

# Kaiser FHP of Georgia - New Plan Design



State: GA

Benefits 2009

		<b>In-Network Coverage</b>	
<b>Plan facts</b>	Member services	(888) 865-5813	Annual enrollment information: (888) 865-5813
	Member services hours	Mon-Fri: 7:00 AM-9:00 PM; Sat-Sun: 8:00 AM-2:00 PM ET	
	Web address	http://my.kp.org/citigroup	
	Product name	Kaiser Foundation Health Plan of Georgia	
<b>Your medical expenses</b>	Annual deductible	\$100 (individual) / \$200 (family max)*	
	Out-of-pocket maximum (includes deductible)	\$2,000 (individual) / \$4,000 (family max) per calendar year*	
	Office visits	Covered at 90% after deductible*	
	Maternity care prenatal office visits	Covered at 90% after deductible*	
	Inpatient hospitalization	Covered at 90% after deductible*	
	Outpatient surgical care	Covered at 90% after deductible*	
	Outpatient lab and X-ray	Covered at 90% after deductible*	
	Emergency room care	Covered at 90% after deductible*	
	Urgent care facility	Covered at 90% after deductible*	
<b>Your prescription drug expenses</b>	Retail	\$10 copay (generic), \$20 copay (brand name), \$40 copay (non-preferred brand) per prescription up to 30-day supply*	
	Mail order	\$20 copay (generic), \$40 copay (brand name), \$80 copay (non-preferred brand) per prescription up to 90-day supply*	
<b>Preventive care</b>	Routine physical and GYN exam	Covered at 100%, no deductible*	
	Routine vision exam	Covered at 100%, no deductible*	
	Well-child care and immunizations	Covered at 100%, no deductible*	
	Routine mammography	Covered at 100%, no deductible*	
<b>Mental health</b>	Inpatient	Covered at 90% after deductible. Limit 30 days per year*	
	Outpatient	Covered at 90% after deductible. Limit 20 visits per calendar year*	
<b>Substance abuse</b>	Inpatient detoxification	Covered at 90% after deductible. Unlimited days*	
	Inpatient rehabilitation	Covered at 90% after deductible. Limit 30 days per calendar year*	
	Outpatient detoxification	Covered at 90% after deductible. Unlimited visits*	
	Outpatient rehabilitation	Covered at 90% after deductible. Limit 20 visits per calendar year*	
<b>Other professional care</b>	Outpatient physical/speech/occupational therapy	Covered at 90% after deductible. Limit 20 visits per therapy per calendar year*	
	Chiropractic care	Covered at 90% after deductible. Limit 20 visits per calendar year*	
	Infertility	Diagnosis/Treatment: Covered at 50% after deductible within plan guidelines. Contact plan for details*	
<b>Out-of-network coverage</b>	Out-of-network non-emergency care	Not covered	
<b>Key facts</b>	NCQA status:	Excellent	Domestic partner coverage available: Yes
	PCP referral required for specialist:	Yes	Domestic partner children coverage avail.: Yes
	Lifetime maximum benefit:	NA	
	Provider network:	See website for details	

\* Indicates a benefit change

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions.