For **Washington** (Clark and Cowlitz counties)
groups with 1–50 employees

MEDICAL PLANS OVERVIEW

For coverage effective on or after January 1, 2024

WASHINGTON
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 producer

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 27 for corresponding footnotes.

KAISER PERMANENTE®

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Plan options

METAL TIER	Traditional	Deductible	HSA-qualified high deductible	Kaiser Permanente Plus™	Added Choice® point-of-service[1]	PPO Plus*
Platinum	KP WA Platinum 0/20	KP WA Platinum 250/20 KP WA Platinum 500/20		KP WA Platinum 0/20 KP Plus	KP WA Platinum 250/20 3T POS	KP WA Platinum 250/20 PPO Plus
Gold	KP WA Gold 0/30	KP WA Gold 1000/20 KP WA Gold 1500/35 KP WA Gold 2000/35		KP WA Gold 1000/20 KP Plus	KP WA Gold 500/35 3T POS KP WA Gold 1000/20 3T POS	KP WA Gold 1000/35 PPO Plus
Silver		KP WA Silver 3000/45 KP WA Silver 4000/45 KP WA Silver 5000/50 KP WA Silver 6000/50	KP WA Silver 3500/25% HSA	KP WA Silver 3000/45 KP Plus	KP WA Silver 3000/45 3T POS KP WA Silver 4000/45 3T POS	KP WA Silver 3000/45 PPO Plus KP WA Silver 4000/45 PPO Plus
Bronze		KP WA Bronze 7000/50 KP WA Bronze 9400/40	KP WA Bronze 7100/0% HSA	KP WA Bronze 7000/50 KP Plus	KP WA Bronze 7000/50 3T POS	KP WA Bronze 7000/50 PPO Plus

Buy-up option	Any of the above medical plans can be paired with the following vision coverage buy-up option: **Adult vision hardware and vision exam:** $200 hardware benefit allowance every 2-year period and primary care office visit cost share applies for exam.

*If you have employees who both live and work outside our service area, they may be eligible for a PPO Plus plan. Rates and approval subject to underwriting.

TRADITIONAL PLANS

PLAN NAME	KP WA Platinum 0/20	KP WA Gold 0/30
ANNUAL OUT-OF-POCKET MAXIMUM	$2,000 per individual; $4,000 per family	$8,200 per individual; $16,400 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$30
Urgent care	$40	$60
Specialty care	$30	$50
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$30	$50
Chiropractic services[2]	$30	$50
Naturopathic services	$20	$30
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$30	$50
OUTPATIENT THERAPIES[4]	$30	$50
OUTPATIENT SURGERY	$100	$200
LAB	$20	$30
X-RAY/DIAGNOSTIC TEST	$30	$30
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 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

DEDUCTIBLE PLANS

PLAN NAME	KP WA Platinum 250/20	KP WA Platinum 500/20	KP WA Gold 1000/20
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$250 per individual; $500 per family	$500 per individual; $1,000 per family	$1,000 per individual; $2,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$3,000 per individual; $6,000 per family	$3,000 per individual; $6,000 per family	$8,200 per individual; $16,400 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$20	$20	$20
Urgent care	$40	$40	$50
Specialty care	$30	$30	$40
TELEHEALTH (PHONE/VIDEO)	$0	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$30	$30	$40
Chiropractic services[2]	$30	$30	$40
Naturopathic services	$20	$20	$20
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$30	$30	$40
OUTPATIENT THERAPIES[4]	$30	$30	$40
OUTPATIENT SURGERY	15%*	20%*	25%*
LAB	$20	$20	$20
X-RAY/DIAGNOSTIC TEST	$20	$20	$20
CT, MRI, AND PET SCANS	15%*	20%*	$300
INPATIENT HOSPITAL CARE	15%*	20%*	25%*
EMERGENCY DEPARTMENT VISIT	15%*	20%*	25%*
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	$10 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% specialty
MATERNITY CARE Inpatient	15%*	20%*	25%*

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

DEDUCTIBLE PLANS

PLAN NAME	KP WA Gold 1500/35	KP WA Gold 2000/35
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,500 per individual; $3,000 per family	$2,000 per individual; $4,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,200 per individual; $16,400 per family	$8,200 per individual; $16,400 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$35	$35
Urgent care	$55	$60
Specialty care	$45	$50
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$45	$50
Chiropractic services[2]	$45	$50
Naturopathic services	$35	$35
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$45	$50
OUTPATIENT THERAPIES[4]	$45	$50
OUTPATIENT SURGERY	25%*	25%*
LAB	$35	$35
X-RAY/DIAGNOSTIC TEST	$35	$45
CT, MRI, AND PET SCANS	$300	$300
INPATIENT HOSPITAL CARE	25%*	25%*
EMERGENCY DEPARTMENT VISIT	25%*	25%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $60 non-preferred brand-name; 50% specialty	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty
MATERNITY CARE Inpatient	25%*	25%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

DEDUCTIBLE PLANS

PLAN NAME	KP WA Silver 3000/45	KP WA Silver 4000/45
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,000 per individual; $6,000 per family	$4,000 per individual; $8,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,700 per individual; $17,400 per family	$8,900 per individual; $17,800 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$45	$45
Urgent care	$65	$70
Specialty care	$55	$60
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$55	$60
Chiropractic services[2]	$55	$60
Naturopathic services	$45	$45
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$55	$60
OUTPATIENT THERAPIES[4]	$55	$60
OUTPATIENT SURGERY	40%*	40%*
LAB	$35	$45
X-RAY/DIAGNOSTIC TEST	$45	$45
CT, MRI, AND PET SCANS	40%*	40%*
INPATIENT HOSPITAL CARE	40%*	40%*
EMERGENCY DEPARTMENT VISIT	40%*	40%*
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
MATERNITY CARE Inpatient	40%*	40%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

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 WA Silver 5000/50	KP WA Silver 6000/50
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$5,000 per individual; $10,000 per family	$6,000 per individual; $12,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,900 per individual; $17,800 per family	$9,100 per individual; $18,200 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$50	$50
Urgent care	$75	40%*
Specialty care	$70	$70
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$70	$70
Chiropractic services[2]	$70	$70
Naturopathic services	$50	$50
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$70	$70
OUTPATIENT THERAPIES[4]	$70	$70
OUTPATIENT SURGERY	40%*	40%*
LAB	$50	40%*
X-RAY/DIAGNOSTIC TEST	$50	40%*
CT, MRI, AND PET SCANS	40%*	40%*
INPATIENT HOSPITAL CARE	40%*	40%*
EMERGENCY DEPARTMENT VISIT	40%*	40%*
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
MATERNITY CARE Inpatient	40%*	40%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

DEDUCTIBLE PLANS

PLAN NAME	KP WA Bronze 7000/50	KP WA Bronze 9400/40
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$9,400 per individual; $18,800 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,450 per individual; $18,900 per family	$9,400 per individual; $18,800 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$50	$40 for first 3 visits; then $0*
Urgent care	40%*	$0*
Specialty care	$70*	$0*
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$70*	$0*
Chiropractic services[2]	$70*	$0*
Naturopathic services	$50	$0*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$70*	$0*
OUTPATIENT THERAPIES[4]	$70*	$0*
OUTPATIENT SURGERY	40%*	$0*
LAB	40%*	$0*
X-RAY/DIAGNOSTIC TEST	40%*	$0*
CT, MRI, AND PET SCANS	40%*	$0*
INPATIENT HOSPITAL CARE	40%*	$0*
EMERGENCY DEPARTMENT VISIT	40%*	$0*
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$30 generic; $0* preferred brand-name; $0* non-preferred brand-name; $0* specialty
MATERNITY CARE Inpatient	40%*	$0*

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS

PLAN NAME	KP WA Silver 3500/25% HSA	KP WA Bronze 7100/0% HSA
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,500/$7,000	$7,100/$14,200
ANNUAL OUT-OF-POCKET MAXIMUM	$6,500/$13,000	$7,100/$14,200
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	0%
Primary care	25%*	0%*
Urgent care	25%*	0%*
Specialty care	25%*	0%*
TELEHEALTH (PHONE/VIDEO)	$0*	0%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	25%*	0%*
Chiropractic services[2]	25%*	0%*
Naturopathic services	25%*	0%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	25%*	0%*
OUTPATIENT THERAPIES[4]	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; $40* preferred brand-name; 30%* 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 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

KP PLUS PLANS

PLAN NAME	KP WA 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 (PER CALENDAR YEAR)	$0	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$2,000 per individual; $4,000 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$40
Urgent care	$40	Not covered, except for services received outside the service area[2,3]
Specialty care	$30	$50
TELEHEALTH (PHONE/VIDEO)	$0	$40
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$30[4]	$50
Chiropractic services	$30[5]	$50
Naturopathic services	$20	$40
PHYSICIAN-REFERRED ALTERNATIVE CARE	$30[6]	Not covered
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[2]
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)[2]
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.** The 10 covered services limit does not apply. **3.** 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. **4.** Limited to 12 visits per year. **5.** Limited to 10 visits per year. **6.** Referred chiropractic/acupuncture based upon medical criteria. **7.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

KP PLUS PLANS

PLAN NAME	KP WA 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 (PER CALENDAR YEAR)	$1,000 per individual; $2,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$8,200 per individual; $16,400 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$40
Urgent care	$50	Not covered, except for services received outside the service area[2,3]
Specialty care	$40	$60
TELEHEALTH (PHONE/VIDEO)	$0	$40
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$40[4]	$60
Chiropractic services	$40[5]	$60
Naturopathic services	$20	$40
PHYSICIAN-REFERRED ALTERNATIVE CARE	$40[6]	Not covered
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[2]
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% specialty	$30 generic; $50 preferred brand-name; 50% non-preferred brand-name; 50% specialty (limited to 5 prescriptions fills per year)[2]
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]The 10 covered services limit does not apply. [3]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. [4]Limited to 12 visits per year. [5]Limited to 10 visits per year. [6]Referred chiropractic/acupuncture based upon medical criteria. [7]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

KP PLUS PLANS

PLAN NAME	KP WA 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 (PER CALENDAR YEAR)	$3,000 per individual; $6,000 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	$45	$65
Urgent care	$65	Not covered, except for services received outside the service area[2,3]
Specialty care	$55	$75
TELEHEALTH (PHONE/VIDEO)	$0	$65
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$55[4]	$75
Chiropractic services	$55[5]	$75
Naturopathic services	$45	$65
PHYSICIAN-REFERRED ALTERNATIVE CARE	$55[6]	Not covered
OUTPATIENT THERAPIES	$55[7]	$75
OUTPATIENT SURGERY	40%*	Not covered
LAB	$35	$55
X-RAY/DIAGNOSTIC TEST	$45	$65
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[2]
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)[2]
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.** The 10 covered services limit does not apply. **3.** 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. **4.** Limited to 12 visits per year. **5.** Limited to 10 visits per year. **6.** Referred chiropractic/acupuncture based upon medical criteria. **7.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

KP PLUS PLANS

PLAN NAME	KP WA Bronze 7000/50 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 (PER CALENDAR YEAR)	$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	$50	$70
Urgent care	40%*	Not covered, except for services received outside the service area[2,3]
Specialty care	$70*	$90
TELEHEALTH (PHONE/VIDEO)	$0	$70
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$70*[4]	$90
Chiropractic services	$70*[5]	$90
Naturopathic services	$50	$70
PHYSICIAN-REFERRED ALTERNATIVE CARE	$70*[6]	Not covered
OUTPATIENT THERAPIES	$70*[7]	$90
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[2]
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)[2]
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]The 10 covered services limit does not apply. [3]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. [4]Limited to 12 visits per year. [5]Limited to 10 visits per year. [6]Referred chiropractic/acupuncture based upon medical criteria. [7]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP WA 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	$3,000 per individual; $6,000 per family	$3,800 per individual; $7,600 per family	$7,000 per individual; $14,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	35%*
Primary care	$20	$30	35%*
Urgent care	$40	$60	35%*
Specialty care	$30	$40	35%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	35%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$30	$40	35%*
Chiropractic services[2]	$30	$40	35%*
Naturopathic services	$20	$30	35%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$30	$40	35%*
OUTPATIENT THERAPIES[4]	$30	$40	35%*
OUTPATIENT SURGERY	15%*	25%*	35%*
LAB	$20	$30	35%*
X-RAY/DIAGNOSTIC TEST	$20	$30	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 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP WA 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	$5,500 per individual; $11,000 per family	$7,500 per individual; $15,000 per family	$9,500 per individual; $19,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$35	$60	50%*
Urgent care	$60	$80	50%*
Specialty care	$55	$80	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$55	$80	50%*
Chiropractic services[2]	$55	$80	50%*
Naturopathic services	$35	$60	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$55	$80	50%*
OUTPATIENT THERAPIES[4]	$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 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP WA 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	$6,500 per individual; $13,000 per family	$8,500 per individual; $17,000 per family	$10,500 per individual; $21,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$20	$40	50%*
Urgent care	$50	$100	50%*
Specialty care	$40	$60	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$40	$60	50%*
Chiropractic services[2]	$40	$60	50%*
Naturopathic services	$20	$40	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$40	$60	50%*
OUTPATIENT THERAPIES[4]	$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 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP WA 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	$8,700 per individual; $17,400 per family	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$45	$60	50%*
Urgent care	$65	$80	50%*
Specialty care	$55	$70	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$55	$70	50%*
Chiropractic services[2]	$55	$70	50%*
Naturopathic services	$45	$60	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$55	$70	50%*
OUTPATIENT THERAPIES[4]	$55	$70	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	$35	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 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP WA 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	$8,900 per individual; $17,800 per family	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$45	$60	50%*
Urgent care	$70	$90	50%*
Specialty care	$60	$70	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$60	$70	50%*
Chiropractic services[2]	$60	$70	50%*
Naturopathic services	$45	$60	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$60	$70	50%*
OUTPATIENT THERAPIES[4]	$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 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP WA Bronze 7000/50 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$8,500 per individual; $17,000 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	$50	$60	50%*
Urgent care	40%*	45%*	50%*
Specialty care	$70*	$85*	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$70*	$85*	50%*
Chiropractic services[2]	$70*	$85*	50%*
Naturopathic services	$50	$60	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$70*	$85*	50%*
OUTPATIENT THERAPIES[4]	$70*	$85*	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; $60 preferred brand-name; 50%* nonpreferred brand-name; 50%* specialty	$40 generic; $80 preferred brand-name; 50%* nonpreferred 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 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

If you have employees who both live and work outside our service area, they may be eligible for a PPO Plus plan. Rates and approval subject to underwriting.

PPO PLUS PLANS (OUT-OF-AREA MEMBERS ONLY)

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

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies. **5.** Using Kaiser Permanente owned and operated pharmacies or those part of the MedImpact Pharmacy network.

PPO PLUS PLANS (OUT-OF-AREA MEMBERS ONLY)

PLAN NAME	KP WA Gold 1000/35 PPO Plus		KP WA Silver 3000/45 PPO Plus	
NETWORK	PPO Provider Network	Nonparticipating Providers	PPO Provider Network	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,000 per individual; $2,000 per family	$3,000 per individual; $6,000 per family	$3,000 per individual; $6,000 per family	$9,000 per individual; $18,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$6,500 per individual; $13,000 per family	$10,500 per individual; $21,000 per family	$8,700 per individual; $17,400 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays			
OFFICE VISITS Preventive care	$0	45%*	$0	50%*
Primary care	$35	45%*	$45	50%*
Urgent care	$65	45%*	$65	50%*
Specialty care	$55	45%*	$55	50%*
TELEHEALTH (PHONE/VIDEO)	$0	45%*	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$55	45%*	$55	50%*
Chiropractic services[2]	$55	45%*	$55	50%*
Naturopathic services	$35	45%*	$45	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$55	45%*	$55	50%*
OUTPATIENT THERAPIES[4]	$55	45%*	$55	50%*
OUTPATIENT SURGERY	35%*	45%*	40%*	50%*
LAB	$35	45%*	$35	50%*
X-RAY/DIAGNOSTIC TEST	$35	45%*	$45	50%*
CT, MRI, AND PET SCANS	35%*	45%*	40%*	50%*
INPATIENT HOSPITAL CARE	35%*	45%*	40%*	50%*
EMERGENCY DEPARTMENT VISIT	35%*		40%*	
OUTPATIENT PRESCRIPTION DRUGS[5]	$15 generic; $30 preferred brand-name; $50 non-preferred brand-name; 50% specialty	Not covered	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not Covered
MATERNITY CARE Inpatient	35%*	45%*	40%*	50%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies. **5.** Using Kaiser Permanente owned and operated pharmacies or those part of the MedImpact Pharmacy network.

PPO PLUS PLANS (OUT-OF-AREA MEMBERS ONLY)

PLAN NAME	KP WA Silver 4000/45 PPO Plus	
NETWORK	PPO Provider Network	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$4,000 per individual; $8,000 per family	$9,000 per individual; $18,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	50%*
Primary care	$45	50%*
Urgent care	$70	50%*
Specialty care	$60	50%*
TELEHEALTH (PHONE/VIDEO)	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$60	50%*
Chiropractic services[2]	$60	50%*
Naturopathic services	$45	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$60	50%*
OUTPATIENT THERAPIES[4]	$60	50%*
OUTPATIENT SURGERY	40%*	50%*
LAB	$45	50%*
X-RAY/DIAGNOSTIC TEST	$45	50%*
CT, MRI, AND PET SCANS	40%*	50%*
INPATIENT HOSPITAL CARE	40%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*	
OUTPATIENT PRESCRIPTION DRUGS[5]	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not Covered
MATERNITY CARE Inpatient	40%*	50%*

***Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies. **5.** Using Kaiser Permanente owned and operated pharmacies or those part of the MedImpact Pharmacy network.

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.

PPO PLUS PLANS (OUT-OF-AREA MEMBERS ONLY)

PLAN NAME	KP WA Bronze 7000/50 PPO Plus	
Network	PPO Provider Network	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$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	$15,000 per individual; $30,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	50%*
Primary care	$50	50%*
Urgent care	40%*	50%*
Specialty care	$70*	50%*
TELEHEALTH (PHONE/VIDEO)	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$70*	50%*
Chiropractic services[2]	$70*	50%*
Naturopathic services	$50	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$70*	50%*
OUTPATIENT THERAPIES[4]	$70*	50%*
OUTPATIENT SURGERY	40%*	50%*
LAB	40%*	50%*
X-RAY/DIAGNOSTIC TEST	40%*	50%*
CT, MRI, AND PET SCANS	40%*	50%*
INPATIENT HOSPITAL CARE	40%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*	
OUTPATIENT PRESCRIPTION DRUGS[5]	$30 generic; $60 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	Not Covered
MATERNITY CARE Inpatient	40%*	50%*

*Subject to annual medical deductible. **1.** Limited to 12 visits per year. **2.** Limited to 10 visits per year. **3.** Referred chiropractic/acupuncture based upon medical criteria. **4.** Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies. **5.** Using Kaiser Permanente owned and operated pharmacies or those part of the MedImpact Pharmacy network.

SENIOR ADVANTAGE PLAN

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
TELEHEALTH (PHONE/VIDEO)	$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.

Pediatric dental (benefits embedded in all medical plans)

All embedded pediatric dental plans are Dental Choice (PPO) plans.

PREVENTIVE AND DIAGNOSTIC SERVICES (ORAL EXAM, X-RAYS, TEETH CLEANING, FLUORIDE TREATMENTS)	$0
BASIC RESTORATIVE SERVICES (ROUTINE FILLINGS, BASIC CROWNS, SIMPLE EXTRACTIONS)	50%*
MAJOR RESTORATIVE SERVICES (GOLD OR PORCELAIN CROWNS, INLAYS, BRIDGE ABUTMENTS, PONTICS)	50%*

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 frames with lenses, conventional or disposable contact lenses in lieu of eyeglasses (limited to 1 pair per year for conventional lenses or a 12-month supply of disposable contact lenses per year); no charge for low vision aid or medically necessary contact lenses (does not apply to non-contracted provider networks).

HSA plans: Pediatric dental services are subject to the medical deductible, up to the maximum out of pocket, on HSA-qualified plans.

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 provides 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, PPO Plus, or Senior Advantage plans).

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.

Members on our PPO Plus plans can access these benefits through PPO and other nonparticipating providers and facilities.

*Pediatric dental services are subject to deductible, up to the maximum out of pocket, on HSA-qualified plans.

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**.

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 PPO Plus benefits

PPO Plus provides you with the opportunity to give your employees who live and work outside the service area the freedom to choose any doctor or hospital they want, anywhere in the country. Members can choose care from Kaiser Permanente providers, First Choice Health, First Health Network, and nonparticipating providers.

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, PPO Plus 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 2022. 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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