes as an address. If your mailing address is a P.O. Box, please provide your street address below. CVT will continue to mail your benefit materials to the P.O. Box if that is your preferred address.

Street Address

City State ZIP Code

Signature of Retiree or Spouse/Dependent who is becoming eligible for Medicare Date

_____ Please check here if the person signing this form is the authorized representative for the Retiree or Spouse/Dependent.

Name of Authorized Representative (first/last – please print) Phone Number

Address City State ZIP Code

Relationship to Retiree or Dependent:

___ Child ___ Spouse ___ Friend Other (please specify)
_____

Please return this form at least two weeks before your coverage begins via fax to 559-437-2965 or mail to 520 E Herndon Ave. Fresno, CA 93720.

California's Valued Trust
Healthcare Benefits for the Education Community

MEDICARE PLANS FOR CSEA RETIREE
ANTHEM PPO HEALTH PLANS WITH SILVERSCRIPT RX
October 1, 2020 – September 30, 2021

BENEFIT	MEDICARE ADVANTAGE PPO PLAN RX-UV	MEDICARE ADVANTAGE PPO PLAN RX-C	PPO PLAN 1C
Calendar Year Deductible	$0	$0	$0
Coinsurance	Paid at 100%*	Paid at 100%*	Paid at 100%*
Calendar Year Out of Pocket Maximum (includes medical/pharmacy deductible, coinsurance, and copays)[2]	Individual: $1,250[2]	Individual: $1,250[2]	Individual: $1,250[2] Family: $2,500[2]
Doctor Visits	**Primary Care Physician** - $10 Copay **Specialty Physician** - $10 Copay	**Primary Care Physician** - $10 Copay **Specialty Physician** - $10 Copay	**Primary Care Physician** - $10 Copay **Specialty Physician** - $10 Copay
Preventive Care/ Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*
Outpatient Laboratory	Paid at 100%*	Paid at 100%*	**Non-Hospital** - Paid at 100%* **Hospital** - $50 copay, then paid at 100%*
Outpatient Radiology	Paid at 100%*	Paid at 100%*	**Non-Hospital** - Paid at 100%* **Hospital** - $75 copay, then paid at 100%*
Durable Medical Equipment	Paid at 100%*	Paid at 100%*	Paid at 100%*
Ambulance – Ground / Air	$50 Copay per one-way trip	$50 Copay per one-way trip	Paid at 100%* of covered charges
Physical Therapy	$10 Copay	$10 Copay	Paid at 100%*[1] (Copay, if applicable.)
Chiropractic	$10 Copay for Medicare-covered Chiropractic visit	$10 Copay for Medicare-covered Chiropractic visit	Paid at 100%*[1] (Copay, if applicable.)
Acupuncture	Not Covered	Not Covered	Paid at 100%* (Copay, if applicable) Maximum of 12 visits per calendar year
Outpatient Surgery	Paid at 100%*	Paid at 100%*	**Non-Hospital** - Paid at 100%* **Hospital** - $250 copay, then paid at 100%*
Hospital Inpatient	Paid at 100%* Unlimited days, Semi-private room	Paid at 100%* Unlimited days, Semi-private room	Paid at 100%* Unlimited days, Semi-private room
Hospital Emergency Room	$100 Emergent Copay (Copay waived if admitted as in-patient) After copay, paid at 100%	$100 Emergent Copay (Copay waived if admitted as in-patient) After copay, paid at 100%	**$100 Emergent Copay;** **$175 Non-Emergent Copay** (Copay waived if admitted as inpatient) After copay, paid at 100%*

BENEFIT	MEDICARE ADVANTAGE PPO PLAN RX-UV	MEDICARE ADVANTAGE PPO PLAN RX-C		PPO PLAN 1C	
Urgent Care	$10 Copay	$10 Copay		$10 Copay	
Home Health Care	Paid at 100%*	Paid at 100%*		Paid at 100%* Limited to 100 visits per calendar year	
Telehealth	MDLIVE - Paid at 100% for non-emergency medical and dermatology.[2] Call **1-888-632-2738** or visit **www.mdlive.com/CVT**	MDLIVE - Paid at 100% for non-emergency medical and dermatology.[2] Call **1-888-632-2738** or visit **www.mdlive.com/CVT**		MDLIVE - Paid at 100% for non-emergency medical, dermatology and behavioral conditions.[2] Call **1-888-632-2738** or visit **www.mdlive.com/CVT**	
Medical Decision Support	Not Covered	Not Covered		Consumer Medical - Your Medical Ally Call **1-888-361-3944** or visit **myconsumermedical.com** for expert medical guidance[2]	
Employee Assistance Program (EAP) through Beacon Health Options	Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit[3]	Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit[3]		Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit[3]	
Prescription Drugs	See attached Ultra ValuRx Prescription benefit details	**Retail**[4] $7 Generic $25 Pref $40 Non-Pref (30-Day Supply)	**Mail Order**[4] $15 Generic $60 Pref $90 Non-Pref (90-Day Supply)	**Retail**[4] $7 Generic $25 Pref $40 Non-Pref (30-Day Supply)	**Mail Order**[4] $15 Generic $60 Pref $90 Non-Pref (90-Day Supply)
2020-2021 Rates **Retiree Only** **Retiree + One**	**$223.00** **$446.00**	**$395.00** **$790.00**		**$506.00** **$974.00**	

***For Covered Expenses Only: When using Non-PPO & Other Health Care Providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible & percentage copay. All percentages are based on payments to preferred hospitals, physicians and other network providers.**

1 Non-Par Providers limited to a combined maximum of 13 visits per year.

2 Retired members enrolled in Medicare: (1) MDLIVE Behavioral Health and Consumer Medical visits are excluded (2) Pharmacy copayments will not apply to out of pocket maximums (3) CVT plans pay according to non-duplication of Medicare benefits therefore this plan design is inclusive of Medicare's payment.

3 EAP – Up to 6 counseling sessions per covered member, per benefit year (max 2 episodes / courses of treatment).

4 Copays for certain specialty medications may be set to available manufacturer-funded copay assistance for prescription plans A, B, C (includes Wellness), D and ValuRx

This summary is for comparison purposes only. Please refer to the actual benefit booklet for complete benefits at www.cvtrust.org/plan-documents.

California's Valued Trust
Healthcare Benefits for the Education Community

CSEA MEDICARE RETIREE PROGRAM
KAISER PERMANENTE SENIOR ADVANTAGE PLANS
NORTHERN CALIFORNIA RATES
October 1, 2020 – September 30, 2021

BENEFIT	KAISER PERMANENTE ESSENTIAL PLAN	KAISER PERMANENTE PLAN 4	KAISER PERMANENTE PLAN 1
Calendar Year Deductible[1]	$0	$0	$0
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, & medical copays)	Individual: $1,500	Individual: $1,500	Individual: $1,500
Doctor Visits	$30 Copay	$25 Copay	$10 Copay
Preventive Care & Immunizations	Paid at 100%*		
Outpatient Laboratory	Paid at 100%*		
Outpatient Radiology	Radiation Therapy: Paid at 100%* Chemotherapy: $30 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: $25 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: $10 Copay
Durable Medical Equipment	Paid at 80%* in accord with DME Formulary		
Ambulance – Ground / Air	$100 Copay per Trip	$100 Copay per Trip	$50 Copay per Trip
Physical Therapy	$30 Copay	$25 Copay	$10 Copay
Chiropractic	Not Covered		
Acupuncture	$30 Copay (Referral by Plan Physician)	$25 Copay (Referral by Plan Physician)	$10 Copay (Referral by Plan Physician
Hospital Inpatient	$500 per Admission	Paid at 100%*	Paid at 100%*
Outpatient Surgery	$30 Copay	$30 Copay	$10 Copay
Hospital Emergency Room	$100 Copay (Copay waived if admitted as in-patient)	$50 Copay (Copay waived if admitted as in-patient)	$35 Copay (Copay waived if admitted as in-patient)
Home Health Care	Paid at 100%* (Limits)		
Hospice	Paid at 100%*		
Vision Exam and Optical Benefit	$30 Vision Exam No Optical	$25 Copay Vision Exam $150 Optical allowance every 24 months	$10 Copay Vision Exam $150 Optical allowance every 24 months
Prescription Drugs	Retail $15 Generic $30 Brand (Up to 30 Day Supply) Mail Order $15 Generic $30 Brand (30 Day Supply) $30 Generic $60 Brand (31-100 Day Supply)	Retail $10 Generic $20 Brand (Up to 30 Day Supply) $20 Generic $40 Brand (31- 60 Day Supply) $30 Generic $60 Brand (61-100 Day Supply) Mail Order $10 Generic $20 Brand (30 Day Supply) $20 Generic $40 Brand (31-100 Day Supply)	Retail $5 Generic $10 Brand (Up to 30 Day Supply) $10 Generic $20 Brand (31- 60 Day Supply) $15 Generic $30 Brand (61-100 Day Supply) Mail Order $5 Generic $10 Brand (30 Day Supply) $10 Generic $20 Brand (31-100 Day Supply)
2020-2021 Rates **Retiree Only** **Retiree + One**	 **$254.00** **$508.00**	 **$303.00** **$606.00**	 **$379.00** **$758.00**

* For Covered Expenses Only. **This summary is for comparison purposes only. Please refer to the Evidence of Coverage for complete benefits.**

[1] only applies to Inpatient Services, Outpatient Services & Hospital Emergency Room

California's Valued Trust
Healthcare Benefits for the Education Community

CSEA MEDICARE RETIREE PROGRAM
KAISER PERMANENTE SENIOR ADVANTAGE PLANS
SOUTHERN CALIFORNIA RATES
October 1, 2020 – September 30, 2021

BENEFIT	KAISER PERMANENTE ESSENTIAL PLAN	KAISER PERMANENTE PLAN 4	KAISER PERMANENTE PLAN 1
Calendar Year Deductible[1]	$0	$0	$0
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, & medical copays)	Individual: $1,500	Individual: $1,500	Individual: $1,500
Doctor Visits	$30 Copay	$25 Copay	$10 Copay
Preventive Care & Immunizations	Paid at 100%*		
Outpatient Laboratory	Paid at 100%*		
Outpatient Radiology	Radiation Therapy: Paid at 100%* Chemotherapy: $30 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: $25 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: $10 Copay
Durable Medical Equipment	Paid at 80%* in accord with DME Formulary		
Ambulance – Ground / Air	$100 Copay per Trip	$100 Copay per Trip	$50 Copay per Trip
Physical Therapy	$30 Copay	$25 Copay	$10 Copay
Chiropractic	Not Covered		
Acupuncture	$30 Copay (Referral by Plan Physician)	$25 Copay (Referral by Plan Physician)	$10 Copay (Referral by Plan Physician
Hospital Inpatient	$500 per Admission	Paid at 100%*	Paid at 100%*
Outpatient Surgery	$30 Copay	$30 Copay	$10 Copay
Hospital Emergency Room	$100 Copay (Copay waived if admitted as in-patient)	$50 Copay (Copay waived if admitted as in-patient)	$35 Copay (Copay waived if admitted as in-patient)
Home Health Care	Paid at 100%* (Limits)		
Hospice	Paid at 100%*		
Vision Exam and Optical Benefit	$30 Vision Exam No Optical	$25 Copay Vision Exam $150 Optical allowance every 24 months	$10 Copay Vision Exam $150 Optical allowance every 24 months
Prescription Drugs	Retail: $15 Generic, $30 Brand (Up to 30 Day Supply) Mail Order: $15 Generic, $30 Brand (30 Day Supply), $30 Generic, $60 Brand (31-100 Day Supply)	Retail: $10 Generic, $20 Brand (Up to 30 Day Supply), $20 Generic, $40 Brand (31- 60 Day Supply), $30 Generic, $60 Brand (61-100 Day Supply) Mail Order: $10 Generic, $20 Brand (30 Day Supply), $20 Generic, $40 Brand (31-100 Day Supply)	Retail: $5 Generic, $10 Brand (Up to 30 Day Supply), $10 Generic, $20 Brand (31- 60 Day Supply), $15 Generic, $30 Brand (61-100 Day Supply) Mail Order: $5 Generic, $10 Brand (30 Day Supply), $10 Generic, $20 Brand (31-100 Day Supply)
2020-2021 Rates **Retiree Only** **Retiree + One**	 **$131.00** **$262.00**	 **$177.00** **$354.00**	 **$251.00** **$502.00**

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[1] only applies to Inpatient Services, Outpatient Services & Hospital Emergency Room

KAISER PERMANENTE®

Group Plan

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.

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

Employer Group #:

Employer Receipt Date: / /

Authorized Rep:

Please contact Kaiser Permanente if you need information in another language or accessible format (Braille).

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

Employer or Union Name:

Group #:

LAST Name:

☐ Mr. ☐ Mrs. ☐ Ms.

FIRST Name:

Middle Initial:

Sex:
☐ Male ☐ Female

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former

Kaiser Permanente Medical/Health Record Number:

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

City:

County:

State:

ZIP Code:

Home Phone Number: - -

Mobile Phone Number: - -

Birth Date: (mm/dd/yyyy) / /

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

Street Address:

City:

State:

ZIP Code:

E-mail Address:

Last Name _____ First Name _____

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	/ /
MEDICAL (Part B)	/ /

You must have Medicare Part B, however some employer groups require both Parts A and B to join a Medicare Advantage plan.

Please Read and Answer These Important Questions

1. Do you or your spouse work? ☐ Yes ☐ No

2. If your employer provides retiree coverage, are you the retiree? ☐ Yes ☐ No ☐ N/A
   If yes, retirement date (mm/dd/yyyy): / /
   If no, name of retiree: Retirement date (mm/dd/yyyy): / /

3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse:
   Name(s) of dependent(s):

4. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to Kaiser Permanente? ☐ Yes ☐ No
   If yes, please list your other coverage and your identification (ID) number(s) for that coverage.
   Name of other coverage: ID # for other coverage:

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 (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:

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:

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**.

KAISER PERMANENTE®

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
ਧਿਆਨ 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।

KAISER PERMANENTE®

Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ 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**).