KP Plus Plans - SILVER

KP PLUS/2700/35/50/S13

FEATURES	In Network	Out of Network [4]
DEDUCTIBLE (Individual/Family)	$2,700 / $5,400	N/A
OUT-OF-POCKET MAXIMUM (Individual/Family)	$9,500 / $19,000	N/A
MAXIMUM BENEFIT WHILE COVERED [1]	Unlimited	Unlimited
COINSURANCE (after deductible)	35%	N/A
OFFICE SERVICES		
Telehealth Visits	$0	$20
Primary Care	$50	$70
Specialty Care	$80	$100
Mental Health/Chemical Dependency	$50	$70
Chiropractic Care (spinal manipulation only; 20 visits per calendar year)	$80	$100
Vision Exam	$50	$70
Laboratory Services	35%	45%
Radiology Services	35%	45%
High Tech Radiology Services (MRI, CT, PET, others)	$550 after deductible	Not Covered
Preventive Services	$0	$0
EMERGENCY SERVICES		
Emergency Room (per visit; copay waived if admitted)	35%	35%
Ambulance (per trip)	35%	35%
Urgent Care (per visit)	$100	Not Covered
OUTPATIENT SERVICES		
Laboratory Services	35%	45%
Radiology Services	35%	45%
High Tech Radiology Services (MRI, CT, PET, others)	$550 after deductible	Not Covered
Outpatient Hospital or Surgical Facility	35%	Not Covered
Physician and Other Professional Fees	35%	Not Covered
INPATIENT SERVICES		
Hospital (facility)	35%	Not Covered
Physician and Other Professional Fees	35%	Not Covered
Mental Health/Chemical Dependency	35%	Not Covered
PHARMACY SERVICES		
Prescription Drug Deductible	$450 / $900 (except Tier 1 & 2 Generics)	N/A
Tier 1 Generic Drugs	$5 KP / $15 Affiliated	$25
Tier 2 Generic Drugs	$20 KP / $30 Affiliated	$40
Tier 3 Preferred Brand Drugs	$70 KP / $90 Affiliated	$90
Tier 4 Non-Preferred Drugs	$120 KP / $150 Affiliated	$150
Tier 5 Specialty Drugs [2]	35% KP / 45% Affiliated	45%
Mail Order [3]	$10/$40/$140/$240/35%	Not Covered

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.

KAISER PERMANENTE®

Nine Piedmont Center
3495 Piedmont Road, N.E.
Atlanta, GA 30305-1736

Kaiser Foundation Health Plan of Georgia, Inc.