

Board Of Regents

Effective Dates: January 1, 2015 - December 31, 2015

General Information	
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	Not Applicable
Annual Out-of-Pocket Max: Individual/Family	\$6350-Single/ \$12,700-Family
Office Visits (Outpatient)	
Primary Care	\$20 copay
Specialty Care	\$25 copay
Preventive Care	100% covered
Scheduled Prenatal Visits and 1st Postpartum Visit	100% covered for routine care
Well-Baby Care	Covered 100% to age 24 months
Vision Exam - Optometrist	\$25 copay, includes refractions
Vision Exam - Ophthalmologist	\$25 copay
Physical, Occupational, Speech Therapy	\$25 copay (up to 20 visits per year; PT/OT combined, ST limited to 20 visits)
Outpatient/Ambulatory Surgery	\$100 copay
Lab and X-Ray	
Laboratory	100% covered in office; \$100 copay in hospital setting
X-Ray	100% covered in office; \$100 copay in hospital setting
MRI/CT/PET/Nuclear Medicine	\$25 copay in office; \$100 copay in hospital setting
Emergency Care	
Ambulance (Ground or Air)	\$75 copay (per trip)
Emergency Room	\$250 copay; waived if admitted
Urgent Care	\$30 copay; at designated facilities
Hospital Care (Inpatient)	
Inpatient	\$250 copay per admission
Delivery and Inpatient Baby Care	100% covered for OB Services; \$250 copay per admission

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, or to the Disclosure Form for California, or to the Member Handbook for Hawaii.

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Mental Health and Chemical Dependency

Mental Health Outpatient (Individual)	\$20 copay, unlimited visits per year
Mental Health Outpatient (Group)	\$10 copay, unlimited visits per year
Mental Health Inpatient	\$250 copay, 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	\$250 copay, unlimited days per year

Prescription Drugs

Pharmacy/Retail: Generic	\$10 at Kaiser Permanente Pharmacies & \$20 at Network Pharmacies. Network Pharmacies limited to a one-time fill per medication.
Pharmacy/Retail: Brand	\$35 at Kaiser Permanente Pharmacies & \$45 at Network Pharmacies. Network Pharmacies limited to a one-time fill per medication.
Pharmacy/Retail: Day Supply	30 Day Supply
Mail Order - Generic	\$20 through Kaiser Permanente Pharmacies only
Mail Order - Brand	\$70 through Kaiser Permanente Pharmacies only
Mail Order - Day Supply	90 Day Supply

Other

Skilled Nursing Facility (SNF)	100% covered, up to 60 days per calendar year
Infertility Services	\$25 copay Infertility Diagnosis, Treatment not covered
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 50%, unlimited per calendar year
Chiropractic Care	\$25 copay per visit, limited to 20 visits per calendar year

Notes

Additional Information

This is a summary of your benefits and their copayments. This is not a contract. A complete list, exclusions, and limitations are contained in the Group Agreement we have with your employer and the Evidence of Coverage you will receive. In the case of a conflict between this benefit chart and the Evidence of Coverage, the Evidence of Coverage will prevail. For specific questions about coverage, please ask your employer's benefits office or contact Kaiser Permanente Member Services at (404)261-2590. Benefits are subject to approval by the Georgia Department of Insurance.

We do not cover the following services under this plan. For a complete list of exclusions and limitations, refer to your Evidence of Coverage: Services that are not medically necessary; Certain exams and other Services required for obtaining or maintaining employment, for insurance or licensing, for foreign travel, on court order or for parole or probation; Cosmetic services; Experimental or investigational services; Eye surgery, such as laser surgery, radial keratotomy to correct refractive defects; Services related to the treatment of morbid obesity (except certain health education programs are covered); Routine foot care; Sexual reassignment services; Reversal of voluntary infertility; Transportation and lodging expenses;

For details on the benefit and claims review and adjudication procedures, please refer to your Evidence of Coverage.

Kaiser Permanente maintains policies regarding the confidentiality, protection, and disclosure of personal health and member identifiable information, including policies related to access to medical records. If you have questions about our policies and procedures to maintain the confidentiality of personal information or would like a more comprehensive notice describing how Kaiser Permanente collects and uses personal information, please call Member Services at (404)261-2590.