KAISER PERMANENTE®

2021 HMO Plan

University System of Georgia

	Kaiser Permanente Providers
Deductible (Individual/Family)	Not Applicable
Out-of-Pocket Maximum (Individual/Family) *includes deductible, coinsurance, copays for Essential Health Benefits*	$6,350 / $12,700
Maximum Benefit While Covered	Unlimited
Coinsurance	0%
Benefits	**You Pay**
Office Services	
Primary Care	$20 Copay
Specialist Care	$35 Copay
Preventive Services	100% covered
Maternity (Pre Natal and 1st Post Natal visit)	100% covered
Outpatient Services	
Physical ,Occupational and Speech Therapy (PT/OT up to 20 visits per year combined, ST limited to 20 visits)	$35 Copay
Outpatient Hospital or Surgical Facility	$100 Copay
Laboratory Services (performed in an outpatient facility/hospital setting)	100% covered/office $100 Copay/hospital
Radiology Services (performed in an outpatient facility/hospital setting)	100% covered/office $100 Copay/hospital
High Tech Radiology Services (MRI, CT, PET, others copay per procedure when performed in an office or free-standing facility)	$35 Copay/office $100 Copay/hospital
Physician and Other Professional Charges	100% covered

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Emergency Services	
Emergency Services (per visit; copay waived if admitted)	$250 Copay
Urgent Care (Per Visit)	$30 Copay
Ambulance (Per Trip)	$75 Copay
Inpatient Services	
Hospital - Facility Charge (Per Admission)	$250 Copay
Physician and Other Professional Charges	100% Covered
Mental Health & Chemical Dependency Services	
Outpatient (Unlimited Visits)	$20 copay
Inpatient Facility (Per Admission)	$250 Copay
Inpatient Professional and Other Professional Charges	100% Covered
Pharmacy Services	***$1500 RX Out of Pocket Max**
Generic	$15 (KP Pharmacies) $25 (Network Pharmacies one -time fill per m edication)
Brand Preferred	$45 (KP Pharmacies) $55 (Network Pharmacies one -time fill per m edication)
Brand Non-Preferred	$65 (KP Pharmacies) $75 (Network Pharmacies one -time fill per medication)
Specialty	20% up to $200 (KP Pharmacies) 20% (Network Pharmacies)
Mail Order Pharmacy	2 copays per 90-day supply (KP Pharmacies)
Other Services	
Vision Exam - Optometrist (includes refractions)	$35 Copay
Vision Exam Opthalmologist	$35 Copay
Chiropractic Services (up to 20 visits per year)	$35 copay
Infertility Diagnosis only	$35 copay

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.

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