

HMO Plan \$15/\$1750 MS Custom

Addepar, Inc.

	Kaiser Permanente Providers
Deductible (Individual/Family)	None
Out-of-Pocket Maximum (Individual/Family) <i>includes deductible, coinsurance, copays for Essential Health Benefits</i>	\$1750 / \$3,500
Maximum Benefit While Covered	Unlimited
Coinsurance (after deductible)	0%
Benefits	You Pay
Office Services	
Primary Care	\$15 Copay
Specialist Care	\$25 Copay
Preventive Services	\$0 Copay
Maternity (Pre Natal and 1st Post Natal visit)	\$0 Copay
Outpatient Services	
Physical and Occupational Therapy per visit limited to 30 visits per therapy per accumulation period	\$25 Copay
Outpatient Hospital or Surgical Facility	\$125 Copay
Laboratory Services per encounter (performed in an outpatient facility/hospital setting)	\$10 Copay
Radiology Services per encounter (performed in an outpatient facility/hospital setting)	\$10 Copay
High Tech Radiology Services (MRI, CT, PET, others copay per encounter when performed in an office or free-standing facility)	\$75 Copay
Physician and Other Professional Charges	\$0 Copay





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Emergency Services	
Emergency Services (per visit; copay waived if admitted)	\$200 Copay
Urgent Care (Per Visit)	\$25 Copay
Ambulance (Per Trip)	\$100 Copay
Inpatient Services	
Hospital - Facility Charge (Per Admission)	\$250 Copay
Physician and Other Professional Charges	\$0 Copay
Mental Health & Chemical Dependency Services	
Outpatient (Unlimited Visits)	\$15 Copay
Inpatient Facility (Per Admission)	\$250 Copay
Inpatient Professional and Other Professional Charges	\$0 Copay
Pharmacy Services	
Tier 2 Generic Preferred	\$10 (KP Pharmacies) \$20 (Designated Community Pharmacy) ¹
Tier 3 Brand Preferred	\$30 (KP Pharmacies) \$40 (Designated Community Pharmacy) ¹
Tier 4 Generic/Brand Non-Preferred	\$60 (KP Pharmacies) \$70 (Designated Community Pharmacy) ¹
Tier 5 Specialty ²	20% to \$250 max (KP Pharmacies) 20% (Designated Community Pharmacy) ¹
Mail Order Pharmacy 2 copays per 90-day supply (KP Pharmacies)	Mail Order available
Other Services	
Durable Medical Equipment/Prosthetics and Orthotics	20%
Vision Exam	\$25 Copay
Chiropractic & Acupuncture Services up to 20 visits each per accumulation period (not combined)	\$15 Copay
Infertility Diagnosis & Treatment	

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.

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.

