



2010 Out-of-Area PPO Plans

Spreading cost effective, quality health care.

With a growing portfolio of competitive group products and plans, Kaiser Permanente has more options to meet your health care needs.

The Kaiser Permanente Insurance Company (KPIC) Out-of-Area PPO Plans* provide coverage for employees who reside outside the Kaiser Permanente Georgia Service Area.**

Under these plans, employees have the flexibility to receive medical care from Participating Providers (PHCS network)***, or from any licensed Non-participating Provider.

Out-of-area PPO Plans give your employees access to health care while also giving them the freedom to choose their own provider and control their out-of-pocket costs. Usually, their out-of-pocket costs are lower when they receive care from a Participating Provider.

** The Out-of-Area PPO Benefits are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP).*

*** The Service Area includes Barrow, Bartow, Bibb, Bleckley, Bryan, Bulloch, Butts, Carroll, Chatham, Chattahoochee, Cherokee, Clarke, Clayton, Cobb, Coweta, Crawford, Dawson, DeKalb, Douglas, Effingham, Evans, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Harris, Heard, Henry, Houston, Jones, Lamar, Laurens, Liberty, Madison, Marion, Meriwether, Monroe, Muscogee, Newton, Oconee, Oglethorpe, Paulding, Peach, Pickens, Pike, Pulaski, Rockdale, Spalding, Twiggs, and Walton counties.*

**** Kaiser Permanente Insurance Company (KPIC) has contracted with PHCS to provide access to hospitals and physicians with a commitment to keeping out-of-pocket costs low through contracted rates.*

Deductible (Individual/Family)^{1,2}

Coinsurance Out-of-Pocket Max (Individual/Family)^{1,2}

Maximum Benefit while covered

Coinsurance

Office Visits

- Primary Care³ (including lab and radiology)
- Speciality Care³ (including lab and radiology)
- High Tech Radiology Services (CT, MRI, PET, Others)
- Preventive Services⁴
- Maternity (obstetrician / midwife)³

Outpatient Services

- High Tech Radiology Services (CT, MRI, PET, Others)
- Physical and Occupational Therapy⁵– 20 visits per calendar year
- Outpatient Hospital or Surgical Facility
- Physician and Other Professional Charges

Emergency Services

- Emergency Room Visits (per visit, waived if admitted)
- Urgent Care (per visit)
- Ambulance (per trip)

Inpatient Services[†]

- Hospital (facility charge)
- Physician and Other Professional Charges

Mental Health Services

- Outpatient Mental Health⁵– 20 visits per calendar year
- Inpatient Mental Health Facility⁶– 30 days per calendar year
- Inpatient Mental Health Professional

Pharmacy Services

- Generic Drugs
- Brand Preferred Drugs
- Brand Non-Preferred Drugs
- Brand Rx Deductible⁷ (Not applicable to Generic Drugs)

Other Services

- DME / Prosthetics and Orthotics

- Vision Exam
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PLAN A **PLAN B** **PLAN C**

Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
\$500 / \$1,500	\$1,000 / \$3,000	\$500 / \$1,500	\$1,000 / \$3,000	\$1,000 / \$3,000	\$2,000 / \$6,000
\$2,000 / \$6,000	\$4,000 / \$12,000	\$2,000 / \$6,000	\$4,000 / \$12,000	\$2,000 / \$6,000	\$4,000 / \$12,000
\$2,000,000 Combined		\$2,000,000 Combined		\$2,000,000 Combined	
Plan pays 90% (after deductible)	Plan pays 60% (after deductible)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
\$15 copay	Plan pays 60%	\$20 copay	Plan pays 60%	\$20 copay	Plan pays 60%
\$25 copay	Plan pays 60%	\$30 copay	Plan pays 60%	\$30 copay	Plan pays 60%
Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 100%	Plan pays 60%	Plan pays 100%	Plan pays 60%	Plan pays 100%	Plan pays 60%
Plan pays 100%	Plan pays 60%	Plan pays 100%	Plan pays 60%	Plan pays 100%	Plan pays 60%
Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay
\$30 copay	Plan pays 60%	\$40 copay	Plan pays 60%	\$40 copay	Plan pays 60%
\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay
Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
\$25 copay	Plan pays 60%	\$30 copay	Plan pays 60%	\$30 copay	Plan pays 60%
Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
\$15 copay	Plan pays 60%	\$15 copay	Plan pays 60%	\$15 copay	Plan pays 60%
\$35 copay	Plan pays 60%	\$35 copay	Plan pays 60%	\$35 copay	Plan pays 60%
\$55 copay	Plan pays 60%	\$55 copay	Plan pays 60%	\$55 copay	Plan pays 60%
\$50 single/\$150 family		\$150 single/\$450 family		\$150 single/\$450 family	
Plan pays 60%	Plan pays 60%	Plan pays 60%	Plan pays 60%	Plan pays 60%	Plan pays 60%
Limited to a Combined \$5,000 Benefit Maximum per Calendar Year		Limited to a Combined \$5,000 Benefit Maximum per Calendar Year		Limited to a Combined \$5,000 Benefit Maximum per Calendar Year	
\$25 copay	Plan pays 60%	\$30 copay	Plan pays 60%	\$30 copay	Plan pays 60%

This plan summary is intended to only highlight some of the principal provisions of the plan. Please refer to the Group Agreement or Certificate of Insurance for further details of the plan or for specific limitations and exclusions.

PLAN D

PLAN E

Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
\$2,000 / \$6,000	\$4,000 / \$12,000	\$3,000 / \$9,000	\$5,000 / \$15,000
\$2,000 / \$6,000	\$4,000 / \$12,000	\$4,000 / \$12,000	\$8,000 / \$24,000
\$2,000,000 Combined		\$2,000,000 Combined	
Plan pays 80% (after deductible)	Plan pays 60% (after deductible)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
\$25 copay	Plan pays 60%	\$30 copay	Plan pays 60%
\$35 copay	Plan pays 60%	\$40 copay	Plan pays 60%
Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 100%	Plan pays 60%	Plan pays 100%	Plan pays 60%
Plan pays 100%	Plan pays 60%	Plan pays 100%	Plan pays 60%
Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
\$100 copay	\$100 copay	\$100 copay	\$100 copay
\$50 copay	Plan pays 60%	\$60 copay	Plan pays 60%
\$100 copay	\$100 copay	\$100 copay	\$100 copay
Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
\$35 copay	Plan pays 60%	\$40 copay	Plan pays 60%
Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
\$15 copay	Plan pays 60%	\$15 copay	Plan pays 60%
\$35 copay	Plan pays 60%	\$35 copay	Plan pays 60%
\$55 copay	Plan pays 60%	\$55 copay	Plan pays 60%
\$150 single/\$450 family		\$200 single/\$600 family	
Plan pays 60%	Plan pays 60%	Plan pays 60%	Plan pays 60%
Limited to a Combined \$5,000 Benefit Maximum per Calendar Year		Limited to a Combined \$5,000 Benefit Maximum per Calendar Year	
\$35 copay	Plan pays 60%	\$40 copay	Plan pays 60%

For more information

For more information about our Out-of-Area PPO plans, you can call your broker or use one of the following resources:

Broker Sales:
(404) 364-7105

Benefits and claims:
(404) 261-2590
1-888-865-5813

Pharmacy (MedImpact Pharmacy Help Desk):
1-800-788-2949

MedImpact.com

Provider Listings (PHCS):
1-888-541-7427

phcs.com

Billing: 1-866-238-2262

Customer Account Services:
kp.org/ouremployers

Take another look at Kaiser Permanente.

For a complete understanding of benefits, please read this brochure in conjunction with the Kaiser Permanente Insurance Company *Certificate of Insurance*, which contains a complete explanation of benefits, exclusions, and limitations. The information provided in this brochure is not intended for use as a Summary Plan Description, nor is it designed to serve as the *Certificate of Insurance*.

Footnotes

- ¹ Deductibles do not count toward satisfying the Out-of-Pocket Maximum.
- ² Covered charges applied to satisfy the Deductible or Out-of-Pocket Maximum at the Participating Provider level will not be applied towards satisfaction of the Deductible or Out-of-Pocket Maximum at the Non-participating Provider level. However, covered charges applied to satisfy the Deductible and Out-of-Pocket Maximum at the Non-participating Provider level will be applied towards satisfaction of the Deductible and Out-of-Pocket Maximum at the Participating Provider level.
- ³ Services to be included as part of the Office Visit copay: Preventive Services, immunizations, injection administration, lab tests routinely provided in office, basic in-office ultrasound (heart beat checks; not full 20 week ultrasound) medical supplies incident to the visit.
- ⁴ Preventive Services (to be included in office visit copay): annual Pap test, annual prostate specific antigen (PSA), annual mammogram, blood glucose test every 3 years, cholesterol screening every 5 years, chlamydia screening annually, fecal occult blood test annually.
- ⁵ Limited to a combined Benefit Maximum of 20 visits per Calendar Year.
- ⁶ Limited to a combined Benefit Maximum of 30 days per Calendar Year.
- ⁷ Plans A, B, C, and D can be offered without a Pharmacy Deductible.

†Preauthorization of Services

Preauthorization is required for all hospital confinements, including preadmission testing, inpatient care at a skilled nursing facility, or other licensed, freestanding facilities, such as hospice care, home health care, or care at rehabilitation facility, and select outpatient procedures. If preauthorization is not obtained when required, or obtained but not followed, all Covered Charges in connection with the treatment or service will be reduced by a preauthorization penalty. For a copy of the preauthorization brochure, contact your broker.

Exclusions and Limitations

Unless specifically covered under the Group Policy or in the Certificate of Insurance, expenses incurred in connection with the following services are excluded: Charges, services, or care that are not medically necessary; in excess of the Maximum Allowable Charge; not available in the United States; or for personal comfort. Charges for nonemergency care in emergency care setting or charges for non-emergency weekend (Friday through Sunday) hospital admissions. Charges arising from work or that can be covered under workers' compensation or any similar law, or for which the Group Policy holder or Covered Person is required by law to maintain alternative insurance or coverage. Charges for military services related conditions or where care is provided at government expense. Services or care provided in a Covered Person's home, by a family member, or by a resident of the household. Dental care or orthodontia, including surgery on the jawbone, unless due to injury to natural teeth. Cosmetic services; plastic surgery; sex transformation; sexual dysfunction; surrogacy arrangements; biotechnology drugs or diagnostic; nonprescription drugs or medicines; drugs and medicine for smoking cessation; treatment, procedures, or drugs KPIC determines to be experimental or investigational. Education, counseling, therapy, or care for learning deficiencies or behavioral problems. Services, care, or treatment of or in connection with: obesity; weight management; musculoskeletal therapy; health education; biofeedback; hypnotherapy; medical social services; hearing aids or therapy; radial keratotomy or similar procedures; reversal of sterilization; or routine foot care. Services or care required by a court of law or for insurance, travel, employment, school, camp, government licensing, or similar purposes. Custodial care; care in an intermediate care facility; maintaining therapy for rehabilitation; or living or transportation expenses. Services of a private-duty nurse. Vision care, eye refractions, glasses, contact lenses, or fittings (unless provided under Optional Vision Care Benefit), orthoptics.

Important information: Written information on topics related to coverage offered to employer groups in the small group market is available and can be obtained by calling **(404) 364-7105**. Topics include:

- 1)** Factors that affect rate setting and rate adjustments.
- 2)** Provisions related to renewing coverage.
- 3)** Plan designs and premiums available to small groups.

Note: Kaiser Permanente group plans do not include a pre-existing condition clause.