

For the plan year beginning on January 01, 2007 and ending on December 31, 2007.

## HMO C

Deductible Individual / Family	\$250/\$750
Coinsurance Max Individual / Family	\$2,000 / \$6,000
Maximum Benefit While Covered	Unlimited <sup>1</sup>
Coinsurance	Plan Pays 90%
<b>Benefits</b>	<b>You Pay</b>
<b>Office Services</b>	
Primary Care	\$20 copay
Specialty Care	\$30 copay
Special Procedures(Cardiac Stress Test, EMG Others)	Plan Pays 90%
Preventive Services	Plan Pays 100% <sup>2</sup>
Maternity (obstetrician/midwife)	Plan Pays 100%
<b>Outpatient Services</b>	
Laboratory Services	Plan Pays 90%
Radiology Services	Plan Pays 90%
High Tech Radiology Services(MRI, CT, PET, others)	Plan Pays 90%
Physical and Occupational Therapy, up to 20 visits per year	Plan Pays 90%
Outpatient Hospital or Surgical Facility	Plan Pays 90%
Physician and Other Professional Charges	Plan Pays 90%
<b>Emergency Services</b>	
Emergency Services (per visit; waived if admitted)	\$100 copay
After-Hours Urgent Care (per visit)	\$40 copay
Ambulance (per trip)	\$100 copay
<b>Inpatient Services</b>	
Hospital (facility charge)	Plan Pays 90%
Physician and Other Professional Charges	Plan Pays 90%
<b>Mental Health Services</b>	
Outpatient Mental Health (20 visits per calendar year)	\$30 copay
Inpatient Mental Health Facility (30 days per calendar year)	Plan Pays 90%
Inpatient Mental Health Professional	Plan Pays 90%

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<p><b>Pharmacy Services (30-day supply)</b></p> <p>Mail Order Pharmacy</p> <p>Generic Drugs</p> <p>Brand Preferred Drugs</p> <p>Brand RX Deductible (Not applicable to Generic Drugs)</p>	<p>Mail Order Available</p> <p>\$10 at Kaiser Permanente Pharmacies; \$16 Network Pharmacies</p> <p>\$20 at Kaiser Permanente Pharmacies; \$26 Network Pharmacies</p> <p>Not Applicable</p>
<p><b>Other Services</b></p> <p>Vision Exam</p> <p>DME / Prosthetics and Orthotics</p>	<p>\$30 copay</p> <p>Plan Pays 90%</p>
<p><b>PCP Selection</b></p> <p><b>Customer Service</b></p>	<p>If a PCP is not chosen upon enrollment, one will be assigned based upon the medical center closest to your home.</p> <p>404)261-2590 (888)865-5813 toll free</p> <p>Monday – Friday 8:30 a.m. until 9:00 p.m. Saturday, Sunday 8:00 a.m. until 2:00 p.m.</p>
<p><b>Referral</b></p>	<p>Self referral to Mental Health/Chemical Dependency, Dermatology, Ophthalmology, Optometry and OB/GYN Care. All Other specialty care services require a referral from your PCP.</p>

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### Additional Information

This is a summary of your benefits and their copayments. This is not a contract. Specific benefits, 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; Custodial or intermediate care; Services that an employer is required by law to provide; Experimental or investigational services; Eye surgery, such as laser surgery, to correct refractive defects; Services that a government agency is required by law to provide; Services for conditions arising from military service; Services related to the treatment of morbid obesity (except certain health education programs are covered); Routine foot care; Sexual reassignment services; Non-human or artificial organs or their implantation; Reversal of voluntary infertility; Transportation and lodging expenses; Conditions covered by workers' compensation or under employer liability law; Services not generally and customarily available in our service area.

In order for Services to be covered, a Plan Physician must determine that the Services are medically necessary to prevent, diagnose, or treat your medical condition. With the exception of emergency services, all covered Services must be provided, prescribed, authorized, or directed by a Plan Physician. You must receive the Services at a Plan Facility inside our Service Area, except where specifically noted to the contrary in the Evidence of Coverage. Certain covered services require pre-authorization by Medical Group.

We use a formulary, which is a listing of medications approved by our Pharmacy and Therapeutics Committee based on a number of factors, including safety and effectiveness as determined from a review of the medical literature and research. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary. For a copy of the formulary brochure or for more information about the exception process, contact Customer Service at (404)261-2590.

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.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you or those of your eligible dependents who later have that coverage terminated for a reason other than fraud, misrepresentation or non-payment, may at that time be able to enroll in this health plan, provided that you request enrollment within 30 days after the other coverage ends. We may require sufficient proof of that other coverage and the reason for its termination. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

<sup>1</sup>Some benefits may have limitations.

<sup>2</sup>Office visit copay may apply. Well-Child Visit: No Charge up to age 2.