January 1–December 31, 2022

2022 Summary of Benefits

Kaiser Permanente Senior Advantage Core Plan (HMO),
Kaiser Permanente Senior Advantage Silver Plan (HMO),
and Kaiser Permanente Senior Advantage Gold Plan (HMO)

Denver Metropolitan service area

H0630_22005DB_M
PBPs 13, 15 & 16
697210266

KAISER PERMANENTE®

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 plans. It includes information about:

- Premiums
- Benefits and costs
- Part D prescription drugs
- Optional supplemental benefits (Advantage Plus)
- Additional benefits
- 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 3 Kaiser Permanente Senior Advantage plans. It doesn't include everything about what's covered and not covered or all the plan rules. For details, see the **Evidence of Coverage (EOC)**, which is located on our website at **kp.org/eoccodb** or ask for a copy from Member Services by calling **1-800-476-2167** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

Have questions?

- If you're not a member, please call **1-877-408-3492** (TTY **711**).
- If you're a member, please call Member Services at **1-800-476-2167** (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	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
Monthly plan premium	**$0**	**$38**	**$186**
Deductible	**None**	**None**	**None**
Your maximum out-of-pocket responsibility Doesn't include Medicare Part D drugs	**$4,200**	**$3,400**	**$3,000**
Inpatient hospital coverage*† There's no limit to the number of medically necessary inpatient hospital days.	**$195** per day for days 1 through 5 of your stay and **$0** for the rest of your stay	**$165** per day for days 1 through 5 of your stay and **$0** for the rest of your stay	**$125** per day for days 1 through 5 of your stay and **$0** for the rest of your stay
Outpatient hospital coverage*†	**$200** per visit	**$175** per visit	**$100** per visit
Ambulatory Surgery Center*	**$125** per visit	**$100** per visit	**$75** per visit
Doctor's visits • Primary care providers	**$0**	**$0**	**$0**
• Specialists	**$20** per visit	**$15** per visit	**$10** per visit
Preventive care See the **EOC** for details.	**$0**	**$0**	**$0**
Emergency care We cover emergency care anywhere in the world.	**$90** per Emergency Department visit	**$90** per Emergency Department visit	**$80** per Emergency Department visit
Urgently needed services We cover urgent care anywhere in the world.	**$30** per office visit	**$25** per office visit	**$20** per office visit

Benefits and premiums	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
Diagnostic services, lab, and imaging* • Lab tests • Diagnostic tests and procedures (like EKG) • X-rays	**$0**	**$0**	**$0**
• Other imaging procedures (like MRI, CT, and PET)	**$100** per image (**$30** for ultrasounds)	**$75** per image (**$25** for ultrasounds)	**$50** per image (**$15** for ultrasounds)
Hearing services • Evaluations to diagnose medical conditions • Routine hearing exams • Hearing aid fitting or evaluation exam	**$0**	**$0**	**$0**
• Hearing aid allowance every two years to purchase hearing aids* • If you sign up for optional benefits, the allowance is greater (see Advantage Plus Options 1 & 2 for details).	**$500 allowance** per ear. If your hearing aid purchase is more than $500, **you pay the difference**.	**$500 allowance** per ear. If your hearing aid purchase is more than $500, **you pay the difference**.	**$500 allowance** per ear. If your hearing aid purchase is more than $500, **you pay the difference**.
Dental services Preventive and diagnostic dental care: • Oral exam (limited to two oral exams per year) • Prophylaxis (limited to two cleanings per year) • Topical fluoride (once in 12 months) • Full mouth or panoramic X-rays (once per 60 months) • Bitewing X-rays (one set per 12 months) • Periapical X-rays (four per 12 months)	**$10** per service	**$5** per service	**$0**

Benefits and premiums	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
• Occlusal X-rays (two per 12 months) • Pulp vitality tests			
Comprehensive dental care when provided by either Delta Dental Premier® or Delta Dental PPO™ providers (see the **Provider Directory** for network dentists): • Covered services include fillings, crowns, extractions, dentures, endodontics, and periodontics. Please see **EOC** for details. If you sign up for optional benefits, you receive additional comprehensive dental coverage (see Advantage Plus Option 1 for details).	**50%** coinsurance for fillings and periodontics services from Delta Dental PPO dentists until the plan has paid **$250** (annual benefit limit). When you reach the annual limit, you pay **100%** for the rest of the year.	**50%** coinsurance for comprehensive dental services until the plan has paid **$500** (annual benefit limit) for services when provided by Delta Dental Premier providers or **$750** (annual benefit limit) for services when provided by Delta Dental PPO providers. When you reach the $750 combined annual benefit limit for comprehensive dental care provided by Delta Dental PPO and/or Dental Premier dentists, you pay **100%** for the rest of the year. Note: The maximum benefit limit for Delta Dental Premier dentists may not exceed $500.	**50%** coinsurance for comprehensive dental services until the plan has paid **$500** (annual benefit limit) for services when provided by Delta Dental Premier providers or **$750** (annual benefit limit) for services when provided by Delta Dental PPO providers. When you reach the $750 combined annual benefit limit for comprehensive dental care provided by Delta Dental PPO and/or Dental Premier dentists, you pay **100%** for the rest of the year. Note: The maximum benefit limit for Delta Dental Premier dentists may not exceed $500.
Vision services • Visits to diagnose and treat eye diseases and conditions • Preventive glaucoma screening and diabetic retinopathy services	**$0**	**$0**	**$0**
• Routine eye exams	**$0**	**$0**	**$0**
• 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.

Benefits and premiums	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
• Other eyewear • If you sign up for optional benefits, the allowance is greater (see Advantage Plus Option 1 for details).	**$200 allowance** every year. If your eyewear costs more than $200, **you pay the difference**.	**$200 allowance** every year. If your eyewear costs more than $200, **you pay the difference**.	**$300 allowance** every year. If your eyewear costs more than $300, **you pay the difference**.
Mental health services • Outpatient group therapy	**$5** per visit	**$0**	**$0**
• Outpatient individual therapy	**$10** per visit	**$5** per visit	**$0**
Skilled nursing facility*† We cover up to 100 days per benefit period.	**Per benefit period:** • **$0** per day for days 1 through 20 • **$160** per day for days 21 through 47 • **$0** per day for days 48 through 100	**Per benefit period:** • **$0** per day for days 1 through 20 • **$160** per day for days 21 through 42 • **$0** per day for days 43 through 100	**Per benefit period:** • **$0** per day for days 1 through 10 • **$20** per day for days 11 through 100
Physical therapy*	**$15** per visit	**$10** per visit	**$10** per visit
Ambulance	**$165** per one-way trip	**$160** per one-way trip	**$150** per one-way trip
Transportation	**$0** for up to 12 one-way trips per calendar year to get you to and from plan providers. If you sign up for optional benefits, the number of trips is combined (see Advantage Plus Option 2 for details).	**$0** for up to 12 one-way trips per calendar year to get you to and from plan providers. If you sign up for optional benefits, the number of trips is combined (see Advantage Plus Option 2 for details).	**$0** for up to 30 one-way trips per calendar year to get you to and from plan providers. If you sign up for optional benefits, the number of trips is combined (see Advantage Plus Option 2 for details).
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 and the **Pharmacy Directory** for preferred and standard plan pharmacy locations. • Drugs that must be administered by a	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance

Benefits and premiums	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
health care professional			
• Up to a 30-day supply of a generic drug	• **$0** at a preferred plan pharmacy • **$20** at a standard plan pharmacy	• **$0** at a preferred plan pharmacy • **$20** at a standard plan pharmacy	• **$0** at a preferred plan pharmacy • **$20** at a standard plan pharmacy
• Up to a 30-day supply of a brand-name drug	• **$40** at a preferred plan pharmacy • **$47** at a standard plan pharmacy	• **$40** at a preferred plan pharmacy • **$47** at a standard plan pharmacy	• **$40** at a preferred plan pharmacy • **$47** at a standard plan pharmacy

Medicare Part D prescription drug coverage†

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

- The plan you enroll in (Core, Silver, or Gold).
- The tier your drug is in. There are 6 drug tiers. 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 **1-800-476-2167** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.
- The day supply quantity you get (like a 30-day or 90-day supply). Note: A supply greater than a 30-day supply isn't available for all drugs.
- The type of plan pharmacy that fills your prescription (preferred pharmacy, standard pharmacy, or our mail-order pharmacy). To find our pharmacy locations, see the **Pharmacy Directory** at **kp.org/directory**. Note: Not all drugs can be mailed.
- The coverage stage you're in (deductible, initial, coverage gap, or catastrophic coverage stages).

Deductible stage

Because we have no deductible, this payment stage does not apply to you and you start the year in the initial coverage stage.

Initial coverage stage

You pay the copays and coinsurance shown in the chart below until your total yearly drug costs reach **$4,430**. (Total yearly drug costs are the amounts paid by both you and any Part D plan during a calendar year.) If you reach the $4,430 limit in 2022, you move on to the coverage gap stage and your coverage changes.

Drug tier	Retail plan pharmacies (up to a 30-day supply)		Preferred mail-order plan pharmacy	
	Preferred pharmacy	**Standard pharmacy**	**31-60 day supply**	**61-90 day supply**
Tier 1 (Preferred generic)	**$0**	**$19**	**$0** up to a 90-day supply	
Tier 2 (Generic)	**$0**	**$20**	**$0** up to a 90-day supply	
Tier 3 (Preferred brand-name) • **Core** plan members	**$40**	**$47**	**$80**	**$120**
• **Silver** or **Gold** plan members	**$40**	**$47**	**$80**	**$100**
Tier 4 (Nonpreferred brand-name)	**$80**	**$100**	**$160**	**$240**
Tier 5 (Specialty)	**33%** coinsurance			
Tier 6 (Vaccines)	**$0**		Not applicable	

Note: When you get a 31- to 90-day supply of drugs in Tiers 1-4 from a retail plan pharmacy or standard mail-order plan pharmacy, the copays listed above for a 30-day supply for retail plan pharmacies will be multiplied as follows:

- If you get a 31- to 60-day supply, you pay 2 copays.
- If you get a 61- to 90-day supply, you pay 3 copays.

For a 31- to 90-day supply of Tier 5 drugs, you pay the coinsurance listed above in the chart.

Coverage gap stage

The coverage gap stage begins if you or a Part D plan spends **$4,430** on your drugs during 2022. During this stage, you pay **25%** coinsurance for your covered Part D drugs (generic and brand-name drugs).

Catastrophic coverage stage

If you spend **$7,050** on your Part D prescription drugs in 2022, 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 2022. You pay the following per prescription during the catastrophic coverage stage:

- For **generic** drugs, you will pay either a **5%** coinsurance or a **$3.95** copay, whichever amount is larger.
- For **brand-name** drugs, you will pay either a **5%** coinsurance or a **$9.85** copay, whichever amount is larger.

Long-term care, plan home-infusion, 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 standard plan pharmacy and you can get up to a 31-day supply.
- Covered Part D **home infusion** drugs from a plan home-infusion pharmacy are provided at no charge.
- If you get covered Part D drugs from a **non-plan pharmacy**, you pay the same as at a standard 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 **Evidence of Coverage** for details.

Advantage Plus (optional benefits)

In addition to the benefits that come with your plan, you can choose to buy one or both optional supplemental benefit packages. We call the packages Advantage Plus Option 1 and Advantage Plus Option 2. The packages give you extra coverage for an additional monthly cost that's added to your monthly plan premium. See the **Evidence of Coverage** for details.

Advantage Plus Option 1 benefits and premiums	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
Additional monthly premium	**$39**	**$39**	**$39**
Eyewear An additional $200 allowance to buy eyewear every 12 months	A $200 allowance is added to the $200 allowance described in "Vision services" above. If your eyewear costs more than the combined allowance of $400, **you pay the difference**.	A $200 allowance is added to the $200 allowance described in "Vision services" above. If your eyewear costs more than the combined allowance of $400, **you pay the difference**.	A $200 allowance is added to the $300 allowance described in" Vision services" above. If your eyewear costs more than the combined allowance of $500, **you pay the difference**.
Hearing aids* $500 allowance to buy 1 aid per ear every 2 years.	A $500 allowance is added to the $500 allowance described in "Hearing services" above. If your hearing aid costs more than $1,000 per ear, **you pay the difference**.	A $500 allowance is added to the $500 allowance described in "Hearing services" above. If your hearing aid costs more than $1,000 per ear, **you pay the difference**.	A $500 allowance is added to the $500 allowance described in "Hearing services" above. If your hearing aid costs more than $1,000 per ear, **you pay the difference**.
Comprehensive dental care Covered basic and major			

Advantage Plus Option 1 benefits and premiums	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
services include fillings, crowns, extractions, endodontics, periodontics, and dentures when provided by either Delta Dental Premier® or Delta Dental PPO™ providers (see the **Provider Directory** for network dentists):			
• Annual benefit limit **Note:** All plan members have coverage for comprehensive dental as described in "Dental services." The benefit limits of both benefits are combined as shown on the right.	After the plan pays **$1,000** in a calendar year for comprehensive dental care provided by Delta Dental Premier network providers, you pay 100% for the rest of the year. After the plan pays **$1,250** in a calendar year for comprehensive dental care provided by Delta Dental PPO network providers, you pay 100% for the rest of the year.	After the plan pays **$1,500** in a calendar year for comprehensive dental care provided by Delta Dental Premier network providers, you pay 100% for the rest of the year. After the plan pays **$1,750** in a calendar year for comprehensive dental care provided by Delta Dental PPO network providers, you pay 100% for the rest of the year.	After the plan pays **$1,500** in a calendar year for comprehensive dental care provided by Delta Dental Premier network providers, you pay 100% for the rest of the year. After the plan pays **$1,750** in a calendar year for comprehensive dental care provided by Delta Dental PPO network providers, you pay 100% for the rest of the year.
• Basic comprehensive services	**50%** coinsurance for basic comprehensive dental services provided by Delta Dental Premier network providers, up to the annual benefit limit. **30%** coinsurance for basic comprehensive dental services provided by Delta Dental PPO network providers, up to the annual benefit limit.	**50%** coinsurance for basic comprehensive dental services provided by Delta Dental Premier network providers, up to the annual benefit limit. **30%** coinsurance for basic comprehensive dental services provided by Delta Dental PPO network providers, up to the annual benefit limit.	**50%** coinsurance for basic comprehensive dental services provided by Delta Dental Premier network providers, up to the annual benefit limit. **30%** coinsurance for basic comprehensive dental services provided by Delta Dental PPO network providers, up to the annual benefit limit.

Advantage Plus Option 1 benefits and premiums	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
• Major comprehensive services Please see **EOC** for details.	**50%** coinsurance for major comprehensive dental services up to the annual benefit limit.	**50%** coinsurance for major comprehensive dental services up to the annual benefit limit.	**50%** coinsurance for major comprehensive dental services up to the annual benefit limit.
In-home support We cover up to 8 hours of non-medical, in-home support services every month to address assistance with ADLs and IADLs within the home.	**$0** If you enroll in Options 1 and 2, the benefits are combined to give you 16 hours of support.	**$0** This benefit and the benefit described in "In-home support for Silver or Gold plan members" are combined to give you 16 hours of support, or 24 hours of support if you enroll in Options 1 and 2.	**$0** This benefit and the benefit described in "In-home support for Silver or Gold plan members" are combined to give you 16 hours of support, or 24 hours of support if you enroll in Options 1 and 2.

Advantage Plus Option 2 benefits and premiums	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
Additional monthly premium	**$14**	**$14**	**$14**
Acupuncture 16 visits per calendar year	**$15** per visit	**$15** per visit	**$15** per visit
Hearing aids* $500 allowance to buy 1 aid per ear every 2 years. Note: If you enroll in both Advantage Plus options (Option 1 and Option 2), the allowance is $1,000 per ear, which is added	A $500 allowance is added to the $500 allowance described in "Hearing services" above. If your hearing aid costs more than $1,000 per ear, **you pay the difference**.	A $500 allowance is added to the $500 allowance described in "Hearing services" above. If your hearing aid costs more than $1,000 per ear, **you pay the difference**.	A $500 allowance is added to the $500 allowance described in "Hearing services" above. If your hearing aid costs more than $1,000 per ear, **you pay the difference**.

Advantage Plus Option 2 benefits and premiums	With our **Core** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
to the allowance described in "Hearing services."			
Transportation We cover up to 20 one-way trips per calendar year (limited to 50 miles one way) to get you to or from a plan provider when provided by our transportation provider.	**$0** This benefit and the benefit described in "Transportation" are combined to give you 32 one-way trips per calendar year.	**$0** This benefit and the benefit described in "Transportation" are combined to give you 32 one-way trips per calendar year.	**$0** This benefit and the benefit described in "Transportation" are combined to give you 50 one-way trips per calendar year.
In-home support We cover up to 8 hours of non-medical, in-home support services every month to address assistance with ADLs and IADLs within the home.	**$0** If you enroll in Options 1 and 2, the benefits are combined to give you 16 hours of support.	**$0** This benefit and the benefit described in "In-home support for Silver or Gold plan members" are combined to give you 16 hours of support, or 24 hours of support if you enroll in Options 1 and 2.	**$0** This benefit and the benefit described in "In-home support for Silver or Gold plan members" are combined to give you 16 hours of support, or 24 hours of support if you enroll in Options 1 and 2.

Additional benefits

These benefits are available to you as a plan member:	**You pay**
Over-the-counter (OTC) items We cover OTC items listed in our OTC catalog for free home delivery. You may order OTC items each quarter of the year (January, April, July, October) up to the quarterly benefit limit shown in the right column. Each order must be at least **$35**. To view our catalog and place an order online, please visit **kp.org/otc/co**. You may place an order over the phone or request a printed catalog be mailed to you by calling **1-833-238-6616** (TTY **711**), 6 a.m. to 5 p.m. MST, Monday through Friday.	**$0** up to the following quarterly benefit limit, depending upon the plan: • **$90** quarterly benefit limit for Gold plan members. • **$80** quarterly benefit limit for Silver plan members. • **$50** quarterly benefit limit for Core plan members.
In-home support for Gold or Silver plan members only We cover 8 hours of non-medical, in-home support services every month to address assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) within the home. See the **EOC** for details. Note: This benefit is not covered for Core plan members unless they sign up for optional supplemental benefits (see "Advantage Plus" for details).	**$0**

Who can enroll

You can sign up for one of our plans if:

- You have both Medicare Part A and Part B. (To get and keep Medicare, most people must pay Medicare premiums directly to Medicare. These are separate from the premiums you pay our plan.)
- You're a citizen or lawfully present in the United States.
- You live in the service area for these plans, which includes all of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson and Park counties.

Coverage rules

We cover the services and items listed in this document and the **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
- Routine care from a Colorado Permanente Medical Group (CPMG) physician at a Kaiser Permanente medical office in our Northern or Southern Colorado service areas

Note: You pay the same plan copays and coinsurance when you get covered care listed above from non-plan providers. If you receive non-covered care or services, you must pay the full cost.

For details about coverage rules, including non-covered services (exclusions), see the **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. 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 **1-800-476-2167** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

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 must choose one of our available plan providers 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 **1-855-208-7221** (TTY **711**), weekdays 7 a.m. to 5:30 p.m. or at **kp.org**.

Help managing conditions

If you have more than one 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 **Evidence of Coverage** for details about the processes for making complaints and making coverage decisions and appeals, including fast or urgent decisions for drugs, services, or hospital care.

Language assistance services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-476-2167** (TTY: **711**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-476-2167** (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 **1-800-476-2167**（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 **1-800-476-2167** (TTY: **711**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-476-2167** (TTY: **711**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-476-2167** (TTY: **711**)번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-476-2167** (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。**1-800-476-2167**（TTY:**711**）まで、お電話にてご連絡ください。

Farsi: **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-476-2167** (TTY: **711**) تماس بگیرید.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-**800-476-2167 (رقم هاتف الصم والبكم: -**711**).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-476-2167** (መስማት ለተሳናቸው: **711**).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-476-2167** (TTY: **711**).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-476-2167** (ATS : **711**).

Yoruba: AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-476-2167** (TTY: **711**).

Cushite-Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-476-2167** (TTY: **711**).

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् **1-800-476-2167** (टिटिवाइ: **711**)।

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 **1-800-476-2167** (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 2500 South Havana, Aurora, CO 80014 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**.

Privacy

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

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 difference.

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.

Deductible

It's the amount you must pay for Medicare Part D drugs before you will enter the initial coverage stage.

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.

Preferred pharmacy

A plan pharmacy where you can get your prescriptions at preferred copays. These pharmacies are usually located at plan medical offices (see the **Pharmacy Directory** for locations). The amount you pay at these pharmacies is less than you pay at other plan pharmacies that only offer standard copays, which are referred to in this document as standard pharmacies.

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.

Standard pharmacy

A plan pharmacy where you can get your prescriptions at standard copays. These pharmacies aren't usually located at plan medical offices (see the **Pharmacy Directory** for locations). The amount you pay at these pharmacies is more than you pay at plan pharmacies that only offer preferred copays, which are referred to in this document as preferred pharmacies.

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.

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**.

kp.org/medicare

Kaiser Foundation Health Plan of Colorado
2500 South Havana St.
Aurora, CO 80014

KAISER PERMANENTE®