# Dual Choice PPO Plans - Bronze

PPO/6500/20/60/S11

| FEATURES | In Network | Out of Network 4 |
|---|---|---|
| **DEDUCTIBLE** (Individual/Family) | $6,500 / $13,000 | $13,000 / $26,000 |
| **OUT-OF-POCKET MAXIMUM** (Individual/Family) | $9,000 / $18,000 | $18,000 / $36,000 |
| **MAXIMUM BENEFIT WHILE COVERED 1** | Unlimited | Unlimited |
| **COINSURANCE** (after deductible) | 20% | 40% |
| **OFFICE SERVICES** | | |
| Telehealth Visits | Primary: $0 KP / $80 after ded Network (ded waived first 3 visits)<br>Specialty: $0 KP / $100 after ded Network | 40% |
| Primary Care | $60 after ded (ded waived for first 3 visits) (KP Providers)<br>$80 after ded (ded waived for first 3 visits) (Network Providers) | 40% |
| Specialty Care | $80 after ded (KP Providers) / $100 after ded (Network Providers) | 40% |
| Mental Health/Chemical Dependency | $60 after ded (ded waived for first 3 visits) (KP Providers)<br>$80 after ded (ded waived for first 3 visits) (Network Providers) | 40% |
| Chiropractic Care (spinal manipulation only; 20 visits per calendar year) | 20% | 40% |
| Vision Exam | 20% | 40% |
| Laboratory Services | 20% | 40% |
| Radiology Services | 20% | 40% |
| High Tech Radiology Services (MRI, CT, PET, others) | 20% | 40% |
| Preventive Services | $0 | 30% |
| **EMERGENCY SERVICES** | | |
| Emergency Room (per visit; copay waived if admitted) | 20% | 20% |
| Ambulance (per trip) | 20% | 20% |
| Urgent Care (per visit) | $120 after ded (ded waived first 3 visits) (KP Providers) $160 after ded (ded waived first 3 visits) (Network Providers) | 40% |
| **OUTPATIENT SERVICES** | | |
| Laboratory Services | 20% | 40% |
| Radiology Services | 20% | 40% |
| High Tech Radiology Services (MRI, CT, PET, others) | 20% | 40% |
| Outpatient Hospital or Surgical Facility | 20% | 40% |
| Physician and Other Professional Fees | 20% | 40% |
| **INPATIENT SERVICES** | | |
| Hospital (facility) | 20% | 40% |
| Physician and Other Professional Fees | 20% | 40% |
| Mental Health/Chemical Dependency | 20% | 40% |
| **PHARMACY SERVICES** | | |
| Prescription Drug Deductible | Medical ded applies (except Tier 1 & 2 Generics) | Medical ded applies |
| Tier 1 Generic Drugs | $5 KP / $15 MedImpact | 40% |
| Tier 2 Generic Drugs | $30 KP / $40 MedImpact | 40% |
| Tier 3 Preferred Brand Drugs | $60 KP / $80 MedImpact | 40% |
| Tier 4 Non-Preferred Drugs | $100 KP / $130 MedImpact | 40% |
| Tier 5 Specialty Drugs 2 | 20% KP / 30% MedImpact | 40% |
| Mail Order 3 | $10 / $60 / $120 / $200 / 20% KP<br>$45 / $120 / $240 / $390 / 30% | 40% |

**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.

KAISER PERMANENTE®

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

Kaiser Foundation Health Plan of Georgia, Inc.