

January 1–December 31, 2024

2024 Summary of Benefits

Kaiser Permanente Senior Advantage Value Lane Plan
(HMO-POS)

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 plan. 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
- 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. 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/eocnw or ask for a copy from Member Services by calling **1-877-221-8221 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.

Kaiser Permanente Senior Advantage plans have a Point-of-Service (POS) benefit. "Point-of-Service" means you can use providers outside the plan's network for certain services for an additional cost. 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 **1-877-408-3496 (TTY 711)**.
- If you're a member, please call Member Services at **1-877-221-8221 (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	You pay
Monthly plan premium	\$0
Deductible	None
Your maximum out-of-pocket responsibility Includes copays and other costs for medical services for the year. Doesn't include Medicare Part D drugs	\$3,800
Inpatient hospital services*† There's no limit to the number of medically necessary inpatient hospital days.	\$375 per day for days 1 through 4 of your stay and \$0 for the rest of your stay
Outpatient hospital services*†	\$0–\$300 per visit
Ambulatory Surgical Center (ASC)*†	\$300 per visit
Doctor's visits	
• Primary care providers	\$5 per visit
• Specialists*†	\$30 per visit
Preventive care See the EOC for details.	\$0
Emergency care We cover emergency care anywhere in the world.	\$110 per Emergency Department visit
Urgently needed services We cover urgent care anywhere in the world.	\$35 per office visit
Diagnostic services, lab, and imaging*†	
• Lab tests	\$0
• X-rays	\$10 per visit
• Diagnostic tests and procedures (like EKG)	\$15 or \$40 per visit depending on the service
• MRI, CT, and PET	\$200 per visit
Hearing services	
• Evaluations to diagnose medical conditions	
• Routine hearing exams	
Note: Hearing aids aren't covered unless you sign up for optional benefits (see Advantage Plus for details).	\$35 per visit
Dental services Preventive and comprehensive dental coverage	Not covered unless you sign up for optional benefits (see Advantage Plus for details).

Benefits and premiums	You pay
Vision services <ul style="list-style-type: none"> • Visits to diagnose and treat eye diseases and conditions • Routine eye exams • Preventive glaucoma screenings 	\$35 per visit
<ul style="list-style-type: none"> • Diabetic retinopathy services 	\$0
<ul style="list-style-type: none"> • Eyeglasses or contact lenses after cataract surgery • Other eyewear isn't covered unless you sign up for optional benefits (see Advantage Plus for details). 	\$0 up to Medicare's limit, but you pay any amounts beyond that limit.
Mental health services <ul style="list-style-type: none"> • Inpatient mental health*† 	You pay \$375 per day for days 1–4 (\$0 for the rest of your stay).
<ul style="list-style-type: none"> • Outpatient group therapy† 	\$2 per visit
<ul style="list-style-type: none"> • Outpatient individual therapy† 	\$5 per visit
Skilled nursing facility*† We cover up to 100 days per benefit period.	Per benefit period: <ul style="list-style-type: none"> • \$0 per day for days 1 through 20 • \$196 per day for days 21 through 100
Physical therapy*†	\$35 per visit
Ambulance†	\$250 per one-way trip
Transportation	Not covered
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. <ul style="list-style-type: none"> • Drugs that must be administered by a health care professional 	\$0–20% coinsurance depending upon the drug (please call Member Services to find out which drugs are provided at a coinsurance). Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.
<ul style="list-style-type: none"> • Up to a 30-day supply of a generic drug 	<ul style="list-style-type: none"> • \$10 at a preferred plan pharmacy • \$20 at a standard plan pharmacy
<ul style="list-style-type: none"> • Up to a 30-day supply of a brand-name drug 	<ul style="list-style-type: none"> • \$40 at a preferred plan pharmacy, 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 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 **1-877-221-8221 (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 deductible and coinsurance discussed below do 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

For drugs in Tiers 1, 2, and 6, there is no deductible and you start the year in the initial coverage stage. There is a deductible stage for drugs in Tiers 3, 4, and 5 and you must pay the full cost of those drugs until you have spent the deductible amount of **\$175**. After you have met the deductible, you move on to the initial coverage stage for drugs in Tiers 3, 4, and 5. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

Initial coverage stage

You pay the copays and coinsurance shown in the chart below for up to a 30-day supply 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	\$19	\$0	\$38	\$0	\$57
Tier 2 (Generic)	\$10	\$20	\$20	\$40	\$30	\$60
Tier 3* (Preferred brand-name)	\$40	\$47	\$80	\$94	\$120	\$141
Tier 4* (Nonpreferred drugs)	\$93	\$100	\$186	\$200	\$279	\$300
Tier 5* (Specialty)	29%					
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)	\$10	\$20	\$20
Tier 3* (Preferred brand-name)	\$40	\$80	\$80
Tier 4* (Nonpreferred drugs)	\$93	\$186	\$186
Tier 5* (Specialty)	29%	29%	29%

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, **\$70** for a 31- to 60-day supply, or **\$80** for a 61- to 90-day supply of Tier 3 drugs and **\$105** for a 61- to 90-day supply of Tiers 4-5 drugs, regardless of the tier.

Coverage gap stage

The coverage gap stage begins if you or a Part D plan spends **\$5,030** on your drugs during 2024. You pay the following copays and coinsurance during the coverage gap stage:

Drug tier	You pay
Tiers 1, 2, and 6	The same copays listed above that you pay during the initial coverage stage
Tiers 3, 4, and 5	25% coinsurance

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 a supplemental benefit package called Advantage Plus. Advantage Plus gives you extra coverage for an additional monthly cost that's added to your monthly plan premium. See the **Evidence of Coverage** for details.

Advantage Plus benefits and premiums	You pay
Additional monthly premium	\$44
Eyewear \$175 allowance to buy eyewear once within a 2-calendar-year period	If your eyewear costs more than \$175, you pay the difference.
Hearing aids • \$500 allowance to buy 1 aid, per ear every 3 years	If your hearing aid costs more than \$500 per ear, you pay the difference.
• Hearing exam for fitting and evaluation of hearing aids	\$0
Dental care • Annual benefit limit for preventive and comprehensive dental care	Once you reach the annual dental benefit maximum of \$1,250 , you pay 100% for dental care for the rest of the year.
• Annual deductible for comprehensive dental care	\$50 (You pay 100% at the beginning of the year for comprehensive dental care until you have spent \$50.)
Preventive dental: • Oral exam (up to 2 per calendar year) • Teeth cleaning (up to 2 per calendar year) • Topical fluoride • Bitewing X-rays • Full mouth X-rays	\$0

Advantage Plus benefits and premiums	You pay
<ul style="list-style-type: none"> Comprehensive dental (covered services include fillings, extractions, crowns, endodontics, periodontics, and dentures). Referral and prior authorization are required. 	After the deductible is met, 50% coinsurance

Additional benefits

These benefits are available to you as a plan member:	You pay
<p>Combined acupuncture, chiropractic, and alternative care benefit</p> <p>We provide up to 18 visits total per calendar year for acupuncture, naturopathy care, and chiropractic care not covered by Medicare. No prior authorization or referral is required.</p>	\$20 per visit
<p>Medicare Explorer by Kaiser Permanente (point-of-service supplemental benefit)</p> <p>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 \$1,200 in covered plan charges per calendar year.</p> <p>Covered services, include, but are not limited to:</p> <ul style="list-style-type: none"> Preventive services covered at \$0 under Original Medicare. Primary care and specialty care visits. Outpatient diagnostic tests and services. X-rays, ultrasounds, and diagnostic mammograms. Mental health care outpatient visits. Medicare Part B drugs. <p>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, please see Chapter 4, Section 2.2, in the Evidence of Coverage.</p>	<p>You pay the following up to the \$1,200 annual benefit limit:</p> <ul style="list-style-type: none"> \$55 per specialty care visit. \$55 per visit for physical, speech, and occupational therapy. \$55 per visit for cardiac rehabilitation and intensive cardiac rehabilitation. \$25 per individual therapy visit and \$15 per group therapy visit for mental health care. \$25 per visit, per department for X-rays, ultrasounds, and other basic imaging. \$25 per visit, per department for EKGs, holter monitoring, and EEGs. \$20 per primary care visit. \$10 per visit, per department for lab tests. \$10 for blood, including storage and administration. \$0 for preventive care visits. You pay 20% of physician allowed charges for Medicare Part B drugs administered in an office or clinic.

These benefits are available to you as a plan member:	You pay
	Once you reach the maximum plan benefit coverage amount of \$1,200 per calendar year, you pay any amounts that exceed the benefit maximum.

Out-of-network/non-contracted providers are under no obligation 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 carelinx.com/kaiserpermanente-affinity or call toll-free **1-855-271-2656** 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. ©2022 Best Buy. All rights reserved.

Who can enroll

You can sign up for this plan 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 is all of Lane County.

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
 - 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

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. You aren't restricted to a particular plan facility or pharmacy, and we encourage you to use the plan facility or pharmacy that will be most convenient for you. 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 **1-877-221-8221** (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 may choose any available plan provider 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 Member Services 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 Tiers 3, 4, and 5 drugs before you will enter the initial coverage stage for those drugs. Also, if you sign up for Advantage Plus (optional supplemental benefits), it's the amount you must pay for comprehensive dental services before our plan begins to pay.

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 for an additional cost.

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-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.

Kaiser Permanente's pharmacy network includes limited lower-cost, preferred pharmacies in Lane County in Oregon. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call **1-877-221-8221 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m. or consult the online pharmacy directory at **kp.org/directory**.

For information about Original Medicare, refer to your "**Medicare & You**" handbook. You can view it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

kp.org/medicare

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