

PLANS & BENEFITS

Use this brochure to compare plans
and choose the one that's best for you.

Nine Piedmont Center
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Atlanta, GA 30305
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Benefit highlights

	HMO				
	Premier	Plan 500	Plan 1000	Plan 2000	Plan 3000
Features					
Annual deductible (individual/family)	None	\$500/\$1,500	\$1,000/\$3,000	\$2,000/\$6,000	\$3,000/\$9,000
Annual out-of-pocket maximum (individual/family)	None	\$2,000/\$6,000			
Lifetime benefit maximum	Unlimited				
Benefits					
Benefits with copays not subject to deductible/Benefits with coinsurance subject to deductible					
Preventive care (not subject to deductible—office visit copay may apply)					
Immunizations	No charge				
Well-child visit (to age 2)	No charge				
Certain preventive screenings	No charge				
Mammogram	No charge				
Outpatient services (per visit or procedure)					
Primary care office visit	\$30 copay				
Specialist office visit	\$50 copay				
Most X-rays and lab tests	No charge				
MRI, CT, and PET	\$100 copay	30% coinsurance			
Outpatient surgery	\$100 copay	30% coinsurance			
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, and medication	\$500 per admission	30% coinsurance			
Maternity (other charges will apply for professional services)					
Obstetrician/Midwife	\$1,000 copay				
Hospital delivery	\$2,000 copay				
Emergency and urgent care					
Emergency Room visit (waived if admitted)	\$150 copay				
After-hours visit	\$60 copay				
Ambulance service	\$150 copay				
Prescription drugs					
Pharmacy deductible (individual/family)	\$200/\$600				
Generic drugs (Kaiser Permanente pharmacy/network pharmacy)	\$15 copay/\$21 copay (after pharmacy deductible)				
Brand drugs (Kaiser Permanente pharmacy/network pharmacy)	\$30 copay/\$36 copay (after pharmacy deductible)				
Other services					
Vision exam	\$50 copay				

Have a question? We have answers. Call your broker today!

	BALANCE (individual subscriber only)				
Plan 5000	Balance 2000	Balance 3000	Balance 5000	Balance 7500	Balance 10000
\$5,000/\$15,000	\$2,000	\$3,000	\$5,000	\$7,500	\$10,000
	\$5,000	\$6,000		\$10,000	
			\$3 million		
Benefits with copays not subject to deductible/Benefits with coinsurance subject to deductible					
			No charge		
			No charge		
			No charge		
			No charge		
			\$40 copay		
			\$50 copay		
			30% coinsurance		
			30% coinsurance		
			30% coinsurance		
			30% coinsurance		
			Not covered		
			Not covered		
			\$150 copay		
			\$60 copay		
			\$150 copay		
\$500/\$1,500			\$500 (brand drugs only)		
			\$20 copay/\$30 copay		
			\$40 copay/\$50 copay (after pharmacy deductible)		
			No coverage		

This plan summary is intended to only highlight some of the principal provisions of our plans. Please refer to your *Evidence of Coverage* for more details of your plan or for specific limitations and exclusions. Certain underwriting guidelines apply. Applicants are subject to medical review.

NOW PLUS

Now Premier Plus	Now 500 Plus	Now 1000 Plus	Now 2000 Plus	Now 4000 Plus	Now 6000 Plus	Now 10000 Plus
None	\$500/\$1,500	\$1,000/\$3,000	\$2,000/\$6,000	\$4,000/\$12,000	\$6,000/\$18,000	\$10,000/\$30,000
None	\$2,000/\$6,000		\$5,000/\$9,000			
Unlimited	\$6 million					
Benefits with copays not subject to deductible/Benefits with coinsurance subject to deductible						
No charge						
No charge						
No charge						
No charge						
Kaiser Permanente medical centers/non-Kaiser Permanente facilities						
\$30 copay	\$40 copay					
\$50 copay	\$60 copay					
No charge/\$100 copay	No charge/30% coinsurance					
\$50 copay/\$100 copay	30% coinsurance					
\$100 copay	30% coinsurance					
\$500 copay per admission	30% coinsurance					
\$1,000 copay	\$1,500 copay					
\$2,000 copay	\$3,000 copay					
\$150 copay	\$250 copay					
\$60 copay	\$70 copay					
\$150 copay	\$250 copay					
\$200/\$600 (brand drugs only)	\$300/\$600 (brand drugs only)					
\$15 copay/\$21 copay						
\$40 copay/\$46 copay (after pharmacy deductible)						
\$50 copay	\$60 copay					

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Benefit highlights

	NOW			
	Now 2000	Now 4000	Now 6000	Now 10000
Features				
Annual deductible (individual/family)	\$2,000/\$6,000	\$4,000/\$12,000	\$6,000/\$18,000	\$10,000/\$30,000
Annual out-of-pocket maximum (individual/family)	\$5,000/\$9,000			
Lifetime benefit maximum	\$6 million			
Benefits				
Benefits with copays not subject to deductible Benefits with coinsurance subject to deductible				
Preventive care (not subject to deductible—office visit copay may apply)				
Immunizations	No charge			
Well-child visit (to age 2)	No charge			
Certain preventive screenings	No charge			
Mammogram	No charge			
Outpatient services (per visit or procedure)				
Kaiser Permanente medical centers/non-Kaiser Permanente facilities				
Primary care office visit	\$40 copay			
Specialist office visit	\$60 copay			
Most X-rays and lab tests	No charge/30% coinsurance			
MRI, CT, and PET	30% coinsurance			
Outpatient surgery	30% coinsurance			
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, and medication	30% coinsurance			
Maternity (other charges will apply for professional services)				
Obstetrician/Midwife	\$1,500 copay			
Hospital delivery	\$3,000 copay			
Emergency and urgent care				
Emergency Room visit (waived if admitted)	\$250 copay			
After-hours visit	\$70 copay			
Ambulance service	\$250 copay			
Prescription drugs				
Generic/Brand drugs	Not covered			
Other services				
Vision exam	\$60 copay			

This plan summary is intended to only highlight some of the principal provisions of our plans. Please refer to your *Evidence of Coverage* for more details of your plan or for specific limitations and exclusions. Certain underwriting guidelines apply. Applicants are subject to medical review.

HMO WITH HSA OPTION PLANS FOR INDIVIDUALS			
	HSA Option 3500/100% Self	HSA Option 5000/100% Self	HSA Option 3500/80% Self
Features			
Annual deductible	\$3,500	\$5,000	\$3,500
Annual out-of-pocket maximum	\$3,500	\$5,000	\$5,000
Lifetime benefit maximum	None		
Benefits			
Benefits with copays not subject to deductible Benefits with coinsurance subject to deductible			
Preventive care (not subject to deductible)			
Preventive care visit	\$15 office visit copay		
Preventive care services	No charge (office visit copay may apply)		
All other covered services			
Coinsurance	No charge (after deductible)		20% coinsurance (after deductible)

HMO WITH HSA OPTION PLANS FOR FAMILIES (2+)				
	HSA Option 3500/100% Family	HSA Option 5000/100% Family	HSA Option 3500/80% Family	HSA Option 5000/80% Family
Features				
Annual deductible	\$3,500	\$5,000	\$3,500	\$5,000
Annual out-of-pocket maximum	\$3,500	\$5,000	\$7,500	\$9,000
Lifetime benefit maximum	None			
Benefits				
Benefits with copays not subject to deductible Benefits with coinsurance subject to deductible				
Preventive care (not subject to deductible)				
Preventive care visit	\$15 office visit copay			
Preventive care services	No charge (office visit copay may apply)			
All other covered services				
Coinsurance	No charge (after deductible)		20% coinsurance (after deductible)	

BALANCE HSA		
	Balance HSA 1200	Balance HSA 2000
Features		
Annual deductible	\$1,200	\$2,000
Annual out-of-pocket maximum	\$1,200	\$4,000
Lifetime benefit maximum	\$3 million	
Benefits		
Benefits with copays not subject to deductible Benefits with coinsurance subject to deductible		
Preventive care (not subject to deductible)		
Preventive care visit	\$15 office visit copay	
Preventive care services	No charge (office visit copay may apply)	
All other covered services		
Coinsurance	No charge (after deductible)	20% coinsurance (after deductible)