Kaiser Permanente Senior Advantage Core Plan (HMO) Offered by Kaiser Foundation Health Plan of Colorado (Core Plan)

Annual Notice of Changes for 2021

You are currently enrolled as a member of Kaiser Permanente Senior Advantage Core plan. Next year, there will be some changes to our plan's costs and benefits. This booklet tells about the changes.

You have from October 15 until December 7 to make changes to your Medicare coverage for next year.

What to do now

1. **Ask:** Which changes apply to you?

   ☐ Check the changes to our benefits and costs to see if they affect you.

   - ♦ It's important to review your coverage now to make sure it will meet your needs next year.
   - ♦ Do the changes affect the services you use?
   - ♦ Look in Section 1 for information about benefit and cost changes for our plan.

   ☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

   - ♦ Will your drugs be covered?
   - ♦ Are your drugs in a different tier, with different cost-sharing?
   - ♦ Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
   - ♦ Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
   - ♦ Review the 2021 Drug List and look in Section 1.6 for information about changes to our drug coverage.

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- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices, visit **go.medicare.gov/drugprices**. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our **Provider Directory**.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. Compare: Learn about other plan choices.

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at the **www.medicare.gov/plan-compare** website.
- Review the list in the back of your **Medicare & You** handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. Choose: Decide whether you want to change your plan.

- If you don't join another plan by December 7, 2020, you will be enrolled in our Senior Advantage Core plan.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. Enroll: To change plans, join a plan between October 15 and December 7, 2020.

- If you don't **join another plan by December 7, 2020**, you will be enrolled in our Senior Advantage Core plan.
- If you **join another plan by December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

Additional resources

- This document is available for free in Spanish. Please contact our Member Services number at **1-800-476-2167** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.
- Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **1-800-476-2167** (los usuarios de la línea TTY deben llamar al 711). El horario es de 8 a. m. a 8 p. m., los 7 días de la semana.
- This document is available in braille, large print, or CD if you need it by calling Member Services.
- Coverage under this plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

About Kaiser Permanente Senior Advantage Core plan

- Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Kaiser Foundation Health Plan of Colorado (Health Plan). When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

Summary of important costs for 2021

The table below compares the 2020 costs and 2021 costs for our Senior Advantage Core plan in several important areas. Please note this is only a summary of changes. A copy of the **Evidence of Coverage** is located on our website at **kp.org/eoccodb**. You may also call Member Services to ask us to mail you an **Evidence of Coverage**.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	**$0***	**$0***
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	**$4,400**	**$4,400**
Doctor office visits	Primary care visits: **$5** per visit. Specialist visits: **$50** per visit.	Primary care visits: **$5** per visit. Specialist visits: **$35** per visit.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	Per admission, **$295** per day for days 1–6.	Per admission, **$200** per day for days 1–5.
Part D prescription drug coverage	(See Section 1.6 for details.)	
• Deductible Stage	**$225** (Tiers 3–5)	**$95** (Tiers 4 & 5)
• Preferred cost-sharing during the Initial Coverage Stage (up to a 30-day supply)	Drug Tier 1: **$4** Drug Tier 2: **$10** Drug Tier 3: **$40** Drug Tier 4: **$95** Drug Tier 5: **28%** Drug Tier 6: **$0**	Drug Tier 1: **$2** Drug Tier 2: **$10** Drug Tier 3: **$40** Drug Tier 4: **$95** Drug Tier 5: **31%** Drug Tier 6: **$0**

Annual Notice of Changes for 2021

Table of Contents

Section 1 — Changes to benefits and costs for next year

Section 1.1 – Changes to the monthly premium

Cost	2020 (this year)	2021 (next year)
Monthly premium without optional supplemental benefits (You must also continue to pay your Medicare Part B premium.)	**$0**	**$0**
Monthly premium with optional supplemental benefits One of these plan premiums applies to you only if you are enrolled in one or both of our optional supplemental benefits packages. (You must also continue to pay your Medicare Part B premium.)		
Advantage Plus Option 1	**$35**	**$35**
Advantage Plus Option 2	**$14**	**$14**
Both Advantage Plus Options	**$49**	**$49**

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to your maximum out-of-pocket amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services (and other health care services not covered by Medicare as described in Chapter 4 of the **Evidence of Coverage**) for the rest of the year.

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$4,400**	**$4,400** Once you have paid $4,400 out-of-pocket for covered Part A and Part B services (and certain health care services not covered by Medicare), you will pay nothing for these covered services for the rest of the calendar year.

Section 1.3 – Changes to the provider network

There are changes to our network of providers for next year. An updated **Provider Directory** is located on our website at **kp.org/directory**. You may also call Member Services for updated provider information or to ask us to mail you a **Provider Directory**. Please review our 2021 **Provider Directory** to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the pharmacy network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Our network includes pharmacies with

preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated **Pharmacy Directory** is located on our website at **kp.org/directory**. You may also call Member Services for updated provider information or to ask us to mail you a **Pharmacy Directory**. Please review our 2021 **Pharmacy Directory** to see which pharmacies are in our network.

Section 1.5 – Changes to benefits and costs for medical services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, "Medical Benefits Chart (what is covered and what you pay)," in your 2021 **Evidence of Coverage**.

Cost	2020 (this year)	2021 (next year)
Cardiac rehabilitation services	You pay **$10** per group visit and **$50** per individual visit.	You pay **$5** per group visit and **$35** per individual visit.
Dental services We cover the following dental services when provided by Delta Dental Premier or Delta Dental PPO dentists (listed in the **Provider Directory**): • Oral exam (limited to two oral exams per calendar year). • Prophylaxis (limited to two cleanings per calendar 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). • Occlusal X-rays (two per 12 months). • Pulp vitality tests.	Not covered.	You pay **$15** per service.
Hearing services • Routine hearing exams. • Evaluation and fitting exams for hearing aids.	You pay **$5** per visit.	You pay **$0** per visit.

Cost	2020 (this year)	2021 (next year)
• Diagnostic hearing and balance evaluations.		
Inpatient stays in an acute care hospital	You pay **$295** per day for days 1–6 ($0 for the rest of your stay).	You pay **$200** per day for days 1–5 ($0 for the rest of your stay).
Inpatient stays in a psychiatric hospital We cover up to 190 days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital.	You pay **$295** per day for days 1–5 ($0 for the rest of your stay).	You pay **$200** per day for days 1–5 ($0 for the rest of your stay).
MRI, CT, and PET	You pay **$240** per procedure, per body part studied.	You pay **$115** per procedure, per body part studied.
Outpatient mental health care and substance abuse visits	You pay **$20** per group therapy visit and **$30** per individual therapy visit.	You pay **$10** per group therapy visit and **$20** per individual therapy visit.
Outpatient hospital services including surgery	You pay **$275** per visit.	You pay **$195** per visit.
Over-the-counter nicotine replacement therapy We will provide over-the-counter tobacco cessation medications up to a 90-day supply twice during the calendar year when ordered by a network provider and obtained from a network pharmacy.	Not covered.	You pay **$0**.
Physical, occupational, and speech therapy	You pay **$40** per visit.	You pay **$35** per visit.
Routine foot care Routine foot care not covered by Medicare, which includes cutting or removal of corns or calluses, the trimming of nails (including mycotic nails), and other hygienic and preventive maintenance foot care.	Not covered.	You pay **$0** for up to **4** visits per calendar year.

Cost	2020 (this year)	2021 (next year)
Specialist office visits Includes visits for diabetes self-management training, kidney disease education, opioid treatment program, and podiatry.	You pay **$50** per visit.	You pay **$35** per visit.
Vision services • Routine eye exams.	You pay **$20** per visit.	You pay **$5** per visit.
• Visits to diagnose and treat diseases and injuries of the eye and diabetic retinopathy services.	You pay **$5** per optometrist visit and **$50** per ophthalmologist visit.	You pay **$0** per visit.
Optional supplemental benefits (Advantage Plus Option 1) This change only applies to members enrolled in Advantage Plus Option 1.	Preventive and diagnostic dental care is included in Advantage Plus Option 1 package.	Preventive and diagnostic dental care is not included in Advantage Plus Option 1 package and is covered for all members as described in "Dental services" above.

Section 1.6 – Changes to Part D prescription drug coverage

Changes to our Drug List

Our list of covered drugs is called a formulary, or Drug List. A copy of our Drug List is provided electronically at **kp.org/seniorrx**.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.

If you are affected by a change in drug coverage, you can:

- Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug. We encourage current members to ask for an exception before next year.
- To learn what you must do to ask for an exception, see Chapter 9 of your **Evidence of Coverage**, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)" or call Member Services.
- Work with your doctor (or other prescriber) to find a different drug that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the **Evidence of Coverage**.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary

supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Note: Certain drugs have been removed from our 2021 Drug List. If your drug has been removed from our Drug List, you can discuss with your physician if there are other drugs on our Drug List that will work for you. If your physician determines that the other drugs will not work for you, you or your physician can request that we make a formulary exception. If we approve your request, for brand-name drugs, you will pay the cost-sharing applicable to Tier 4 drugs (nonpreferred brand-name), or for generic drugs, you will pay the cost-sharing applicable to Tier 2 drugs (generic). In addition, if we approved a formulary exception for you during 2020, you or your physician will need to ask us for a formulary exception for 2021.

Most of the changes in our Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to our Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to our Drug List, see Chapter 5, Section 6, of the **Evidence of Coverage**.)

Changes to prescription drug costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), the information about costs for Part D prescription drugs does not apply to you. We sent you a separate document, called the "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this rider by September 30, 2020, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2, of your **Evidence of Coverage** for more information about the stages.)

The information below shows the changes for next year to the first two stages—the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages—the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the **Evidence of Coverage**, which is located on our website at **kp.org/eoccodb**. You may also call Member Services to ask us to mail you an **Evidence of Coverage**.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your nonpreferred brand-name drugs (Tier 4) and specialty drugs (Tier 5) until you have reached the yearly deductible.	The deductible is **$225**. During this stage, you pay the following cost-sharing for up to a 30-day supply: • **$4** for **Tier 1** drugs filled at a network pharmacy with preferred cost-sharing. • **$19** for **Tier 1** drugs filled at a network pharmacy with standard cost-sharing. • **$10** for **Tier 2** drugs filled at a network pharmacy with preferred cost-sharing. • **$20** for **Tier 2** drugs filled at a network pharmacy with standard cost-sharing. • **$0** for drugs on **Tier 6**. You pay the full cost of drugs in **Tier 3** (preferred brand-name), **Tier 4** (nonpreferred brand-name), and **Tier 5** (specialty) until you have reached the yearly deductible.	The deductible is **$95**. During this stage, you pay the following cost-sharing for up to a 30-day supply: • **$2** for **Tier 1** drugs filled at a network pharmacy with preferred cost-sharing. • **$19** for **Tier 1** drugs filled at a network pharmacy with standard cost-sharing. • **$10** for **Tier 2** drugs filled at a network pharmacy with preferred cost-sharing. • **$20** for **Tier 2** drugs filled at a network pharmacy with standard cost-sharing. • **$40** for **Tier 3** drugs filled at a network pharmacy with preferred cost-sharing. • **$47** for **Tier 3** drugs filled at a network pharmacy with standard cost-sharing. • **$0** for drugs on **Tier 6**. You pay the full cost of drugs in **Tier 4** (nonpreferred brand-name) and **Tier 5** (specialty) until you have reached the yearly deductible.

Changes to your cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, "Types of out-of-pocket costs you may pay for covered drugs," in your **Evidence of Coverage**.

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the	Your cost for a one-month supply filled at a network pharmacy:	Your cost for a one-month supply filled at a network pharmacy:

Stage	2020 (this year)	2021 (next year)
Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5, of your **Evidence of Coverage**. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Tier 1 – Preferred generic drugs** • Preferred cost-sharing: You pay **$4** per prescription. • Standard cost-sharing: You pay **$19** per prescription. **Tier 2 – Generic drugs** • Preferred cost-sharing: You pay **$10** per prescription. • Standard cost-sharing: You pay **$20** per prescription. **Tier 3 – Preferred brand-name drugs** • Preferred cost-sharing: You pay **$40** per prescription. • Standard cost-sharing: You pay **$47** per prescription. **Tier 4 – Nonpreferred brand-name drugs** • Preferred cost-sharing: You pay **$95** per prescription. • Standard cost-sharing: You pay **$100** per prescription. **Tier 5 – Specialty-tier drugs** • You pay **28%** of the total cost. **Tier 6 – Injectable Part D vaccines** • You pay **$0** per prescription. Once your total drug costs have reached **$4,020**, you will move to the next stage (the Coverage Gap Stage).	**Tier 1 – Preferred generic drugs** • Preferred cost-sharing: You pay **$2** per prescription. • Standard cost-sharing: You pay **$19** per prescription. **Tier 2 – Generic drugs** • Preferred cost-sharing: You pay **$10** per prescription. • Standard cost-sharing: You pay **$20** per prescription. **Tier 3 – Preferred brand-name drugs** • Preferred cost-sharing: You pay **$40** per prescription. • Standard cost-sharing: You pay **$47** per prescription. **Tier 4 – Nonpreferred brand-name drugs** • Preferred cost-sharing: You pay **$95** per prescription. • Standard cost-sharing: You pay **$100** per prescription. **Tier 5 – Specialty-tier drugs** • You pay **31%** of the total cost. **Tier 6 – Injectable Part D vaccines** • You pay **$0** per prescription. Once your total drug costs have reached **$4,130**, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages—the Coverage Gap Stage and the Catastrophic Coverage Stage—are for people with high drug costs. Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your **Evidence of Coverage**.

Section 2 — Deciding which plan to choose

Section 2.1 – If you want to stay in our Senior Advantage Core plan

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Senior Advantage Core plan for 2021.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year, but if you want to change for 2021, follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely.
- Or you can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read **Medicare & You** 2021, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to **www.medicare.gov/plan-compare**. Here, you can find information about costs, coverage, and quality ratings for Medicare plans.

As a reminder, Kaiser Permanente offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from our Senior Advantage Core plan.
- To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from our Senior Advantage Core plan.
- To change to Original Medicare without a prescription drug plan, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
  - Or contact **Medicare** at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.

Section 3 — Deadline for changing plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from October 15 until December 7. The change will take effect on January 1, 2021.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3, of the **Evidence of Coverage**.

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.2, of the **Evidence of Coverage**.

Section 4 — Programs that offer free counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Colorado, the SHIP is called Colorado State Health Insurance Assistance Program.

Colorado State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Colorado State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Colorado State Health Insurance Assistance Program at **1-888-696-7213**. You can learn more about Colorado State Health Insurance Assistance Program by visiting their website (**https://www.colorado/gov/pacific/dora/senior-healthcare-medicare**).

Section 5 — Programs that help pay for prescription drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare**. People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;

- ♦ The Social Security office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778** (applications); or
- ♦ Your state Medicaid office (applications).

- **Help from your state's pharmaceutical assistance program.** Colorado has a program called Bridging the Gap Colorado that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through **Bridging the Gap Colorado**. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Bridging the Gap Colorado at **303-692-2716**.

Section 6 — Questions?

Section 6.1 – Getting help from our plan

Questions? We're here to help. Please call Member Services at **1-800-476-2167**. (TTY only, call **711**.) We are available for phone calls 7 days a week, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your 2021 Evidence of Coverage (it has details about next year's benefits and costs)

This **Annual Notice of Changes** gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 **Evidence of Coverage** for our plan. The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs.

A copy of the **Evidence of Coverage** is located on our website at **kp.org/eoccodb**. You may also call Member Services to ask us to mail you an **Evidence of Coverage**.

Visit our website

You can also visit our website at **kp.org**. As a reminder, our website has the most up-to-date information about our provider network (**Provider Directory**) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting help from Medicare

To get information directly from Medicare:

- **Call 1-800-MEDICARE (1-800-633-4227)**
  - You can call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- **Visit the Medicare website**
  - You can visit the Medicare website (**www.medicare.gov**). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to **www.medicare.gov/plan-compare**).
- **Read Medicare & You 2021**
  - You can read the **Medicare & You** 2021 handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (**www.medicare.gov**) or 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**.

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Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services – contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Foundation Health Plan of Colorado 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	**kp.org**