

2027 Summary of Benefits

Kaiser Permanente Senior Advantage Care Plus Plan
(HMO-POS)

About this Summary of Benefits

Thank you for considering Kaiser Permanente Senior Advantage Care Plus. 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
- 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 of 1 Kaiser Permanente Senior Advantage Care Plus plan that includes Medicare Part D prescription drug coverage. 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/eocga** or ask for a copy from Member Services by calling **1-800-232-4404 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.

We also offer a plan without Part D drug coverage. If you'd like information about our other plan, call **1-877-408-3493 (TTY 711)**, 8 a.m. to 8 p.m., 7 days a week or go to **kp.org/medicare**.

Kaiser Permanente Senior Advantage Care Plus plan has a Point-of-Service (POS) benefit. "Point-of-Service" means you can use providers outside the plan's network for an additional cost. Not all services are covered under POS. Covered services under POS are noted in the "Additional benefits" section and in your **EOC**.

Have questions?

- If you're not a member, please call **1-877-408-3493 (TTY 711)**.
- If you're a member, please call Member Services at **1-800-232-4404 (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	\$0
Your maximum out-of-pocket responsibility Includes copays and other costs for medical services for the year. Doesn't include Medicare Part D drugs.	\$9,650
Inpatient hospital services*† There's no limit to the number of medically necessary inpatient hospital days.	\$407 per day for days 1–6 of your stay and \$0 for the rest of your stay
Outpatient hospital services*†	\$0–\$375 per visit
Ambulatory Surgical Center (ASC)*†	\$375 per visit
Doctor visits • Primary care providers	\$10 per visit
• Specialists*	\$45 per visit
Preventive care*† See the EOC for details.	\$0
Emergency care We cover emergency care anywhere in the world.	\$115 per Emergency Department visit
Urgently needed services We cover urgent care anywhere in the world.	\$40 per office visit
Diagnostic services, lab, and imaging • Lab tests*† • Diagnostic tests and procedures (like EKG)*†	• \$0 in a medical office • \$35 per encounter in an outpatient hospital department
• X-rays • Ultrasounds*†	• \$15 per encounter in a medical office • \$50 per encounter in an outpatient hospital department
• MRI, CT, and PET*†	• \$350 per encounter in a medical office • \$450 per encounter in an outpatient hospital department

Benefits and premiums	You pay
Hearing services Evaluations to diagnose medical conditions	\$45 per visit
1 Routine hearing exam per calendar year Note: If you sign up for optional supplemental benefits, you receive additional hearing benefits (see Advantage Plus for details).	\$0
Dental services* - Preventive and diagnostic dental services: - Oral exams (every 1 to 3 calendar years, depending on type) - Prophylaxis (cleanings), periodontal maintenance, or scaling in presence of generalized gingival inflammation (2 total services per calendar year) - X-rays (every 1 to 3 calendar years, depending on type) - Fluoride treatments (2 per calendar year)	\$0
- Comprehensive dental services: - Restorative services - Endodontic services - Periodontic services - Prosthodontic services - Oral surgery services See the EOC for details. Dental care is provided by Delta Dental Insurance Company and its DeltaCare USA Medicare Plan. For information about dental providers, please refer to the DeltaCare USA Medicare network “Find a dentist” page by visiting www1.deltadentalins.com/kaiser-ga. Note: If you sign up for optional supplemental benefits, you receive additional dental benefits (see Advantage Plus for details).	\$0–\$738, depending on the service. See the EOC for details.
Vision services Visits to diagnose and treat eye diseases and conditions	\$45 per visit
1 Routine eye exam per calendar year - Preventive glaucoma screening and diabetic retinopathy services	\$0
Eyeglasses or contact lenses after cataract surgery	20% coinsurance up to Medicare’s limit and you pay any amounts beyond that limit

Benefits and premiums	You pay
Other eyewear (\$300 allowance to purchase eyewear every year)	If your eyewear costs more than \$300 , you pay the difference.
Mental health services Inpatient mental health*†	You pay \$407 per day for days 1–5 (\$0 for the rest of your stay)
Outpatient group therapy	\$22 per visit
Outpatient individual therapy	\$45 per visit
Skilled nursing facility*† We cover up to 100 days per benefit period.	Per benefit period: \$0 per day for days 1 through 20 \$221 per day for days 21 through 100
Physical therapy*	\$35 per visit
Ambulance†	\$310 per one-way trip
Transportation Routine: To get you to and from plan providers.	\$0 for 18 one-way trips per calendar year.
Transportation*† Non-routine: Medically necessary, non-emergency transportation to and from medical facilities within our service area, when ordered by a network provider. Refer to the EOC for more details.	\$60–\$125 , depending on the mode of transportation.
Medicare Part B drugs† Medicare Part B drugs are covered when you get them from a plan provider. See the EOC for details. 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.
Up to a 30-day supply from a plan pharmacy	\$0 for generic drugs \$47 for brand-name drugs, 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 **1-800-232-4404** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

- The day supply quantity you get (like a 30-day or 100-day supply). Note: A supply greater than a 30-day supply isn't available for all drugs.
- For drugs in Tiers 3–4, when you get a 31- to 100-day supply, 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 **EOC 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 out-of-pocket costs reach **\$2,400**. If you reach the \$2,400 limit in 2027, 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 100-day supply
Tier 1 (Preferred generic)	\$0		
Tier 2 (Generic)	\$0		
Tier 3 (Preferred brand-name)	\$47	\$94	\$141
Tier 4 (Nonpreferred)	\$100	\$200	\$300
Tier 5 (Specialty-tier)	31%		
Tier 6* (Part D vaccines)	\$0	N/A	

*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 100-day supply
Tier 1 (Preferred generic)	\$0		
Tier 2 (Generic)	\$0		
Tier 3 (Preferred brand-name)	\$47	\$94	

Drug tier	Mail-order plan pharmacy		
	Up to a 30-day supply	31- to 60-day supply	61- to 100-day supply
Tier 4 (Nonpreferred)	\$100	\$200	
Tier 5 (Specialty-tier)	31%		

Note: Tier 6 (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 **\$2,400** on your Part D prescription drugs in 2027, you'll enter the catastrophic coverage stage. If you reach the catastrophic coverage stage, you pay nothing for your covered Part D drugs for the remainder of the year.

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 **EOC** for details.

Advantage Plus (optional supplemental 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 **EOC** for details.

*Your plan provider may need to provide a referral.

†Prior authorization may be required.

Advantage Plus benefits and premium	You pay
Additional monthly premium	\$13
Hearing aids*† • \$500 allowance to buy 1 aid, per ear every 3 years Note: This hearing aid benefit may not be available next year.	If your hearing aid costs more than \$500 per ear, you pay the difference.
• Hearing exam for fitting and evaluation of hearing aids	\$0

Advantage Plus benefits and premium	You pay
Dental Services* Coverage for implant services Additional X-rays (1 per calendar year)	\$41-\$2,000 for implant services. \$11-\$105 for additional X-rays.
- Comprehensive dental services: - Restorative services - Endodontic services - Periodontic services - Prosthodontic services - Oral surgery services See the EOC for details. Dental care is provided by Delta Dental Insurance Company and its DeltaCare USA Medicare Plan. For information about dental providers, please refer to the DeltaCare USA Medicare network "Find a dentist" page by visiting www1.deltadentalins.com/kaiser-ga .	\$7-\$257 , depending on the service. See the EOC for details.

Additional benefits

*Your plan provider may need to provide a referral.

†Prior authorization may be required.

These benefits are available to you as a plan member:	You pay
Fitness benefit – One Pass® You have access to the One Pass complete fitness program for the body and mind. One Pass includes: - A large core gym network featuring national, local, and community fitness centers and boutique fitness studios. You can use any in-network location. - Live, on-demand, and digital fitness programs at home. - Social clubs and activities available on the One Pass member website and mobile app. - One home fitness kit annually for strength, yoga, or dance. - Online brain health cognitive training programs. For more information about participating gyms and fitness locations, the program's benefits, or to set up your online account, visit YourOnePass.com	\$0

These benefits are available to you as a plan member:	You pay
or call 1-877-614-0618 (TTY 711), Monday through Friday, 9 a.m. to 10 p.m.	
Home medical care not covered by Medicare (Advanced Care at Home)*† We cover medical care in your home that is not otherwise covered by Medicare when found medically appropriate by a physician based on your health status, to provide you with an alternative to receiving or continuing to receive acute care in a hospital. Referral and prior authorization are required. See the EOC for details.	\$0 when prescribed as part of your home treatment plan, otherwise you pay the applicable cost share
Over-the-counter (OTC) items You will receive a preloaded healthy extras card with the quarterly allowance listed on the right to purchase eligible OTC items online and at participating retail stores, including at Kaiser Permanente retail pharmacies. Your card will be reloaded on January 1, April 1, July 1, and October 1. Any unused portion of the quarterly allowance will not roll over to the next quarter. Note: The healthy extras card cannot be used for tips or fees (such as delivery or shipping fees). For more information, please see the EOC, visit mybenefitscenter.com, or call 1-833-524-7035 (TTY 711), 7 days a week, 8 a.m. to 8 p.m. EST.	\$0 up to the \$25 quarterly allowance. Note: This benefit is available on the same card as the SSBCI benefit described below.
Point-of-Service (POS) Care Plus out-of-network benefit When you are anywhere in the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits, outpatient tests and services, and Part B drugs obtained from out-of-network Medicare providers not to exceed a benefit maximum of \$1,500 in covered plan charges per calendar year. Covered services, include, but are not limited to: • Primary care and specialty care visits. • Mental health care outpatient visits. • Outpatient tests and services, such as lab tests, X-rays, and ultrasounds. • 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, and claims, please see	You pay the following up to the \$1,500 annual benefit limit: • \$60 per specialty care visit. • \$60 per mental health care individual therapy visit or \$30 per mental health care group therapy visit. • \$50 per lab test or X-ray. • \$50 per ultrasound • \$50 per for blood, including storage and administration • \$25 per primary care visit. • \$0 for preventive care visits • You pay 0%–20% of the provider's fee schedule 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.

These benefits are available to you as a plan member:	You pay
the Medical Benefits Chart, Chapter 4, Section 2.2 in the Evidence of Coverage .	Once you reach the maximum plan benefit coverage amount of \$1,500 per calendar year, you pay any amounts that exceed the benefit maximum.
Special Supplemental Benefits for the Chronically Ill (SSBCI) – Healthy Food ** Eligible members with certain chronic conditions who meet specific criteria will receive a preloaded healthy extras card with a quarterly allowance to buy approved foods, such as produce, online and at participating retail stores. The list of approved foods is subject to change. Your card will be reloaded on January 1, April 1, July 1, and October 1. You must meet all criteria, including one or more of the SSBCI-eligible conditions listed below: • Chronic alcohol use disorder and other substance use disorders (SUDs) • Autoimmune disorders • Cancer • Cardiovascular disorders • Chronic heart failure • Dementia • Diabetes mellitus • Overweight, obesity, and metabolic syndrome • Chronic gastrointestinal disease • Chronic kidney disease (CKD) • Severe hematologic disorders • HIV/AIDS • Chronic lung disorders • Chronic and disabling mental health conditions • Neurologic disorders • Stroke • Post-organ transplantation care • Immunodeficiency and Immunosuppressive disorders • Conditions associated with cognitive impairment • Conditions with functional challenges and require similar services • Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell	If you qualify for SSBCI, you will receive a preloaded healthy extras card to purchase approved healthy foods with a quarterly allowance of \$85 for your plan. Note: This benefit is available on the same card as the OTC benefit described above.

These benefits are available to you as a plan member:	You pay
• Conditions that require continued therapy services in order for individuals to maintain or retain functioning Any unused portion of the quarterly allowance will not roll over to the next quarter. Note: The allowance cannot be used for tips or fees (such as delivery or shipping fees). For more information, please see the EOC, visit mybenefitscenter.com, or call 1-833-524-7035 (TTY 711), 7 days a week, 8 a.m. to 8 p.m. EST.	

****The Healthy Food Card benefit is part of a special supplemental program for the chronically ill. Not all members qualify. Members must have specific chronic conditions, like diabetes, chronic lung disorders, cardiovascular disorders, chronic heart failure, or cancer to be eligible. There are other conditions that may qualify you for the benefit. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.**

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 **shop.lively.com/pages/kp** or call **1-800-205-6548 (TTY 711)** for more information Monday-Friday, 9 a.m. to 9 p.m. EST, and on weekends, 9 a.m. to 8 p.m. EST.

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 and personal care, 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 24 hours a day, 7 days a week.

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 **momsmeals.com/kaiser** or call **1-866-224-9483 (TTY 711)** for more information Monday-Friday, 8 a.m. to 7 p.m. EST.

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 United States citizen or national, or an eligible noncitizen.
- You live in our plan's service area, which includes:
 - Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, and Henry counties
 - These ZIP codes in Paulding County: 30127, 30134, and 30141

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 Care Plus 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. 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 **1-800-232-4404** (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.

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.

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.

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.

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. For the latest Kaiser Permanente Region locations, visit **kp.org**.

Retail plan pharmacy

A plan pharmacy where you can get prescriptions. These pharmacies are usually located at plan medical offices.

Kaiser Permanente is an HMO-POS 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**.

kp.org/medicare

Kaiser Foundation Health Plan of Georgia, Inc.
3495 Piedmont Road NE
Atlanta, GA 30305

Kaiser Foundation Health Plan of Georgia, Inc. A nonprofit corporation and Health Maintenance Organization (HMO)