

2026 HMO Plan

Cobb County Government

Kaiser Permanente Providers	
Deductible (Individual/Family)	\$0
Out-of-Pocket Maximum (Individual/Family) includes coinsurance, copays for Essential Health Benefits	\$1,700 / \$5,100
Maximum Benefit While Covered	Unlimited
Coinsurance	10%
Benefits	You Pay
Office Services	
Primary Care	\$35 copay
Specialist Care	\$40 copay
Preventive Services	\$0 copay
Maternity (Pre Natal and 1st Post Natal visit)	10% coinsurance
Outpatient Services	
Physical and Occupational Therapy (up to 40 visits per year combined)	10% coinsurance
Outpatient Hospital or Surgical Facility	\$300 per visit; 10% thereafter
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)	10% coinsurance
Physician and Other Professional Charges	10% coinsurance

Emergency Services	
Emergency Services (per visit; copay waived if admitted)	\$200 copay
Urgent Care (per visit)	\$75 copay
Ambulance (per trip)	\$100 copay
Inpatient Services	
Hospital - Facility Charge (per admission)	\$300 per visit; 10% thereafter
Physician and Other Professional Charges	10% coinsurance
Mental Health & Chemical Dependency Services	
Outpatient (unlimited visits)	\$35 copay
Inpatient Facility (per admission)	\$300 per visit; 10% thereafter
Inpatient Professional and Other Professional Charges	10% coinsurance
Pharmacy Services	
Generic	\$15 (KP Pharmacies) \$25 (Network Pharmacies)
Brand Preferred	\$35 (KP Pharmacies) \$45 (Network Pharmacies)
Brand Non-Preferred	\$60 (KP Pharmacies) \$70 (Network Pharmacies)
Specialty*	\$200 (KP Pharmacies)
Mail Order Pharmacy 2 copays per 90-day supply (KP Pharmacies) 3 copays per 90-day supply (Network Pharmacies)	Mail Order Available
Other Services	
Durable Medical Equipment/Prosthetics and Orthotics	No Charge
Vision Exam	\$40 copay
Chiropractic Services (up to 20 visits per year)	\$40 copay
Infertility Diagnosis only	\$40 copay

*Mail Oder available for coinsurance amount shown

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.