

# 2026 Summary of Benefits

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Kaiser Permanente Senior Advantage Maui Plan (HMO)

# 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
- Member discounts for products and services
- Who can enroll
- Coverage rules
- Getting care
- Medicare prescription payment plan

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/eochi** or ask for a copy from Member Services by calling **1-800-805-2739 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.

### Have questions?

- If you're not a member, please call **1-877-408-3494 (TTY 711)**.
- If you're a member, please call Member Services at **1-800-805-2739 (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                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium</b>                                                                                            | <b>\$181</b>                                                                                                                                                                                      |
| <b>Deductible</b>                                                                                                      | <b>\$0</b>                                                                                                                                                                                        |
| <b>Your maximum out-of-pocket responsibility</b><br>Doesn't include Medicare Part D drugs.                             | <b>\$5,100</b>                                                                                                                                                                                    |
| <b>Inpatient hospital services*†</b><br>There's no limit to the number of medically necessary inpatient hospital days. | Per admission: <ul style="list-style-type: none"> <li>• <b>\$340</b> per day for days 1–6</li> <li>• <b>\$70</b> per day for days 7–30</li> <li>• <b>\$0</b> for the rest of your stay</li> </ul> |
| <b>Outpatient hospital services*</b>                                                                                   | <b>\$0–\$325</b> per visit                                                                                                                                                                        |
| <b>Ambulatory Surgical Center (ASC)*</b>                                                                               | <b>\$325</b> per visit                                                                                                                                                                            |
| <b>Doctor's visits</b> <ul style="list-style-type: none"> <li>• Primary care providers</li> </ul>                      | <b>\$10</b> per visit                                                                                                                                                                             |
| <ul style="list-style-type: none"> <li>• Specialists*</li> </ul>                                                       | <b>\$35</b> per visit                                                                                                                                                                             |
| <b>Preventive care*</b><br>See the <b>EOC</b> for details.                                                             | <b>\$0</b>                                                                                                                                                                                        |
| <b>Emergency care</b><br>We cover emergency care anywhere in the world.                                                | <b>\$130</b> per Emergency Department visit                                                                                                                                                       |
| <b>Urgently needed services</b><br>We cover urgent care anywhere in the world.                                         | <b>\$40</b> per visit                                                                                                                                                                             |
| <b>Diagnostic services, lab, and imaging</b> <ul style="list-style-type: none"> <li>• Lab tests</li> </ul>             | <b>\$0</b>                                                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>• X-rays and ultrasounds*</li> </ul>                                            | <b>\$15</b> per X-ray or ultrasound                                                                                                                                                               |
| <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures (like EKGs)*</li> </ul>                       | <b>\$15</b> per test                                                                                                                                                                              |
| <ul style="list-style-type: none"> <li>• MRI, CT, and PET*</li> </ul>                                                  | <b>\$275</b> per test                                                                                                                                                                             |

| Benefits and premiums                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | You pay                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <p><b>Hearing services*</b></p> <ul style="list-style-type: none"> <li>• Evaluations to diagnose medical conditions</li> <li>• Routine hearing exams</li> </ul> <p>Note: If you sign up for optional benefits, you receive additional hearing benefits (see Advantage Plus for details).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <p><b>\$10</b> per visit</p>                                                                          |
| <p><b>Dental services</b></p> <p>Covered preventive dental services listed below are provided by Hawaii Dental Service (HDS) Medicare Advantage Network:</p> <ul style="list-style-type: none"> <li>• Two preventive oral exams and teeth cleanings per calendar year</li> <li>• One bite-wing X-ray per calendar year</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p><b>\$0</b></p>                                                                                     |
| <ul style="list-style-type: none"> <li>• One full-mouth X-ray every five years</li> <li>• Adjunctive general services: anesthesia, consultation, and minor pain relief</li> </ul> <p>See the <b>EOC</b> for details.</p> <p>For the list of HDS Medicare Advantage Network dentists, visit <b><a href="http://hawaiidental-service.com">hawaiidental-service.com</a></b>, or call HDS customer service at <b>1-844-379-4325</b> (Monday through Friday, 7:30 a.m. to 4:30 p.m.).</p> <p>Note: Dental services covered out-of-state are only covered when provided by Delta Dental Medicare Advantage network dentists. Coverage, limitations, and exclusions are subject to the same HDS terms and conditions. To locate a Delta Dental Medicare Advantage network dentist, contact the State's local Delta Dental office.</p> <p>Note: If you sign up for optional benefits, you receive additional dental benefits (see Advantage Plus for details).</p> | <p><b>30%</b> coinsurance</p>                                                                         |
| <p><b>Vision services</b></p> <ul style="list-style-type: none"> <li>• Visits to diagnose and treat eye diseases and conditions*</li> <li>• Routine eye exams*</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>\$10</b> per visit</p>                                                                          |
| <ul style="list-style-type: none"> <li>• Preventive glaucoma screening and diabetic retinopathy services*</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <p><b>\$0</b></p>                                                                                     |
| <ul style="list-style-type: none"> <li>• Eyeglasses or contact lenses after cataract surgery</li> </ul> <p>Note: If you sign up for optional benefits, you receive additional eyewear benefits (see Advantage Plus for details).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <p><b>20%</b> coinsurance up to Medicare's limit and <b>you pay any amounts beyond that limit</b></p> |

| Benefits and premiums                                                                                                                                                                                                                                     | You pay                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Mental health services*</b> <ul style="list-style-type: none"> <li>Inpatient mental health</li> </ul>                                                                                                                                                  | Per admission:<br><b>\$300</b> per day for days 1–6<br><b>(\$0)</b> for the rest of your stay                                                                                                                    |
| <ul style="list-style-type: none"> <li>Outpatient group therapy</li> </ul>                                                                                                                                                                                | <b>\$10</b> per visit                                                                                                                                                                                            |
| <ul style="list-style-type: none"> <li>Outpatient individual therapy</li> </ul>                                                                                                                                                                           | <b>\$35</b> per visit                                                                                                                                                                                            |
| <b>Skilled nursing facility*</b><br>We cover up to 100 days per benefit period.                                                                                                                                                                           | Per benefit period: <ul style="list-style-type: none"> <li><b>\$0</b> for days 1–20</li> <li><b>\$218</b> per day for days 21–40</li> <li><b>\$0</b> for days 41–100</li> </ul>                                  |
| <b>Physical therapy*</b>                                                                                                                                                                                                                                  | <b>\$10</b> per visit                                                                                                                                                                                            |
| <b>Ambulance</b>                                                                                                                                                                                                                                          | <b>\$250</b> per one-way trip                                                                                                                                                                                    |
| <b>Transportation</b>                                                                                                                                                                                                                                     | Not covered                                                                                                                                                                                                      |
| <b>Medicare Part B drugs</b><br>Medicare Part B drugs are covered when you get them from a plan provider. See the <b>EOC</b> for details. <ul style="list-style-type: none"> <li>Drugs that must be administered by a health care professional</li> </ul> | <b>0%–20%</b> coinsurance depending on the drug. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.                                                                |
| <ul style="list-style-type: none"> <li>Up to a 30-day supply from a plan pharmacy</li> </ul>                                                                                                                                                              | <ul style="list-style-type: none"> <li><b>\$10</b> for generic drugs</li> <li><b>\$43</b> for brand-name drugs, except you pay <b>\$35</b> for Part B insulin drugs furnished through an item of DME.</li> </ul> |

## Medicare Part D prescription drug coverage†

†Prior authorization may be required.

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](http://kp.org/seniorrx) or call Member Services to ask for a copy at **1-800-805-2739** (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.
- Whether you get your prescription filled by one of our retail plan pharmacies or our mail-order pharmacy. Note: Not all drugs can be mailed.
- The coverage stage you're in (deductible, initial coverage 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 out-of-pocket costs reach **\$2,100**. If you reach the \$2,100 limit in 2026, you move on to the catastrophic 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 |
| <b>Tier 1</b> (Preferred generic)           | <b>\$4</b>            | <b>\$8</b>           | <b>\$12</b>          |
| <b>Tier 2</b> (Generic)                     | <b>\$10</b>           | <b>\$20</b>          | <b>\$30</b>          |
| <b>Tier 3</b> (Preferred brand-name)        | <b>\$43</b>           | <b>\$86</b>          | <b>\$129</b>         |
| <b>Tier 4</b> (Nonpreferred)                | <b>\$90</b>           | <b>\$180</b>         | <b>\$270</b>         |
| <b>Tier 5</b> (Specialty-tier)              | <b>30%</b>            |                      |                      |
| <b>Tier 6*</b> (Injectable Part D vaccines) | <b>\$0</b>            | <b>N/A</b>           |                      |

\*Our plan covers most Injectable 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                      |                      |                      |
| Tier 2 (Generic)              | \$10                     | \$20                 |                      |
| Tier 3 (Preferred brand-name) | \$43                     | \$86                 |                      |
| Tier 4 (Nonpreferred)         | \$90                     | \$180                |                      |
| Tier 5 (Specialty-tier)       | 30%                      |                      |                      |

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

**Important message about what you pay for insulin:** You won't pay more than **\$35** for up to a one-month supply, **\$70** for up to a two-month supply or **\$105** for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

**Catastrophic coverage stage**

If you or others on your behalf spend **\$2,100** on your Part D prescription drugs in 2026, 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 2026.

**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 retail 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 retail 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.

\*Your plan provider may need to provide a referral.

†Prior authorization may be required.

| Advantage Plus benefits and premium                                                                                                                                                          | You pay                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional monthly premium</b>                                                                                                                                                            | <b>\$46</b>                                                                                                                                                                                                                        |
| <b>Eyewear allowance</b><br>Allowance available every January 1st                                                                                                                            | <b>\$300</b> allowance. If your eyewear costs more than \$300, you pay the difference.                                                                                                                                             |
| <b>Hearing aids</b> *† <ul style="list-style-type: none"><li>• Allowance every 36 months for up to two hearing aids</li></ul> Note: This hearing aid benefit may not be available next year. | <b>\$1,500</b> allowance for both ears. If your hearing aid(s) cost more than \$1,500, you pay the difference.                                                                                                                     |
| <ul style="list-style-type: none"><li>• Exams for fitting and evaluation of hearing aids</li></ul>                                                                                           | <b>\$0</b>                                                                                                                                                                                                                         |
| <b>Dental services</b><br>Covered dental services listed below are provided by Hawaii Dental Service (HDS) Medicare Advantage Network:                                                       | <b>30%–50%</b> coinsurance, depending on the service, up to a <b>\$1,000</b> annual benefit limit (diagnostic and preventive services do not apply to limit). After our plan has paid \$1,000, you pay <b>100%</b> for the rest of |

| Advantage Plus benefits and premium                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | You pay                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Comprehensive dental care that includes fillings, extractions, crowns, endodontics, periodontics, bridges, dentures, implants, and oral surgery.</li> </ul> <p>For the list of HDS Medicare Advantage Network dentists, visit <a href="http://hawaiidental-service.com">hawaiidental-service.com</a>, or call HDS customer service at <b>1-844-379-4325</b> (Monday through Friday, 7:30 a.m. to 4:30 p.m.).</p> <p>Note: Dental services covered out-of-state are only covered when provided by Delta Dental Medicare Advantage network dentists. Coverage, limitations, and exclusions are subject to the same HDS terms and conditions. To locate a Delta Dental Medicare Advantage network dentist, contact the State's local Delta Dental office.</p> | <p>the calendar year. See the <b>Evidence of Coverage</b> for details.</p> |

## Additional benefits

| These benefits are available to you as a plan member:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | You pay                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| <p><b>Acupuncture and chiropractic care not covered by Medicare</b></p> <p>We provide 20 visits total per calendar year for acupuncture and chiropractic care not covered by Medicare.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <p><b>\$20</b> per visit</p> |
| <p><b>Fitness benefit – One Pass™</b></p> <p>You have access to the One Pass complete fitness program for the body and mind. One Pass includes:</p> <ul style="list-style-type: none"> <li>A large core and premium gym network featuring national, local, and community fitness centers and boutique fitness studios. You can use any in-network location.</li> <li>Live, on-demand, and digital fitness programs at home.</li> <li>Social clubs and activities available on the One Pass member website and mobile app.</li> <li>One home fitness kit annually for strength, yoga, or dance.</li> <li>Online brain health cognitive training programs.</li> </ul> <p>For more information about participating gyms and fitness locations, the program's benefits, or to set up your online account, visit <b>YourOnePass.com</b></p> | <p><b>\$0</b></p>            |

| These benefits are available to you as a plan member:                                          | You pay |
|------------------------------------------------------------------------------------------------|---------|
| or call <b>1-877-614-0618</b> (TTY <b>711</b> ), Monday through Friday, 3 a.m. to 4 p.m., HST. |         |

## 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](https://greatcall.com/KP) or call **1-800-205-6548** (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 [www.momsmealsnc.com/kp/home.aspx](https://www.momsmealsnc.com/kp/home.aspx) 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 our 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 this plan's service area, which is the following **ZIP codes in Maui County**: 96708, 96713, 96732, 96733, 96753, 96761, 96767, 96768, 96779, 96784, 96788, 96790, and 96793.

## 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 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

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 and Pharmacy Directory** at [kp.org/directory](https://kp.org/directory) or ask us to mail you a copy by calling Member Services at **1-800-805-2739 (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 Member Services or at [kp.org/finddoctors](https://kp.org/finddoctors).

## 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.

## Medicare prescription payment plan

The Medicare Prescription Payment Plan is a payment option that can help you manage your drug costs by spreading them out during the year as monthly payments. This program is available to anyone with

Medicare Part D and works with your drug coverage. It can be especially helpful to people with high drug cost sharing earlier in the plan year and help manage out-of-pocket drug costs, but it doesn't save you money or lower your drug costs. Contact us or visit **medicare.gov** to learn more about this program.

## 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.

### Kaiser Foundation Health Plan

Kaiser Foundation Health Plan Inc., Hawaii Region is a nonprofit corporation and a Medicare Advantage plan called Kaiser Permanente Senior Advantage. We offer several Senior Advantage plans in our Hawaii Region's service area, which includes Honolulu County, most of Hawaii County (Big Island), and the Island of Maui.

Each plan has different benefits, copays, coinsurance, premiums, and plan service areas. But you can get care from plan providers anywhere in our Hawaii Region.

If you move from your plan's service area to another service area in our Hawaii Region, you'll have to enroll in a Senior Advantage plan in your new service area.

### Privacy

We protect your privacy. See the **Evidence of Coverage** or view our **Notice of Privacy Practices** at **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.

**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.

**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.

**Service area**

The geographic area where we offer Senior Advantage plans. To enroll and remain a member of our plan, you must live in one of our Senior Advantage plan's service area.

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

## NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides free 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, braille, and accessible electronic formats
- Provides free 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 **1-800-966-5955** (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, or sex, you can file a grievance by mail or phone at:

### Membership Services

**Attn: Kaiser Civil Rights Coordinator**  
**711 Kapiolani Blvd**  
**Honolulu, HI 96813**  
**1-800-966-5955**

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, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at <https://healthy.kaiserpermanente.org/hawaii/language-assistance/nondiscrimination-notice>

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## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-966-5955** (TTY: **711**).

**Cebuano (Bisaya) PAGPAHIMANGNO:** Kung nag-istorya ka og Cebuano, ang mga serbisyo sa tabang sa pinulongan lakip ang angay nga mga auxiliary nga mga himan ug serbisyo, libre, anaa kanimo. Tawag sa **1-800-966-5955** (TTY: **711**).

**中文 (Chinese) 注意事項:** 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-966-5955** (TTY: **711**)。

**Chuuk (Chukese) ESINESIN:** Ika en mi sine Fosun Chuuk, mi kawor aninisin fosun fonu mei pachonong pisekin aninis, ese kamo, mi kawor ngonuk. Kekeru **1-800-966-5955** (TTY: **711**).

**‘Ōlelo Hawai‘i (Hawaiian) E NĀNĀ MAI:** Inā ho‘opuka ‘oe i ka ‘ōlelo Hawai‘i, hiki iā ‘oe ke nā lawelawe kōkua ‘ōlelo me nā kōkua kōkua kūpono a me nā lawelawe, manuahi ‘ole, loa‘a i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

**Iloko (Ilocano) ATENSION:** No makasaoka iti Ilokano, dagiti serbisio a tulong iti pagsasao agraman dagiti maitutop a kanayonan a tulong ken serbisio, a libre, ket mabalin a mausar para kenka. Tawagan ti **1-800-966-5955** (TTY: **711**).

**日本語 (Japanese) 注意:** 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-966-5955** までお電話ください (TTY: **711**)。

**한국어 (Korean) 주의:** 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-966-5955** (TTY: **711**)로 전화해 주세요.

**ລາວ (Laotian) ເອົາໃຈໃສ່:** ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-966-5955** (TTY: **711**).

**Kajin Majōl (Marshallese) Roñjake:** Ñe kwōjelā kajin Kajin Majōl, eo ej jipañ eok ilo kajin in ekaoba jerbāl ko jet, ejjelōk oñāāer, repelōk ñan eok. Kūr tok **1-800-966-5955** (TTY: **711**).

**Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN:** Díí saad bee yánítí'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'I bí'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, kojí' hódíílnih **1-800-966-5955** (TTY: **711**).

**Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR:** Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien me kele mehlel oh sarawi kan me pahn limpoak, en kak sawa ni ke, lokaia kak sawas ni sohte isais. Koahl nempe **1-800-966-5955** (TTY: **711**).

**Faa-Samoa (Samoan) FA'AMALU:** Afai e te tautala i le Gagana Samoa, o auaunaga fesoasoani i le gagana, e aofia ai meafaigaluega talafeagai ma auaunaga, e leai ni totogi, o lo'o avanoa mo oe. Fa'amalie atu i le **1-800-966-5955** (TTY: **711**).

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-966-5955** (TTY: **711**).

**Tagalog (Tagalog) PAALALA:** Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-966-5955** (TTY: **711**).

**Lea Faka-Tonga (Tongan) FAKATOKANGA:** Kapau 'oku ke lea Faka-Tonga, 'oku 'i ai ha sevesi tokoni fakatonu lea pea mo ha naunau me'a fanongo, 'oku ta'etotongi, mo faingamalie kiate koe. Taa **1-800-966-5955** (TTY: **711**).

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-966-5955** (TTY: **711**).

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

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