Silver 70 2000/65 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)	Individual – $2,000[2] / Family – $4,000[2]	Not applicable
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $9,500[2,3] / Family – $19,00[2,3]	
IN THE MEDICAL OFFICE Primary care visits	$65	$75[4]
Urgent care visits	$65	Not covered[5]
Specialty office visits	$100	$120[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
Fertility services	Not covered[8]	Not covered
Physical, occupational, and speech therapy	$65	$85[4]
Most laboratory tests	$35[9]	$45[4]
Most X-rays and diagnostic testing	$80[9]	$90[4]
Most MRI / CT / PET scans	$400 after plan deductible[9]	Not covered
Outpatient surgery (per procedure)	45% after plan deductible	Not covered
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	45% after plan deductible	45% after plan deductible
Ambulance	45% after plan deductible	45% after plan deductible
PRESCRIPTIONS (up to a 30-day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	 $20[10,11] $100[10,11] 20% per prescription up to $250 maximum[11]	 $25[12] $120[12] Not covered
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	45% (after plan deductible)	Not covered
Skilled nursing facility care (up to 100 days per benefit period)	45% (after plan deductible)	Not covered
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$0	$20[4]
Inpatient (in the hospital)	45% (after plan deductible)	Not covered
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$0	$20[4]
Inpatient (in the hospital) – detoxification only	45% (after plan deductible)	Not covered
OTHER Virtual care	$0	$20[4]
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)	Not covered
Certain durable medical equipment (DME) (supplemental and base)	45% after plan deductible to $2,000 annual max[14]	Not covered
Certain prosthetic and orthotic devices	$0	Not covered
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[15]	Not covered
Pediatric vision exam	$0	$0[4]
Adult optical (eyewear)	Not covered[16]	Not covered
Adult vision exam (for eye refraction)	$0	$0[4]

*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 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. 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 $65 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. After the 5 days, additional days for the same admission are covered at no charge.
14. Both base and supplemental DME are covered. Supplemental DME is subject to the plan deductible and 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. Limited to 5 out-of-network (OON) prescription fills (combined from any tier).
15. Under age 19. One pair of eyeglasses from a limited selection.
16. Kaiser Permanente members are entitled to a discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts can't be combined with any other Health Plan vision benefit. The discounts won't apply to any sale, promotion, or packaged eyewear program; for any contact lens extended purchase agreement; or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.

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*.