KAISER PERMANENTE®

2024 HDHP/ HSA Plan

City of Atlanta

	Kaiser Permanente Providers
Deductible (Individual/Family)	$1,600 / $3,200
Out-of-Pocket Maximum (Individual/Family) *includes deductible, coinsurance, copays for Essential Health Benefits*	$3,500 / $7,000
Maximum Benefit While Covered	Unlimited
Coinsurance (after deductible)	10%
Benefits	**You Pay**
Office Services	
Primary Care	10% after deductible
Specialist Care	10% after deductible
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)	10% after deductible
Outpatient Hospital or Surgical Facility	10% after deductible
Laboratory Services (performed in an outpatient facility/hospital setting)	10% after deductible
Radiology Services (performed in an outpatient facility/hospital setting)	10% after deductible
High Tech Radiology Services (MRI, CT, PET, others copay per procedure when performed in an office or free-standing facility)	10% after deductible
Physician and Other Professional Charges	10% after deductible

Kaiser Foundation Health Plan of Georgia, Inc. Nine Piedmont Center3495 Piedmont Road, N.E. Atlanta, GA 30305-1736

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Emergency Services	
Emergency Services (per visit; copay waived if admitted)	10% after deductible
Urgent Care (Per Visit)	10% after deductible
Ambulance (Per Trip)	10% after deductible
Inpatient Services	
Hospital - Facility Charge (Per Admission)	10% after deductible
Physician and Other Professional Charges	10% after deductible
Mental Health & Chemical Dependency Services	
Outpatient (Unlimited Visits)	10% after deductible
Inpatient Facility (Per Admission)	10% after deductible
Inpatient Professional and Other Professional Charges	10% after deductible
Pharmacy Services	
RX Deductible	Same Annual Deductible
Tier 2 Generic Preferred	10% after deductible (KP Pharmacies) 10% after deductible (Designated Community Pharmacy)[1]
Tier 3 Brand Preferred	10% after deductible (KP Pharmacies) 10% after deductible (Designated Community Pharmacy)[1]
Tier 4 Generic/Brand Non-Preferred	10% after deductible (KP Pharmacies) 10% after deductible (Designated Community Pharmacy)[1]
Mail Order Pharmacy 2 copays per 90-day supply (KP Pharmacies)	Mail Order available
Other Services	
Durable Medical Equipment/Prosthetics and Orthotics	10% after deductible
Vision Exam	10% after deductible
Chiropractic Services (up to 20 visits per year)[3]	10% after deductible
Infertility Diagnosis only	10% after deductible

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 Oder 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.

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