Kaiser FHP of Georgia

State: GA

citi **Benefits 2012**

		In-Network Coverage		
Plan facts	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 Permanente of Georgia HMO Product		
Your medical expenses	Annual deductible	$500 (individual) / $1,000 (family max)		
	Out-of-pocket maximum (includes deductible)	$3,000 (individual) / $6,000 (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	$100 copay/visit (waived if admitted)		
	Urgent care facility	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 $20 copay (generic), $30 copay (preferred brand, $50 copay (non-preferred brand) per prescription up to 30-day supply at participating		
	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	Covered at 100%, no deductible. Limit 1 visit per year		
	Routine vision exam	Covered at 100%, no deductible. Services provided by optometrist covered at 90% after deductible		
	Well-child care and immunizations	Covered at 100%, no deductible (Through age 24 months)		
	Routine mammography	Covered at 100%, no deductible. Limits apply per Plan guidelines		
Mental health	Inpatient	Covered at 90% after deductible		
	Outpatient	Covered at 90% after deductible		
Substance abuse	Inpatient detoxification	Covered at 90% after deductible		
	Inpatient rehabilitation	Covered at 90% after deductible		
	Outpatient detoxification	Covered at 90% after deductible		
	Outpatient rehabilitation	Covered at 90% after deductible		
Other professional care	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 year		
	Infertility	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:	Excellent	Domestic partner coverage available:	Yes
	PCP referral required for specialist:	Yes	Domestic partner children coverage available:	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.