

January 1–December 31, 2021

# 2021 Summary of Benefits

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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

## 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)
- 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/eocodb](http://kp.org/eocodb) 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 <b>Core</b> plan, you pay	With our <b>Silver</b> plan, you pay	With our <b>Gold</b> plan, you pay
<b>Monthly plan premium</b>	<b>\$0</b>	<b>\$47</b>	<b>\$193</b>
<b>Deductible</b>	<b>None</b>	<b>None</b>	<b>None</b>
<b>Your maximum out-of-pocket responsibility</b> Doesn't include Medicare Part D drugs	<b>\$4,400</b>	<b>\$3,400</b>	<b>\$3,000</b>
<b>Inpatient hospital coverage*†</b> There's no limit to the number of medically necessary inpatient hospital days.	<b>\$200</b> per day for days 1 through 5 of your stay and <b>\$0</b> for the rest of your stay	<b>\$175</b> per day for days 1 through 5 of your stay and <b>\$0</b> for the rest of your stay	<b>\$125</b> per day for days 1 through 5 of your stay and <b>\$0</b> for the rest of your stay
<b>Outpatient hospital coverage*†</b>	<b>\$195</b> per visit	<b>\$150</b> per visit	<b>\$100</b> per visit
<b>Ambulatory Surgery Center*</b>	<b>\$195</b> per visit	<b>\$150</b> per visit	<b>\$100</b> per visit
<b>Doctor's visits</b>			
• Primary care providers	<b>\$5</b> per visit	<b>\$0</b>	<b>\$0</b>
• Specialists	<b>\$35</b> per visit	<b>\$25</b> per visit	<b>\$15</b> per visit
<b>Preventive care</b> See the <b>EOC</b> for details.	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Emergency care</b> We cover emergency care anywhere in the world.	<b>\$90</b> per Emergency Department visit	<b>\$90</b> per Emergency Department visit	<b>\$80</b> per Emergency Department visit
<b>Urgently needed services</b> We cover urgent care anywhere in the world.	<b>\$30</b> per office visit	<b>\$25</b> per office visit	<b>\$20</b> per office visit
<b>Diagnostic services, lab, and imaging*</b>			
• Lab tests	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
• Diagnostic tests and procedures (like EKG)			
• X-rays	<b>\$10</b> per X-ray	<b>\$0</b>	<b>\$0</b>

<b>Benefits and premiums</b>	With our <b>Core</b> plan, you pay	With our <b>Silver</b> plan, you pay	With our <b>Gold</b> plan, you pay
<ul style="list-style-type: none"> <li>Other imaging (like MRI, CT, and PET)</li> </ul>	<b>\$115</b> per image ( <b>\$80</b> for ultrasounds)	<b>\$115</b> per image ( <b>\$80</b> for ultrasounds)	<b>\$85</b> per image ( <b>\$30</b> for ultrasounds)
<p><b>Hearing services</b></p> <ul style="list-style-type: none"> <li>Evaluations to diagnose medical conditions</li> <li>Routine hearing exams</li> <li>Hearing aid fitting or evaluation exam</li> </ul> <p>Hearing aids aren't covered unless you sign up for optional benefits (see "Advantage Plus optional benefits" for details).</p>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<p><b>Dental services</b></p> <p>Preventive and diagnostic dental care:</p> <ul style="list-style-type: none"> <li>Oral exam (limited to two oral exams per year).</li> <li>Prophylaxis (limited to two cleanings per year).</li> <li>Topical fluoride (once in 12 months).</li> <li>Full mouth or panoramic X-rays (once per 60 months).</li> <li>Bitewing X-rays (one set per 12 months).</li> <li>Periapical X-rays (four per 12 months).</li> <li>Occlusal X-rays (two per 12 months).</li> <li>Pulp vitality tests.</li> </ul>	<b>\$15</b> per service	<b>\$10</b> per service	<b>\$5</b> per service
<p>Comprehensive dental care:</p> <ul style="list-style-type: none"> <li>Covered services include fillings, crowns, extractions, dentures, endodontics, and</li> </ul>	Not covered for Core plan members unless you sign up for optional benefits (see Advantage Plus – Option 1 for details)	<b>50%</b> coinsurance for comprehensive dental services until the plan has paid \$500 (annual benefit limit).	<b>50%</b> coinsurance for comprehensive dental services until the plan has paid \$500 (annual benefit limit).

<b>Benefits and premiums</b>	With our <b>Core</b> plan, you pay	With our <b>Silver</b> plan, you pay	With our <b>Gold</b> plan, you pay
periodontics. Please see <b>EOC</b> for details.		You pay 100% for the rest of the year. If you sign up for optional benefits, you receive additional comprehensive dental coverage (see Advantage Plus Option 1 for details).	You pay 100% for the rest of the year. If you sign up for optional benefits, you receive additional comprehensive dental coverage (see Advantage Plus Option 1 for details).
<b>Vision services</b>			
<ul style="list-style-type: none"> <li>• Visits to diagnose and treat eye diseases and conditions</li> <li>• Preventive glaucoma screening and diabetic retinopathy services</li> </ul>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<ul style="list-style-type: none"> <li>• Routine eye exams</li> </ul>	<b>\$5</b> per visit	<b>\$0</b>	<b>\$0</b>
<ul style="list-style-type: none"> <li>• Eyeglasses or contact lenses after cataract surgery</li> </ul>	<b>\$0</b> up to Medicare's limit, but you pay any amounts beyond that limit.	<b>\$0</b> up to Medicare's limit, but you pay any amounts beyond that limit.	<b>\$0</b> up to Medicare's limit, but you pay any amounts beyond that limit.
<ul style="list-style-type: none"> <li>• Other eyewear</li> <li>• If you sign up for optional benefits, the allowance is greater (see Advantage Plus Option 1 for details).</li> </ul>	<b>\$100 allowance</b> every 2 years. If your eyewear costs more than \$100, <b>you pay the difference.</b>	<b>\$200 allowance</b> every 2 years. If your eyewear costs more than \$200, <b>you pay the difference.</b>	<b>\$200 allowance</b> every 2 years. If your eyewear costs more than \$200, <b>you pay the difference.</b>
<b>Mental health services</b>			
<ul style="list-style-type: none"> <li>• Outpatient group therapy</li> </ul>	<b>\$10</b> per visit	<b>\$10</b> per visit	<b>\$5</b> per visit
<ul style="list-style-type: none"> <li>• Outpatient individual therapy</li> </ul>	<b>\$20</b> per visit	<b>\$20</b> per visit	<b>\$10</b> per visit
<b>Skilled nursing facility*†</b> We cover up to 100 days per benefit period.	<b>Per benefit period:</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> per day for days 1 through 20</li> <li>• <b>\$160</b> per day for days 21 through 48</li> <li>• <b>\$0</b> per day for days 49 through 100</li> </ul>	<b>Per benefit period:</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> per day for days 1 through 20</li> <li>• <b>\$160</b> per day for days 21 through 42</li> <li>• <b>\$0</b> per day for days 43 through 100</li> </ul>	<b>Per benefit period:</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> per day for days 1 through 10</li> <li>• <b>\$20</b> per day for days 11 through 100</li> </ul>
<b>Physical therapy*</b>	<b>\$35</b> per visit	<b>\$20</b> per visit	<b>\$15</b> per visit

<b>Benefits and premiums</b>	With our <b>Core</b> plan, you pay	With our <b>Silver</b> plan, you pay	With our <b>Gold</b> plan, you pay
<b>Ambulance</b>	<b>\$265</b> per one-way trip	<b>\$250</b> per one-way trip	<b>\$230</b> per one-way trip
<b>Transportation</b>	Not covered unless you sign up for optional benefits (see Advantage Plus Option 2 for details).	Not covered unless you sign up for optional benefits (see Advantage Plus Option 2 for details).	<b>\$0</b> for up to 30 one-way trips 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).
<b>Medicare Part B drugs†</b> A limited number of Medicare Part B drugs are covered when you get them from a plan provider. See the <b>EOC</b> for details and the <b>Pharmacy Directory</b> for preferred and standard plan pharmacy locations. <ul style="list-style-type: none"> <li>• Drugs that must be administered by a health care professional</li> </ul>	<b>20%</b> coinsurance	<b>20%</b> coinsurance	<b>20%</b> coinsurance
<ul style="list-style-type: none"> <li>• Up to a 30-day supply of a generic drug</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$10</b> at a preferred plan pharmacy</li> <li>• <b>\$20</b> at a standard plan pharmacy</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$10</b> at a preferred plan pharmacy</li> <li>• <b>\$20</b> at a standard plan pharmacy</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$8</b> at a preferred plan pharmacy</li> <li>• <b>\$20</b> at a standard plan pharmacy</li> </ul>
<ul style="list-style-type: none"> <li>• Up to a 30-day supply of a brand-name drug</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$40</b> at a preferred plan pharmacy</li> <li>• <b>\$47</b> at a standard plan pharmacy</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$40</b> at a preferred plan pharmacy</li> <li>• <b>\$47</b> at a standard plan pharmacy</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$40</b> at a preferred plan pharmacy</li> <li>• <b>\$47</b> at a standard plan pharmacy</li> </ul>

## 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](http://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](http://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**

### Gold plan

There is no deductible for the Gold plan and you start the year in the initial coverage stage.

### Core and Silver plans

For drugs in Tiers 1, 2, 3, and 6, there is no deductible and you start the year in the initial coverage stage.

There is a deductible stage for drugs in Tier 4 and 5 and you must pay the full cost of those drugs until you have spent the following deductible amount for your plan:

- **\$95** for Core plan members
- **\$50** for Silver plan members

After you have met the deductible, you move on to the initial coverage stage for drugs in Tier 4–5.

## **Initial coverage stage**

You pay the copays and coinsurance shown in the chart below until your total yearly drug costs reach **\$4,130**. (Total yearly drug costs are the amounts paid by both you and any Part D plan during a calendar year.) If you reach the \$4,130 limit in 2021, 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
<b>Tier 1 (Preferred generic)</b>				
• <b>Core</b> or <b>Silver</b> plan members	<b>\$2</b>	<b>\$19</b>	<b>\$0</b> up to a 90-day supply	
• <b>Gold</b> plan members	<b>\$0</b>	<b>\$19</b>	<b>\$0</b> up to a 90-day supply	
<b>Tier 2 (Generic)</b>				
• <b>Core</b> or <b>Silver</b> plan members	<b>\$10</b>	<b>\$20</b>	<b>\$0</b> up to a 90-day supply	
• <b>Gold</b> plan members	<b>\$8</b>	<b>\$20</b>	<b>\$0</b> up to a 90-day supply	
<b>Tier 3 (Preferred brand-name)</b>	<b>\$40</b>	<b>\$47</b>	<b>\$80</b>	<b>\$100</b>
<b>Tier 4 (Nonpreferred brand-name)</b>				
• <b>Core</b> or <b>Silver</b> plan members**	<b>\$95</b>	<b>\$100</b>	<b>\$190</b>	<b>\$245</b>
• <b>Gold</b> plan members	<b>\$90</b>	<b>\$100</b>	<b>\$180</b>	<b>\$245</b>
<b>Tier 5 (Specialty)**</b>	<b>31% coinsurance</b>			
<b>Tier 6 (Vaccines)</b>	<b>\$0</b>		Not applicable	

\*\*Cost-sharing after you have met the deductible for Core and Silver plan members

**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 **\$4,130** on your drugs during 2021. During this stage, you pay **25%** coinsurance for your covered Part D drugs (generic and brand-name drugs).



## Catastrophic coverage stage

If you spend **\$6,550** on your Part D prescription drugs in 2021, 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 2021. You pay the following per prescription during the catastrophic coverage stage:

- For **generic** drugs, you will pay either a **5%** coinsurance or a **\$3.70** copay, whichever amount is larger.
- For **brand-name** drugs, you will pay either a **5%** coinsurance or a **\$9.20** 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.

<b>Advantage Plus Option 1 benefits and premiums</b>	With our <b>Core</b> plan, you pay	With our <b>Gold</b> or <b>Silver</b> plan, you pay
<b>Additional monthly premium</b>	<b>\$35</b>	<b>\$35</b>
<b>Eyewear</b> An additional \$200 allowance to buy eyewear every 24 months	A \$200 allowance is added to the \$100 allowance described in vision services above. If your eyewear costs more than the combined allowance of \$300, <b>you pay the difference.</b>	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, <b>you pay the difference.</b>
<b>Hearing aids*</b> \$500 allowance to buy 1 aid, per ear every 3 years	If your hearing aid costs more than \$500 per ear, <b>you pay the difference.</b>	If your hearing aid costs more than \$500 per ear, <b>you pay the difference.</b>

<p><b>Comprehensive dental care</b> Covered services include fillings, crowns, extractions, endodontics, periodontics, and dentures. Please see <b>EOC</b> for details.</p>	<p><b>50%</b> coinsurance until the plan has paid <b>\$1,000</b> (annual benefit limit). You pay 100% after you reach the benefit limit.</p>	<p><b>50%</b> coinsurance until the plan has paid <b>\$1,500</b> (annual benefit limit). Advantage Plus adds an additional \$1,000 to the benefit limit described in "Dental services" earlier in this booklet. You pay 100% after you reach the benefit limit.</p>
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<p><b>Advantage Plus Option 2 benefits and premiums</b></p>	<p>With our <b>Core</b> or <b>Silver</b> plan, you pay</p>	<p>With our <b>Gold</b> plan, you pay</p>
<p><b>Additional monthly premium</b></p>	<p><b>\$14</b></p>	<p><b>\$14</b></p>
<p><b>Acupuncture</b> 16 visits per calendar year</p>	<p><b>\$15</b> per visit</p>	<p><b>\$15</b> per visit</p>
<p><b>Hearing aids*</b> \$500 allowance to buy 1 aid, per ear every 3 years</p>	<p>If your hearing aid costs more than \$500 per ear, <b>you pay the difference.</b></p>	<p>If your hearing aid costs more than \$500 per ear, <b>you pay the difference.</b></p>
<p><b>Transportation</b> We cover up to 20 one-way trips per year (limited to 50 miles one way) to get you to or from a plan provider when provided by our transportation provider.</p>	<p><b>\$0</b></p>	<p><b>\$0</b>  This benefit and the benefit described in "Transportation" are combined to give you 50 one-way trips per calendar year.</p>

## 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, and Jefferson 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.

For details about coverage rules, including services that aren't covered (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](http://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](http://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.

## 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 تماس بگیرد. **1-800-476-2167** (TTY: **711**) فراهم می باشد. با

## 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 ተዘጋጅተዋል። 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](http://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 in Tiers 4 and 5 before you will enter the initial coverage stage for those drugs.

### **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**.

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-476-2167**, (TTY: **711**) from 8 a.m. to 8 p.m., 7 days a week.

### **Understanding the Benefits**

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit [kp.org/medicare](http://kp.org/medicare) or call 1-800-476-2167, (TTY: **711**) from 8 a.m. to 8 p.m., 7 days a week, to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

### **Understanding Important Rules**

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory)

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



**[kp.org/medicare](http://kp.org/medicare)**

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

Kaiser Foundation Health Plan of Colorado. A nonprofit corporation and Health Maintenance Organization (HMO)

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