Platinum 90 0/10 PCP KP Plus™ + Child Dental ALT†

FOR EFFECTIVE DATES JANUARY 1 THROUGH DECEMBER 1, 2027

FEATURES	In-network[1]	Out-of-network[1] Limited to 10 medical services[4] and 5 pharmacy fills or refills per year[12]
PLAN DEDUCTIBLE (Embedded)	Not applicable	Not applicable
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $4,800[2,3] / Family – $9,600[2,3]	
IN THE MEDICAL OFFICE		
Primary care visits	$10	$30[4]
Urgent care visits	$10	Not covered[5]
Specialty office visits	$30	$50[4]
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0[6,7]	$0[6,7]
Well-child preventive care visits (through age 23 months)	$0	$0[4]
Fertility services	Not covered[8]	Not covered
Physical, occupational, and speech therapy	$10	$30[4]
Most laboratory tests	$25[9]	$35[4]
Most X-rays and diagnostic testing	$50[9]	$70[4]
Most MRI / CT / PET scans	$150[9]	Not covered
Outpatient surgery (per procedure)	$400 per procedure	Not covered
EMERGENCY SERVICES		
Emergency department visits (waived if admitted directly to hospital)	$200	$200
Ambulance	$150	$150
PRESCRIPTIONS (up to a 30-day supply)		
Generic (Tier 1)	$10[10,11]	$15[12]
Brand-name (Tier 2)	$20[10,11]	$40[12]
Specialty drugs (Tier 4)	10% after plan deductible up to $250 maximum[11]	Not covered
HOSPITAL INPATIENT CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per admission	Not covered
Skilled nursing facility care (up to 100 days per benefit period)	$250 per admission	Not covered
MENTAL HEALTH SERVICES		
Outpatient (in the medical office)	$0	$20[4]
Inpatient (in the hospital)	$500 per admission	Not covered
SUBSTANCE USE DISORDER SERVICES		
Outpatient (in the medical office)	$0	$20[4]
Inpatient (in the hospital) – detoxification only	$500 per admission	Not covered
OTHER		
Virtual care	$0	$20[4]
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	Not covered
Certain durable medical equipment (DME) (supplemental and base)	10% to $2,000 annual maximum[13]	Not covered
Certain prosthetic and orthotic devices	$0	Not covered
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[14]	Not covered
Pediatric vision exam	$0	$0[4]
Adult optical (eyewear)	$175 Allowance[15]	Not covered
Adult vision exam (for eye refraction)	$0	$0[4]

(continues)

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*Kaiser Permanente Plus™ is a limited Point-of-Service (POS) plan with coverage for certain outpatient services and prescriptions from out-of- network providers as described in the *Evidence of Coverage*.

†The abbreviation "ALT," in certain plan names, indicates Kaiser Permanente developed plans.

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1. Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge may be less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.
2. This plan has an embedded out-of-pocket maximum. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.
3. Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.
4. Limited to a combined total of 10 covered outpatient services from out-of-network (OON) providers. Refer to the Evidence of Coverage for a complete list of outpatient services that are covered.
5. Out-of-network urgent care providers are covered as in-network benefit when visiting outside the service area at a $10 copay. Refer to the *Evidence of Coverage*.
6. Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
7. Scheduled prenatal visits and postpartum visits.
8. Fertility benefits may be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.
9. Laboratory and diagnostic test, X-rays and MRI/CT/PET scans related to preventive services are no charge.
10. Prescription drugs are covered in accordance with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copays. For information on our formulary, including the drugs on the specialty tier, go to kp.org/formulary or call our Member Service Contact Center.
11. Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply.
12. Limited to 5 out-of-network (OON) prescription fills (combined from any tier). Refer to the Evidence of Coverage for a complete list of prescription drugs or items that are covered.
13. Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of $2,000 per year for services. Refer to the Evidence of Coverage for information on what's included in your DME benefit.
14. Under age 19. One pair of eyeglasses from a limited selection.
15. Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months.

This is a summary of benefits only and is subject to change. The KFHP *Evidence of Coverage* and the KPIC *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided isn't intended to describe all the benefits included in each plan, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.