January 1–December 31, 2024

2024
Summary of Benefits

Kaiser Permanente Senior Advantage Core DM Plan (HMO), Kaiser Permanente Senior Advantage Silver DM Plan (HMO-POS), Kaiser Permanente Senior Advantage Gold Plan (HMO-POS), and Kaiser Permanente Senior Advantage Bronze DM Plan (HMO-POS)

Denver Metropolitan service area

H0630_24SB013015016025_M
PBP #: 013, 015, 016 & 025
1130784149 DB13151625

KAISER PERMANENTE®

About this Summary of Benefits

Thank you for considering Kaiser Permanente Senior Advantage. You can use this **Summary of Benefits** to learn more about our plans. It includes information about:

- Premiums
- Benefits and costs
- Part D prescription drugs
- Optional supplemental benefits (Advantage Plus)
- Additional benefits, including Point-of-Service (POS) benefits for Silver, Gold, and Bronze plan members
- Member discounts for products and services
- 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 4 Kaiser Permanente Senior Advantage plans, Core DM (referred to in this document as the "Core plan"), Silver DM (referred to in this document as the "Silver plan"), Gold, and Bronze DM (referred to in this document as the "Bronze plan"). It doesn't include everything about what's covered and not covered or all the plan rules. For details, see the **Evidence of Coverage (EOC)**, which is located on our website at **kp.org/eoccodb** or ask for a copy from Member Services by calling **1-800-476-2167** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

Kaiser Permanente Senior Advantage Silver, Gold, and Bronze plans have a Point-of-Service (POS) benefit. “Point-of-Service” means you can use providers outside the plan’s network for certain services. Not all services are covered under POS. Covered services under POS are noted in the “Additional benefits" section and also in your EOC.

Have questions?

- If you're not a member, please call **1-877-408-3492** (TTY **711**).
- If you're a member, please call Member Services at **1-800-476-2167** (TTY **711**).
- 7 days a week, 8 a.m. to 8 p.m.

What's covered and what it costs

*Your plan provider may need to provide a referral.
†Prior authorization may be required.

Benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
Monthly plan premium	**$0**	**$0**	**$35.30**	**$181**
Deductible	**None**	**None**	**None**	**None**
Your maximum out-of-pocket responsibility Doesn't include Medicare Part D drugs	**$3,900**	**$4,100**	**$3,400**	**$3,000**
Inpatient hospital services*† There's no limit to the number of medically necessary inpatient hospital days.	**$195** per day for days 1 through 5 of your stay and **$0** for the rest of your stay	**$250** per day for days 1 through 5 of your stay and **$0** for the rest of your stay	**$165** per day for days 1 through 5 of your stay and **$0** for the rest of your stay	**$125** per day for days 1 through 5 of your stay and **$0** for the rest of your stay
Outpatient hospital services*†	**$195** per visit	**$225** per visit	**$175** per visit	**$100** per visit
Ambulatory Surgical Center (ASC)*†	**$115** per visit	**$150** per visit	**$100** per visit	**$75** per visit
Doctor's visits				
• Primary care providers	**$0**	**$0**	**$0**	**$0**
• Specialists	**$15** per visit	**$35** per visit	**$10** per visit	**$10** per visit
Preventive care • Abdominal aortic aneurysm screening • Alcohol misuse screenings & counseling • Bone mass measurements (bone density) • Cardiovascular disease screenings • Cardiovascular disease (behavioral therapy) • Cervical & vaginal cancer screening • Colorectal cancer screenings (barium enemas, colonoscopies, fecal occult blood tests, flexible sigmoidoscopies, and multi-target stool DNA tests)	**$0** Any additional preventive services approved by Medicare during the contract year will be covered. See your **EOC** for frequency of covered services.	**$0** Any additional preventive services approved by Medicare during the contract year will be covered. See your **EOC** for frequency of covered services.	**$0** Any additional preventive services approved by Medicare during the contract year will be covered. See your **EOC** for frequency of covered services.	**$0** Any additional preventive services approved by Medicare during the contract year will be covered. See your **EOC** for frequency of covered services.

Benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
• Depression screenings • Diabetes screenings • Diabetes self-management training • Glaucoma tests • Hepatitis B Virus (HBV) infection screenings • Hepatitis C screening tests • HIV screenings • Lung cancer screenings • Mammograms (screening) • Medicare Diabetes Prevention Program • Nutrition therapy services • Obesity screenings & counseling • One-time “Welcome to Medicare” preventive visit • Prostate cancer screenings • Sexually transmitted infections screenings & counseling • Shots that include COVID-19 vaccines, flu shots, Hepatitis B shots and Pneumococcal shots • Tobacco use cessation counseling • Yearly "Wellness" visit				
Emergency care We cover emergency care anywhere in the world.	**$120** per Emergency Department visit	**$120** per Emergency Department visit	**$120** per Emergency Department visit	**$110** per Emergency Department visit
Urgently needed services We cover urgent care anywhere in the world.	**$35** per visit	**$40** per visit	**$35** per visit	**$25** per visit
Diagnostic services, lab, and imaging* • Lab tests† • Diagnostic tests and procedures (like EKG)† • X-rays	**$0**	**$0**	**$0**	**$0**

Benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
• Other imaging procedures (like MRI, CT, and PET)†	**$90** per procedure, per body part studied (**$40** for ultrasounds)	**$140** per procedure, per body part studied (**$40** for ultrasounds)	**$75** per procedure, per body part studied (**$35** for ultrasounds)	**$50** per procedure, per body part studied (**$20** for ultrasounds)
Hearing services • Evaluations to diagnose medical conditions • Routine hearing exams • Hearing aid fitting or evaluation exam	**$0**	**$0**	**$0**	**$0**
• Hearing aid allowance every two years to purchase hearing aids* • If you sign up for optional benefits, the allowance is greater (see Advantage Plus Options 1 & 2 for details).	**$500 allowance** per ear. If your hearing aid purchase is more than **$500, you pay the difference**.	**$500 allowance** per ear. If your hearing aid purchase is more than **$500, you pay the difference**.	**$500 allowance** per ear. If your hearing aid purchase is more than **$500, you pay the difference**.	**$500 allowance** per ear. If your hearing aid purchase is more than **$500, you pay the difference**.
Dental services Preventive and diagnostic dental care: • Oral exam (limited to two oral exams per year) • Prophylaxis (limited to two cleanings per year) • Topical fluoride (once in 12 months) • Full mouth or panoramic X-rays (once per 60 months) • Bitewing X-rays (one set per 12 months) • Periapical X-rays (four per 12 months) • Occlusal X-rays (two per 12 months) • Pulp vitality tests	**$0**	**$0**	**$0**	**$0**
Comprehensive dental care when provided by either Delta Dental Premier® or Delta Dental PPO™ dentists (see the **Provider Directory** for network dentists).	**30%** coinsurance for fillings and **50%** coinsurance for root canals and periodontics services from	**30%** coinsurance for basic comprehensive dental services and **50%** coinsurance for	**30%** coinsurance for basic comprehensive dental services and **50%** coinsurance for	**30%** coinsurance for basic comprehensive dental services and **50%** coinsurance for

Benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
• Covered services include fillings, crowns, extractions, dentures, endodontics, and periodontics. Please see **EOC** for details. Not all comprehensive services are covered for all plans. See your specific plan coverage to the right. For more information, visit **https://healthy.kaiserpermanente.org/colorado/health-wellness/senior-health/extras**. If you sign up for optional benefits, you receive additional comprehensive dental coverage (see Advantage Plus Option 1 for details).	Delta Dental PPO dentists until the plan has paid **$1,450 (combined annual benefit limit)** for preventive and comprehensive services. When you reach the annual limit, you pay **100%** for the rest of the year.	major comprehensive services from Delta Dental PPO dentists until the plan has paid **$2,350 (combined annual benefit limit)** for preventive and comprehensive services, or **50%** coinsurance for comprehensive dental services from Delta Dental Premier dentists until the plan has paid **$500 (annual benefit limit)** for preventive and comprehensive services. When you reach the **$2,350 combined annual benefit limit** for preventive and comprehensive services provided by Delta Dental PPO and/or Dental Premier dentists, you pay **100%** for the rest of the year. Note: The maximum	major comprehensive services from Delta Dental PPO dentists until the plan has paid **$1,650 (combined annual benefit limit)** for preventive and comprehensive services, or **50%** coinsurance for comprehensive dental services from Delta Dental Premier dentists until the plan has paid **$500 (annual benefit limit)** for preventive and comprehensive services. When you reach the **$1,650 combined annual benefit limit** for preventive and comprehensive services provided by Delta Dental PPO and/or Dental Premier dentists, you pay **100%** for the rest of the year. Note: The maximum	major comprehensive services from Delta Dental PPO dentists until the plan has paid **$1,650 (combined annual benefit limit)** for preventive and comprehensive services, or **50%** coinsurance for comprehensive dental services from Delta Dental Premier dentists until the plan has paid **$500 (annual benefit limit)** for preventive and comprehensive services. When you reach the **$1,650 combined annual benefit limit** for preventive and comprehensive services provided by Delta Dental PPO and/or Dental Premier dentists, you pay **100%** for the rest of the year. Note: The

Benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
		benefit limit for Delta Dental Premier dentists may not exceed **$500**.	benefit limit for Delta Dental Premier dentists may not exceed **$500**.	maximum benefit limit for Delta Dental Premier dentists may not exceed **$500**.
Vision services • Visits to diagnose and treat eye diseases and conditions • Preventive glaucoma screening • Routine eye exams	**$0**	**$0**	**$0**	**$0**
• Eyeglasses or contact lenses after cataract surgery	**$0** up to Medicare's limit, but you pay any amounts beyond that limit.	**$0** up to Medicare's limit, but you pay any amounts beyond that limit.	**$0** up to Medicare's limit, but you pay any amounts beyond that limit.	**$0** up to Medicare's limit, but you pay any amounts beyond that limit.
• Other eyewear • If you sign up for optional benefits, the allowance is greater (see Advantage Plus Option 1 for details).	**$350 allowance** every year. If your eyewear costs more than **$350, you pay the difference**.	**$350 allowance** every year. If your eyewear costs more than **$350, you pay the difference**.	**$250 allowance** every year. If your eyewear costs more than **$250, you pay the difference**.	**$350 allowance** every year. If your eyewear costs more than **$350, you pay the difference**.
Mental health services • Inpatient mental health*†	You pay **$195** per day for days 1–5 ($0 for the rest of your stay).	You pay **$250** per day for days 1–5 ($0 for the rest of your stay).	You pay **$165** per day for days 1–5 ($0 for the rest of your stay).	You pay **$125** per day for days 1–5 ($0 for the rest of your stay).
• Outpatient group therapy	**$5** per visit	**$5** per visit	**$0**	**$0**
• Outpatient individual therapy	**$10** per visit	**$10** per visit	**$5** per visit	**$0**
Skilled nursing facility*† We cover up to 100 days per benefit period.	**Per benefit period:** • **$0** per day for days 1 through 20 • **$203** per day for days 21 through 41	**Per benefit period:** • **$0** per day for days 1 through 20 • **$203** per day for days 21 through 45	**Per benefit period:** • **$0** per day for days 1 through 20 • **$203** per day for days 21 through 37	**Per benefit period:** • **$0** per day for days 1 through 10 • **$20** per day for days 11 through 100

Benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
	• **$0** per day for days 42 through 100	• **$0** per day for days 46 through 100	• **$0** per day for days 38 through 100	
Physical therapy*	**$15** per visit	**$25** per visit	**$10** per visit	**$10** per visit
Ambulance†	**$200** per one-way trip	**$200** per one-way trip	**$160** per one-way trip	**$150** per one-way trip
Transportation We cover a certain amount of one-way trips per calendar year as noted on the right (limited to 55 miles one way) to get you to or from a plan provider when provided by our transportation provider. For more information, visit **https://healthy.kaiserpermanente.org/colorado/health-wellness/senior-health/extras**.	**$0** for up to 12 one-way trips per calendar year to get you to and from plan providers. If you sign up for optional benefits, the number of trips is combined (see Advantage Plus Option 2 for details).	**$0** for up to 8 one-way trips per calendar year to get you to and from plan providers. If you sign up for optional benefits, the number of trips is combined (see Advantage Plus Option 2 for details).	**$0** for up to 16 one-way trips per calendar year to get you to and from plan providers. If you sign up for optional benefits, the number of trips is combined (see Advantage Plus Option 2 for details).	**$0** for up to 30 one-way trips per calendar year to get you to and from plan providers. If you sign up for optional benefits, the number of trips is combined (see Advantage Plus Option 2 for details).
Medicare Part B drugs† Medicare Part B drugs are covered when you get them from a plan provider. See the **EOC** for details and the **Pharmacy Directory** for preferred and standard plan pharmacy locations. • Drugs that must be administered by a health care professional	**0%–20%** coinsurance depending on the drug. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.	**0%–20%** coinsurance depending on the drug. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.	**0%–20%** coinsurance depending on the drug. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.	**0%–20%** coinsurance depending on the drug. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.
• Up to a 30-day supply of a generic drug	• **$0** at a preferred plan pharmacy • **$20** at a standard plan pharmacy	• **$5** at a preferred plan pharmacy • **$20** at a standard plan pharmacy	• **$0** at a preferred plan pharmacy • **$20** at a standard plan pharmacy	• **$0** at a preferred plan pharmacy • **$20** at a standard plan pharmacy
• Up to a 30-day supply of a brand-name drug	• **$40** at a preferred plan pharmacy,	• **$40** at a preferred plan pharmacy,	• **$40** at a preferred plan pharmacy,	• **$40** at a preferred plan pharmacy,

Benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
	except you pay $35 for Part B insulin drugs furnished through an item of DME. • **$47** at a standard plan pharmacy, except you pay $35 for Part B insulin drugs furnished through an item of DME.	except you pay $35 for Part B insulin drugs furnished through an item of DME. • **$47** at a standard plan pharmacy, except you pay $35 for Part B insulin drugs furnished through an item of DME.	except you pay $35 for Part B insulin drugs furnished through an item of DME. • **$47** at a standard plan pharmacy, except you pay $35 for Part B insulin drugs furnished through an item of DME.	except you pay $35 for Part B insulin drugs furnished through an item of DME. • **$47** at a standard plan pharmacy, except you pay $35 for Part B insulin drugs furnished through an item of DME.

Medicare Part D prescription drug coverage†

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

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

Note: Medicare provides Extra Help to pay prescription drug costs for people who have limited income and resources. If you are entitled to Extra Help, the cost-sharing below may not apply to you; instead, please refer to the **Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**.

Deductible stage

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

Initial coverage stage

You pay the copays and coinsurance shown in the chart below until your total yearly drug costs reach **$5,030**. (Total yearly drug costs are the amounts paid by both you and any Part D plan during a calendar year.) If you reach the $5,030 limit in 2024, you move on to the coverage gap stage and your coverage changes.

Drug tier	Retail plan pharmacy					
	Up to a 30-day supply		31- to 60-day supply		61- to 90-day supply	
	Preferred pharmacy	**Standard pharmacy**	**Preferred pharmacy**	**Standard pharmacy**	**Preferred pharmacy**	**Standard pharmacy**
Tier 1 (Preferred generic)	**$0**	**$15**	**$0**	**$30**	**$0**	**$45**
Tier 2 (Generic) • **Core, Silver** and **Gold** plan members	**$0**	**$20**	**$0**	**$40**	**$0**	**$60**
• **Bronze** plan members	**$5**	**$20**	**$10**	**$40**	**$15**	**$60**
Tier 3* (Preferred brand-name)	**$40**	**$47**	**$80**	**$94**	**$120**	**$141**
Tier 4* (Nonpreferred drugs)	**$80**	**$100**	**$160**	**$200**	**$240**	**$300**
Tier 5* (Specialty)	**33%**					
Tier 6** (Vaccines)	**$0**	**$0**	**N/A**		**N/A**	

*For each insulin product covered by our plan, you will not pay more than **$35** for a 30-day supply, **$70** for a 31- to 60-day supply, and **$105** for a 61- to 90-day supply, regardless of the tier.

**Our plan covers most Part D vaccines at no cost to you.

Drug tier	Mail-order plan pharmacy		
	Up to a 30-day supply	31- to 60-day supply	61- to 90-day supply
Tier 1 (Preferred generic)	**$0**	**$0**	**$0**
Tier 2 (Generic)	**$0**	**$0**	**$0**
Tier 3* (Preferred brand-name) • **Bronze or Core** plan members	**$40**	**$80**	**$120**
• **Silver or Gold** plan members	**$40**	**$80**	**$100**
Tier 4* (Nonpreferred drugs)	**$80**	**$160**	**$240**
Tier 5* (Specialty)	**33%**		

Note: Tier 6 (vaccines) are not available through mail order.

*For each insulin product covered by our plan, you will not pay more than **$35** for a 30-day supply and **$70** for a 31- to 60-day supply. Bronze and Core plan members will not pay more than **$105** for a 61- to 90-day supply for Tier 3 drugs. Gold and Silver plan members will not pay more than **$100** for a 61- to 90-day supply for Tier 3 drugs. All members will pay no more than **$105** for a 61- to 90-day supply of Tiers 4-5 drugs.

Coverage gap stage

The coverage gap stage begins if you or a Part D plan spends **$5,030** on your drugs during 2024. During this stage, you pay **25%** coinsurance for your covered Part D drugs (generic and brand name drugs).

Catastrophic coverage stage

If you or others on your behalf spend **$8,000** on your Part D prescription drugs in 2024, you'll enter the catastrophic coverage stage. Most people never reach this stage, but if you do, you pay nothing for covered Part D drugs in 2024.

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.

*Your plan provider may need to provide a referral.

Advantage Plus Option 1 benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
Additional monthly premium	**$39**	**$39**	**$39**	**$39**
Eyewear An additional $200 allowance to buy eyewear every 12 months	A **$200** allowance is added to the **$350** allowance described in "Vision	A **$200** allowance is added to the **$350** allowance described in "Vision	A **$200** allowance is added to the **$250** allowance described in "Vision	A **$200** allowance is added to the **$350** allowance described in"

Advantage Plus Option 1 benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
	services" above. If your eyewear costs more than the combined allowance of **$550, you pay the difference**.	services" above. If your eyewear costs more than the combined allowance of **$550, you pay the difference**.	services" above. If your eyewear costs more than the combined allowance of **$450, you pay the difference**.	Vision services" above. If your eyewear costs more than the combined allowance of **$550, you pay the difference**.
Hearing aids* $500 allowance to buy 1 aid per ear every 2 years. **Note:** If you enroll in both Advantage Plus options (Option 1 and Option 2), the allowance is $1,000 per ear, which is added to the allowance described in "Hearing services."	A **$500** allowance is added to the **$500** allowance described in "Hearing services" above. If your hearing aid costs more than **$1,000** per ear, **you pay the difference**.	A **$500** allowance is added to the **$500** allowance described in "Hearing services" above. If your hearing aid costs more than **$1,000** per ear, **you pay the difference**.	A **$500** allowance is added to the **$500** allowance described in "Hearing services" above. If your hearing aid costs more than **$1,000** per ear, **you pay the difference**.	A **$500** allowance is added to the **$500** allowance described in "Hearing services" above. If your hearing aid costs more than **$1,000** per ear, **you pay the difference**.
Comprehensive dental care Covered basic and major services include fillings, crowns, extractions, endodontics, periodontics, and dentures when provided by either Delta Dental Premier® or Delta Dental PPO™ dentists (see the **Provider Directory** for network dentists): • Annual benefit limit: $1,000 **Note:** All plan members have coverage for comprehensive dental as described in "Dental services." The benefit limits of both benefits are combined as shown on the right.	After the plan pays **$1,000** in a calendar year for preventive and comprehensive dental care provided by Delta Dental Premier network	After the plan pays **$1,500** in a calendar year for preventive and comprehensive dental care provided by Delta Dental Premier network	After the plan pays **$1,500** in a calendar year for preventive and comprehensive dental care provided by Delta Dental Premier network	After the plan pays **$1,500** in a calendar year for preventive and comprehensive dental care provided by Delta Dental Premier network

Advantage Plus Option 1 benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
For more information, visit **https://healthy.kaiserpermanente.org/colorado/health-wellness/senior-health/extras**.	dentists, you pay 100% for the rest of the year. After the plan pays **$2,450** in a calendar year for preventive and comprehensive dental care provided by Delta Dental PPO network dentists, you pay 100% for the rest of the year. When you reach the **$2,450 combined annual benefit limit** for preventive and comprehensive dental care provided by Delta Dental PPO and/or Dental Premier dentists, you pay **100%** for the rest of the year. Note: The maximum benefit limit for Delta Dental Premier dentists may not exceed **$1,000**.	dentists, you pay 100% for the rest of the year. After the plan pays **$3,350** in a calendar year for preventive and comprehensive dental care provided by Delta Dental PPO network dentists, you pay 100% for the rest of the year. When you reach the **$3,350 combined annual benefit limit** for preventive and comprehensive dental care provided by Delta Dental PPO and/or Dental Premier dentists, you pay **100%** for the rest of the year. Note: The maximum benefit limit for Delta Dental Premier dentists may not exceed **$1,500**.	dentists, you pay 100% for the rest of the year. After the plan pays **$2,650** in a calendar year for preventive and comprehensive dental care provided by Delta Dental PPO network dentists, you pay 100% for the rest of the year. When you reach the **$2,650 combined annual benefit limit** for preventive and comprehensive dental care provided by Delta Dental PPO and/or Dental Premier dentists, you pay **100%** for the rest of the year. Note: The maximum benefit limit for Delta Dental Premier dentists may not exceed **$1,500**.	dentists, you pay 100% for the rest of the year. After the plan pays **$2,650** in a calendar year for preventive and comprehensive dental care provided by Delta Dental PPO network dentists, you pay 100% for the rest of the year. When you reach the **$2,650 combined annual benefit limit** for preventive and comprehensive dental care provided by Delta Dental PPO and/or Dental Premier dentists, you pay **100%** for the rest of the year. Note: The maximum benefit limit for Delta Dental Premier dentists may not exceed **$1,500**.
Basic comprehensive services	**50%** coinsurance for basic	**50%** coinsurance for basic	**50%** coinsurance for basic	**50%** coinsurance for basic

Advantage Plus Option 1 benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
	comprehensive dental services provided by Delta Dental Premier network dentists, up to the annual benefit limit. **30%** coinsurance for basic comprehensive dental services provided by Delta Dental PPO network dentists, up to the annual benefit limit.	comprehensive dental services provided by Delta Dental Premier network dentists, up to the annual benefit limit. **30%** coinsurance for basic comprehensive dental services provided by Delta Dental PPO network dentists, up to the annual benefit limit.	comprehensive dental services provided by Delta Dental Premier network dentists, up to the annual benefit limit. **30%** coinsurance for basic comprehensive dental services provided by Delta Dental PPO network dentists, up to the annual benefit limit.	comprehensive dental services provided by Delta Dental Premier network dentists, up to the annual benefit limit. **30%** coinsurance for basic comprehensive dental services provided by Delta Dental PPO network dentists, up to the annual benefit limit.
• Major comprehensive services Please see **EOC** for details.	**50%** coinsurance for major comprehensive dental services up to the annual benefit limit.	**50%** coinsurance for major comprehensive dental services up to the annual benefit limit.	**50%** coinsurance for major comprehensive dental services up to the annual benefit limit.	**50%** coinsurance for major comprehensive dental services up to the annual benefit limit.
In-home support We cover up to 8 hours of non-medical, in-home support services every month to address assistance with ADLs and IADLs within the home. For more information, visit **https://healthy.kaiserpermanente.org/colorado/health-wellness/senior-health/extras**.	**$0** 8 hours of support or 16 hours of support if you enroll in both Advantage Plus options (Option 1 and Option 2).	**$0** 8 hours of support or 16 hours of support if you enroll in both Advantage Plus options (Option 1 and Option 2).	**$0** This benefit and the benefit described in “Additional benefits” are combined to give you 16 hours of support, or 24 hours of support if you enroll in both Advantage Plus options (Option 1 and Option 2).	**$0** This benefit and the benefit described in “Additional benefits” are combined to give you 16 hours of support, or 24 hours of support if you enroll in both Advantage Plus options (Option 1 and Option 2).

Advantage Plus Option 2 benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
Additional monthly premium	**$14**	**$14**	**$14**	**$14**
Acupuncture 16 visits per calendar year	**$15** per visit	**$15** per visit	**$15** per visit	**$15** per visit
Hearing aids* $500 allowance to buy 1 aid per ear every 2 years. **Note:** If you enroll in both Advantage Plus options (Option 1 and Option 2), the allowance is $1,000 per ear, which is added to the allowance described in "Hearing services."	A **$500** allowance is added to the **$500** allowance described in "Hearing services" above. If your hearing aid costs more than **$1,000** per ear, **you pay the difference**.	A **$500** allowance is added to the **$500** allowance described in "Hearing services" above. If your hearing aid costs more than **$1,000** per ear, **you pay the difference**.	A **$500** allowance is added to the **$500** allowance described in "Hearing services" above. If your hearing aid costs more than **$1,000** per ear, **you pay the difference**.	A **$500** allowance is added to the **$500** allowance described in "Hearing services" above. If your hearing aid costs more than **$1,000** per ear, **you pay the difference**.
Transportation We cover up to 20 one-way trips per calendar year (limited to 55 miles one way) to get you to or from a plan provider when provided by our transportation provider. For more information, visit **https://healthy.kaiserpermanente.org/colorado/health-wellness/senior-health/extras**.	**$0** This benefit and the benefit described in "Transportation" are combined to give you 32 one-way trips per calendar year.	**$0** This benefit and the benefit described in "Transportation" are combined to give you 28 one-way trips per calendar year.	**$0** This benefit and the benefit described in "Transportation" are combined to give you 36 one-way trips per calendar year.	**$0** This benefit and the benefit described in "Transportation" are combined to give you 50 one-way trips per calendar year.

Advantage Plus Option 2 benefits and premiums	With our **Core** plan, you pay	With our **Bronze** plan, you pay	With our **Silver** plan, you pay	With our **Gold** plan, you pay
In-home support We cover up to 8 hours of non-medical, in-home support services every month to address assistance with ADLs and IADLs within the home. For more information, visit **https://healthy.kaiserpermanente.org/colorado/health-wellness/senior-health/extras**.	**$0** 8 hours of support or 16 hours of support if you enroll in both Advantage Plus options (Option 1 and Option 2).	**$0** 8 hours of support or 16 hours of support if you enroll in both Advantage Plus options (Option 1 and Option 2).	**$0** This benefit and the benefit described in "Additional benefits" are combined to give you 16 hours of support, or 24 hours of support if you enroll in both Advantage Plus options (Option 1 and Option 2).	**$0** This benefit and the benefit described in "Additional benefits" are combined to give you 16 hours of support, or 24 hours of support if you enroll in both Advantage Plus options (Option 1 and Option 2).

Additional benefits

These benefits are available to you as a plan member:	**You pay**
Medicare Explorer by Kaiser Permanente (point-of-service supplemental benefit) for Bronze, Silver, and Gold plan members only If you travel outside any Kaiser Permanente service area, but inside the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits obtained from out-of-network Medicare providers not to exceed a benefit maximum of **$1,000** in covered plan charges per calendar year. Covered services, include, but are not limited to: • Preventive services covered at **$0** under Original Medicare. • Primary care and specialty care visits. • Outpatient diagnostic tests and services. • X-rays and ultrasounds. • Mental health care outpatient visits. • Medicare Part B drugs. For coverage details, including a full list of covered services, how to locate an eligible provider, how to schedule an appointment, claims, and how to determine if you are outside a Kaiser Permanente service area,	**Bronze, Silver, and Gold plan members:** You pay the following up to the **$1,000** annual benefit limit: • **$40** per ultrasound for Bronze plan members, **$35** per ultrasound for Silver plan members, and **$20** per ultrasound for Gold plan members. • **$35** per specialty care visit for Bronze plan members and **$10** per specialty care visit for Silver or Gold plan members. • **$35** per individual specialty care visit and **$0** per group visit for cardiac rehabilitation and intensive cardiac rehabilitation for Bronze plan members and **$10** per individual specialty care visit and **$0** per group visit for cardiac rehabilitation and intensive cardiac rehabilitation for Silver or Gold plan members. • **$35** per kidney disease education specialty care visit and **$0** per kidney disease education primary care visit

please see Chapter 4, Section 2.2, in the **Evidence of Coverage**.	for Bronze plan members, and **$10** per kidney disease education specialty care visit and **$0** per kidney disease education primary care visit for Silver or Gold plan members. • **$35** per opioid treatment program services visit for Bronze plan members and **$10** per opioid treatment program services for Silver or Gold Plan members. • **$35** per podiatry visit for Bronze plan members and **$10** per podiatry visit for Silver or Gold Plan members. • **$25** per visit for physical, speech, and occupational therapy for Bronze plan members and **$10** per visit for physical, speech, and occupational therapy for Silver or Gold plan members. • **$20** per chiropractic visit for Bronze or Silver plan members and **$15** per chiropractic visits for Gold plan members. • **$10** per individual therapy visit and **$5** per group therapy visit for mental health, psychiatric and substance abuse care for Bronze plan members, **$5** per individual therapy visit and **$0** per group therapy visit for mental health, psychiatric and substance abuse care for Silver plan members, and **$0** for mental health, psychiatric and substance abuse care for Gold plan members. • **$5** per visit for pulmonary rehabilitation. • **$0** for primary care visits. • **$0** for lab tests, X-rays, and diagnostic tests. • **$0** for preventive care visits. • **$0** for blood, including storage and administration. • **$0** for annual physical exams. • **$0** for diabetes self-management training. • **$0** for glaucoma screening visits. • **$0** for Medicare-covered hearing exams. • **$0** for Medicare-covered ophthalmology services.

	• You pay **0%–20% of physician allowed charges** for Medicare Part B drugs administered in an office or clinic. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation. Once you reach the maximum plan benefit coverage amount of **$1,000** per calendar year, you pay any amounts that exceed the benefit maximum.
Over-the-counter (OTC) items We cover OTC items listed in our OTC catalog for free home delivery. You may order OTC items each quarter of the year (January, April, July, October) up to the quarterly benefit limit shown in the right column. Each order must be at least **$35**. For more information, visit **https://healthy.kaiserpermanente.org/colorado/health-wellness/senior-health/extras**.	**$0** up to the following quarterly benefit limit, depending upon the plan: • **$120** quarterly benefit limit for Bronze plan members. • **$90** quarterly benefit limit for Gold plan members. • **$80** quarterly benefit limit for Silver plan members. • **$70** quarterly benefit limit for Core plan members.
In-home support for Gold or Silver plan members only We cover 8 hours of non-medical, in-home support services every month to address assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) within the home. See the **EOC** for details. Note: This benefit is not covered for Core or Bronze plan members unless they sign up for optional supplemental benefits (see "Advantage Plus" for details). For more information, visit **https://healthy.kaiserpermanente.org/colorado/health-wellness/senior-health/extras**.	**$0**

Out-of-network/non-contracted providers are not required to treat plan members, except in emergency situations. Please call our customer service number or see your **Evidence of Coverage** for more information, including the cost-sharing that applies to out-of-network services.

Member discounts for products and services

Kaiser Permanente partners with leading companies to support your health, safety, and well-being — and offer substantial savings and discounts.

Lively™ Mobile Plus

Get a personal emergency response system that provides 24/7 help with the push of a button. Receive a reduced one-time device fee and choice of two monthly service plans (coverage limits may apply). Visit **greatcall.com/KP** or call **1-800-205-6548** (TTY **711**) for more information.

CareLinx

Kaiser Permanente has partnered with CareLinx to provide you with a discount for purchasing non-medical, in-home help with daily activities. Your caregiver can help you live an independent lifestyle in your own home by assisting with light housekeeping, meal preparation, companionship and more.

Visit **kp.org/homesupport/co** or call toll-free **1-844-636-4592** Monday-Friday, 7 a.m. – 6 p.m., and on weekends, 9 a.m. – 5 p.m.

Comfort Keepers® in-home care and assistance

In-home care services to help you maintain independence at home with everything from 24-hour care, respite, meal preparation, and light housekeeping. Receive a discount on all services and get a free in-home safety assessment. Visit **comfortkeepers.com/kaiser-permanente** or call **1-800-611-9689** (TTY **711**) for more information.

Mom's Meals® healthy meal delivery

Getting the right nutrition is essential to achieving and maintaining good health. Receive delivery of refrigerated ready-to-heat-and-eat meals to homes nationwide. Crafted by chefs and registered dietitians, meals are medically tailored to support most major chronic conditions and overall wellness. Kaiser Permanente members enjoy discounted pricing and free shipping from Mom's Meals. Visit **momsmealsnc.com** or call **1-866-224-9483** (TTY **711**) for more information.

Kaiser Permanente members may continue to use or select these products or services from any company of their choice but Kaiser Permanente discounts are only available with the partner listed above. The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Kaiser Permanente Senior Advantage grievance process. BEST BUY HEALTH, GREATCALL, LIVELY and LINK are trademarks of Best Buy and its affiliated companies.

Who can enroll

You can sign up for one of our plans if:

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

Coverage rules

We cover the services and items listed in this document and the **Evidence of Coverage**, if:

- The services or items are medically necessary.
- The services and items are considered reasonable and necessary according to Original Medicare's standards.
- You get all covered services and items from plan providers listed in our **Provider Directory** and **Pharmacy Directory**. But there are exceptions to this rule. We also cover:
    - Care from plan providers in another Kaiser Permanente Region
    - For Bronze, Silver, and Gold plan members only, care covered under the Medicare Explorer point-of-service benefit. See the **Evidence of Coverage** for details.
    - Emergency care
    - Out-of-area dialysis care
    - Out-of-area urgent care (covered inside the service area from plan providers and in rare situations from non-plan providers)
    - Referrals to non-plan providers if you got approval in advance (prior authorization) from our plan in writing
    - Routine care from a Colorado Permanente Medical Group (CPMG) physician at a Kaiser Permanente medical office in our Northern or Southern Colorado service areas

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

For details about coverage rules, including non-covered services (exclusions), see the **Evidence of Coverage**.

Getting care

At most of our plan facilities, you can usually get all the covered services you need, including specialty care, pharmacy, and lab work. To find our provider locations, see our **Provider Directory** or **Pharmacy Directory** at **kp.org/directory** or ask us to mail you a copy by calling Member Services at **1-800-476-2167** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Your personal doctor

Your personal doctor (also called a primary care physician) will give you primary care and will help coordinate your care, including hospital stays, referrals to specialists, and prior authorizations. Most personal doctors are in internal medicine or family practice. You must choose one of our available plan providers to be your personal doctor. You can change your doctor at any time and for any reason. You can choose or change your doctor by calling **1-855-208-7221** (TTY **711**), weekdays 7 a.m. to 5:30 p.m. or at **kp.org**.

Help managing conditions

If you have more than one ongoing health condition and need help managing your care, we can help. Our case management programs bring together nurses, social workers, and your personal doctor to help you manage your conditions. The program provides education and teaches self-care skills. If you're interested, please ask your personal doctor for more information.

Notices

Appeals and grievances

You can ask us to provide or pay for an item or service you think should be covered by submitting a claim to us within a specific time period that includes the date you received the item or service. If we say no, you can ask us to reconsider our decision. This is called an appeal. You can ask for a fast decision if you think waiting could put your health at risk. If your doctor agrees, we'll speed up our decision.

If you have a complaint that's not about coverage, you can file a grievance with us. See the **Evidence of Coverage** for details about the processes for making complaints and making coverage decisions and appeals, including fast or urgent decisions for drugs, services, or hospital care.

Privacy

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

Helpful definitions (glossary)

Allowance

A dollar amount you can use toward the purchase of an item. If the price of the item is more than the allowance, you pay the difference.

Benefit period

The way our plan measures your use of skilled nursing facility services. A benefit period starts the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't gotten any inpatient hospital care or skilled care in an SNF for 60 days in a row. The benefit period isn't tied to a calendar year. There's no limit to how many benefit periods you can have or how long a benefit period can be.

Calendar year

The year that starts on January 1 and ends on December 31.

Coinsurance

A percentage you pay of our plan's total charges for certain services or prescription drugs. For example, a 20% coinsurance for a $200 item means you pay $40.

Copay

The set amount you pay for covered services — for example, a $20 copay for an office visit.

Deductible

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

Evidence of Coverage

A document that explains in detail your plan benefits and how your plan works.

HMO-POS

An HMO-POS plan is an HMO plan with a Point-of-Service (POS) benefit. "Point-of-Service" means you can use providers outside the plan's network for certain services.

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 and HMO-POS 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**.

Notice of Nondiscrimination

Kaiser Permanente complies with applicable Federal and Colorado state civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, gender expression, or any other basis protected by applicable federal or state laws. 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 Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity or gender expression, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**). 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**, (TTY **1-800-537-7697**). Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

KAISER PERMANENTE®

1127252361 CO
June 2023

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-476-2167** (TTY **711**). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-800-476-2167** (TTY **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-800-476-2167** (TTY **711**)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-800-476-2167** (TTY **711**)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-800-476-2167** (TTY **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-800-476-2167** (TTY **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-800-476-2167** (TTY **711**). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-800-476-2167** (TTY **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

KAISER PERMANENTE®

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-800-476-2167** (TTY **711**). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-800-476-2167** (TTY **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY **711**) **1-800-476-2167**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-800-476-2167** (TTY **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-800-476-2167** (TTY **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-800-476-2167** (TTY **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-476-2167** (TTY **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-800-476-2167** (TTY **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-800-476-2167** (TTY **711**). にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

kp.org/medicare

Kaiser Foundation Health Plan of Colorado
10350 East Dakota Avenue
Denver, CO 80247