KAISER PERMANENTE®

Philips North America LLC – Current

Georgia
HMO
Group Number 5167

Effective Dates: January 1, 2018 - December 31, 2018

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	$1,500 / $3,000
Office Visits (Outpatient)	
Primary Care	$25 copay
Specialty Care	$25 copay
Preventive Care	100% covered after applicable copay
Scheduled Prenatal Visits and 1st Postpartum Visit	100% covered for routine care
Well-Baby Care (through age 5)	Covered 100% through age 5
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	$25 copay
Lab and X-Ray	
Laboratory	100% covered in office; $25 copay in hospital setting
X-Ray	100% covered in office; $25 copay in hospital setting
MRI/CT/PET/Nuclear Medicine	$25 copay in office; $25 copay in hospital setting, per procedure
Emergency Care	
Ambulance (Ground or Air)	Plan pays 100% (per trip)
Emergency Room	$25 copay; waived if admitted
Urgent Care	$25 copay; at designated facilities
Hospital Care (Inpatient)	
Inpatient	$500 copay
Delivery and Inpatient Baby Care	$500 copay

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)	$25 copay, unlimited visits per year
Mental Health Outpatient (Group)	$12 copay, unlimited visits per year
Mental Health Inpatient	$500 copay, unlimited days per year
Chemical Dependency Outpatient (Individual)	$25 copay, unlimited visits per year
Chemical Dependency Outpatient (Group)	$25 copay, unlimited visits per year
Chemical Dependency Inpatient	$500 copay, unlimited days per year
Prescription Drugs	
Pharmacy/Retail: Generic	$10 copay at Kaiser Permanente Pharmacies & $20 copay at Network Pharmacies for a 30 day supply. Network pharmacies limited to a one-time fill per medication
Pharmacy/Retail: Brand	$30 copay at Kaiser Permanente Pharmacies & $40 copay at Network Pharmacies for a 30 day supply. Network pharmacies limited to a one-time fill per medication
Pharmacy/Retail: Day Supply	30 Day Supply
Mail Order - Generic	$20 copay through Kaiser Permanente Pharmacies only
Mail Order - Brand	$60 copay through Kaiser Permanente Pharmacies only
Mail Order - Day Supply	90 Day Supply
Other	
Skilled Nursing Facility (SNF)	100% covered, up to 100 days per calendar year
Infertility Services	50% covered for treatment and reproductive diagnostic testing
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 100%
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 Customer Service 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 Customer Service at (404)261-2590.

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