2027 Summary of Benefits

KP Medicare Value H2960 028 (HMO)

January 1, 2027 – December 31, 2027

H2960_27SB028_M

KAISER PERMANENTE®

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for considering **KP Medicare Value H2960 028**. You can use this **Summary of Benefits** to learn more about **KP Medicare Value H2960 028**. It includes information about:

- Who can enroll
- Coverage rules
- Getting care
- Premiums
- Benefits and costs
- Part D prescription drugs
- Additional benefits
- Medicare prescription payment plan

For definitions of some of the terms used in this booklet, see the glossary at the end.

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/eocnv.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **KP Medicare Value H2960 028** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- 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.

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 7 a.m. – 8 p.m., Monday – Friday and 8 a.m. – 8 p.m. Saturday and Sunday.
- From April 1 to September 30, we're open 7 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-888-775-7003, TTY: 711.
- If you are not a member of this plan, call us at 1-800-807-1189, TTY: 711.
- Our website: kp.org

Who can enroll?

To join **KP Medicare Value H2960 028**, you must have Medicare Part A and Part B, be a United States citizen or national, or an eligible noncitizen, and you must live in our service area. Our service area includes these counties in Nevada: Storey and Washoe counties.

Which doctors, hospitals, and pharmacies can I use?

KP Medicare Value H2960 028 has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's **Provider Directory** and **Pharmacy Directory** at our website kp.org/directory.

Or, call us and we will send you a copy of the provider and pharmacy directories.

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

What do we cover?

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
    - Out-of-area dialysis care
    - Emergency care
    - Out-of-area urgent care
    - 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**.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use our Part D formulary to locate what tier your drug is on to determine how much it will cost you. To find out which of the 6 tiers your drug is in, see our Part D formulary at kp.org/seniorrx or call Customer Service to ask for a copy.

The amount you pay depends on the drug's tier, the type of pharmacy (preferred pharmacy, standard pharmacy, or our mail-order pharmacy), the day supply quantity you get (like a 30-day or 100-day supply), and what coverage stage of the benefit you have reached. Later in this document we discuss the coverage stages that occur: Deductible, Initial Coverage, and Catastrophic Coverage.

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.**

2 SECTION II - SUMMARY OF BENEFITS

KP Medicare Value H2960 028

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: $0
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,300 for Part A and Part B services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the calendar year. Please note that you will still need to pay any monthly premiums and cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	**Preferred Facility:** Days 1-4: $325 copay per day per benefit period. $0 for the rest of your covered stay. **Non-Preferred Facility:** Days 1-5: $450 copay per day per benefit period. $0 for the rest of your covered stay. May require prior authorization. May require a referral from your doctor.
Outpatient Hospital	**Preferred Facility:** Outpatient hospital: $275 copay per visit. Outpatient surgery: $275 copay per visit. **Non-Preferred Facility:** Outpatient hospital: $440 copay per visit. Outpatient surgery: $440 copay per visit.
Ambulatory Surgical Center (ASC) Services	**Preferred Facility:** Ambulatory Surgical Center: $325 copay per visit.

	<u>Non-Preferred Facility:</u> Ambulatory Surgical Center: $440 copay per visit. May require prior authorization. May require a referral from your doctor.
Doctor Visits	Primary care physician visit: $0. Specialist visit: $40 copay per visit. May require a referral from your doctor.
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. See your **EOC** for frequency of covered services.
Emergency Care	$150 copay per visit. If you are admitted to the hospital within 12 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $150 copay per visit, up to a maximum plan benefit amount of $10,000 per calendar year.
Urgently Needed Services	**<u>Preferred Facility:</u>** $30 copay per visit. **<u>Non-Preferred Facility:</u>** $65 copay per visit. Worldwide Urgent Coverage: $65 copay per visit. If you are admitted to the hospital immediately, you do not have to pay your share of the cost for urgent care
Diagnostic Services/Labs/Imaging	Diagnostic tests and procedures: $35 - $275 copay per visit, depending on the service. Lab services: $0 - $120 copay per visit, depending on the service ($0 for routine blood work). Ultrasounds, MRI, CT, PET and Nuclear Scan: $65 - $100 copay per visit, depending on the service. X-rays: $40 copay per visit. Therapeutic radiology services (such as radiation treatment for cancer): $70 copay per visit. May require prior authorization. May require a referral from your doctor.

Hearing Services	Exam to diagnose and treat hearing and balance issues: $35 copay per visit. Routine hearing exam (up to 1 visit every year): $0. Fitting/evaluation for hearing aid (up to 1 visit every year): $0. Hearing Aid: $495 - $1,970 copay, depending on hearing aid type and is per each hearing aid up to two hearing aids every year (one per ear per year)
Dental Services	Medicare Covered: $35 copay per visit. Preventive dental services: • Oral exam (up to 1 visit(s) every year): $0 • Cleaning (up to 2 visit(s) every year): $0 • Dental X-rays (varies based on the type of X-ray): $0 Comprehensive dental services: • Restorative Services: $0 • Endodontics: $0 • Periodontics: $0 • Prosthodontics, removable: $0 • Oral/Maxillofacial Surgery: $0 • You pay $0 for comprehensive dental services up to **$500** annual benefit maximum per calendar year. After you reach your annual benefit maximum, you pay **100%** of the costs for the rest of the calendar year.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye: $35 copay per visit. Glaucoma screening: $0 Routine eye exam (up to 1 visit(s) every year): You pay $0 up to the annual benefit maximum of $150 per calendar year. After you reach your annual benefit maximum, you pay **100%** of the costs for the rest of the calendar year. Eyeglasses or contact lenses after cataract surgery: 20% coinsurance up to Medicare's limit; you pay any amounts beyond that limit. Additional eyeglasses or contact lenses: You pay $0 up to the $250 allowance every year for eyewear or contact lenses. If your eyewear costs more than the allowance, you pay the difference.

Mental Health Services	Outpatient group therapy visit: $40 copay per visit. Individual therapy visit: $40 copay per visit. Inpatient Mental Health Care: **Preferred Facility:** Days 1-4: $275 copay per day per benefit period. $0 for the rest of your covered stay. **Non-Preferred Facility:** Days 1-5: $450 copay per day per benefit period. $0 for the rest of your covered stay. May require prior authorization. May require a referral from your doctor.
Skilled Nursing Facility (SNF)	We cover up to 100 days per benefit period. Per benefit period, you pay: Days 1-20: $20 copay per day. Days 21-34: $220 copay per day. Days 35-100: $0. May require prior authorization.
Physical Therapy	$40 copay per visit. May require prior authorization.
Ambulance	Ground Ambulance: $345 copay per one-way trip. Air Ambulance: $345 copay per one-way trip. May require prior authorization for non-emergency services.
Transportation	$0 for up to 12 one-way rides per calendar year, up to the $1,250 annual benefit maximum. May require prior authorization. May require a referral from your doctor.
Medicare Part B Drugs	Part B drugs: 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. Part B Insulin: $35 for a one-month's supply. May require prior authorization.

Part D PRESCRIPTION DRUG BENEFITS

May require prior authorization.

Deductible Stage

Prescription Drug Deductible: $300 for Tiers 3, 4 and 5.

For drugs in Tiers 1, 2, and 6, there's no drug deductible and you start the year in the initial coverage stage. For drugs in Tiers 3, 4, and 5, you must pay the full cost of the drugs until you have spent **$300** for them in 2027. After you have met the deductible, you move on to the initial coverage stage for Tiers 3, 4, and 5 drugs. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

Initial Coverage Stage

Drug tier	Retail plan pharmacy					
	Up to a 30-day supply		31- to 60-day supply		61- to 100-day supply	
	Preferred pharmacy	**Standard pharmacy**	**Preferred pharmacy**	**Standard pharmacy**	**Preferred pharmacy**	**Standard pharmacy**
Tier 1 (Preferred generic)	**$3**	**$11**	**$6**	**$22**	**$7.50**	**$27.50**
Tier 2 (Generic)	**$10**	**$20**	**$20**	**$40**	**$25**	**$50**
Tier 3 (Preferred brand-name)	**$40**	**$47**	**$80**	**$94**	**$100**	**$117.50**
Tier 4 (Non-preferred)	**32%**					
Tier 5 (Specialty-tier)	**30%**					
Tier 6 (Part D vaccines)	**$0**		**NA**			

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)	**$10**	**$20**	

Drug tier	Mail-order plan pharmacy		
	Up to a 30-day supply	31- to 60-day supply	61- to 100-day supply
Tier 3 (Preferred brand-name)	**$40**	**$80**	
Tier 4 (Non-preferred)	**32%**		
Tier 5 (Specialty-tier)	**30%**		

Your cost-sharing may be different if you use a Preferred pharmacy, a Standard pharmacy, a Long-Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 100 days) of a drug. Not all drugs can be mailed.

Please call us or see the plan's **Evidence of Coverage** on our website kp.org/eocnv for complete information about your costs for covered drugs.

Catastrophic Coverage

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.

Additional benefits

These benefits are available to you as a plan member:	You pay
Fitness benefit You have access to a gym membership at select gym facilities in our service area. Please visit kp.org for information on signing up for this benefit or contact Customer Service at 1-888-775-7003. Participating facilities may change throughout the plan year.	**$0**
Over the Counter (OTC) items Your coverage includes OTC items, medications and products from our OTC catalog. You can access the catalog by visiting Nations online KPNevada.NationsBenefits.com or by calling a NationsBenefits Member Experience Advisor at **1-(877) 200-4189 (TTY: 711)**, 8 am - 8 pm, 7 days a week, local member time. **$20 allowance every month** Any unused portion of the allowance does not roll over to the next month.	**$0 up to the $20 monthly allowance.**

DISCLAIMERS

This document is available in braille, large print, audio file, or data file if you need it by calling Customer Service. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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

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 www.medicare.gov to learn more about this program.

Helpful Definitions (glossary)

Allowance – A dollar amount you can use to help pay for items and services.

Benefit period –The way our plan measures your use of inpatient hospital and 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 Medicare Part B 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 – KP Medicare Value H2960 028.

Plan premium – The amount you pay for your KP Medicare Value H2960 028 health care 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. 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).

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.

Service area – The geographic area where we offer KP Medicare Value H2960 028. To enroll and remain a member of our plan, you must live in our service area.

Standard pharmacy – A plan pharmacy where you can get your prescriptions at standard copays. 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.