

		In-Network Coverage		
Plan facts	Member services Member services hours Web address Product name	(888) 865-5813 Mon-Fri: 7:00 AM-9:00 PM; Sat-Sun: 8:00 AM-2:00 PM ET http://my.kp.org/citigroup Kaiser Permanente of Georgia HMO Product	Annual enrollment information:	(888) 865-5813
Your medical expenses	Annual deductible Out-of-pocket maximum (includes deductible) Office visits Maternity care prenatal office visits Inpatient hospitalization Outpatient surgical care Outpatient lab and X-ray Emergency room care Urgent care facility	\$500 (individual) / \$1,000 (family max) \$3,000 (individual) / \$6,000 (family max) per calendar year Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible \$100 copay/visit (waived if admitted) Covered at 90% after deductible		
Your prescription drug expenses	Retail	\$10 copay (generic), \$20 copay (preferred brand), \$40 copay (non-preferred brand) per prescription up to 30-day supply at Kaiser Pharmacy \$16 copay (generic), \$26 copay (preferred brand), \$46 copay (non-preferred brand) per prescription up to 30-day supply at participating community pharmacy*		
	Mail order	\$20 copay (generic), \$40 copay (preferred brand name), \$80 copay (non-preferred brand name) per prescription up to 90-day supply		
Preventive care	Routine physical and GYN exam Routine vision exam Well-child care and immunizations Routine mammography	Covered at 100%, no deductible. Limit 1 visit per year* Covered at 100%, no deductible. Services provided by optometrist covered at 90% after deductible Covered at 100%, no deductible (Through age 24 months)* Covered at 100%, no deductible. Limits apply per Plan guidelines		
Mental health	Inpatient Outpatient	Covered at 90% after deductible Covered at 90% after deductible		
Substance abuse	Inpatient detoxification Inpatient rehabilitation Outpatient detoxification Outpatient rehabilitation	Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible		
Other professional care	Outpatient physical/speech/occupational therapy Chiropractic care Infertility	Covered at 90% after deductible. Limit 20 visits per therapy per calendar year Covered at 90% after deductible. Limit 20 visits per year Diagnosis/Treatment/Artificial Insemination: Covered at 50% within plan guidelines. In-vitro fertilization not covered. Contact Plan for details*		
Out-of-network coverage	Out-of-network non-emergency care	Not covered		
Key facts	NCQA status: PCP referral required for specialist: Lifetime maximum benefit: Provider network:	Excellent Yes NA See website for details	Domestic partner coverage available: Domestic partner children coverage available:	Yes Yes

* Indicates a benefit change

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