The Kaiser Permanente Preferred Provider Organization (PPO) Plan

Welcome to Kaiser Permanente

New Member Guide
Colorado

kp.org/kpic-colorado

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

KAISER PERMANENTE®

Dear Member,

One of the major advantages of your PPO Insurance Plan is flexibility. You can choose personalized care from participating providers in First Health network, or you can get care from nonparticipating providers in your community. Or you can stay with the doctor you already know and trust. We'll be right there with you to help you make smart, well-informed decisions along the way.

You can also get most prescription drugs for a convenient copay. And you can fill your prescriptions at any MedImpact pharmacy.

By now, you should have received your ID card in the mail. It gives you access to medical care nationwide and contains useful phone numbers for Customer Service, precertification, claims, First Health, and MedImpact. If you haven't received your ID card yet, please call Customer Service at **1-855-364-3184** (TTY **711**), Monday through Friday from 8 a.m. to 6 p.m.

Thank you for choosing our PPO Insurance Plan. We look forward to taking care of you in the years to come.

Wishing you good health,

Kaiser Permanente

The Kaiser Permanente Preferred Provider Organization (PPO) Plan

Welcome! In this guidebook, you'll find details about your PPO Plan benefits, instructions on how to choose a doctor and fill your prescriptions, get care, and important resources.

1 Understand your plan **2 Transfer prescriptions** **3 Get care**

New Member? We're here to help

Learn about your benefits and more!

You can reach Customer Service at **1-855-364-3184** (TTY **711**), Monday through Friday, from 8 a.m. to 6 p.m., Mountain time.

1 Understand your plan

How the Preferred Provider Organization (PPO) Plan works

Your PPO plan works the way you want it to. You can choose your own provider under either tier and you can move between tiers at any time.

Your plan is governed by KPIC's Certificate of Insurance (COI). Inside this resource guide, we refer to the COI as your plan agreement. This resource guide provides an overview of your benefits and services. If there are any differences between this document and your plan agreement, your plan agreement will prevail.

The benefits provided under the participating and non-participating tiers are not the same.

KPIC is contracted with First Health®. First Health is a brand name of First Health Group Corp.

	Participating Provider Tier	Non-Participating Provider Tier
Provider Choice	First Health, Direct Contracted Providers & MedImpact Contracted Pharmacies	Any Licensed Provider & Any Pharmacy
Out-of-Pocket Cost	Lower Cost Some services are subject to a deductible, and then coinsurance	Higher Cost Most services are subject to a deductible and then coinsurance
Claims	Provider generally completes and submit claims forms You will not be balance billed	You will generally complete and submit claim forms You can be balance billed if your provider bills you for more than your plan allows

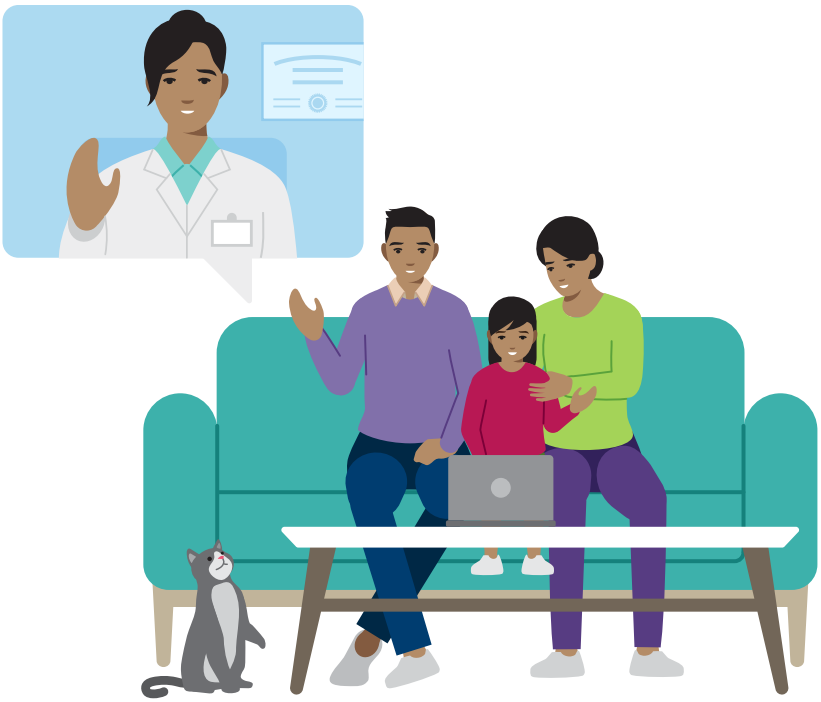
For questions about your plan

Please call Customer Service at **1-855-364-3184** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m., Mountain time.

Choose your doctor—and change anytime

Your PPO plan gives you the freedom to choose how you receive care, each time you receive care. When you go to your appointments, please make sure you bring your ID card. If your provider has questions about your plan, you can refer them to the customer service phone number on the front of your ID card.

Participating Provider Tier	**Choosing a Participating Provider** First Health providers and hospitals are in Colorado and nationwide. For assistance finding a direct contracted provider, visit **kp.org/kpic-colorado** or call **1-855-364-3184** (TTY **711**).
Non-Participating Provider Tier	**Choosing a provider in the community** If you seek care in the Non-Participating Provider Tier, you can work directly with any licensed provider or facility anywhere. You may pay more if you choose to see a non-participating provider. You can call the provider's office and make an appointment. Simply state that your plan allows you to see any provider in the community.



2 Transfer or fill your prescriptions

You can fill prescriptions from any provider at any pharmacy using one of these pharmacy options.

Participating Provider Tier	Fill prescriptions at participating MedImpact pharmacies including Walgreens, Safeway, Kroger, and many more. • Not all locations within a pharmacy chain are contracted with MedImpact; some are independently contracted. • To verify if a specific pharmacy participates, or to obtain a complete list of participating pharmacies call MedImpact at **1-800-788-2949** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m., Mountain time. • Walgreen's mail order is available through MedImpact's pharmacy network. For a list of covered drugs, please visit **kp.org/kpic-colorado**, and click on "Drug Formulary" to see a preferred drug list.
Non-Participating Provider Tier	To transfer a prescription to a non-participating pharmacy, you will need to contact the pharmacy directly. • Mail Order is not available under this pharmacy option. • You may need to pay full costs and submit claims to MedImpact for reimbursement subject to the terms and conditions of your plan. Claim forms can be found at **kp.org/kpic-colorado**. Please have the following information ready when you call: • The name and strength of the medication • The prescription number of the prescribed medication • The name and phone number of the transferring pharmacy For a list of covered drugs, please visit **kp.org/kpic-colorado**, and click on "Drug Formulary" to see a preferred drug list.

3 Get care

Prior Approval (Pre-certification)

To ensure that the medical service ordered is medically necessary, prior approval may be required. This is known as pre-certification for services ordered by a participating or non-participating provider.

Participating Provider Tier	Pre-certification is required for all inpatient care (such as hospital surgical procedures) and certain outpatient procedures. Your Participating Provider is required to obtain pre-certification at least three days before you receive certain services or have any inpatient hospital stays, or within 24 hours of an emergency department admission. Some examples of services requiring pre-certification include: • Inpatient hospital stay • Outpatient surgery • Home health, hospice, and skilled nursing facility care • Imaging Permanente Advantage may be contacted at **1-888-525-1553** (TTY **711**) anytime, day or night, to initiate pre-certification.
Non-Participating Provider Tier	Pre-certification is required for all inpatient care (such as hospital surgical procedures) and certain outpatient procedures. You are required to obtain pre-certification at least three days before you receive certain services or have any inpatient hospital stays, or within 24 hours of an emergency department admission. Your physician, hospital, or authorized representative may obtain pre-certification on your behalf. Some examples of services requiring pre-certification include: • Inpatient hospital stay • Outpatient surgery • Home health, hospice, and skilled nursing facility care • Imaging You may request pre-certification 24 hours a day, 7 days a week. Call Permanente Advantage at **1-888-525-1553** (TTY **711**). If you do not obtain pre-certification for covered services that require it, you may pay a penalty or services may not be covered at all.

Prior Authorization of Outpatient Prescription Drugs

As a Kaiser Permanente PPO plan member, certain outpatient prescription drugs are subject to utilization management requirements: prior authorization, step therapy, age and quantity limits. We've partnered with Medimpact to help ensure that outpatient prescription drugs ordered by your doctor are medically necessary, and the most appropriate treatment for your condition. Before you receive certain outpatient prescription drugs, your prescribing provider should request prior authorization by completing and submitting the KPIC Prior Authorization request **in writing**. For questions on utilization management requirements, you can reach MedImpact Pharmacy Helpdesk at **1-800-788-2949** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m., Mountain time.

Seeing your doctor

See your doctor for preventive screenings, new or existing health concerns, or a change in a health condition that is not an urgent need.

Participating Provider Tier	Provider networks change regularly. Before making your appointment, confirm that the provider is still participating in the First Health Network or is a direct contracted provider. See page 3 for how to do this. When you see a participating provider for the first time, let the office staff know you are using the Participating Provider Tier of your Kaiser Permanente plan, which allows you to see participating providers who are part of the First Health Network or is a direct contracted provider. For assistance finding a direct contracted provider, visit **kp.org/kpic-colorado** or call **1-855-364-3184** (TTY **711**).
Non-Participating Provider Tier	If you see a non-participating provider for care, speak with your non-participating provider for information on making appointments and to learn about how his/her care team is structured. When you see a non-participating provider for the first time, let the office staff know you are using the Non-Participating Provider Tier of your plan, which lets you see any licensed provider.

Medical Advice

Whenever you need medical advice or are unsure whether you need urgent care, call your participating or non-participating provider, who can direct your care.

Coverage for Newborns

Your newborn will receive care from the time of birth through the first 31 days. Coverage is provided according to the terms of your plan agreement, and coordination of benefits may apply. For information on enrolling your newborn for health coverage beyond 31 days, call **1-855-364-3184** (TTY **711**).

Hospital Care

Participating Provider Tier	• You can receive inpatient and outpatient services from the participating provider network. • See page 5 for any pre-certification requirements.
Non-Participating Provider Tier	• You can receive inpatient and outpatient services from any licensed or accredited hospitals/facilities and providers. • See page 5 for any pre-certification requirements. • Depending on your benefit plan, you may be responsible for a higher out-of-pocket expense if you receive care from a non-participating provider or facility. • The provider/facility may require you to pay upfront for these services. If that should occur then you will also need to submit a member reimbursement form for each provider or facility. See claims section on page 10 for more information.

Emergency Care

When your health is in danger and you require immediate care. For example, if you feel like you are having a heart attack, have severe difficulty breathing, lose the ability to talk or to move one side of your body, develop slurred speech, experience a sudden change in consciousness, have serious wounds or injuries, or have a psychiatric emergency.

If you think you are experiencing an emergency medical condition, call **911**, or if time and safety permit, go to the nearest emergency room. Your care will be covered. For a complete definition of an emergency medical condition, please refer to your coverage documents at **kp.org/kpic-colorado**.

Within 24 hours of an emergency department admission, contact Permanente Advantage. See page 5 for any pre-certification requirements.

Emergency care is covered at the Participating Provider Tier benefit level, and you will be responsible only for the Participating Provider Tier copay or coinsurance, regardless of where you seek care.

Urgent Care

For illnesses or injuries requiring prompt attention but that are not medical or psychiatric emergencies. This can include abdominal pain, asthma, cough, fever, sore throat, earaches, headaches, migraines, minor lacerations, ankle sprains, and other urgent conditions.

Participating Provider Tier	• If you think you need urgent care, call your participating provider who can direct your care. • You have access to urgent care facilities that are part of the participating provider network anywhere in the country. • Before seeking urgent care, you should confirm that the facility is part of the participating provider network.
Non-Participating Provider Tier	• If you think you need urgent care, call your non-participating provider who can direct your care. • You have access to any urgent care facility not already in the Participating Provider Tier, anywhere in the country. • The facility may ask you to pay in full when you receive care. If so, retain a copy of the bill as proof of payment, and submit your claim for reimbursement.

X-Ray and Imaging Services

Participating Provider Tier	• Before scheduling any X-rays or other imaging services, check first to be sure the facilities are part of the participating provider network. • Pre-certification may be required. Refer to your plan agreement. For more information on pre-certification, see page 5.
Non-Participating Provider Tier	• You can receive X-rays and other imaging services at any facility. • Pre-certification may be required. Refer to your plan agreement. For more information on pre-certification, see page 5. • If you receive tests and screenings in non-participating facilities, you will likely pay in full and submit a claim for reimbursement subject to the terms and conditions of your plan. The provider may also bill you for the difference, if any, between actual billed charges and the maximum allowable charge (as determined by KPIC). Refer to your Certificate of Insurance for more details.

Lab Tests and Results

Participating Provider Tier	Before scheduling any lab test, check first to be sure the facilities are part of the participating provider network.
Non-Participating Provider Tier	• You can receive lab services at any facility. • If you receive tests and screenings at non-participating facilities, you will likely pay in full and submit a claim for reimbursement subject to the terms and conditions of your plan. The provider may also bill you for the difference, if any, between actual billed charges and the maximum allowable charge (as determined by KPIC). Refer to your Certificate of Insurance for more details.

Behavioral/Mental Health

Participating Provider Tier	You can receive outpatient care for mental illness, emotional disorders, and drug or alcohol abuse from a provider in the First Health Network or from a direct contracted provider without a referral. For assistance in finding a First Health or direct contracted provider, call Customer Service at **1-855-364-3184** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m., Mountain time or visit **kp.org/kpic-colorado**. Pre-certification is required before receiving inpatient hospital care. Depending on your plan, it may also be required for certain outpatient procedures. See page 5 for more information about pre-certification. Permanente Advantage may be contacted at **1-888-525-1553** (TTY **711**), 24 hours a day, 7 days a week. See page 5 for details.
Non-Participating Provider Tier	You can receive outpatient care from any licensed behavioral health or chemical dependency professional for mental illness, emotional disorders, and drug or alcohol abuse. Pre-certification is required before receiving inpatient hospital care. Depending on your plan, it may also be required for certain outpatient procedures. See page 5 for more information about pre-certification. You may request pre-certification 24 hours a day, 7 days a week. See page 5 for details.

Claims

Generally speaking, when you have care under the Participating Provider Tier, you will not have to file a claim. That is handled by your provider. You may be required to pay the full amount you are charged when you receive care from a non-participating provider. If you are asked to pay out-of-pocket, you must submit three items to be reimbursed.

1. Completed claim form

- Name of the patient
- Patient's ID number (on each page of the document)
- Date of service

2. Itemized bill from your provider (please contact your provider and request the itemized bill)

- Service provided (procedures performed, with CPT code)
- Diagnosis with ICD code
- Amount charged for each service

3. Proof of payment (one of the following)

- Credit card receipt
- Bank statement
- Copies of your original check (front and back)

To obtain medical claim forms, go to **kp.org/kpic-colorado** or contact Customer Service at **1-855-364-3184** (TTY **711**), Monday through Friday, from 8 a.m. to 6 p.m., Mountain time.

Timelines for filing a claim

Participating Provider Tier	• Provider generally completes and submits claim forms. • If you do have to pay for services out-of-pocket, you have up to 15 months from the date you received care to submit your claim.
Non-Participating Provider Tier	• Your non-participating provider does not have a contracted rate and can establish their own fee. • You will be responsible for the balance if your provider bills you for more than your plan allows. • You have up to 15 months from the date you received care to submit your claim.

Where to send your claim

Mail your claim form and itemized statement to:
Kaiser Permanente Claims Department
PO Box 373150
Denver, CO 80237-3150

What to expect next

You'll receive a response within 30 days. If your claim form is submitted incomplete or is missing information or documentation or unsigned it will be returned for correction and re-submission.

If the claim submitted is complete you will receive an Explanation of Benefits (EOB) that will show you a breakdown of the charges and payments for your visit and will also show how much you are responsible for paying, as well as your deductible and out-of-pocket maximum.

If your claim is denied

If your claim is denied, in whole or in part, you will receive detailed written information on the EOB document you receive. You have the right to file an appeal if you disagree with the decision not to authorize medical services or drugs, or not to pay for a claim. Refer to your plan agreement for specific details about your appeals process. Read your COI for more information.

Getting care away from home

You are covered to receive care for emergency illness or injury anywhere in the world, regardless of provider. Use this checklist before you get care away from home. A little planning makes a big difference. Plan now for a healthy trip.

- ☐ Contact your doctor if you need to manage a condition during your trip.
- ☐ Refill your prescriptions to have enough while you're away.
- ☐ Make sure your immunizations are up to date, including your yearly flu shot.
- ☐ Bring your health insurance ID card. It has important phone numbers on the back.

Visit **kp.org/travel** or call the Away From Home team at **951-268-3900** (TTY **711**) for helpful resources to help you plan for your trip, and for claim forms in case you need to file a claim.

Glossary

Preventive care

With most plans, preventive care is at no additional cost to you when you access a provider in the Participating Provider Tier. If you receive preventive care services through a non-participating provider you may have to pay the full cost of services and submit a claim for reimbursement. Additionally, a copayment, deductible, and/or coinsurance may apply.

Preventive care includes routine physicals, well-child visits, and certain screenings and tests (such as mammograms). So there's no need to delay making your first appointment with your doctor.

Sometimes, the doctor will want to do something that is not preventive care. For example, during your routine appointment, the doctor may find a mole that needs to be removed for testing. Because that's not covered as preventive care, you will be asked to pay a copayment, deductible, or coinsurance for the service. In most cases, you will get a bill in the mail for such additional, non preventive services.

Types of Cost Share

Here are different types of costs (such as copays, coinsurance, or deductibles) you may be required to pay under your plan.

Copayments (copays)

The specific dollar amount you pay for a covered service (e.g., non-preventive office visit) every time that service is provided. Copayments vary depending on your plan and count toward your annual out-of-pocket maximum for most services.

Coinsurance

The percentage of charges you pay for a covered service. For example, if your coinsurance is 15 percent and your allowed office visit cost is $100, then you pay $15 and the health plan pays $85. Services are often subject to a deductible. Coinsurance varies according to your plan. Coinsurance payments also count toward your annual out-of-pocket maximum for most services.

Nearly all plans have copayments or coinsurance. A copayment or coinsurance may be owed on the day you receive services, for each visit, even if multiple visits occur on the same day.

Out-of-pocket maximum

The maximum amount you pay out of pocket each plan year for most covered services. Once you meet your out-of-pocket maximum, you won't pay anything for most covered services for the remainder of the plan year. For a detailed description, including any cross accumulation of your out-of-pocket maximum between tiers, see your COI. Fees, penalties, or balance billing won't count toward your out-of-pocket maximum.

Deductible

The set amount you must pay each plan year for covered medical services before the health plan begins to pay its share. Not all services may be subject to the deductible. Deductibles vary depending on the plan you have.

Once you have met your deductible, you will be required to pay only the applicable copayment or coinsurance for most covered services for the remainder of your plan year until you reach your out-of-pocket maximum. Certain conditions may apply.

If you have a deductible, you will be billed for the full allowed amount for each service that is subject to the deductible during check-in or after the service via mailed bill. You may also receive an estimate of your charges before your office visit for certain services, and you may choose to make a deposit payment based on that estimate.

Balance Billing

This may occur when you are billed for any charges above the maximum allowable charge set out in your Certificate of Insurance. There is no balance billing in the Participating Provider Tier. **You may be balance billed for services received at the Non-Participating Provider Tier**.

Maximum Allowable Charge

For providers in the Participating Provider Tier, the maximum allowable charge is the negotiated contracted rate agreed upon to provide discounts for covered services.

For all other providers, it is the lesser of the usual, customary, and reasonable (UCR) charges and the actual billed charges.

When you go to a provider or facility or receive services in the Non-Participating Provider Tier, you may be balance billed for any amount in excess of the maximum allowable charge. It is important that you understand that you are responsible for 100% of all amounts balance billed, and that payments of a balance bill do not count towards your deductible or out-of-pocket maximum.

Usual, Customary, and Reasonable (UCR)

The general level of charges made by other providers for specified covered services within the area where the charge is incurred.

Learn more at **kp.org/kpic-colorado**

- Get benefit details
- Access forms
- Find a provider

Important Contacts

Participating Provider Tier	**See your primary care or specialty physician** Call your participating provider directly. For assistance finding a First Health or direct contracted provider, visit **kp.org/kpic-colorado** or call **1-855-364-3184** (TTY **711**). **Urgent Care** Visit **kp.org/kpic-colorado** for a list of urgent care facilities participating in the First Health Network, or call **1-855-364-3184** (TTY **711**). Visit **kp.org/kpic-colorado** for a list of direct contracted providers or call **1-855-364-3184** (TTY **711**). **Emergency Care** Emergency care is covered at the participating provider benefit level regardless of the participating status of the provider.
Non-Participating Provider Tier	**See your primary care or specialty physician** Call your Non-Participating Provider directly. **Urgent Care** You can visit any licensed out-of-network urgent care facility. Make sure to keep a copy of your bill to submit with your claim for reimbursement. **Emergency Care** Emergency care is covered at the Participating Provider benefit level regardless of the participating status of the provider.

Notices and references

Nondiscrimination Notice

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC 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 **1-800-632-9700** (TTY **711**).

If you believe that KPIC 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 by mail at: Customer Experience Department, Attn: KPIC Civil Rights Coordinator, 2500 S. Havana St., Aurora, CO 80014, or by phone at Member Services: **1-800-632-9700**.

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 **ocrportal.hhs.gov**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **1-800-537-7697** (TDD). Complaint forms are available at **hhs.gov/ocr/filing-with-ocr**.

Help in Your Language

Attention: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة:
إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY **711**)

Bàsɔ́ ɔ̀ Wù dù (Bassa) Dè dɛ nià kɛ dyédé gbo:
Ɔ jǔ ké m̀Bàsɔ́ɔ̀-wùdù-po-nyɔ̀ jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀gbo kpáa. Đá **1-800-632-9700** (TTY **711**)

中文 (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 1-800-632-9700 (TTY **711**) 。

فارسی (Farsi) توجه:
اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION:
Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY **711**).

continued on next page >

日本語 (Japanese) 注意事項: 日本語を話さる場合、無料の言語支援をご利用いただけます。**1-800-632-9700** (TTY **711**) まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용 하실 수 있습니다. **1-800-632-9700** (TTY **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hól ọ́, koj ị' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस् : तपा ंले नेपाली बोल्नुहुन्छ भने तपा ंको ननमतत भाषा सहायता सेवाह न शुल्क पमा उपलब्ध छ। **1-800-632-9700** (TTY **711**) फोन गनहोस।

Afaan Oromoo (Oromo) XIYYEEFFANNAA:
Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.
Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ:
если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN:
si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).

For questions about your plan

Please call Customer Service at **1-855-364-3184** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m., Mountain time.

Notes

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Kaiser Foundation Health Plan of Colorado
Communications
2500 S. Havana Street
Aurora, CO 80014

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Member and Marketing Communications 792087371 January 2022 DB PPO

Your guide to better health

Keep this book handy as a quick reference to getting the most out of your new plan

For information about your POS Plan benefits, call Customer Service at:

1-855-364-3184 (TTY **711**)
Monday through Friday
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