



KAISER PERMANENTE

KP Plans - GOLD

KP/0/0/30/S10

FEATURES

DEDUCTIBLE (Individual/Family)

N/A

OUT-OF-POCKET MAXIMUM (Individual/Family)

\$8,700 / \$17,400

MAXIMUM BENEFIT WHILE COVERED ¹

Unlimited

COINSURANCE (after deductible)

0%

OFFICE SERVICES

Telehealth Visits

\$0

Primary Care

\$30

Specialty Care

\$60

Mental Health/Chemical Dependency

\$30

Chiropractic Care

\$60

(spinal manipulation only; 20 visits per calendar year)

Vision Exam

\$30

Laboratory Services

\$0

Radiology Services

\$20

High Tech Radiology Services (MRI, CT, PET, others)

\$400

Preventive Services

\$0

EMERGENCY SERVICES

Emergency Room (per visit; copay waived if admitted)

\$550

Ambulance (per trip)

\$550

Urgent Care (per visit)

\$60

OUTPATIENT SERVICES

Laboratory Services

\$0

Radiology Services

\$20

High Tech Radiology Services (MRI, CT, PET, others)

\$400

Outpatient Hospital or Surgical Facility

\$550

Physician and Other Professional Fees

\$0

INPATIENT SERVICES

Hospital (facility)

\$800 copay per day

Physician and Other Professional Fees

\$0

Mental Health/Chemical Dependency

\$800 copay per day

PHARMACY SERVICES ²

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

\$50 KP / \$70 Affiliated

Tier 4 Non-Preferred Drugs

\$80 KP / \$110 Affiliated

Tier 5 Specialty Drugs

35% KP / 45% Affiliated

Mail Order ³

\$10 / \$20 / \$100 / \$160 / 35%

KP and HDHP plans are also available on the SHOP (with the exception of Platinum Plans KP/0/0/20/S10 and KP/500/20/20/S10)

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.

Coinsurance amounts shown are subject to the deductible (if there is a deductible).

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.



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