For **Oregon groups with 1–50** employees

MEDICAL PLANS OVERVIEW

For coverage effective on or after January 1, 2024

OREGON 2024

WHY CHOOSE KAISER PERMANENTE

Convenience

Scheduled and no-appointment-needed 24/7 phone and video visits, e-visits, 24/7 advice, and the ability for employees to email their doctor nonurgent questions on **kp.org** are convenient alternatives that offer high-quality care, comparable with an in-person visit.[1] To find all the ways to obtain care, visit **kp.org/getcare**.

Choice

Your employees have access to more than 1,250 Kaiser Permanente providers across Oregon and Southwest Washington, plus a network of providers and specialists, including primary and specialty care from The Portland Clinic.[2] Visit **kp.org/locations** for more information.

Value

Kaiser Permanente members can enjoy no-cost and discounted online apps, tools, classes, programs, and activities that can help keep your employees happy and healthy. Visit **kp.org/healthyliving** to learn more.

Quality

Kaiser Foundation Health Plan of the Northwest commercial plans tied for the highest rating in Oregon and Washington, according to the 2022-2023 Health Insurance Plan ratings from the National Committee for Quality Assurance (NCQA).[3]

Tools for employers: **account.kp.org**

With our online portal, **account.kp.org**, you have everything you need to take care of business in one place.

- Manage members by enrolling, terminating, and updating group membership.
- Make one-time premium payments, set up or manage recurring payments, and view payment history and transaction details.
- Manage email notification preferences for invoices and e-receipts.
- Download and save your group contracts online.

Tools for members: **kp.org and the Kaiser Permanente app**

Members have access to information and tools to better manage their health, so they can:

- Schedule, review, or cancel routine appointments
- Complete an e-visit, phone, or video visit
- Email their doctor
- Fill and refill most prescriptions
- View most test results and immunizations
- View their digital ID card
- Pay bills and see cost estimates

Give us a call or talk to your broker

We can answer your questions about medical coverage, eligibility, plan design, or renewal. Please contact us or your producer/broker if you would like a booklet with more details about our plans and options.

Toll free..... **1-800-813-2630**
TTY..... **711**
Language interpretation services.... **1-800-324-8010**
Fax..... **1-877-237-5548**

account.kp.org

[1,2,3]See page 29 for corresponding footnotes.

KAISER PERMANENTE®

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Small business tax credit

Qualified small employers who wish to claim the small business health care tax credit through the Oregon Health Insurance Marketplace must select a plan without buy-up coverage. Additionally, our Choice products are not qualified plans for this tax credit. The IRS Small Business Health Care Tax Credit helps qualified small businesses lower the cost of offering health insurance to employees. Small businesses in Oregon must also meet the minimum criteria to qualify for the tax credit, available on **Oregon.gov**.

Plan options

METAL TIER	Traditional	Deductible	HSA-qualified high deductible	Kaiser Permanente Plus™	Added Choice® point-of-service[1]
Platinum	KP OR Platinum 0/20	KP OR Platinum 250/20 KP OR Platinum 500/20		KP OR Platinum 0/20 KP Plus	KP OR Platinum 250/20 3T POS[2] KP OR Platinum 250/20 3T POS OOA[2]
Gold	KP OR Gold 0/30	KP OR Gold 1000/20 KP OR Gold 1500/35 KP OR Gold 2000/35 KP Oregon Standard Gold Plan		KP OR Gold 1000/20 KP Plus	KP OR Gold 500/35 3T POS[2] KP OR Gold 500/35 3T POS OOA[2] KP OR Gold 1000/20 3T POS[2] KP OR Gold 1000/35 3T POS OOA[2]
Silver		KP OR Silver 3000/45 KP OR Silver 4000/45 KP OR Silver 5000/50 KP OR Silver 6000/50 KP Oregon Standard Silver Plan	KP OR Silver 3500/25% HSA	KP OR Silver 3000/45 KP Plus	KP OR Silver 3000/45 3T POS[2] KP OR Silver 3000/45 3T POS OOA[2] KP OR Silver 4000/45 3T POS[2] KP OR Silver 4000/45 3T POS OOA[2]
Bronze		KP OR Bronze 7000/60 KP OR Bronze 9400/0% KP Oregon Standard Bronze Plan	KP OR Bronze 7100/0% HSA	KP OR Bronze 7000/60 KP Plus	KP OR Bronze 7000/60 3T POS[2] KP OR Bronze 7000/60 3T POS OOA[2]

Buy-up options	Any of the above medical plans can be paired with a buy-up option listed below, with the exception of the Standard plans. **A. Vision:** $200/2-year period vision hardware benefit and vision exam **B. Vision + Massage:** Bundle option A and receive $25 massage therapy (limit 12 per year). Cost shares are after deductible for all high deductible plans. Massage on the 7100/0% HSA plan will be 0% after deductible is met. Added Choice plans: $25 select providers, 20% coinsurance PPO providers, 40% nonparticipating providers. Added Choice out-of-area plans: $25 select providers, $25 PPO providers, 40% nonparticipating providers.

[1]If you have employees who live or work outside our service area, they may be eligible for an Added Choice out-of-area (OOA) plan. Rates and approval subject to underwriting.
[2]Added Choice OOA plans: Groups must meet underwriting requirements to purchase.

TRADITIONAL PLANS

PLAN NAME	KP OR Platinum 0/20	KP OR Gold 0/30
ANNUAL OUT-OF-POCKET MAXIMUM	$2,200 per individual; $4,400 per family	$8,700 per individual; $17,400 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $30[4]
Urgent care	$40	$60
Specialty care	$30	$50
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25
Chiropractic services[2]	$25	$25
Naturopathic services	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $30[4]
OUTPATIENT THERAPIES[3]	$30	$50
OUTPATIENT SURGERY	$100	$200
LAB	$20	$30
X-RAY/DIAGNOSTIC TEST	$30	$40
CT, MRI, AND PET SCANS	$75	$300
INPATIENT HOSPITAL CARE	$300 per day, $1,500 per admission	$500 per day, $2,500 per admission
EMERGENCY DEPARTMENT VISIT	$150	$500
OUTPATIENT PRESCRIPTION DRUGS	$5 generic; $15 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$15 generic; $40 preferred brand-name; $60 non-preferred brand-name; 50% specialty
MATERNITY CARE Inpatient	$300 per day, $1,500 per admission	$500 per day, $2,500 per admission

1. Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

DEDUCTIBLE PLANS

PLAN NAME	KP OR Platinum 250/20	KP OR Platinum 500/20
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$250 per individual; $500 per family	$500 per individual; $1,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$3,300 per individual; $6,600 per family	$3,200 per individual; $6,400 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $20[4]
Urgent care	$40	$40
Specialty care	$30	$30
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25
Chiropractic services[2]	$25	$25
Naturopathic services	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $20[4]
OUTPATIENT THERAPIES[3]	$30	$30
OUTPATIENT SURGERY	15%*	20%*
LAB	$20	$20
X-RAY/DIAGNOSTIC TEST	$30	$30
CT, MRI, AND PET SCANS	15%*	20%*
INPATIENT HOSPITAL CARE	15%*	20%*
EMERGENCY DEPARTMENT VISIT	15%*	20%*
OUTPATIENT PRESCRIPTION DRUGS	$5 generic; $15 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$5 generic; $15 preferred brand-name; $50 non-preferred brand-name; 50% specialty
MATERNITY CARE Inpatient	15%*	20%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC).* To get a copy of the *EOC,* please contact your sales executive or account manager.

DEDUCTIBLE PLANS

PLAN NAME	KP OR Gold 1000/20	KP OR Gold 1500/35	KP OR Gold 2000/35
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,000 per individual; $2,000 per family	$1,500 per individual; $3,000 per family	$2,000 per individual; $4,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,700 per individual; $17,400 per family	$8,700 per individual; $17,400 per family	$8,700 per individual; $17,400 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $35[4]	$5 for the first 3 visits; then $35[4]
Urgent care	$50	$55	$60
Specialty care	$40	$45	$50
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	$0[4]
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	$25
Chiropractic services[2]	$25	$25	$25
Naturopathic services	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $35[4]	$5 for the first 3 visits; then $35[4]
OUTPATIENT THERAPIES[3]	$40	$45	$50
OUTPATIENT SURGERY	25%*	25%*	25%*
LAB	$20	$35	$35
X-RAY/DIAGNOSTIC TEST	$20	$45	$40
CT, MRI, AND PET SCANS	$300	$300	$300
INPATIENT HOSPITAL CARE	25%*	25%*	25%*
EMERGENCY DEPARTMENT VISIT	25%*	25%*	25%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $40 preferred brand-name; 50% non-preferred brand-name; 50% specialty	$10 generic; $30 preferred brand-name; $60 non-preferred brand-name; 50% specialty	$15 generic; $45 preferred brand-name; 50% non-preferred brand-name; 50% specialty
MATERNITY CARE Inpatient	25%*	25%*	25%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

DEDUCTIBLE PLANS

PLAN NAME	KP Oregon Standard Gold Plan[5]	KP OR Silver 3000/45	KP OR Silver 4000/45
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,800 per individual; $3,600 per family	$3,000 per individual; $6,000 per family	$4,000 per individual; $8,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$7,550 per individual; $15,100 per family	$8,900 per individual; $17,800 per family	$9,400 per individual; $18,800 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $45[4]
Urgent care	$60	$65	$70
Specialty care	$40	$55	$60
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	$0[4]
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$20	$25	$25
Chiropractic services[2]	$20	$25	$25
Naturopathic services	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $45[4]
OUTPATIENT THERAPIES[3]	$20	$55	$60
OUTPATIENT SURGERY	20%*	40%*	40%*
LAB	20%*	$45	$45
X-RAY/DIAGNOSTIC TEST	20%*	$50	$45
CT, MRI, AND PET SCANS	20%*	40%*	40%*
INPATIENT HOSPITAL CARE	20%*	40%*	40%*
EMERGENCY DEPARTMENT VISIT	20%*	40%*	40%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% (up to a max of $500) specialty	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty
MATERNITY CARE Inpatient	20%*	40%*	40%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. **5.** These plans may not be sold with additional coverage such as adult vision hardware and eye exam and massage. Only medically necessary eye exams are covered. These plans exclude the following benefits: Dependent Out of Area and Fertility Diagnosis.

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC).* To get a copy of the *EOC,* please contact your sales executive or account manager.

DEDUCTIBLE PLANS

PLAN NAME	KP OR Silver 5000/50	KP OR Silver 6000/50	KP Oregon Standard Silver Plan[5]
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$5,000 per individual; $10,000 per family	$6,000 per individual; $12,000 per family	$5,500 per individual; $11,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,400 per individual; $18,800 per family	$9,400 per individual; $18,800 per family	$9,450 per individual; $18,900 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$5 for the first 3 visits; then $50[4]	$5 for the first 3 visits; then $50[4]	$5 for the first 3 visits; then $40[4]
Urgent care	$75	40%*	$70
Specialty care	$70	$75	$80
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	$0[4]
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	$40
Chiropractic services[2]	$25	$25	$40
Naturopathic services	$5 for the first 3 visits; then $50[4]	$5 for the first 3 visits; then $50[4]	$5 for the first 3 visits; then $40[4]
OUTPATIENT THERAPIES[3]	$70	$75	$40
OUTPATIENT SURGERY	40%*	40%*	30%*
LAB	$50	40%*	30%*
X-RAY/DIAGNOSTIC TEST	$50	40%*	30%*
CT, MRI, AND PET SCANS	40%*	40%*	30%*
INPATIENT HOSPITAL CARE	40%*	40%*	30%*
EMERGENCY DEPARTMENT VISIT	40%*	40%*	30%*
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$30 generic; $75 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$15 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50% specialty
MATERNITY CARE Inpatient	40%*	40%*	30%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. **5.** These plans may not be sold with additional coverage such as adult vision hardware and eye exam and massage. Only medically necessary eye exams are covered. These plans exclude the following benefits: Dependent Out of Area and Fertility Diagnosis.

DEDUCTIBLE PLANS

PLAN NAME	KP OR Bronze 7000/60	KP OR Bronze 9400/0%	KP Oregon Standard Bronze Plan[5]
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$9,400 per individual; $18,800 per family	$9,450 per individual; $18,900 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,450 per individual; $18,900 per family	$9,400 per individual; $18,800 per family	$9,450 per individual; $18,900 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$5 for the first 3 visits; then $60[4]	$5 for the first 3 visits; then 0%*[4]	$5 for the first 3 visits; then $50[4]
Urgent care	40%*	$0*	$100
Specialty care	$80*	$0*	$150
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	$0[4]
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	$50
Chiropractic services[2]	$25	$25	$50
Naturopathic services	$5 for the first 3 visits; then $60[4]	$5 for the first 3 visits; then 0%*[4]	$5 for the first 3 visits; then $50[4]
OUTPATIENT THERAPIES[3]	$80*	$0*	$50
OUTPATIENT SURGERY	40%*	$0*	0%*
LAB	40%*	$0*	0%*
X-RAY/DIAGNOSTIC TEST	40%*	$0*	0%*
CT, MRI, AND PET SCANS	40%*	$0*	0%*
INPATIENT HOSPITAL CARE	40%*	$0*	0%*
EMERGENCY DEPARTMENT VISIT	40%*	$0*	0%*
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $100 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$30 generic; $0* preferred brand-name; $0* non-preferred brand-name; $0* specialty	$25 generic; 0%* preferred brand-name; 0%* non-preferred brand-name; 0%* specialty
MATERNITY CARE Inpatient	40%*	$0*	0%*

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. **5.** These plans may not be sold with additional coverage such as adult vision hardware and eye exam and massage. Only medically necessary eye exams are covered. These plans exclude the following benefits: Dependent Out of Area and Fertility Diagnosis.

HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS

PLAN NAME	KP OR Silver 3500/25% HSA	KP OR Bronze 7100/0% HSA
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,500/$7,000	$7,100/$14,200
ANNUAL OUT-OF-POCKET MAXIMUM	$7,000/$14,000	$7,100/$14,200
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	0%
Primary care	$5* for the first 3 visits; then 25%*[4]	0%* for the first 3 visits, then 0%*[4]
Urgent care	25%*	0%*
Specialty care	25%*	0%*
TELEHEALTH (PHONE/VIDEO)	0%*[4]	0%*[4]
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25*	0%*
Chiropractic services[2]	$25*	0%*
Naturopathic services	$5* for the first 3 visits; then 25%*[4]	0%* for the first 3 visits, then 0%*[4]
OUTPATIENT THERAPIES[3]	25%*	0%*
OUTPATIENT SURGERY	25%*	0%*
LAB	25%*	0%*
X-RAY/DIAGNOSTIC TEST	25%*	0%*
CT, MRI, AND PET SCANS	25%*	0%*
INPATIENT HOSPITAL CARE	25%*	0%*
EMERGENCY DEPARTMENT VISIT	25%*	0%*
OUTPATIENT PRESCRIPTION DRUGS	$20* generic; $50* preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	0%* generic; 0%* preferred brand-name; 0%* non-preferred brand-name; 0%* specialty
MATERNITY CARE Inpatient	25%*	0%*

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

KP PLUS PLANS

PLAN NAME	KP OR Platinum 0/20 KP Plus	
NETWORK	In-network (Consists of Kaiser Permanente providers and facilities, including pharmacies)	Out-of-network (Consists of any licensed provider, facility, or pharmacy outside Kaiser Permanente. Limited to 10 covered services per year, combined.)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	$0	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$2,200 per individual; $4,400 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$5 for the first 3 visits; then $20[2]	$40
Urgent care	$40	Not covered, except for services received outside the service area[3,4]
Specialty care	$30	$50
TELEHEALTH (PHONE/VIDEO)	$0[2]	$40
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$25[5]	$45
Chiropractic services	$25[6]	$45
Naturopathic services	$5 for the first 3 visits; then $20[2]	$40
OUTPATIENT THERAPIES	$30[7]	$50
OUTPATIENT SURGERY	$100	Not covered
LAB	$20	$40
X-RAY/DIAGNOSTIC TEST	$30	$50
CT, MRI, AND PET SCANS	$75	Not covered
INPATIENT HOSPITAL CARE	$300 per day, $1,500 per admission	Not covered
EMERGENCY DEPARTMENT VISIT	$150	Covered at the in-network cost share[3]
OUTPATIENT PRESCRIPTION DRUGS	$5 generic; $15 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$25 generic; $35 preferred brand-name; $70 non-preferred brand-name; 50% specialty (limited to 5 prescriptions fills per year)[3]
MATERNITY CARE Inpatient	$300 per day, $1,500 per admission	Not covered

*Subject to annual medical deductible. **1.** These plans include a Dependent out-of-area (OOA) benefit which provides limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% of the billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills. **2.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. **3.** The limit of 10 covered services does not apply. **4.** If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating Facility may be covered if the services are deemed necessary to prevent serious deterioration of health. **5.** Limited to 12 visits per year. **6.** Limited to 20 visits per year. **7.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

KP PLUS PLANS

PLAN NAME	KP OR Gold 1000/20 KP Plus	
NETWORK	In-network (Consists of Kaiser Permanente providers and facilities, including pharmacies)	Out-of-network (Consists of any licensed provider, facility, or pharmacy outside Kaiser Permanente. Limited to 10 covered services per year, combined.)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	$1,000 per individual; $2,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$8,700 per individual; $17,400 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$5 for the first 3 visits; then $20[2]	$40
Urgent care	$50	Not covered, except for services received outside the service area[3,4]
Specialty care	$40	$60
TELEHEALTH (PHONE/VIDEO)	$0[2]	$40
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$25[5]	$45
Chiropractic services	$25[6]	$45
Naturopathic services	$5 for the first 3 visits; then $20[2]	$40
OUTPATIENT THERAPIES	$40[7]	$60
OUTPATIENT SURGERY	25%*	Not covered
LAB	$20	$40
X-RAY/DIAGNOSTIC TEST	$20	$40
CT, MRI, AND PET SCANS	$300	Not covered
INPATIENT HOSPITAL CARE	25%*	Not covered
EMERGENCY DEPARTMENT VISIT	25%*	Covered at the in-network cost share[3]
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $40 preferred brand-name; 50% non-preferred brand-name; 50% specialty	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50% specialty (limited to 5 prescriptions fills per year)[3]
MATERNITY CARE Inpatient	25%*	Not covered

*Subject to annual medical deductible. **1.** These plans include a Dependent out-of-area (OOA) benefit which provides limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% of the billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills. **2.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. **3.** The limit of 10 covered services does not apply. **4.** If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating Facility may be covered if the services are deemed necessary to prevent serious deterioration of health. **5.** Limited to 12 visits per year. **6.** Limited to 20 visits per year. **7.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

KP PLUS PLANS

PLAN NAME	KP OR Silver 3000/45 KP Plus	
NETWORK	In-network (Consists of Kaiser Permanente providers and facilities, including pharmacies)	Out-of-network (Consists of any licensed provider, facility, or pharmacy outside Kaiser Permanente. Limited to 10 covered services per year, combined.)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	$3,000 per individual; $6,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$8,900 per individual; $17,800 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$5 for the first 3 visits; then $45[2]	$65
Urgent care	$65	Not covered, except for services received outside the service area[3,4]
Specialty care	$55	$75
TELEHEALTH (PHONE/VIDEO)	$0[2]	$65
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$25[5]	$45
Chiropractic services	$25[6]	$45
Naturopathic services	$5 for the first 3 visits; then $45[2]	$65
OUTPATIENT THERAPIES	$55[7]	$75
OUTPATIENT SURGERY	40%*	Not covered
LAB	$45	$65
X-RAY/DIAGNOSTIC TEST	$50	$70
CT, MRI, AND PET SCANS	40%*	Not covered
INPATIENT HOSPITAL CARE	40%*	Not covered
EMERGENCY DEPARTMENT VISIT	40%*	Covered at the in-network cost share[3]
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$50 generic; $80 preferred brand-name; 50% non-preferred brand-name; 50% specialty (limited to 5 prescriptions fills per year)[3]
MATERNITY CARE Inpatient	40%*	Not covered

***Subject to annual medical deductible. **1.** These plans include a Dependent out-of-area (OOA) benefit which provides limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% of the billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills. **2.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. **3.** The limit of 10 covered services does not apply. **4.** If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating Facility may be covered if the services are deemed necessary to prevent serious deterioration of health. **5.** Limited to 12 visits per year. **6.** Limited to 20 visits per year. **7.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

KP PLUS PLANS

PLAN NAME	KP OR Bronze 7000/60 KP Plus	
NETWORK	In-network (Consists of Kaiser Permanente providers and facilities, including pharmacies)	Out-of-network (Consists of any licensed provider, facility, or pharmacy outside Kaiser Permanente. Limited to 10 covered services per year, combined.)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	$7,000 per individual; $14,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$9,450 per individual; $18,900 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$5 for the first 3 visits; then $60[2]	$80
Urgent care	40%*	Not covered, except for services received outside the service area[3,4]
Specialty care	$80*	$100
TELEHEALTH (PHONE/VIDEO)	$0[2]	$80
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$25[5]	$45
Chiropractic services	$25[6]	$45
Naturopathic services	$5 for the first 3 visits; then $60[2]	$80
OUTPATIENT THERAPIES	$80*[7]	$100
OUTPATIENT SURGERY	40%*	Not covered
LAB	40%*	50%
X-RAY/DIAGNOSTIC TEST	40%*	50%
CT, MRI, AND PET SCANS	40%*	Not covered
INPATIENT HOSPITAL CARE	40%*	Not covered
EMERGENCY DEPARTMENT VISIT	40%*	Covered at the in-network cost share[3]
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $100 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$50 generic; $120 preferred brand-name; 50% non-preferred brand-name; 50% specialty (limited to 5 prescriptions fills per year)[3]
MATERNITY CARE Inpatient	40%*	Not covered

*Subject to annual medical deductible. **1.** These plans include a Dependent out-of-area (OOA) benefit which provides limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% of the billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills. **2.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. **3.** The limit of 10 covered services does not apply. **4.** If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating Facility may be covered if the services are deemed necessary to prevent serious deterioration of health. **5.** Limited to 12 visits per year. **6.** Limited to 20 visits per year. **7.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP OR Platinum 250/20 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$250 per individual; $500 per family	$500 per individual; $1,000 per family	$750 per individual; $1,500 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$3,200 per individual; $6,400 per family	$4,500 per individual; $9,000 per family	$7,000 per individual; $14,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	35%*
Primary care	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $30[4]	35%*
Urgent care	$40	$60	35%*
Specialty care	$30	$40	35%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	35%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	20%	40%
Chiropractic services[2]	$25	20%	40%
Naturopathic services	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $30[4]	35%*
OUTPATIENT THERAPIES[3]	$30	$40	35%*
OUTPATIENT SURGERY	15%*	25%*	35%*
LAB	$20	$30	35%*
X-RAY/DIAGNOSTIC TEST	$30	$40	35%*
CT, MRI, AND PET SCANS	15%*	25%*	35%*
INPATIENT HOSPITAL CARE	15%*	25%*	35%*
EMERGENCY DEPARTMENT VISIT	15%*		
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$15 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% specialty	Not covered
MATERNITY CARE Inpatient	15%*	25%*	35%*

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.
These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC).* To get a copy of the *EOC,* please contact your sales executive or account manager.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP OR Gold 500/35 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$500 per individual; $1,000 per family	$1,500 per individual; $3,000 per family	$4,500 per individual; $9,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$6,200 per individual; $12,400 per family	$8,200 per individual; $16,400 per family	$10,200 per individual; $20,400 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $35[4]	$5 for the first 3 visits; then $60[4]	50%*
Urgent care	$60	$80	50%*
Specialty care	$55	$80	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	20%	40%
Chiropractic services[2]	$25	20%	40%
Naturopathic services	$5 for the first 3 visits; then $35[4]	$5 for the first 3 visits; then $60[4]	50%*
OUTPATIENT THERAPIES[3]	$55	$80	50%*
OUTPATIENT SURGERY	30%*	50%*	50%*
LAB	$35	40%*	50%*
X-RAY/DIAGNOSTIC TEST	$35	40%*	50%*
CT, MRI, AND PET SCANS	30%*	50%*	50%*
INPATIENT HOSPITAL CARE	30%*	50%*	50%*
EMERGENCY DEPARTMENT VISIT	30%*		
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$25 generic; $75 preferred brand-name; 50% non-preferred brand-name; 50% specialty	Not covered
MATERNITY CARE Inpatient	30%*	50%*	50%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP OR Gold 1000/20 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,000 per individual; $2,000 per family	$2,000 per individual; $4,000 per family	$6,000 per individual; $12,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$7,000 per individual; $14,000 per family	$9,000 per individual; $18,000 per family	$11,000 per individual; $22,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $40[4]	50%*
Urgent care	$50	$100	50%*
Specialty care	$40	$60	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	20%	40%
Chiropractic services[2]	$25	20%	40%
Naturopathic services	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $40[4]	50%*
OUTPATIENT THERAPIES[3]	$40	$60	50%*
OUTPATIENT SURGERY	25%*	40%*	50%*
LAB	$20	40%*	50%*
X-RAY/DIAGNOSTIC TEST	$20	40%*	50%*
CT, MRI, AND PET SCANS	$300	40%*	50%*
INPATIENT HOSPITAL CARE	25%*	40%*	50%*
EMERGENCY DEPARTMENT VISIT	25%*		
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% specialty	$25 generic; $75 preferred brand-name; 50% non-preferred brand-name; 50% specialty	Not covered
MATERNITY CARE Inpatient	25%*	40%*	50%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.
These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC).* To get a copy of the *EOC,* please contact your sales executive or account manager.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP OR Silver 3000/45 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,000 per individual; $6,000 per family	$5,000 per individual; $10,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,000 per individual; $18,000 per family	$9,000 per individual; $18,000 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $60[4]	50%*
Urgent care	$65	$80	50%*
Specialty care	$55	$70	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	20%	40%
Chiropractic services[2]	$25	20%	40%
Naturopathic services	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $60[4]	50%*
OUTPATIENT THERAPIES[3]	$55	$70	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	$45	45%*	50%*
X-RAY/DIAGNOSTIC TEST	$50	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$40 generic; $70 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not covered
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

OREGON PLAN
COMPARISON

If you have employees who live or work outside our service area, they may be eligible for an Added Choice out-of-area (OOA) plan. Rates and approval subject to underwriting. Groups must meet underwriting requirements to purchase. These plans are only offered outside the Oregon Health Insurance Marketplace.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	**KP OR Silver 4000/45 3T POS**		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$4,000 per individual; $8,000 per family	$6,000 per individual; $12,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,400 per individual; $18,800 per family	$9,400 per individual; $18,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $60[4]	50%*
Urgent care	$70	$90	50%*
Specialty care	$60	$70	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	20%	40%
Chiropractic services[2]	$25	20%	40%
Naturopathic services	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $60[4]	50%*
OUTPATIENT THERAPIES[3]	$60	$70	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	$45	45%*	50%*
X-RAY/DIAGNOSTIC TEST	$45	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$40 generic; $70 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not covered
MATERNITY CARE Inpatient	40%*	45%*	50%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP OR Bronze 7000/60 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$9,000 per individual; $18,000 per family	$11,000 per individual; $22,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,450 per individual; $18,900 per family	$9,450 per individual; $18,900 per family	$15,000 per individual; $30,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $60[4]	$5 for the first 3 visits; then $75[4]	50%*
Urgent care	40%*	45%*	50%*
Specialty care	$80*	$100*	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	20%	40%
Chiropractic services[2]	$25	20%	40%
Naturopathic services	$5 for the first 3 visits; then $60[4]	$5 for the first 3 visits; then $75[4]	50%*
OUTPATIENT THERAPIES[3]	$80*	$100*	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	40%*	45%*	50%*
X-RAY/DIAGNOSTIC TEST	40%*	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $100 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$45 generic; $120 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	Not covered
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Platinum 250/20 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$250 per individual; $500 per family	$250 per individual; $500 per family	$750 per individual; $1,500 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$3,200 per individual; $6,400 per family	$3,200 per individual; $6,400 per family	$7,000 per individual; $14,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	35%*
Primary care	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $20[4]	35%*
Urgent care	$40	$40	35%*
Specialty care	$30	$30	35%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	35%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	40%
Chiropractic services[2]	$25	$25	40%
Naturopathic services	$5 for the first 3 visits; then $20[4]	$5 for the first 3 visits; then $20[4]	35%*
OUTPATIENT THERAPIES[3]	$30	$30	35%*
OUTPATIENT SURGERY	15%*	15%*	35%*
LAB	$20	$20	35%*
X-RAY/DIAGNOSTIC TEST	$30	$30	35%*
CT, MRI, AND PET SCANS	$100	$100	35%*
INPATIENT HOSPITAL CARE	15%*	15%*	35%*
EMERGENCY DEPARTMENT VISIT	15%*		
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	Not covered
MATERNITY CARE Inpatient	15%*	15%*	35%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.
4. First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Gold 500/35 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$500 per individual; $1,000 per family	$500 per individual; $1,000 per family	$4,500 per individual; $9,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$6,900 per individual; $13,800 per family	$6,900 per individual; $13,800 per family	$10,000 per individual; $20,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $35[4]	$5 for the first 3 visits; then $35[4]	50%*
Urgent care	$60	$60	50%*
Specialty care	$55	$55	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	40%
Chiropractic services[2]	$25	$25	40%
Naturopathic services	$5 for the first 3 visits; then $35[4]	$5 for the first 3 visits; then $35[4]	50%*
OUTPATIENT THERAPIES[3]	$55	$55	50%*
OUTPATIENT SURGERY	35%*	35%*	50%*
LAB	$35	$35	50%*
X-RAY/DIAGNOSTIC TEST	$40	$40	50%*
CT, MRI, AND PET SCANS	$250*	$250*	50%*
INPATIENT HOSPITAL CARE	35%*	35%*	50%*
EMERGENCY DEPARTMENT VISIT	35%*		
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $30 preferred brand-name; $60 non-preferred brand-name; 50% specialty	$10 generic; $30 preferred brand-name; $60 non-preferred brand-name; 50% specialty	Not covered

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. **4.** First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Gold 1000/35 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,000 per individual; $2,000 per family	$1,000 per individual; $2,000 per family	$6,000 per individual; $12,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$7,000 per individual; $14,000 per family	$7,000 per individual; $14,000 per family	$11,000 per individual; $22,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $35[4]	$5 for the first 3 visits; then $35[4]	50%*
Urgent care	$75	$75	50%*
Specialty care	$55	$55	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	40%
Chiropractic services[2]	$25	$25	40%
Naturopathic services	$5 for the first 3 visits; then $35[4]	$5 for the first 3 visits; then $35[4]	50%*
OUTPATIENT THERAPIES[3]	$55	$55	50%*
OUTPATIENT SURGERY	35%*	35%*	50%*
LAB	$35	$35	50%*
X-RAY/DIAGNOSTIC TEST	$35	$35	50%*
CT, MRI, AND PET SCANS	$300	$300	50%*
INPATIENT HOSPITAL CARE	35%*	35%*	50%*
EMERGENCY DEPARTMENT VISIT	35%*		
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $60 non-preferred brand-name; 50% specialty	$10 generic; $20 preferred brand-name; $60 non-preferred brand-name; 50% specialty	Not covered
MATERNITY CARE Inpatient	35%*	35%*	50%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.
4. First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Silver 3000/45 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,000 per individual; $6,000 per family	$3,000 per individual; $6,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,000 per individual; $18,000 per family	$9,000 per individual; $18,000 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $45[4]	50%*
Urgent care	$65	$65	50%*
Specialty care	$55	$55	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	40%
Chiropractic services[2]	$25	$25	40%
Naturopathic services	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $45[4]	50%*
OUTPATIENT THERAPIES[3]	$55	$55	50%*
OUTPATIENT SURGERY	45%*	45%*	50%*
LAB	$45	$45	50%*
X-RAY/DIAGNOSTIC TEST	$50	$50	50%*
CT, MRI, AND PET SCANS	45%*	45%*	50%*
INPATIENT HOSPITAL CARE	45%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	45%*		
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not covered
MATERNITY CARE Inpatient	45%*	45%*	50%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.
4. First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Silver 4000/45 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$4,000 per individual; $8,000 per family	$4,000 per individual; $8,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,400 per individual; $18,800 per family	$9,400 per individual; $18,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $45[4]	50%*
Urgent care	$70	$70	50%*
Specialty care	$60	$60	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	40%
Chiropractic services[2]	$25	$25	40%
Naturopathic services	$5 for the first 3 visits; then $45[4]	$5 for the first 3 visits; then $45[4]	50%*
OUTPATIENT THERAPIES[3]	$60	$60	50%*
OUTPATIENT SURGERY	45%*	45%*	50%*
LAB	$45	$45	50%*
X-RAY/DIAGNOSTIC TEST	$45	$45	50%*
CT, MRI, AND PET SCANS	45%*	45%*	50%*
INPATIENT HOSPITAL CARE	45%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	45%*		
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not covered
MATERNITY CARE Inpatient	45%*	45%*	50%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.
4. First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Bronze 7000/60 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$7,000 per individual; $14,000 per family	$11,000 per individual; $22,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,450 per individual; $18,900 per family	$9,450 per individual; $18,900 per family	$15,000 per individual; $30,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$5 for the first 3 visits; then $60[4]	$5 for the first 3 visits; then $60[4]	50%*
Urgent care	45%*	45%*	50%*
Specialty care	$80*	$80*	50%*
TELEHEALTH (PHONE/VIDEO)	$0[4]	$0[4]	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	40%
Chiropractic services[2]	$25	$25	40%
Naturopathic services	$5 for the first 3 visits; then $60[4]	$5 for the first 3 visits; then $60[4]	50%*
OUTPATIENT THERAPIES[3]	$80*	$80*	50%*
OUTPATIENT SURGERY	45%*	45%*	50%*
LAB	45%*	45%*	50%*
X-RAY/DIAGNOSTIC TEST	45%*	45%*	50%*
CT, MRI, AND PET SCANS	45%*	45%*	50%*
INPATIENT HOSPITAL CARE	45%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	45%*		
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $100 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$30 generic; $100 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	Not covered
MATERNITY CARE Inpatient	45%*	45%*	50%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 20 visits per year. **3.** Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.
4. First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

PLAN NAME	SENIOR ADVANTAGE
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$0
ANNUAL OUT-OF-POCKET MAXIMUM	$1,000 per individual
BENEFITS	Member pays
OFFICE VISITS — PREVENTIVE CARE	$0
Primary care	$20
Urgent care	$25
Specialty care	$20
OUTPATIENT THERAPIES	$20
LAB	$0
X-RAY/DIAGNOSTIC TEST	$0
CT, MRI, AND PET SCANS	$0
OUTPATIENT SURGERY	$50
INPATIENT HOSPITAL CARE	$200 per admission
EMERGENCY CARE	$50
SELF-REFERRED ALTERNATIVE CARE	$20 copay covers self-referred chiropractic, naturopathic, and acupuncture visits. $25 copay for massage therapy up to 12 visits per calendar year, $1,000 benefit max per calendar year for all services combined.
OUTPATIENT PRESCRIPTION DRUGS	$20 generic; $40 brand-name and specialty. $0 generic/brand-name and specialty in the catastrophic coverage stage.*

Senior Advantage plans cannot be modified. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

*Catastrophic coverage begins when the member's annual out-of-pocket costs (how much the member and those paying on member's behalf) reach $8,000.

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC).* To get a copy of the *EOC,* please contact your sales executive or account manager.

Plan highlights

Out-of-pocket maximum:

All benefits displayed accumulate to the out-of-pocket maximum.

Pediatric benefits:

All plans include pediatric vision exams at $0 and pediatric vision hardware at no charge for 1 pair standard frames with lenses, conventional or disposable contact lenses in lieu of eyeglasses (limited to 1 pair per year for conventional lenses or up to a 6-month supply of disposable contact lenses per year); no charge for low vision aid from selected list or medically necessary contact lenses.

Pediatric dental coverage is required, and we offer a choice of 6 different plans (please see the dental brochure).

Dependent out-of-area (OOA) benefit:

Your dependent children have access to care beyond urgent and emergency care outside the Kaiser Permanente network. This benefit covers limited coverage for routine, continuing, and follow-up care for dependent children residing outside the service area. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills. For covered services the member pays 20% of the billed charges. (Does not apply to Added Choice or Senior Advantage plans).

Standard plans:

Standard plans are designed by the state of Oregon and cover only essential health benefits.* These plans have the same benefits from one company to the next so consumers can compare like plans across carriers that offer qualified health plans to small employers.

Alternative care (self-referred)

Visit **chpgroup.com** for a list of providers. If enrolled under Added Choice plans, these benefits may be used at CHP, PPO, and other nonparticipating providers and facilities.

PPO networks include First Choice Network and First Health Network in states where Kaiser Permanente operates and the Cigna Healthcare℠ PPO Network in all other states.[1,2] Visit **kp.org/choiceproducts/nw** for additional network information.

Integrated eye health

We treat eye health as a component of total health, not in isolation. When you choose the vision option, you're choosing the option that is more convenient and connected, which can help uncover major health issues and lead to better health outcomes. Learn more at **kp2020.org**.

Dental coverage

Our unique medical-dental integration helps improve quality of care and patient safety while boosting member satisfaction. Choose from our cost-effective Traditional plans or flexible Choice PPO plans. We have a range of options with comprehensive coverage to meet the needs of your employees. Learn more at **kp.org/dental/nw**.

*These plans may not be sold with additional coverage such as adult vision hardware and eye exam and massage. Only medically necessary eye exams are covered. These plans exclude the following benefits: Physician Referred Alternative Care, Dependent Out of Area, and Fertility diagnosis.

[1]The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.
[2]Kaiser Permanente operates in the states of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C. Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Healthcare Intellectual Property, Inc.

Explanation of Added Choice benefits

Select provider services, in most cases, are provided by select providers and select facilities. *The Evidence of Coverage (EOC)* provides a complete definition of select providers and select facilities and explains when select provider services are provided by other providers and facilities.

PPO provider services are provided by PPO providers and facilities. Refer to the *EOC* for a complete definition of PPO providers and facilities.

Nonparticipating provider services are provided by nonparticipating providers and facilities. Refer to the *EOC* for a complete definition of nonparticipating providers and facilities.

Deductible and out-of-pocket maximum amounts cross-accumulate between select providers and PPO providers. There is a separate deductible and out-of-pocket maximum amount for nonparticipating providers, which does not accumulate across any other provider networks.

Visit **kp.org/choiceproducts/nw** for more information.

Explanation of KP Plus Benefits

KP Plus is an affordable option that gives your employees access to high-quality care from Kaiser Permanente and affiliated providers, plus the flexibility to receive certain types of care from out-of-network providers for a limited number of visits per year.

Visit **kp.org/kpplus/nw** for more information.

Bundled plan options when you purchase coverage outside the health insurance exchange

You can offer up to 3 medical plans in a bundle, with the limitation that there can only be 1 Added Choice plan per bundle. For groups that qualify, Added Choice Out-of-Area plans are not counted toward the 3-plan limit. Once you select your plan offerings, employees choose the plan that best meets their needs.

[1]The NCQA's Health Insurance Plan Ratings are based on combined scores for health plans in HEDIS® (Healthcare Effectiveness Data and Information Set); CAHPS® (Consumer Assessment of Healthcare Providers and Systems); and NCQA Accreditation standards scores. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Accessed January 2023. healthinsuranceratings.ncqa.org

[2]The Portland Clinic is not available as an in-network provider to members on Medicaid, receiving full Medical Financial Assistance from Kaiser Permanente, or visiting from another Kaiser Permanente region

[3]When appropriate and available. These features apply to care you get at Kaiser Permanente facilities. For high deductible health plan members, e-visits, phone visits, and video visits are subject to your plan's annual deductible. If you travel out of state, phone and video visits may not be available due to state laws that may prevent doctors from providing care across state lines. Laws differ by state. To have a video visit, members must be registered on kp.org and have a camera-equipped computer or mobile device. Applicable cost shares will apply for services or items ordered during an e-visit. For high deductible health plan members, e-visits, phone visits, and video visits are subject to your plan's annual deductible.

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