

## KP/0/0/40/S9

DEDUCTIBLE (Individual/Family) OUT-OF-POCKET MAXIMUM (Individual/Family)  MAXIMUM BENEFIT WHILE COVERED¹ Unlimited  COINSURANCE (after deductible) O%  OFFICE SERVICES Telehealth Visits \$0 Primary Care \$40 Specialty Care \$70 Mental Health/Chemical Dependency Chiropractic Care (spinal manipulation only: 20 visits per calendar year) Vision Exam Laboratory Services Radiology Services High Tech Radiology Services (MRI, CT, PET, others) Preventive Services Emergency Room (per visit; copay waived if admitted) Ambulance (per trip) Urgent Care (per visit) OUTPATIENT SERVICES Radiology Services Radiology Services  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$
MAXIMUM BENEFIT WHILE COVERED¹  COINSURANCE (after deductible)  OFFICE SERVICES  Telehealth Visits  S0  Primary Care  \$40  Specialty Care  Mental Health/Chemical Dependency  Chiropractic Care (spinal manipulation only; 20 visits per calendar year)  Vision Exam  Laboratory Services  Radiology Services High Tech Radiology Services (MRI, CT, PET, others)  Preventive Services  Emergency Room (per visit; copay waived if admitted)  Ambulance (per trip)  Urgent Care (per visit)  OUTPATIENT SERVICES  Ligh Tech Radiology Services  \$50  Dutpatient Hospital or Surgical Facility Physician and Other Professional Fees  Inpatient's SERVICES
COINSURANCE (after deductible)  OFFICE SERVICES  Telehealth Visits \$0 Primary Care \$40 Specialty Care \$770 Mental Health/Chemical Dependency \$40 Chiropractic Care \$70 (spinal manipulation only; 20 visits per calendar year)  Vision Exam \$40 Laboratory Services \$0 Radiology Services \$50 High Tech Radiology Services (MRI, CT, PET, others) \$550 Preventive Services Emergency Room (per visit; copay waived if admitted) \$650 Ambulance (per trip) \$3350 Urgent Care (per visit) \$80  OUTPATIENT SERVICES Laboratory Services (MRI, CT, PET, others) \$550 Pigh Tech Radiology Services \$50 Urgent Care (per visit) \$80  OUTPATIENT SERVICES Laboratory Services \$50 High Tech Radiology Services (MRI, CT, PET, others) \$550 Outpatient Hospital or Surgical Facility \$700 Physician and Other Professional Fees \$0
Telehealth Visits \$0 Primary Care \$40 Specialty Care \$70 Mental Health/Chemical Dependency \$40 Chiropractic Care \$70 Mental Health/Chemical Dependency \$40 Chiropractic Care \$70 (spinal manipulation only; 20 visits per calendar year) Vision Exam \$40 Laboratory Services \$0 Radiology Services \$50 High Tech Radiology Services (MRI, CT, PET, others) \$550 Preventive Services \$0 EMERGENCY SERVICES Emergency Room (per visit; copay waived if admitted) \$650 Ambulance (per trip) \$3350 Urgent Care (per visit) \$80  OUTPATIENT SERVICES Laboratory Services \$50 High Tech Radiology Services (MRI, CT, PET, others) \$550 Outpatient Hospital or Surgical Facility \$700 Physician and Other Professional Fees \$0
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Primary Care  Specialty Care  Mental Health/Chemical Dependency  Chiropractic Care (spinal manipulation only; 20 visits per calendar year)  Vision Exam  Laboratory Services  Radiology Services  Radiology Services (MRI, CT, PET, others)  Preventive Services  Emergency Room (per visit; copay waived if admitted)  Ambulance (per trip)  Urgent Care (per visit)  OUTPATIENT SERVICES  Laboratory Services (MRI, CT, PET, others)  Basic Stope St
Specialty Care \$70  Mental Health/Chemical Dependency \$40  Chiropractic Care (spinal manipulation only; 20 visits per calendar year)  Vision Exam \$40  Laboratory Services \$50  Radiology Services \$550  High Tech Radiology Services (MRI, CT, PET, others) \$550  Preventive Services \$0  EMERGENCY SERVICES  Emergency Room (per visit; copay waived if admitted) \$650  Ambulance (per trip) \$350  Urgent Care (per visit) \$80  OUTPATIENT SERVICES  Laboratory Services \$50  High Tech Radiology Services (MRI, CT, PET, others) \$550  Outpatient Hospital or Surgical Facility \$700  Physician and Other Professional Fees \$0
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Ambulance (per trip) \$350  Urgent Care (per visit) \$80  OUTPATIENT SERVICES  Laboratory Services \$0  Radiology Services \$50  High Tech Radiology Services (MRI, CT, PET, others) \$550  Outpatient Hospital or Surgical Facility \$700  Physician and Other Professional Fees \$0  INPATIENT SERVICES
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Outpatient Hospital or Surgical Facility \$700  Physician and Other Professional Fees \$0  INPATIENT SERVICES
Physician and Other Professional Fees \$0  INPATIENT SERVICES
INPATIENT SERVICES
Hospital (facility) \$950 copay per day for first 3 days
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Physician and Other Professional Fees \$0
Mental Health/Chemical Dependency \$950 copay per day for first 3 days
PHARMACY SERVICES <sup>2</sup>
Prescription Drug Deductible N/A
Tier 1 Generic Drugs \$5 KP / \$15 Affiliated
Tier 2 Generic Drugs \$10 KP / \$20 Affiliated
Tier 3 Preferred Brand Drugs \$60 KP / \$80 Affiliated
Tier 4 Non-Preferred Drugs \$100 KP / \$130 Affiliated
Tier 5 Specialty Drugs 35% KP / 35% Affiliated
Mail Order <sup>3</sup> \$10 / \$20 / \$120 / \$200 / 35%

## KP and HDHP plans are also available on the SHOP (with the exception of Platinum Plans KP/0/0/20/S9 and KP/500/20/20/S9)

- 1 Some benefits may have limitations.
- 2 Refills must be obtained at a Kaiser Permanente Pharmacy or through Mail Order.
- 3 Available 90 day supply through Kaiser Permanente Pharmacy.

Phone visits are available for many specialties and primary care for members who are registered on **kp.org** and have seen their doctor in the past year.

Coverage is provided by Kaiser Foundation Health Plan of Georgia, Inc.

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.

## KAISER PERMANENTE

Kaiser Foundation Health Plan of Georgia, Inc.

Nine Piedmont Center 3495 Piedmont Road, N.E. Atlanta, GA 30305-1736



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