## 2024 HMO Plan Cobb County Government

	Kaiser Permanente Providers
Deductible (Individual/Family)	\$0
<b>Out-of-Pocket Maximum</b> (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 сорау
Specialist Care	\$40 сорау
Preventive Services	\$0 сорау
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 Сорау
Radiology Services (performed in an outpatient facility/hospital setting)	\$0 Сорау
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





## 2024 HMO Plan

Cobb County Government



## KAISER PERMANENTE®

Emergency Services (per visit; copay waived if admitted\$200 copayUrgent Care (per visit)\$100 copayAmbulance (per trip)\$100 copayHospital - Facility Charge (per admission)\$300 per visit; 10% thereafterPhysician and Other Professional Charges10% coinsuranceOutpatient (Unlimited Visits)\$35 copayInpatient Facility (per admission)\$300 per visit; 10% thereafterInpatient Professional and Other Professional Charges\$25 (Network Pharmacies)Beneric\$35 (NP Pharmacies)Generic\$35 (NP Pharmacies)Brand Non-Preferred\$35 (NP Pharmacies)Specialty*\$200 (KP Pharmacies)Specialty*\$200 (KP Pharmacies)Specialty*\$200 (KP Pharmacies)Suld Order Pharmacy 2 copays per 90 day supply (Network Pharmacies)\$70 (Network Pharmacies)Songer Specialty\$100 copayDurable Medical Equipment/Prosthetics and Orthor is Nision ExamNc ChargeVision Exam\$40 copayChiropractic Services (up to 20 visits per year)\$40 copayInfertility Diagnosis only\$40 copay	Emergency Services		
Ambulance (per trip)\$100 copayInpatient ServicesHospital - Facility Charge (per admission)\$300 per visit; 10% thereafterPhysician and Other Professional Charges10% coinsuranceMental Health & Chemical Dependency ServicesOutpatient (Unlimited Visits)\$35 copayInpatient Facility (per admission)\$300 per visit; 10% thereafterInpatient Professional and Other Professional Charges10% coinsurancePharmacy Services5300 per visit; 10% thereafterGeneric\$15 (KP Pharmacies) \$25 (Network Pharmacies)Brand Preferred\$35 (KP Pharmacies) \$45 (Network Pharmacies)Specialty*\$200 (KP Pharmacies) \$70 (Network Pharmacies)Specialty*\$200 (KP Pharmacies) \$70 (Network Pharmacies)Mail Order Pharmacy 3 copays per 90-day supply (NP Pharmacies) 3 copays per 90-day supply (NP Pharmacies)Durable Medical Equipment/Prosthetics and OrthoticsNo ChargeVision Exam\$40 copayVision Exam\$40 copayChiropractic Services (up to 20 visits per year)\$40 copay	Emergency Services (per visit; copay waived if admitted)	\$200 copay	
Inpatient ServicesHospital - Facility Charge (per admission)\$300 per visit; 10% thereafterPhysician and Other Professional Charges10% coinsuranceMental Health & Chemical Dependency ServicesS35 copayOutpatient (Unlimited Visits)\$35 copayInpatient Facility (per admission)\$300 per visit; 10% thereafterInpatient Professional and Other Professional Charges10% coinsurancePharmacy Services10% coinsuranceGeneric\$15 (KP Pharmacies) \$25 (Network Pharmacies)Brand Preferred\$35 (KP Pharmacies) \$45 (Network Pharmacies)Specialty*\$200 (KP Pharmacies) \$70 (Network Pharmacies)Specialty*\$200 (KP Pharmacies) \$70 (Network Pharmacies)Mail Order Pharmacy 2 copays per 90-day supply (NEP Pharmacies) 3 copays per 90-day supply (NEP Pharmacies)Mail Order AvailableOther ServicesUrable Medical Equipment/Prosthetics and OrthoticsNo Charge \$40 copayVision Exam\$40 copay\$40 copayChiropractic Services (up to 20 visits per year)\$40 copay	Urgent Care (per visit)	\$75 сорау	
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Physician and Other Professional Charges10% coinsuranceMental Health & Chemical Dependency ServicesOutpatient (Unlimited Visits)\$35 copayInpatient Facility (per admission)\$300 per visit; 10% thereafterInpatient Professional and Other Professional Charges10% coinsurancePharmacy ServicesGeneric\$15 (KP Pharmacies) \$25 (Network Pharmacies)Brand Preferred\$35 (KP Pharmacies) \$45 (Network Pharmacies)Brand Non-Preferred\$60 (KP Pharmacies) \$70 (Network Pharmacies)Specialty*\$200 (KP Pharmacies) \$70 (Network Pharmacies)Mail Order Pharmacy 2 copays per 90-day supply (Net Pharmacies) 3 copays per 90-day supply (Net Pharmacies)Mail Order AvailableDurable Medical Equipment/Prosthetics and OrthoticsNo ChargeVision Exam\$40 copayChiropractic Services (up to 20 visits per year)\$40 copay	Inpatient Services		
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Vision Exam\$40 copayChiropractic Services (up to 20 visits per year)\$40 copay	Other Services		
Chiropractic Services (up to 20 visits per year) \$40 copay	Durable Medical Equipment/Prosthetics and Orthotics	No Charge	
	Vision Exam	\$40 сорау	
Infertility Diagnosis only \$40 copay	Chiropractic Services (up to 20 visits per year)	\$40 сорау	
	Infertility Diagnosis only	\$40 сорау	

\*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.