Silver 70 PPO 2500/60 PCP + Child Dental

FOR EFFECTIVE DATES JANUARY 1 THROUGH DECEMBER 1, 2027

FEATURES	Participating Provider Tier (in-network)[1]	Non-Participating Provider Tier (out-of-network)[1]
PLAN DEDUCTIBLE (Embedded)	Individual – $2,500[2] / Family – $5,000[2]	Individual – $5,000[2] / Family – $10,000[2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $9,200[2,3] / Family – $18,400[2,3]	Individual – $18,400[2,3] / Family – $36,800[2,3]
IN THE MEDICAL OFFICE		
Primary care visits	$60	40% (after plan deductible)
Urgent care visits	$60	40% (after plan deductible)
Specialty office visits	$90	40% (after plan deductible)
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0[4,5,6,7]	40%[4,5,6,7]
Well-child preventive care visits (through age 23 months)	$0	40%
Allergy injections	20% per visit	40% per visit (after plan deductible)
Fertility services	Not covered[8]	Not covered
Physical, occupational, and speech therapy	$55	40% (after plan deductible)
Most laboratory tests	$55	40% (after plan deductible)
Most X-rays and diagnostic testing	$90	40% (after plan deductible)
Most MRI / CT / PET scans	$300 (after plan deductible)	40% (after plan deductible)
Outpatient surgery (per procedure)	40% (after plan deductible)	50% (after plan deductible)
EMERGENCY SERVICES		
Emergency department visits (waived if admitted directly to hospital)	40% (after plan deductible)	40% (after plan deductible)
Ambulance	40% (after plan deductible)	40% (after plan deductible)
PRESCRIPTIONS (up to a 30-day supply)		
Generic (Tier 1)	$20[9,10,12]	Not covered
Brand-name (Tier 2)	$90 (after $350/$700 drug deductible)[9,10,11,12]	Not covered
Specialty drugs (Tier 4)	30% per prescription up to $250 maximum (after $350/$700 drug deductible)[10,11,12]	Not covered
HOSPITAL INPATIENT CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	50% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	40% (after plan deductible)	50% (after plan deductible)
MENTAL HEALTH SERVICES		
Outpatient (in the medical office)	$60	40% (after plan deductible)
Inpatient (in the hospital)	40% (after plan deductible)	50% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES		
Outpatient (in the medical office)	$60	40% (after plan deductible)
Inpatient (in the hospital) – detoxification only	40% (after plan deductible)	50% (after plan deductible)
OTHER		
Virtual care	$0	$0
Acupuncture (physician referred)	$60 per visit	40% (after plan deductible)
Certain durable medical equipment (DME) (supplemental and base)	40%[13,14]	40% (after plan deductible)[13,14]
Certain prosthetic and orthotic devices	40%	40% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[15]	20% (after plan deductible)[15]
Pediatric vision exam	$0	0% (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	Not covered
Home health care (up to 100 visits per year)	$45[16]	40% (after plan deductible)[16]
Hospice care	$0	40% (after plan deductible)

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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 deductible and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible or out-of-pocket maximum is satisfied. 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. Covered charges incurred toward satisfaction of the out-of-pocket maximum at the non-participating provider tier won't accumulate toward satisfaction of the out-of-pocket maximum on the participating provider tier. Likewise, covered charges incurred toward satisfaction of the out-of-pocket maximum on the participating provider tier won't accumulate toward satisfaction of the out-of-pocket maximum on the non-participating provider tier. For a complete understanding of the out-of-pocket maximum, please refer to your Certificate of Insurance.
4. Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
5. Scheduled prenatal visits and postpartum visits.
6. Routine prenatal care office visits are covered as required under the Affordable Care Act (ACA). This includes the initial and subsequent histories, physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis.
7. Delivery and inpatient care for mother and baby are covered under your inpatient services benefit. For a complete understanding of birth services, please see your KPIC Certificate of Insurance.
8. Fertility benefits may be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.
9. Insured is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when the insured requests a brand-name drug and a generic version is available.
10. Your plan has an open drug formulary; however, select prescription drugs may be excluded from coverage. Please refer to your KPIC Certificate of Insurance for a complete list of limitations and exclusions. Regardless of your provider, prescriptions must be filled at a MedImpact pharmacy. Please call MedImpact at 800-788-2949 for a participating pharmacy.
11. This plan has a drug deductible of $350 per individual and $700 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible is satisfied. 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.
12. Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply.
13. Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of $2,000 per year for services from the participating providers and non-participating providers, excluding diabetic testing supplies and equipment.
14. Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and aren't subject to the DME maximum limit of $2,000 per year.
15. Under age 19. One pair of eyeglasses from a limited selection.
16. Limit doesn't apply to physical, occupational, and speech therapist visits in the home.

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*.