# 2024 HMO Plan
## Cobb County Government

| | Kaiser Permanente Providers |
|---|---|
| **Deductible** (Individual/Family) | $0 |
| **Out-of-Pocket Maximum** (Individual/Family) includes coinsurance, copays for Essential Health Benefits | $1,700 / $5,100 |
| **Maximum Benefit While Covered** | Unlimited |
| **Coinsurance** | 10% |
| **Benefits** | **You Pay** |
| **Office Services** | |
| Primary Care | $35 copay |
| Specialist Care | $40 copay |
| Preventive Services | $0 copay |
| Maternity (Pre Natal and 1st Post Natal visit) | 10% coinsurance |
| **Outpatient Services** | |
| Physical and Occupational Therapy (up to 40 visits per year combined) | 10% coinsurance |
| Outpatient Hospital or Surgical Facility | $300 per visit; 10% thereafter |
| Laboratory Services (performed in an outpatient facility/hospital setting) | $0 Copay |
| Radiology Services (performed in an outpatient facility/hospital setting) | $0 Copay |
| High Tech Radiology Services (MRI, CT, PET, others copay per procedure when performed in an office or free-standing facility) | 10% coinsurance |
| Physician and Other Professional Charges | 10% coinsurance |

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|---|---|
| **Emergency Services** | |
| Emergency Services (per visit; copay waived if admitted) | $200 copay |
| Urgent Care (per visit) | $75 copay |
| Ambulance (per trip) | $100 copay |
| **Inpatient Services** | |
| Hospital - Facility Charge (per admission) | $300 per visit; 10% thereafter |
| Physician and Other Professional Charges | 10% coinsurance |
| **Mental Health & Chemical Dependency Services** | |
| Outpatient (Unlimited Visits) | $35 copay |
| Inpatient Facility (per admission) | $300 per visit; 10% thereafter |
| Inpatient Professional and Other Professional Charges | 10% coinsurance |
| **Pharmacy Services** | |
| Generic | $15 (KP Pharmacies)<br>$25 (Network Pharmacies) |
| Brand Preferred | $35 (KP Pharmacies)<br>$45 (Network Pharmacies) |
| Brand Non-Preferred | $60 (KP Pharmacies)<br>$70 (Network Pharmacies) |
| Specialty* | $200 (KP Pharmacies) |
| Mail Order Pharmacy<br>2 copays per 90-day supply (KP Pharmacies)<br>3 copays per 90-day supply (Network Pharmacies) | Mail Order Available |
| **Other Services** | |
| Durable Medical Equipment/Prosthetics and Orthotics | No Charge |
| Vision Exam | $40 copay |
| Chiropractic Services (up to 20 visits per year) | $40 copay |
| Infertility Diagnosis only | $40 copay |

*Mail Oder 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.