# 2024 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 | $40 copay |
| Specialist Care | $75 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) | $75 copay |
| Outpatient Hospital or Surgical Facility | $400 copay |
| Laboratory Services (performed in an outpatient facility/hospital setting) | 100% covered/office<br>$100 copay/hospital |
| Radiology Services (performed in an outpatient facility/hospital setting) | 100% covered/office<br>$100 copay/hospital |
| High Tech Radiology Services (MRI, CT, PET, others copay per procedure when performed in an office or free-standing facility) | $75 copay/office<br>$400 copay/hospital |
| Physician and Other Professional Charges | 100% covered |

# 2024 HMO Plan
## University System of Georgia

University System of Georgia Benefits | KAISER PERMANENTE®

| | |
|---|---|
| **Emergency Services** | |
| Emergency Services (per visit; copay waived if admitted) | $400 copay |
| Urgent Care (Per Visit) | $75 copay |
| Ambulance (Per Trip) | $75 copay |
| **Inpatient Services** | |
| Hospital - Facility Charge (Per Admission) | $600 copay |
| Physician and Other Professional Charges | 100% covered |
| **Mental Health & Chemical Dependency Services** | |
| Outpatient (Unlimited Visits) | $40 copay |
| Inpatient Facility (Per Admission) | $600 copay |
| Inpatient Professional and Other Professional Charges | 100% covered |
| **Pharmacy Services** | $1500 RX Out of Pocket Max |
| Generic | $15 (KP Pharmacies)<br>$25 (Network Pharmacies one -time fill per medication) |
| Brand Preferred | $45 (KP Pharmacies)<br>$55 (Network Pharmacies one -time fill per medication) |
| Brand Non-Preferred | $75 (KP Pharmacies)<br>$85 (Network Pharmacies one -time fill per medication) |
| Specialty | 30% up to $250 (KP Pharmacies)<br>30% (Network Pharmacies one time fill per medication) |
| Mail Order Pharmacy | 3 copays per 90 day supply (KP Pharmacies) |
| **Other Services** | |
| Vision Exam - Optometrist (includes refractions) | $45 copay |
| Vision Exam Opthalmologist | $45 copay |
| Chiropractic Services (up to 20 visits per year) | $45 copay |
| Infertility Diagnosis only | $75 copay |
| The extraction of bony, impacted wisdom teeth are excluded from Dental Services | Excluded |

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.

  Nine Piedmont Center • 3495 Piedmont Road, NE • Atlanta, GA 30305 • 404-364-7000