

Dual Choice PPO Plans - PLATINUM

PPO/0/0/20/S13

FEATURES	In Network	Out of Network ⁴	PPO plans are not available on the SHOP. 1 Some benefits may have limitations. 2 To pay the in-network member cost-share, specialty medications must be filled at an in-network Specialty Pharmacy. For a current listing of in-network pharmacies that dispense Specialty Drugs call Customer Service at 1-855-364-3185. 3 Available 90-day supply through Kaiser Permanente Pharmacy and Affiliated Pharmacies. 4 Services covered out of network are subject to 10 visits/services and 5 Rx fill/refill per year Phone visits are available for many specialties and primary care for members who are registered on kp.org and have seen their doctor in the past year. Coinsurance amounts shown are subject to the deductible (if there is a deductible). This is a summary description and is not intended to replace the Group Policy, and/or Certificate of Insurance, which contain the complete provisions of this coverage. Some benefits may have specific limitations and/or exclusions.
DEDUCTIBLE (Individual/Family)	\$0 / \$0	\$2,000 / \$4,000	
OUT-OF-POCKET MAXIMUM (Individual/Family)	\$2,500 / \$5,000	\$7,500 / \$15,000	
MAXIMUM BENEFIT WHILE COVERED ¹	Unlimited	Unlimited	
COINSURANCE (after deductible)	0%	30%	
OFFICE SERVICES			
Telehealth Visits	Primary: \$0 KP / \$40 Network Specialty: \$0 KP / \$60 Network	30%	
Primary Care	\$20 (KP Providers) / \$40 (Network Providers)	30%	
Specialty Care	\$20 (KP Providers) / \$40 (Network Providers)	30%	
Mental Health/Chemical Dependency	\$20 (KP Providers) / \$40 (Network Providers)	30%	
Chiropractic Care (spinal manipulation only; 20 visits per calendar year)	\$40	30%	
Vision Exam	\$20	30%	
Laboratory Services	\$0	30%	
Radiology Services	\$0	30%	
High Tech Radiology Services (MRI, CT, PET, others)	\$100	30%	
Preventive Services	\$0	30%	
EMERGENCY SERVICES			
Emergency Room (per visit; copay waived if admitted)	\$400	\$400	
Ambulance (per trip)	\$400	\$400	
Urgent Care (per visit)	\$40 (KP Providers) / \$80 (Network Providers)	30%	
OUTPATIENT SERVICES			
Laboratory Services	\$0	30%	
Radiology Services	\$0	30%	
High Tech Radiology Services (MRI, CT, PET, others)	\$100	30%	
Outpatient Hospital or Surgical Facility	\$250	30%	
Physician and Other Professional Fees	\$0	30%	
INPATIENT SERVICES			
Hospital (facility)	\$600 per day	30%	
Physician and Other Professional Fees	\$0	30%	
Mental Health/Chemical Dependency	\$600 per day	30%	
PHARMACY SERVICES			
Prescription Drug Deductible	N/A	Medical ded applies	
Tier 1 Generic Drugs	\$5 KP / \$15 MedImpact	30%	
Tier 2 Generic Drugs	\$10 KP / \$20 MedImpact	30%	
Tier 3 Preferred Brand Drugs	\$50 KP / \$70 MedImpact	30%	
Tier 4 Non-Preferred Drugs	\$100 KP / \$130 MedImpact	30%	
Tier 5 Specialty Drugs ²	25% KP / 30% MedImpact	30%	
Mail Order ³	\$10 / \$20 / \$100 / \$200 / 25% KP \$45 / \$60 / \$210 / \$390 / 30% MedImpact	30%	

