

FEATURES	In Network	Out of Network ⁴	KP Plus 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)	\$1,000 / \$2,000	N/A	
OUT-OF-POCKET MAXIMUM	\$8,500 / \$17,000	N/A	
MAXIMUM BENEFIT WHILE COVERED ¹	Unlimited	Unlimited	
COINSURANCE (after deductible)	20%	N/A	
OFFICE SERVICES			
Telehealth Visits	\$0	\$20	
Primary Care	\$30	\$50	
Specialty Care	\$60	\$80	
Mental Health/Chemical Dependency	\$30	\$50	
Chiropractic Care	\$60	\$80	
(spinal manipulation only; 20 visits per calendar year)			
Vision Exam	\$30	\$50	
Laboratory Services	\$0	\$20	
Radiology Services	\$60	\$80	
High Tech Radiology Services (MRI, CT, PET, others)	\$400	Not Covered	
Preventive Services	\$0	\$0	
EMERGENCY SERVICES			
Emergency Room (per visit; copay waived if admitted)	\$550	\$550	
Ambulance (per trip)	\$550	\$550	
Urgent Care (per visit)	\$60	Not Covered	
OUTPATIENT SERVICES			
Laboratory Services	\$0	\$20	
Radiology Services	\$60	\$80	
High Tech Radiology Services (MRI, CT, PET, others)	\$400	Not Covered	
Outpatient Hospital or Surgical Facility	20%	Not Covered	
Physician and Other Professional Fees	20%	Not Covered	
INPATIENT SERVICES			
Hospital (facility)	20%	Not Covered	
Physician and Other Professional Fees	20%	Not Covered	
Mental Health/Chemical Dependency	20%	Not Covered	
PHARMACY SERVICES			
Prescription Drug Deductible	\$250 / \$500 (except Tier 1 & 2 Generics)	N/A	
Tier 1 Generic Drugs	\$5 KP / \$15 Affiliated	\$25	
Tier 2 Generic Drugs	\$10 KP / \$20 Affiliated	\$30	
Tier 3 Preferred Brand Drugs	\$40 KP / \$60 Affiliated	\$60	
Tier 4 Non-Preferred Drugs	\$60 KP / \$90 Affiliated	\$90	
Tier 5 Specialty Drugs ²	25% KP / 35% Affiliated	35%	
Mail Order ³	\$10/\$20/\$100/\$160/35%	Not Covered	