

HMO Plan

FANDUEL GROUP, INC.

	Kaiser Permanente Providers
Deductible (Individual/Family)	None
Out-of-Pocket Maximum (Individual/Family) <i>includes deductible, coinsurance, copays for Essential Health Benefits</i>	\$1,500 / \$3,000
Maximum Benefit While Covered	Unlimited
Coinsurance (after deductible)	0%
Benefits	You Pay
Office Services	
Primary Care	\$20 Copay
Specialist Care	\$35 Copay
Preventive Services	\$0 Copay
Maternity (Pre Natal and 1st Post Natal visit)	\$0 Copay
Outpatient Services	
Physical and Occupational Therapy (up to 40 visits per year combined)	\$20 Copay
Outpatient Hospital or Surgical Facility	\$35 Copay
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)	\$0 Copay
Physician and Other Professional Charges	\$0 Copay

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<p>Emergency Services</p> <p>Emergency Services (per visit; copay waived if admitted)</p> <p>Urgent Care (Per Visit)</p> <p>Ambulance (Per Trip)</p>	<p>\$100 Copay</p> <p>\$20 Copay</p> <p>\$50 Copay</p>
<p>Inpatient Services</p> <p>Hospital - Facility Charge (Per Admission)</p> <p>Physician and Other Professional Charges</p>	<p>\$250 Copay</p> <p>\$0 Copay</p>
<p>Mental Health & Chemical Dependency Services</p> <p>Outpatient (Unlimited Visits)</p> <p>Inpatient Facility (Per Admission)</p> <p>Inpatient Professional and Other Professional Charges</p>	<p>\$20 Copay</p> <p>\$250 Copay</p> <p>\$0 Copay</p>
<p>Pharmacy Services</p> <p>Generic Preferred</p> <p>Brand Preferred</p> <p>Specialty²</p> <p>Mail Order Pharmacy 2 copays per 90-day supply (KP Pharmacies)</p>	<p>\$10 (KP Pharmacies) \$20 (Designated Community Pharmacy)¹</p> <p>\$35 (KP Pharmacies) \$45 (Designated Community Pharmacy)¹</p> <p>20% to \$150 max (KP Pharmacies) 20% (Designated Community Pharmacy)¹</p> <p>Mail Order available</p>
<p>Other Services</p> <p>Durable Medical Equipment/Prosthetics and Orthotics</p> <p>Vision Exam</p> <p>Chiropractic Services (up to 20 visits per year)</p> <p>Infertility Treatment</p>	<p>20%</p> <p>\$0 Copay</p> <p>\$15 Copay</p> <p>50%</p>

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.

³ Spinal Manipulation Only.

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.