KAISER PERMANENTE®

City of Atlanta – DHMO Plan (Deductible / 90% Coinsurance)

Effective Dates: January 1, 2024 - December 31, 2024

Website	www.kp.org
Member Services Number	(404) 261-2590; (888) 865-5813 toll-free
Member Services Weekday Hours	Monday-Friday 7:00 a.m. until 7:00 p.m.
Member Services Weekend Hours	None
Annual Deductible: Individual / Family	$500 / $1,500
Annual Out-of-Pocket Max: Individual / Family	$2,500 / $7,500
Office Visits (Outpatient)	
Primary Care	$20 copay
Specialty Care	$35 copay
Preventive Care	100% covered
Scheduled Prenatal Visits and 1st Postpartum Visit	100% covered for routine care
Well-Baby Care (23 months or younger)	Covered 100% to age 24 months
Vision Exam - Optometrist	$35 copay, includes refractions
Vision Exam - Ophthalmologist	$35 copay
Physical, Occupational, Speech Therapy	Plan Pays 90% after deductible (up to 20 visits per year; PT/OT combined, ST limited to 20 visits)
Outpatient/Ambulatory Surgery	Plan pays 90% after deductible
Lab and X-Ray	
Laboratory	100% covered in office; Plan pays 90% after deductible in hospital setting
X-Ray	100% covered in office; Plan pays 90% after deductible in hospital setting
MRI/CT/PET/Nuclear Medicine	Plan pays 90% after deductible in office and hospital setting
Emergency Care	
Ambulance (Ground or Air)	$300 copay (per trip)
Emergency Room	$300 copay; waived if admitted
Urgent Care	$40 copay; at designated facilities
Hospital Care (Inpatient)	
Inpatient	Plan pays 90% after deductible
Delivery and Inpatient Baby Care	Plan pays 90% after deductible

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC.

KAISER PERMANENTE®

City of Atlanta – DHMO Plan (Deductible / 90% Coinsurance)

Effective Dates: January 1, 2024 - December 31, 2024

Mental Health Outpatient (Individual)	$20 copay, unlimited visits per year
Mental Health Outpatient (Group)	$10 copay, unlimited visits per year
Mental Health Inpatient	Plan pays 90% after deductible, unlimited days per year
Chemical Dependency Outpatient (Individual)	$20 copay, unlimited visits per year
Chemical Dependency Outpatient (Group)	$20 copay, unlimited visits per year
Chemical Dependency Inpatient	Plan pays 90% after deductible, unlimited days per year
Prescription Drugs	
Pharmacy/Retail: Generic	$20 at Kaiser Permanente Pharmacies & $30 at Network Pharmacies. Network Pharmacies limited to a one time fill.
Pharmacy/Retail: Brand	$40 at Kaiser Permanente Pharmacies & $50 at Network Pharmacies. Network Pharmacies limited to a one time fill.
Pharmacy/Retail: Specialty	20% ($250 Max) at Kaiser Permanente Pharmacies
Mail Order - Generic	$40 through Kaiser Permanente Pharmacies only
Mail Order - Brand	$80 through Kaiser Permanente Pharmacies only
Mail Order - Day Supply	90 Day Supply
Other	
Skilled Nursing Facility (SNF)	90% covered after deductible, up to 100 days per calendar year
Infertility Services	$35 copay for diagnosis, Services for infertility treatment covered at 50%
Hospice Care	100% covered
Home Health Care	100% covered, up to 120 visits per year. Private Duty nursing not covered
Durable Medical Equipment (DME)	Plan pays 90% after deductible
Chiropractic Care	Not Applicable
Notes	

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC.