

Deductible HMO Plan A 500/20/3K

City of Stonecrest

	Kaiser Permanente Providers
Deductible (Individual/Family)	\$500 / \$1,000
Out-of-Pocket Maximum (Individual/Family) <i>includes deductible, coinsurance, copays for Essential Health Benefits</i>	\$3,000 / \$6,000
Maximum Benefit While Covered	Unlimited
Coinsurance (after deductible)	20%
Benefits	You Pay
Office Services	
Primary Care	\$20 Copay
Specialist Care	\$30 Copay
Preventive Services	\$0 Copay
Maternity (Pre Natal and 1st Post Natal visit)	20% after deductible
Outpatient Services	
Physical and Occupational Therapy (up to 40 visits per year combined)	\$30 Copay
Outpatient Hospital or Surgical Facility	20% after deductible
Laboratory Services (performed in an outpatient facility/hospital setting)	\$0 Copay
Radiology Services (performed in an outpatient facility/hospital setting)	\$0 Copay
High Tech Radiology Services (MRI, CT, PET, others copay per procedure when performed in an office or free-standing facility)	20% after deductible
Physician and Other Professional Charges	20% after deductible

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<p>Emergency Services</p> <p>Emergency Services (per visit; copay waived if admitted)</p> <p>Urgent Care (Per Visit)</p> <p>Ambulance (Per Trip)</p>	<p>\$250 copay</p> <p>\$40 copay</p> <p>\$100 copay</p>
<p>Inpatient Services</p> <p>Hospital - Facility Charge (Per Admission)</p> <p>Physician and Other Professional Charges</p>	<p>20% after deductible</p> <p>20% after deductible</p>
<p>Mental Health & Chemical Dependency Services</p> <p>Outpatient (Unlimited Visits)</p> <p>Inpatient Facility (Per Admission)</p> <p>Inpatient Professional and Other Professional Charges</p>	<p>\$20 copay</p> <p>20% after deductible</p> <p>20% after deductible</p>
<p>Pharmacy Services</p> <p>Tier 1 Generic Maintenance</p> <p>Tier 2 Generic Preferred</p> <p>Tier 3 Brand Preferred</p> <p>Tier 4 Generic/Brand Non-Preferred</p> <p>Tier 5 Specialty²</p> <p>Mail Order Pharmacy 2 copays per 90-day supply (KP Pharmacies)</p>	<p>\$5 (KP Pharmacies) \$15 (Designated Community Pharmacy)¹</p> <p>\$15 (KP Pharmacies) \$25 (Designated Community Pharmacy)¹</p> <p>\$30 (KP Pharmacies) \$50 (Designated Community Pharmacy)¹</p> <p>\$45 (KP Pharmacies) \$75 (Designated Community Pharmacy)¹</p> <p>20% to \$300 max (KP Pharmacies) 20% (Designated Community Pharmacy)¹</p> <p>Mail Order available</p>
<p>Other Services</p> <p>Durable Medical Equipment/Prosthetics and Orthotics</p> <p>Vision Exam</p> <p>Chiropractic Services (up to 20 visits per year)³</p> <p>Infertility Diagnosis only</p>	<p>20% after deductible</p> <p>\$20 copay</p> <p>\$30 copay</p> <p>\$30 copay</p>

¹ One time fill only per medication at Designated Community Pharmacies. Subsequent refills available only through Kaiser Permanente Pharmacies, either at Kaiser Permanente facilities or through mail order.

² Mail Order available for coinsurance amount shown.

³ Spinal Manipulation Only.

In-network coverage is provided by Kaiser Foundation Health Plan of Georgia, Inc. Out-of-network coverage is underwritten by Kaiser Permanente Insurance Company (KPIC). Provider options and benefit levels are described in the *Evidence of Coverage*.

This is a summary description and is not intended to replace the *Group Agreement, Group Policy, and/or Evidence of Coverage*, which contain the complete provisions of this coverage. Some benefits may have specific limitations and/or exclusions.