

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

### Multi Choice Max Plan D

	<b>Select Providers (Tier 1)</b>	<b>PPO Providers (PHCS) (Tier 2)</b>	<b>Non-Participating Providers Tier 3)</b>
<b>Deductible Individual / Family</b>	\$750/\$2,250	\$1,000 / \$3,000	\$2,000 / \$6,000
<b>Coinsurance Max Individual / Family</b>	\$1,000 / \$3,000	\$2,000 / \$6,000	\$4,000 / \$12,000
Maximum Benefit While Covered	Unlimited <sup>1</sup>	\$2,000,000 Combined Maximum	
<b>Coinsurance</b>	Plan Pays 80% After Annual Deductible	Plan Pays 80% After Annual Deductible	Plan Pays 60% After Annual Deductible
<b>Benefits</b>			
<b>Office Services</b>			
Primary Care	\$25 copay	\$35 copay	Plan Pays 60%
Specialty Care	\$35 copay	\$45 copay	Plan Pays 60%
Special Procedures (Cardiac Stress Test, EMG Others)	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
Preventive Services	Plan Pays 100% <sup>2</sup>	Plan Pays 100%	Plan Pays 60% <sup>2</sup>
Maternity (obstetrician/midwife)	Plan Pays 100%	Plan Pays 100%	Plan Pays 60%
<b>Outpatient Services</b>			
Laboratory Services	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
Radiology Services	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
High Tech Radiology Services(MRI, CT, PET, others)	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
Physical and Occupational Therapy	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
	Up to 20 visits per year, combined across all tiers		
Outpatient Hospital or Surgical Facility	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
Physician and Other Professional Charges	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
<b>Emergency Services</b>			
Emergency Services (per visit; waived if admitted)	\$100 copay	\$100 copay	\$100 copay
After-Hours Urgent Care (per visit)	\$50 copay	\$70 copay	Plan Pays 60%
Ambulance (per trip1)	\$100 copay	\$100 copay	\$100 copay

*This plan summary is intended to only highlight some of the principle provisions of the plan. Please refer to the Group Agreement or Evidence of Coverage for further details of the plan or for specific limitations and exclusions.*

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<b>Inpatient Services</b>			
Hospital (facility charge)	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
Physician and Other Professional Charges	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
<b>Mental Health Services</b>			
Outpatient Mental Health	\$35 copay	\$45 copay	Plan Pays 60%
		Up to 20 visits per year, combined across all tiers	
Inpatient Mental Health	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
		Up to 30 days per year, combined across all tiers	
Inpatient Mental Health Professional	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
<b>Pharmacy Services</b>			
30-day supply		Mail Order available	
Generic Preferred Drugs	\$10 copay	\$15 copay <sup>3</sup>	\$15 copay <sup>3</sup>
Brand Preferred Drugs	\$20 copay	\$35 copay <sup>3</sup>	\$35 copay <sup>3</sup>
Non-Preferred Drugs	\$35 copay	\$50 copay <sup>3</sup>	\$50 copay <sup>3</sup>
Brand RX Pharmacy Deductible(Not Applicable to Generic Drugs)	Not Applicable	\$150	\$150
		Combined Deductible between PPO and Non-Participating Providers	
<b>Other Services</b>			
DME / Prosthetics and Orthotics	Plan Pays 80%	Plan Pays 80%	Plan Pays 60%
		Limited to \$250 annually combined	
Vision Exam	\$35 copay	\$45 copay	Plan Pays 60%
		Up to 30 days per year, combined across all tiers	
<b>PCP Selection</b>	If a PCP is not chosen upon enrollment, one will be assigned based upon the medical center closest to your home.		
<b>Customer Service</b>	(404) 261-2590 (888) 865-5813 toll free Monday - Friday 8:30 a.m. until 9:00 p.m. Saturday, Sunday 8:00 a.m. until 2:00 p.m.		

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## Multi Choice Max Plan D

	<b>PPO</b>
	<b>Select Providers (Tier 1)</b>
	<b>Providers (PHCS) (Tier 2)</b>
	<b>Non-Participating Providers Tier 3)</b>
<b>Self Referral for Select Provider Tier</b>	Self referral to Mental Health / Chemical Dependency, Dermatology, Ophthalmology, Optometry and OB / GYN. All other specialty care services require a referral from your Select Provider PCP.

### Additional Information

This is a summary of your benefits. 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.

We only cover Services that are medically necessary to prevent, diagnose, or treat your medical condition. Certain covered services require pre-authorization by Medical Group.

We use a formulary, which is a list of prescription drugs that have been 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. The Pharmacy and Therapeutics Committee meets several times each year to consider adding and removing prescription drugs on the drug formulary. For more information, 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 for KP Select Providers benefit level.

<sup>3</sup>\$5,000 Benefit Maximum per year for prescription drugs under PPO and Non-Participating Provider tiers combined.