

Dual Choice PPO Plan B 1000/10/3.5K

City of Stonecrest

	In-Network Kaiser Permanente Georgia Providers / Network Providers	Out-of-Network Non-Participating Providers
Deductible (Individual/Family)	\$1,000 / \$2,000	\$3,000 / \$6,000
Out-of-Pocket Maximum (Individual/Family) <i>includes deductible, coinsurance, copays for Essential Health Benefits</i>	\$3,500 / \$7,000	\$7,000 / \$14,000
Maximum Benefit While Covered	Unlimited	Unlimited
Coinsurance (after deductible)	10%	30%
Benefits	You Pay	
Office Services		
Primary Care	\$25 copay (KP Providers) \$45 copay (Network Providers)	30% after deductible
Specialist Care	\$35 copay (KP Providers) \$55 copay (Network Providers)	30% after deductible
Preventive Services	\$0 copay	30% after deductible
Maternity (Pre Natal and 1st Post Natal visit)	10% after deductible	30% after deductible
Outpatient Services		
Physical and Occupational Therapy (up to 40 visits per year combined)	\$35 copay	30% after deductible
Outpatient Hospital or Surgical Facility	10% after deductible	30% after deductible
Laboratory Services (performed in an outpatient facility/hospital setting)	\$0 copay	30% after deductible
Radiology Services (performed in an outpatient facility/hospital setting)	\$0 copay	30% after deductible
High Tech Radiology Services (MRI, CT, PET, others copay per procedure when performed in an office or free-standing facility)	10% after deductible	30% after deductible
Physician and Other Professional Charges	10% after deductible	30% after deductible

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Emergency Services Emergency Services (per visit; copay waived if admitted) Urgent Care (Per Visit) Ambulance (Per Trip)	\$250 copay \$50 copay (KP Providers) \$90 copay (Network Providers) \$150 copay	\$250 copay 30% after deductible \$150 copay
Inpatient Services Hospital - Facility Charge (Per Admission) Physician and Other Professional Charges	10% after deductible 10% after deductible	30% after deductible 30% after deductible
Mental Health & Chemical Dependency Services Outpatient (Unlimited Visits) Inpatient Facility (Per Admission) Inpatient Physician and Other Professional Charges	\$25 copay (KP Providers) \$45 copay (Network Providers) 10% after deductible 10% after deductible	30% after deductible 30% after deductible 30% after deductible
Pharmacy Services Tier 1 Generic Maintenance Tier 2 Generic Preferred Tier 3 Brand Preferred Tier 4 Generic/Brand Non-Preferred Tier 5 Specialty Mail Order Pharmacy 2 copays per 90-day supply (KP Pharmacies) 3 copays per 90-day supply (Designated Community Pharmacy)	\$5 (KP Pharmacies) \$15 (Designated Community Pharmacy) \$15 (KP Pharmacies) \$25 (Designated Community Pharmacy) \$30 (KP Pharmacies) \$50 (Designated Community Pharmacy) \$45 (KP Pharmacies) \$75 (Designated Community Pharmacy) 20% to \$300 max (KP Pharmacies) 30% (Designated Community Pharmacy) Mail Order available	30% after deductible 30% after deductible 30% after deductible 30% after deductible 30% after deductible Mail Order available
Other Services Durable Medical Equipment/Prosthetics and Orthotics Vision Exam Chiropractic Services (up to 20 visits per year) ¹ Infertility Diagnosis only	10% after deductible \$25 copay \$35 copay \$35 copay	30% after deductible 30% after deductible 30% after deductible 30% after deductible

¹ Spinal Manipulation Only.

The Dual Choice PPO is fully underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan (KFHP), Inc.. Provider options and benefit levels are described in the *Certificate of Insurance*.

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.