

KP Plus Deductible Plan G 4000/20/6.5K

City of Stonecrest

	In Network	Out of Network (Plus)
Deductible (Individual/Family)	\$4,000 / \$8,000	N/A
Out-of-Pocket Maximum (Individual/Family) <i>includes deductible, coinsurance, copays for Essential Health Benefits</i>	\$6,500 / \$13,000	N/A
Maximum Benefit While Covered	Unlimited	N/A
Coinsurance (after deductible)	20%	N/A
Benefits	You Pay	
Office Services		
Primary Care	\$40 copay	\$60 copay
Specialist Care	\$50 copay	\$70 copay
Preventive Services	\$0 copay	\$0 copay
Maternity (Pre Natal and 1st Post Natal visit)	20% after deductible	N/A
Outpatient Services		
Physical and Occupational Therapy (up to 40 visits per year combined)	\$50 copay	\$70 copay
Outpatient Hospital or Surgical Facility	20% after deductible	N/A
Laboratory Services (performed in an outpatient facility/hospital setting)	\$0 copay	\$20 copay
Radiology Services (performed in an outpatient facility/hospital setting)	\$0 copay	\$20 copay
High Tech Radiology Services (MRI, CT, PET, others copay per procedure when performed in an office or free-standing facility)	20% after deductible	N/A
Physician and Other Professional Charges	20% after deductible	N/A

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Emergency Services		
Emergency Services (per visit; copay waived if admitted)	20% after deductible	Covered In Plan
Urgent Care (Per Visit)	\$80 copay	N/A
Ambulance (Per Trip)	20% after deductible	Covered In Plan
Inpatient Services		
Hospital - Facility Charge (Per Admission)	20% after deductible	N/A
Physician and Other Professional Charges	20% after deductible	N/A
Mental Health & Chemical Dependency Services		
Outpatient (Unlimited Visits)	\$40 copay	\$60 copay
Inpatient Facility (Per Admission)	20% after deductible	N/A
Inpatient Professional and Other Professional Charges	20% after deductible	N/A
Pharmacy Services		
Tier 1 Generic Maintenance	\$5 (KP Pharmacies) \$15 (Designated Community Pharmacy) ¹	\$25
Tier 2 Generic Preferred	\$20 (KP Pharmacies) \$30 (Designated Community Pharmacy) ¹	\$40
Tier 3 Brand Preferred	\$40 (KP Pharmacies) \$60 (Designated Community Pharmacy) ¹	\$60
Tier 4 Generic/Brand Non-Preferred	\$60 (KP Pharmacies) \$90 (Designated Community Pharmacy) ¹	\$90
Tier 5 Specialty ²	20% to \$300 max (KP Pharmacies) 20% (Designated Community Pharmacy) ¹	30% No Out-of-Pocket Max
Mail Order Pharmacy 2 copays per 90-day supply (KP Pharmacies)	Mail Order available	N/A
Other Services		
Durable Medical Equipment/Prosthetics and Orthotics	20% after deductible	N/A
Vision Exam	\$40 copay	\$60 copay
Chiropractic Services (up to 20 visits per year) ³	\$50 copay	\$70 copay
Infertility Diagnosis only	\$50 copay	\$70 copay

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.. 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.