

For the plan year beginning on January 01, 2008 and ending on December 31, 2008.

2008 Multi-Choice Max Plan D

	Select Providers (Tier 1)	PPO Providers (PHCS) (Tier 2)	Non-Participating Providers (Tier 3)
Deductible Individual / Family	\$750/\$2,250	\$1,000 / \$3,000	\$2,000 / \$6,000
Coinsurance Max Individual / Family	\$1,000 / \$3,000	\$2,000 / \$6,000	\$4,000 / \$12,000
Maximum Benefit While Covered	Unlimited ¹	\$2,000,000	\$2,000,000
Coinsurance	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Office Services			
Primary Care (including lab and radiology)	\$25 copay	\$35 copay	Plan Pays 60% after Annual Deductible
Specialty Care (including lab and radiology)	\$35 copay	\$45 copay	Plan Pays 60% after Annual Deductible
High Tech Radiology Services(MRI, CT, PET, others)	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Preventive Services	Plan Pays 100% ²	Plan Pays 100% ²	Plan Pays 60% after Annual Deductible
Maternity (obstetrician/midwife)	Plan Pays 100%	Plan Pays 100%	Plan Pays 60% after Annual Deductible
Outpatient Services			
High Tech Radiology Services(MRI, CT, PET, others)	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Physical and Occupational Therapy	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Outpatient Hospital or Surgical Facility (including lab and radiology)	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Physician and Other Professional Charges	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Emergency Services			

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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% after Annual Deductible
Ambulance (per trip)	\$100 copay	\$100 copay	\$100 copay
Inpatient Services			
Hospital (facility charge) - per admission	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Physician and Other Professional Charges	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Mental Health Services			
Outpatient Mental Health	\$35 copay	\$45 copay	Plan Pays 60% after Annual Deductible
Inpatient Mental Health	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Inpatient Mental Health Professional	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Pharmacy Services - 30 day supply			
Generic Preferred Drugs	\$10 copay	\$20 copay	\$20 copay
Brand Preferred Drugs	\$25 copay	\$40 copay	\$40 copay
Non-Preferred Drugs	\$40 copay	\$60 copay	\$60 copay
Brand RX Pharmacy Deductible(Not Applicable to Generic Drugs)	Not Applicable	\$150 single / \$450 family	\$150 single / \$450 family
Benefit Maximum	Not applicable	\$5,000	\$5,000
Other Services			
DME / Prosthetics and Orthotics	Plan Pays 80% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Vision Exam	\$35 copay	\$45 copay	Plan Pays 60% after Annual Deductible
PCP Selection	If a PCP is not chosen upon enrollment, one will be assigned based upon the medical center closest to your home.		

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Customer Service	(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.
Self Referral for Select Provider Tier	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; Eye surgery, such as laser surgery, to correct refractive defects; Services related to the treatment of morbid obesity; Reversal of voluntary infertility; Conditions covered by workers' compensation or under employer liability law; Certain covered services require pre-authorization by Medical Group. 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.

¹Some benefits may have limitations.

²Office visit copay may apply. Well-Child Visit: No Charge up to age 2 for KP Select Providers benefit level.