

Dekalb County

Effective Dates: July 1, 2022 – June 30, 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
<ul style="list-style-type: none"> ● Appointment Scheduling or Prescription Help: ● Nurse Advice: 	Monday-Friday 7:00 a.m. to 7:00 p.m. 24 hours a day, 7 days a week
Lifetime Benefit Maximum	None
Coinsurance	30% after deductible
Annual Deductible:	
If you enroll in the Self Only Plan	\$1,800
If you enroll in the Family Plan	\$5,400
Annual Out-of-Pocket Max:	
If you enroll in the Self Only Plan	\$6,000
If you enroll in the Family Plan	\$12,000
Office Visits (Outpatient)	
Primary Care	30% after deductible
Specialty Care	30% after deductible
Preventive Care	No charge (No annual deductible)
Well-Baby Care (through age 5)	No charge (No annual deductible)
Vision Exam	30% after deductible, includes refractions
Physical, Occupational, Speech Therapy	30% after deductible (PT/OT limited to 20 visits combined per cal yr; ST limited to 20 visits per calendar year)
Outpatient/Ambulatory Surgery	30% after deductible
Lab and X-Ray	
Laboratory/X-Ray	30% after deductible
MRI/CT/PET/Nuclear Medicine	30% after deductible
Emergency Care	
Ambulance (Ground or Air), per trip	30% after deductible
Emergency Room, per visit	30% after deductible
Urgent Care, per visit	30% after deductible; at designated facilities
Inpatient Services	
Hospital Facility, Physician & other Professional Charges	30% after deductible
Delivery and Inpatient Baby Care	30% after deductible

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Mental Health and Chemical Dependency	
Mental Health Outpatient (Individual)	30% after deductible, unlimited visits per calendar year
Mental Health Outpatient (Group)	30% after deductible, unlimited visits per calendar year
Mental Health Inpatient	30% after deductible, unlimited days per calendar year
Chemical Dependency Outpatient (Individual)	30% after deductible, unlimited visits per calendar year
Chemical Dependency Outpatient (Group)	30% after deductible, unlimited visits per calendar year
Chemical Dependency Inpatient	30% after deductible, unlimited days per calendar year
Prescription Drugs	
Prescription Drug Annual Deductible	Same as annual deductible
Pharmacy/Retail: Generic	\$15 at KP/ \$25 at Network Pharmacy after deductible
Pharmacy/Retail: Preferred Brand	30% after deductible (\$100 max at KP)
Pharmacy/Retail: Non-Preferred	40% after deductible (\$180 max at KP)
Pharmacy/Retail: Specialty	40% after deductible (\$180 max at KP)
Mail Order: Generic	2x copay
Mail Order: Preferred Brand	2x copay
Mail Order: Specialty	2x copay
Mail Order: Day Supply	90-Day Supply
Other	
Skilled Nursing Facility	30% after deductible, up to 100 days per calendar year
Hospice Care	30% after deductible
Home Health Care	30% after deductible, up to 100 visits per calendar year. Private Duty Nursing is not covered.
Infertility Treatment	30% after deductible
Durable Medical Equipment	30% after deductible, unlimited
Prosthetic & Orthotic	30% after deductible
Chiropractic & Acupuncture Care	30% after deductible, up to 30 visits per therapy per calendar year
Hearing aids	No benefit
Notes	