KAISER PERMANENTE®

McLane Company, Inc.

Georgia
DHMO
$1,000 Deductible / 20% Coinsurance
$20/$20 OV

Effective Dates: January 1, 2023 - December 31, 2023

General Information	
Website:	www.kp.org\georgia
Member Services: (Eligibility, Coverage Verification & General Questions)	(404) 261-2590 locally: (888) 865-5813 toll-free Monday-Friday 7:00 a.m. to 7:00 p.m.
Health Line:	(404) 365-0966 locally: (800) 611-1811 toll-free
• Appointment Scheduling or Prescription Help:	Monday-Friday 7:00 a.m. to 7:00 p.m.
• Nurse Advice:	24 hours a day, 7 days a week
Lifetime Benefit Maximum	None
Coinsurance	20% after deductible
Annual Deductible: Individual/Family	$1,000 / $2,000
Annual Out-of-Pocket Max: Individual/Family	$3,000 / $6,000
Office Visits (Outpatient)	
Primary Care	$20 copay
Specialty Care	$20 copay
Preventive Care	No charge
Scheduled Prenatal Visits and 1st Postpartum Visit	No charge for routine care
Well-Baby Care (through age 5)	No charge
Vision Exam	No charge, includes refractions
Physical, Occupational, Speech Therapy	$20 copay after deductible (PT/OT limited to 20 visits combined per cal yr; ST limited to 20 visits per calendar year)
Outpatient/Ambulatory Surgery	20% after deductible
Lab and X-Ray	
Laboratory	$10 copay after deductible regardless of setting
X-Ray	$10 copay after deductible regardless of setting
MRI/CT/PET/Nuclear Medicine	$50 copay after deductible regardless of setting
Emergency Care	
Ambulance (Ground or Air)	$150 copay after deductible, per trip
Emergency Room	20% after deductible, per visit
Urgent Care	$20 copay; at designated facilities
Inpatient Services	
Hospital Facility, Physician & other Professional Charges	20% after deductible
Delivery and Inpatient Baby Care	20% after deductible

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Mental Health and Chemical Dependency	
Mental Health Outpatient (Individual)	$20 copay, unlimited visits per calendar year
Mental Health Outpatient (Group)	$10 copay, unlimited visits per calendar year
Mental Health Inpatient	20% after deductible, unlimited days per calendar
Chemical Dependency Outpatient (Individual)	year $20 copay, unlimited visits per calendar
Chemical Dependency Outpatient (Group)	year $5 copay, unlimited visits per calendar year
Chemical Dependency Inpatient	20% after deductible, unlimited days per calendar year
Prescription Drug Annual Deductible	None
Pharmacy/Retail: Generic	$10 copay at KP Pharmacies & $20 copay at Network Pharmacies for 1x fill*
Pharmacy/Retail: Preferred Brand	$30 copay at KP Pharmacies & $40 copay at Network Pharmacies for 1x fill*
Pharmacy/Retail: Specialty	$30 copay at KP Pharmacies & $40 copay at Network Pharmacies for 1x fill*
Pharmacy/Retail: Day Supply	30-Day Supply
Mail Order: Generic	$20 copay through Kaiser Permanente Pharmacies only
Mail Order: Preferred Brand	$60 copay through Kaiser Permanente Pharmacies only
Mail Order: Specialty	$60 copay through Kaiser Permanente Pharmacies only
Mail Order: Day Supply	90-Day Supply
Other	
Skilled Nursing Facility (SNF)	20% after deductible, up to 100 days per calendar year
Hospice Care	No charge
Home Health Care	No charge, up to 100 visits per calendar year. Private Duty Nursing is not covered.
Durable Medical Equipment (DME)	20% (deductible doesn't apply), unlimited
Infertility Services	$20 copay in office for Diagnosis only. Treatment & Drugs are covered at 50% (no deductible applies)
Chiropractic Care	$20 copay, up to 20 visits per calendar year

Notes

**Members have the option to get their initial prescriptions filled at one of our network pharmacies like Rite Aid and Walgreens at a higher copay. Subsequent refills will be available only through Kaiser Permanente Pharmacies, either at our facilities or through our mail order/home delivery option.*