2023 PLANS AND PRODUCTS | OREGON AND WASHINGTON

Complete Suite™ plan comparison chart

Use this interactive overview of our portfolio of medical plans to see side-by-side comparisons that complement your health care strategy. Contact your Kaiser Permanente sales representative or account manager for more information on offerings.

kp.org/dualchoice/nw/producers

KAISER PERMANENTE®

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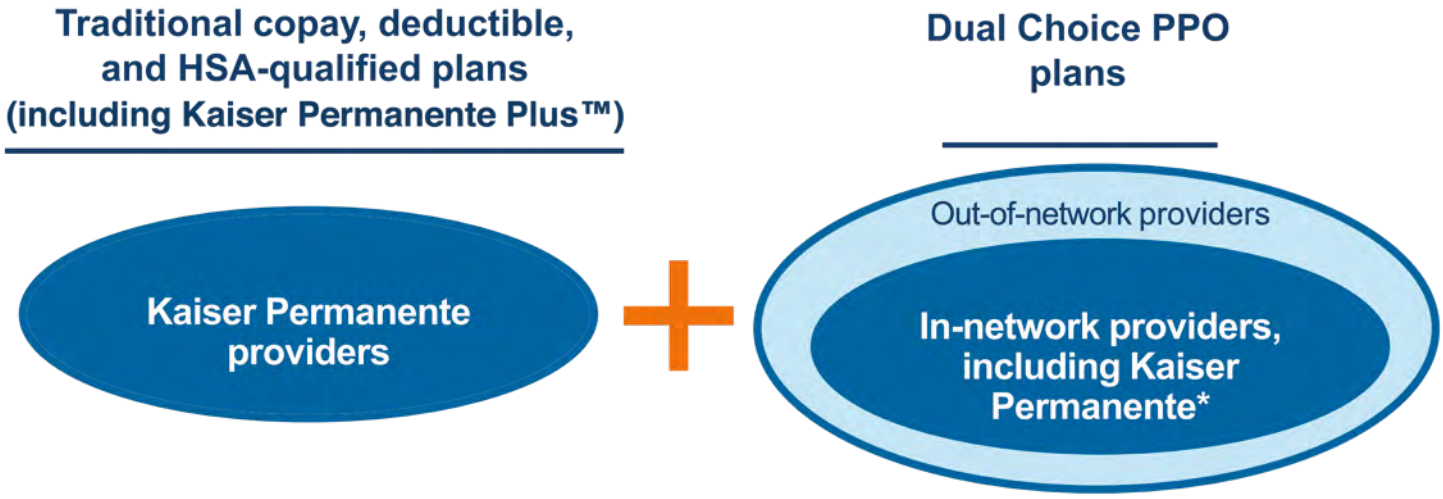
Table of contents

Complete Suite™ plan pairings and plan comparisons

Dual Choice PPO® plans must be paired with a traditional, deductible, or HSA-qualified high deductible base plan.



To see all available plan pairings, view our Complete Suite Pairing Guide. Out-of-Area PPO Plus® and Kaiser Permanente Senior Advantage plans are also available for group coverage.

All traditional copay and deductible plans are available with limited out-of-network benefits, called Kaiser Permanente Plus™ (KP Plus) plans. See the KP Plus tab for additional details.

Note: Deductible and traditional copay plans are designed with embedded accumulations. High deductible health plans using aggregate accumulation have been specifically noted. All other high deductible health plans are designed with embedded accumulations.

*In-network providers for Dual Choice PPO plans include First Choice Health and First Health Network providers.

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Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals.

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."

See plan comparisons

Reset

TRADITIONAL					
Plan Name	☐ TRAD PLAN A 10/1000	☐ TRAD PLAN B 20/1500	☐ TRAD PLAN C 20/2000	☐ TRAD PLAN D 30/2500	☐ TRAD PLAN E 35/3000
Annual medical deductible (IND/FAM) (per calendar year)	$0/$0	$0/$0	$0/$0	$0/$0	$0/$0
Annual out-of-pocket maximum (IND/FAM)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000
Office visits – preventive and well-child care	$0	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0	$0
Telehealth (phone/video)	$0	$0	$0	$0	$0
Office visits – primary care	$10	$20	$20	$30	$35
Office visits – urgent care	$30	$40	$40	$50	$60
Office visits – specialty care	$20	$30	$30	$40	$45
Office visits – naturopathic care	$10	$20	$20	$30	$35
Lab	$10	$20	$20	$30	$35
X-ray/diagnostic tests	$10	$20	$20	$30	$35
CT, MRI, and PET scans	$50	$50	$50	$50	$50
Outpatient surgery	$50	$50	$50	$100	$150
Inpatient hospital care	$100 per day, $500 per admission	$100 per day, $500 per admission	$200 per day, $1,000 per admission	$200 per day, $1,000 per admission	$800 per admission
Emergency care	$100	$100	$200	$200	$200
Routine eye exam	$10	$20	$20	$30	$35

These plans include 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 actual fee. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills.

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.

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See plan comparisons

Reset

DEDUCTIBLE

Plan Name	☐ DED PLAN A 250/10/10%/2000	☐ DED PLAN A 250/15/20%/2500	☐ DED PLAN B 500/20/10%/3000	☐ DED PLAN B 500/10%/10%/2000
Annual medical deductible (IND/FAM) (per calendar year)	$250/$750	$250/$750	$500/$1,500	$500/$1,500
Annual out-of-pocket maximum (IND/FAM)	$2,000/$6,000	$2,500/$7,500	$3,000/$6,000	$2,000/$6,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	$0	$0	$0
Office visits – primary care	$10	$15	$20	10%*
Office visits – urgent care	$10	$35	$40	10%*
Office visits – specialty care	$10	$25	$30	10%*
Office visits – naturopathic care	$10	$15	$20	10%*
Lab	10%*	$15	$20	10%*
X-ray/diagnostic tests	10%*	$15	$20	10%*
CT, MRI, and PET scans	10%*	$100	$100	10%*
Outpatient surgery	10%*	20%*	10%*	10%*
Inpatient hospital care	10%*	20%*	10%*	10%*
Emergency care	$200*	20%*	10%*	$200*
Routine eye exam	$10	$15	$20	10%*

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*After deductible.

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Reset

DEDUCTIBLE				
Plan Name	☐ DED PLAN B 500/10/20%/2000	☐ DED PLAN B 500/20/20%/3000	☐ DED PLAN C 750/20/20%/3000	☐ DED PLAN C 750/20/20%/3250
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	$500/$1,500	$750/$2,250	$750/$2,250
Annual out-of-pocket maximum (IND/FAM)	$2,000/$6,000	$3,000/$9,000	$3,000/$9,000	$3,250/$9,750
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	$0	$0	$0
Office visits – primary care	$10	$20	$20	$20
Office visits – urgent care	$10	$40	$20	$40
Office visits – specialty care	$10	$30	$20	$30
Office visits – naturopathic care	$10	$20	$20	$20
Lab	20%*	$20	20%*	$20
X-ray/diagnostic tests	20%*	$20	20%*	$20
CT, MRI, and PET scans	20%*	$100	20%*	$100
Outpatient surgery	20%*	20%*	$20*	20%*
Inpatient hospital care	20%*	20%*	20%*	20%*
Emergency care	$200*	20%*	$200*	20%*
Routine eye exam	$10	$20	$20	$20

These plans include 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 actual fee. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills.

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Reset

DEDUCTIBLE				
Plan Name	☐ DED PLAN C 750/20%/20%/3000	☐ DED PLAN D 1000/20/20%/3000	☐ DED PLAN D 1000/25/20%/4000	☐ DED PLAN E 1500/25/20%/5500
Annual medical deductible (IND/FAM) (per calendar year)	$750/$2,250	$1,000/$3,000	$1,000/$3,000	$1,500/$4,500
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	$3,000/$9,000	$4,000/$12,000	$5,500/$11,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	$0	$0	$0
Office visits – primary care	20%*	$20	$25	$25
Office visits – urgent care	20%*	$20	$45	$45
Office visits – specialty care	20%*	$20	$35	$35
Office visits – naturopathic care	20%*	$20	$25	$25
Lab	20%*	20%*	$25	$25
X-ray/diagnostic tests	20%*	20%*	$25	$25
CT, MRI, and PET scans	20%*	20%*	$100	$100
Outpatient surgery	20%*	20%*	20%*	20%*
Inpatient hospital care	20%*	20%*	20%*	20%*
Emergency care	$200*	$200*	20%*	20%*
Routine eye exam	20%*	$20	$25	$25

These plans include 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 actual fee. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills.

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See plan comparisons

Reset

DEDUCTIBLE				
Plan Name	☐ DED PLAN E 1500/20/30%/4000	☐ DED PLAN E 1500/30%/30%/4000	☐ DED PLAN F 2000/25/20%/5000	☐ DED PLAN G 2500/25/20%/5000
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$4,500	$1,500/$4,500	$2,000/$6,000	$2,500/$7,500
Annual out-of-pocket maximum (IND/FAM)	$4,000/$12,000	$4,000/$12,000	$5,000/$10,000	$5,000/$10,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	$0	$0	$0
Office visits – primary care	$20	30%*	$25	$25
Office visits – urgent care	$20	30%*	$45	$45
Office visits – specialty care	$20	30%*	$35	$35
Office visits – naturopathic care	$20	30%*	$25	$25
Lab	30%*	30%*	$25	$25
X-ray/diagnostic tests	30%*	30%*	$25	$25
CT, MRI, and PET scans	30%*	30%*	$100	$100
Outpatient surgery	30%*	30%*	20%*	20%*
Inpatient hospital care	30%*	30%*	20%*	20%*
Emergency care	$200*	$200*	20%*	20%*
Routine eye exam	$20	30%*	$25	$25

These plans include 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 actual fee. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills.

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See plan comparisons

Reset

DEDUCTIBLE				
Plan Name	☐ DED PLAN G 2500/30/30%/5000	☐ DED PLAN G 2500/30%/30%/5000	☐ DED PLAN H 3000/30/20%/7350	☐ DED PLAN H 3000/30%/30%/6000
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$2,500/$5,000	$3,000/$9,000	$3,000/$6,000
Annual out-of-pocket maximum (IND/FAM)	$5,000/$10,000	$5,000/$10,000	$7,350/$14,700	$6,000/$12,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	$0	$0	$0
Office visits – primary care	$30	30%*	$30	30%*
Office visits – urgent care	$30	30%*	$50	30%*
Office visits – specialty care	$30	30%*	$40	30%*
Office visits – naturopathic care	$30	30%*	$30	30%*
Lab	30%*	30%*	$30	30%*
X-ray/diagnostic tests	30%*	30%*	$30	30%*
CT, MRI, and PET scans	30%*	30%*	$100	30%*
Outpatient surgery	30%*	30%*	20%*	30%*
Inpatient hospital care	30%*	30%*	20%*	30%*
Emergency care	$200*	$200*	20%*	$200*
Routine eye exam	$30	30%*	$30	30%*

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*After deductible.

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See plan comparisons

Reset

DEDUCTIBLE			
Plan Name	☐ DED PLAN I 3500/30/20%/7350	☐ DED PLAN J 4000/30/20%/7500	☐ DED PLAN K 5000/30/20%/7350
Annual medical deductible (IND/FAM) (per calendar year)	$3,500/$10,500	$4,000/$10,000	$5,000/$10,000
Annual out-of-pocket maximum (IND/FAM)	$7,350/$14,700	$7,500/$15,000	$7,350/$14,700
Office visits – preventive and well-child care	$0	$0	$0
Office visits – prenatal care	$0	$0	$0
Telehealth (phone/video)	$0	$0	$0
Office visits – primary care	$30	$30	$30
Office visits – urgent care	$50	$50	$50
Office visits – specialty care	$40	$40	$40
Office visits – naturopathic care	$30	$30	$30
Lab	$30	$30	$30
X-ray/diagnostic tests	$30	$30	$30
CT, MRI, and PET scans	$100	$100	$100
Outpatient surgery	20%*	20%*	20%*
Inpatient hospital care	20%*	20%*	20%*
Emergency care	20%*	20%*	20%*
Routine eye exam	$30	$30	$30

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*After deductible.

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KAISER PERMANENTE®

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See plan comparisons

Reset

DEDUCTIBLE		
Plan Name	☐ DED PLAN L 6000/35/20%/7500	☐ DED PLAN M 7500/35/30%/8500
Annual medical deductible (IND/FAM) (per calendar year)	$6,000/$12,000	$7,500/$14,500
Annual out-of-pocket maximum (IND/FAM)	$7,500/$15,000	$8,500/$17,000
Office visits – preventive and well-child care	$0	$0
Office visits – prenatal care	$0	$0
Telehealth (phone/video)	$0	$0
Office visits – primary care	$35	$35
Office visits – urgent care	$55	$55
Office visits – specialty care	$45	$45
Office visits – naturopathic care	$35	$35
Lab	$35	$35
X-ray/diagnostic tests	$35	$35
CT, MRI, and PET scans	$150	$150
Outpatient surgery	20%*	30%*
Inpatient hospital care	20%*	30%*
Emergency care	20%*	30%*
Routine eye exam	$35	$35

These plans include 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 actual fee. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills.

*After deductible.

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KAISER PERMANENTE®

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See plan comparisons

Reset

VIRTUAL COMPLETE

Plan Name	☐ DED PLAN VC 2500/40/20%/5500	☐ DED PLAN VC 3000/40/30%/6000	☐ DED PLAN VC 4000/50/30%/7000	☐ DED PLAN VC 5000/50/40%/8000
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$3,000/$6,000	$4,000/$8,000	$5,000/$10,000
Annual out-of-pocket maximum (IND/FAM)	$5,500/$11,000	$6,000/$12,000	$7,000/$14,000	$8,000/$16,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	$0	$0	$0
Office visits – primary care	$40*[1]	$40*[1]	$50*[1]	$50*[1]
Office visits – urgent care	$40*	$40*	$50*	$50*
Office visits – specialty care	$40*	$40*	$50*	$50*
Office visits – naturopathic care	$40*[1]	$40*[1]	$50*[1]	$50*[1]
Lab	$15	$15	$15	$15
X-ray/diagnostic tests	20%*	30%*	30%*	40%*
CT, MRI, and PET scans	20%*	30%*	30%*	40%*
Outpatient surgery	20%*	30%*	30%*	40%*
Inpatient hospital care	20%*	30%*	30%*	40%*
Emergency care	20%*	30%*	30%*	40%*
Routine eye exam	$40*[1]	$40*[1]	$50*[1]	$50*[1]
Outpatient prescription drugs	$15 generic; $40* preferred brand-name; $60* non-preferred brand-name; 20%* (up to a max of $250) specialty	$15 generic; $40* preferred brand-name; $60* non-preferred brand-name; 30%* (up to a max of $250) specialty	$15 generic; $50* preferred brand-name; $70* non-preferred brand-name; 30%* (up to a max of $250) specialty	$15 generic; $50* preferred brand-name; $70* non-preferred brand-name; 40%* (up to a max of $250) specialty

*After deductible.

[1]Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).

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See plan comparisons

Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN A 1500/10%/2500	☐ HDHP PLAN A 1500/20%/3500	☐ HDHP PLAN B 2000/20%/4000	☐ HDHP PLAN B 2000/30%/4000
Accumulation type	Aggregate	Aggregate	Aggregate	Aggregate
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$3,000	$1,500/$3,000	$2,000/$4,000	$2,000/$4,000
Annual out-of-pocket maximum (IND/FAM)	$2,500/$5,000	$3,500/$7,000	$4,000/$8,000	$4,000/$8,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0*	$0*	$0*	$0*
Office visits – primary care	10%*	20%*	20%*	30%*
Office visits – urgent care	10%*	20%*	20%*	30%*
Office visits – specialty care	10%*	20%*	20%*	30%*
Office visits – naturopathic care	10%*	20%*	20%*	30%*
Lab	10%*	20%*	20%*	30%*
X-ray/diagnostic tests	10%*	20%*	20%*	30%*
CT, MRI, and PET scans	10%*	20%*	20%*	30%*
Outpatient surgery	10%*	20%*	20%*	30%*
Inpatient hospital care	10%*	20%*	20%*	30%*
Emergency care	10%*	20%*	20%*	30%*
Routine eye exam	10%*	20%*	20%*	30%*

*After deductible.

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HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN C 2500/20%/5000	☐ HDHP PLAN C 2500/30%/5000	☐ HDHP PLAN E 3000/20%/6000	☐ HDHP PLAN E 3000/30%/6000
Accumulation type	Aggregate	Aggregate	Embedded	Embedded
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$2,500/$5,000	$3,000/$6,000	$3,000/$6,000
Annual out-of-pocket maximum (IND/FAM)	$5,000/$7,500	$5,000/$7,500	$6,000/$12,000	$6,000/$12,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0*	$0*	$0*	$0*
Office visits – primary care	20%*	30%*	20%*	30%*
Office visits – urgent care	20%*	30%*	20%*	30%*
Office visits – specialty care	20%*	30%*	20%*	30%*
Office visits – naturopathic care	20%*	30%*	20%*	30%*
Lab	20%*	30%*	20%*	30%*
X-ray/diagnostic tests	20%*	30%*	20%*	30%*
CT, MRI, and PET scans	20%*	30%*	20%*	30%*
Outpatient surgery	20%*	30%*	20%*	30%*
Inpatient hospital care	20%*	30%*	20%*	30%*
Emergency care	20%*	30%*	20%*	30%*
Routine eye exam	20%*	30%*	20%*	30%*

*After deductible.

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Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN F 3500/20%/7000	☐ HDHP PLAN F 3500/30%/7000	☐ HDHP PLAN G 4000/20%/7000	☐ HDHP PLAN G 4000/30%/7000
Accumulation type	Embedded	Embedded	Embedded	Embedded
Annual medical deductible (IND/FAM) (per calendar year)	$3,500/$7,000	$3,500/$7,000	$4,000/$8,000	$4,000/$8,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0*	$0*	$0*	$0*
Office visits – primary care	20%*	30%*	20%*	30%*
Office visits – urgent care	20%*	30%*	20%*	30%*
Office visits – specialty care	20%*	30%*	20%*	30%*
Office visits – naturopathic care	20%*	30%*	20%*	30%*
Lab	20%*	30%*	20%*	30%*
X-ray/diagnostic tests	20%*	30%*	20%*	30%*
CT, MRI, and PET scans	20%*	30%*	20%*	30%*
Outpatient surgery	20%*	30%*	20%*	30%*
Inpatient hospital care	20%*	30%*	20%*	30%*
Emergency care	20%*	30%*	20%*	30%*
Routine eye exam	20%*	30%*	20%*	30%*

*After deductible.

These plans include limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% after deductible of the actual fee. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills.

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KAISER PERMANENTE®

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See plan comparisons

Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN G 4000/40%/7000	☐ HDHP PLAN H 5000/20%/7000	☐ HDHP PLAN H 5000/30%/7000
Accumulation type	Embedded	Embedded	Embedded
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$5,000/$10,000	$5,000/$10,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000
Office visits – preventive and well-child care	$0	$0	$0
Office visits – prenatal care	$0	$0	$0
Telehealth (phone/video)	$0*	$0*	$0*
Office visits – primary care	40%*	20%*	30%*
Office visits – urgent care	40%*	20%*	30%*
Office visits – specialty care	40%*	20%*	30%*
Office visits – naturopathic care	40%*	20%*	30%*
Lab	40%*	20%*	30%*
X-ray/diagnostic tests	40%*	20%*	30%*
CT, MRI, and PET scans	40%*	20%*	30%*
Outpatient surgery	40%*	20%*	30%*
Inpatient hospital care	40%*	20%*	30%*
Emergency care	40%*	20%*	30%*
Routine eye exam	40%*	20%*	30%*

*After deductible.

These plans include limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% after deductible of the actual fee. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills.

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Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN H 5000/40%/7000	☐ HDHP PLAN H 5000/50%/7000
Accumulation type	Embedded	Embedded
Annual medical deductible (IND/FAM) (per calendar year)	$5,000/$10,000	$5,000/$10,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$7,000/$14,000
Office visits – preventive and well-child care	$0	$0
Office visits – prenatal care	$0	$0
Telehealth (phone/video)	$0*	$0*
Office visits – primary care	40%*	50%*
Office visits – urgent care	40%*	50%*
Office visits – specialty care	40%*	50%*
Office visits – naturopathic care	40%*	50%*
Lab	40%*	50%*
X-ray/diagnostic tests	40%*	50%*
CT, MRI, and PET scans	40%*	50%*
Outpatient surgery	40%*	50%*
Inpatient hospital care	40%*	50%*
Emergency care	40%*	50%*
Routine eye exam	40%*	50%*

*After deductible.

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KP PLUS PLANS

In addition to the high-quality care provided within the Kaiser Permanente network, members may see out-of-network providers for up to 10 outpatient medical services and 5 prescription fills per year from any licensed provider outside the Kaiser Permanente care delivery system, anywhere in the United States.

KP Plus can be purchased as a stand-alone plan, or can be paired with any other product to allow members to take advantage of a variety of cost-saving mechanisms. Refer to the Complete Suite Plan pairing guide for specific Dual Choice plan pairings.

KP Plus Benefit Design Summary

Limited to 10 medical services and 5 Pharmacy fills per year

Services	Out-of-Network coverage
Medical Visits PCP Office Visit Specialty Office Visit Outpatient Mental Health and Substance Use Disorder Services Physical Therapy, Occupational Therapy, Speech Therapy, and Labs/X-Rays	$20 higher copay (or 10% higher coinsurance) than in-network 10 visits per member per year
Pharmacy Fills Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty	$20 higher copay (or 10% higher coinsurance) than in-network 5 pharmacy fills per member per year
Hospital Inpatient Outpatient surgery Skilled nursing facilities Maternity care	Not Covered Out-of-Network

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN A 10/1000		☐ KP PLUS PLAN B 20/1500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	N/A	N/A	N/A	N/A
Annual out-of-pocket maximum (IND/FAM)	$1,000/$2,000	N/A	$1,500/$3,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$10	$30	$20	$40
Office visits – urgent care	$30	Not covered, except for services received outside the service area[1,2]	$40	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$20	$40	$30	$50
Office visits – naturopathic care	$10	$30	$20	$40
Lab	$10	$30	$20	$40
X-ray/diagnostic tests	$10	$30	$20	$40
CT, MRI, and PET scans	$50	Not covered	$50	Not covered
Outpatient surgery	$50	Not covered	$50	Not covered
Inpatient hospital care	$100 per day, $500 per admission	Not covered	$100 per day, $500 per admission	Not covered
Emergency care	$100	Covered at the in-network cost share[1]	$100	Covered at the in-network cost share[1]
Routine eye exam	$10	$30	$20	$40
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

[1]The limit of 10 covered Services does not apply.

[2]If you are temporarily out of the service area, urgent care from a non-participating provider or non-participating facility may be covered if the services are deemed necessary to prevent serious deterioration of health and that the services could not be delayed until returning to the Kaiser Permanente service area.

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Reset

KP Plus

Plan name	☐ KP PLUS PLAN C 20/2000		☐ KP PLUS PLAN D 30/2500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	N/A	N/A	N/A	N/A
Annual out-of-pocket maximum (IND/FAM)	$2,000/$4,000	N/A	$2,500/$5,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$20	$40	$30	$50
Office visits – urgent care	$40	Not covered, except for services received outside the service area[1,2]	$50	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$30	$50	$40	$60
Office visits – naturopathic care	$20	$40	$30	$50
Lab	$20	$40	$30	$50
X-ray/diagnostic tests	$20	$40	$30	$50
CT, MRI, and PET scans	$50	Not covered	$50	Not covered
Outpatient surgery	$50	Not covered	$100	Not covered
Inpatient hospital care	$200 per day, $1,000 per admission	Not covered	$200 per day, $1,000 per admission	Not covered
Emergency care	$200	Covered at the in-network cost share[1]	$200	Covered at the in-network cost share[1]
Routine eye exam	$20	$40	$30	$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN E 35/3000		☐ KP PLUS PLAN A 250/10/10%/2000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	N/A	N/A	$250/$750	N/A
Annual out-of-pocket maximum (IND/FAM)	$3,000/$6,000	N/A	$2,000/$6,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$35	$55	$10	$30
Office visits – urgent care	$60	Not covered, except for services received outside the service area[1,2]	$10	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$45	$65	$10	$30
Office visits – naturopathic care	$35	$55	$10	$30
Lab	$35	$55	10%*	20%
X-ray/diagnostic tests	$35	$55	10%*	20%
CT, MRI, and PET scans	$50	Not covered	10%*	Not covered
Outpatient surgery	$150	Not covered	10%*	Not covered
Inpatient hospital care	$800 per admission	Not covered	10%*	Not covered
Emergency care	$200	Covered at the in-network cost share[1]	$200*	Covered at the in-network cost share[1]
Routine eye exam	$35	$55	$10	$30
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN A 250/15/20%/2500		☐ KP PLUS PLAN B 500/20/10%/3000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$250/$750	N/A	$500/$1,500	N/A
Annual out-of-pocket maximum (IND/FAM)	$2,500/$7,500	N/A	$3,000/$6,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$15	$35	$20	$40
Office visits – urgent care	$35	Not covered, except for services received outside the service area[1,2]	$40	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$25	$45	$30	$50
Office visits – naturopathic care	$15	$35	$20	$40
Lab	$15	$35	$20	$40
X-ray/diagnostic tests	$15	$35	$20	$40
CT, MRI, and PET scans	$100	Not covered	$100	Not covered
Outpatient surgery	20%*	Not covered	10%*	Not covered
Inpatient hospital care	20%*	Not covered	10%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	10%*	Covered at the in-network cost share[1]
Routine eye exam	$15	$35	$20	$40
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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Reset

KP Plus

Plan name	☐ KP PLUS PLAN B 500/10%/10%/2000		☐ KP PLUS PLAN B 500/10/20%/2000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	N/A	$500/$1,500	N/A
Annual out-of-pocket maximum (IND/FAM)	$2,000/$6,000	N/A	$2,000/$6,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	10%*	20%	$10	$30
Office visits – urgent care	10%*	Not covered, except for services received outside the service area[1,2]	$10	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	10%*	20%	$10	$30
Office visits – naturopathic care	10%*	20%	$10	$30
Lab	10%*	20%	20%*	30%
X-ray/diagnostic tests	10%*	20%	20%*	30%
CT, MRI, and PET scans	10%*	Not covered	20%*	Not covered
Outpatient surgery	10%*	Not covered	20%*	Not covered
Inpatient hospital care	10%*	Not covered	20%*	Not covered
Emergency care	$200*	Covered at the in-network cost share[1]	$200*	Covered at the in-network cost share[1]
Routine eye exam	10%*	20%	$10	$30
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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Reset

KP Plus

Plan name	☐ KP PLUS PLAN B 500/20/20%/3000		☐ KP PLUS PLAN C 750/20/20%/3250	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	N/A	$750/$2,250	N/A
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	N/A	$3,250/$9,750	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$20	$40	$20	$40
Office visits – urgent care	$40	Not covered, except for services received outside the service area[1,2]	$40	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$30	$50	$30	$50
Office visits – naturopathic care	$20	$40	$20	$40
Lab	$20	$40	$20	$40
X-ray/diagnostic tests	$20	$40	$20	$40
CT, MRI, and PET scans	$100	Not covered	$100	Not covered
Outpatient surgery	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	$20	$40	$20	$40
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN C 750/20/20%/3000		☐ KP PLUS PLAN C 750/20%/20%/3000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$750/$2,250	N/A	$750/$2,250	N/A
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	N/A	$3,000/$9,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$20	$40	20%*	30%
Office visits – urgent care	$20	Not covered, except for services received outside the service area[1,2]	20%*	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$20	$40	20%*	30%
Office visits – naturopathic care	$20	$40	20%*	30%
Lab	20%*	30%	20%*	30%
X-ray/diagnostic tests	20%*	30%	20%*	30%
CT, MRI, and PET scans	20%*	Not covered	20%*	Not covered
Outpatient surgery	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency care	$200*	Covered at the in-network cost share[1]	$200*	Covered at the in-network cost share[1]
Routine eye exam	$20	$40	20%*	30%
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN D 1000/20/20%/3000		☐ KP PLUS PLAN D 1000/25/20%/4000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$1,000/$3,000	N/A	$1,000/$3,000	N/A
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	N/A	$4,000/$12,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$20	$40	$25	$45
Office visits – urgent care	$20	Not covered, except for services received outside the service area[1,2]	$45	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$20	$40	$35	$55
Office visits – naturopathic care	$20	$40	$25	$45
Lab	20%*	30%	$25	$45
X-ray/diagnostic tests	20%*	30%	$25	$45
CT, MRI, and PET scans	20%*	Not covered	$100	Not covered
Outpatient surgery	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency care	$200*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	$20	$40	$25	$45
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN E 1500/25/20%/5500		☐ KP PLUS PLAN E 1500/20/30%/4000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$4,500	N/A	$1,500/$4,500	N/A
Annual out-of-pocket maximum (IND/FAM)	$5,500/$11,000	N/A	$4,000/$12,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$25	$45	$20	$40
Office visits – urgent care	$45	Not covered, except for services received outside the service area[1,2]	$20	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$35	$55	$20	$40
Office visits – naturopathic care	$25	$45	$20	$40
Lab	$25	$45	30%*	40%
X-ray/diagnostic tests	$25	$45	30%*	40%
CT, MRI, and PET scans	$100	Not covered	30%*	Not covered
Outpatient surgery	20%*	Not covered	30%*	Not covered
Inpatient hospital care	20%*	Not covered	30%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	$200*	Covered at the in-network cost share[1]
Routine eye exam	$25	$45	$20	$40
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

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Reset

KP Plus

Plan name	☐ KP PLUS PLAN E 1500/30%/30%/4000		☐ KP PLUS PLAN F 2000/25/20%/5000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$4,500	N/A	$2,000/$6,000	N/A
Annual out-of-pocket maximum (IND/FAM)	$4,000/$12,000	N/A	$5,000/$10,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	30%*	40%	$25	$45
Office visits – urgent care	30%*	Not covered, except for services received outside the service area[1,2]	$45	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	30%*	40%	$35	$55
Office visits – naturopathic care	30%*	40%	$25	$45
Lab	30%*	40%	$25	$45
X-ray/diagnostic tests	30%*	40%	$25	$45
CT, MRI, and PET scans	30%*	Not covered	$100	Not covered
Outpatient surgery	30%*	Not covered	20%*	Not covered
Inpatient hospital care	30%*	Not covered	20%*	Not covered
Emergency care	$200*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	30%*	40%	$25	$45
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
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Reset

KP Plus

Plan name	☐ KP PLUS PLAN G 2500/25/20%/5000		☐ KP PLUS PLAN G 2500/30/30%/5000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$7,500	N/A	$2,500/$5,000	N/A
Annual out-of-pocket maximum (IND/FAM)	$5,000/$10,000	N/A	$5,000/$10,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$25	$45	$30	$50
Office visits – urgent care	$45	Not covered, except for services received outside the service area[1,2]	$30	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$35	$55	$30	$50
Office visits – naturopathic care	$25	$45	$30	$50
Lab	$25	$45	30%*	40%
X-ray/diagnostic tests	$25	$45	30%*	40%
CT, MRI, and PET scans	$100	Not covered	30%*	Not covered
Outpatient surgery	20%*	Not covered	30%*	Not covered
Inpatient hospital care	20%*	Not covered	30%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	$200*	Covered at the in-network cost share[1]
Routine eye exam	$25	$45	$30	$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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Reset

KP Plus

Plan name	☐ KP PLUS PLAN G 2500/30%/30%/5000		☐ KP PLUS PLAN H 3000/30/20%/7350	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$5,000	N/A	$3,000/$9,000	N/A
Annual out-of-pocket maximum (IND/FAM)	$5,000/$10,000	N/A	$7,350/$14,700	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	30%*	40%	$30	$50
Office visits – urgent care	30%*	Not covered, except for services received outside the service area[1,2]	$50	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	30%*	40%	$40	$60
Office visits – naturopathic care	30%*	40%	$30	$50
Lab	30%*	40%	$30	$50
X-ray/diagnostic tests	30%*	40%	$30	$50
CT, MRI, and PET scans	30%*	Not covered	$100	Not covered
Outpatient surgery	30%*	Not covered	20%*	Not covered
Inpatient hospital care	30%*	Not covered	20%*	Not covered
Emergency care	$200*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	30%*	40%	$30	$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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Reset

KP Plus

Plan name	☐ KP PLUS PLAN H 3000/30%/30%/6000		☐ KP PLUS PLAN I 3500/30/20%/7350	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$3,000/$6,000	N/A	$3,500/$10,500	N/A
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	N/A	$7,350/$14,700	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	30%*	40%	$30	$50
Office visits – urgent care	30%*	Not covered, except for services received outside the service area[1,2]	$50	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	30%*	40%	$40	$60
Office visits – naturopathic care	30%*	40%	$30	$50
Lab	30%*	40%	$30	$50
X-ray/diagnostic tests	30%*	40%	$30	$50
CT, MRI, and PET scans	30%*	Not covered	$100	Not covered
Outpatient surgery	30%*	Not covered	20%*	Not covered
Inpatient hospital care	30%*	Not covered	20%*	Not covered
Emergency care	$200*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	30%*	40%	$30	$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
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Reset

KP Plus

Plan name	☐ KP PLUS PLAN J 4000/30/20%/7500		☐ KP PLUS PLAN K 5000/30/20%/7350	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$10,000	N/A	$5,000/$10,000	N/A
Annual out-of-pocket maximum (IND/FAM)	$7,500/$15,000	N/A	$7,350/$14,700	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$30	$50	$30	$50
Office visits – urgent care	$50	Not covered, except for services received outside the service area[1,2]	$50	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$40	$60	$40	$60
Office visits – naturopathic care	$30	$50	$30	$50
Lab	$30	$50	$30	$50
X-ray/diagnostic tests	$30	$50	$30	$50
CT, MRI, and PET scans	$100	Not covered	$100	Not covered
Outpatient surgery	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	$30	$50	$30	$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN L 6000/35/20%/7500		☐ KP PLUS PLAN M 7500/35/30%/8500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$6,000/$12,000	N/A	$7,500/$14,500	N/A
Annual out-of-pocket maximum (IND/FAM)	$7,500/$15,000	N/A	$8,500/$17,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0	Cost share applicable to the service when provided in person.	$0	Cost share applicable to the service when provided in person.
Office visits – primary care	$35	$55	$35	$55
Office visits – urgent care	$55	Not covered, except for services received outside the service area[1,2]	$55	Not covered, except for services received outside the service area[1,2]
Office visits – specialty care	$45	$65	$45	$65
Office visits – naturopathic care	$35	$55	$35	$55
Lab	$35	$55	$35	$55
X-ray/diagnostic tests	$35	$55	$35	$55
CT, MRI, and PET scans	$150	Not covered	$150	Not covered
Outpatient surgery	20%*	Not covered	30%*	Not covered
Inpatient hospital care	20%*	Not covered	30%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	30%*	Covered at the in-network cost share[1]
Routine eye exam	$35	$55	$35	$55
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
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Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN A 10/1500		☐ DUAL CHOICE PPO PLAN B 20/2000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$0/$0	$1,500/$3,000	$0/$0	$2,000/$4,000
Annual out-of-pocket maximum (IND/FAM)	$1,500/$3,000	$4,500/$9,000	$2,000/$4,000	$6,000/$12,000
Office visits – preventive and well-child care	$0	30%*	$0	30%*
Office visits – prenatal care	$0	30%*	$0	30%*
Telehealth (phone/video)	$0	30%*	$0	30%*
Office visits – primary care	$30 ($10 enhanced benefit)	30%*	$40 ($20 enhanced benefit)	30%*
Office visits – urgent care	$60 ($30 enhanced benefit)	30%*	$80 ($40 enhanced benefit)	30%*
Office visits – specialty care	$40 ($20 enhanced benefit)	30%*	$50 ($30 enhanced benefit)	30%*
Office visits – naturopathic care	$10	30%*	$20	30%*
Lab	$10	30%*	$20	30%*
X-ray/diagnostic tests	$10	30%*	$20	30%*
CT, MRI, and PET scans	$50	30%*	$50	30%*
Outpatient surgery	$50	30%*	$50	30%*
Inpatient hospital care	$100 per day, $500 per admission	30%*	$100 per day, $500 per admission	30%*
Emergency care	$100		$100	
Routine eye exam	$30 ($10 enhanced benefit)	30%*	$40 ($20 enhanced benefit)	30%*

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Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN C 20/2500		☐ DUAL CHOICE PPO PLAN D 30/3000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$0/$0	$2,000/$4,000	$0/$0	$2,000/$4,000
Annual out-of-pocket maximum (IND/FAM)	$2,500/$5,000	$6,000/$12,000	$3,000/$6,000	$6,000/$12,000
Office visits – preventive and well-child care	$0	30%*	$0	30%*
Office visits – prenatal care	$0	30%*	$0	30%*
Telehealth (phone/video)	$0	30%*	$0	30%*
Office visits – primary care	$40 ($20 enhanced benefit)	30%*	$50 ($30 enhanced benefit)	30%*
Office visits – urgent care	$80 ($40 enhanced benefit)	30%*	$100 ($50 enhanced benefit)	30%*
Office visits – specialty care	$50 ($30 enhanced benefit)	30%*	$60 ($40 enhanced benefit)	30%*
Office visits – naturopathic care	$20	30%*	$30	30%*
Lab	$20	30%*	$30	30%*
X-ray/diagnostic tests	$20	30%*	$30	30%*
CT, MRI, and PET scans	$50	30%*	$50	30%*
Outpatient surgery	$50	30%*	$100	30%*
Inpatient hospital care	$200 per day, $1,000 per admission	30%*	$200 per day, $1,000 per admission	30%*
Emergency care	$200		$200	
Routine eye exam	$40 ($20 enhanced benefit)	30%*	$50 ($30 enhanced benefit)	30%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN E 35/3500		☐ DUAL CHOICE PPO PLAN A 250/10/10%/2500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$0/$0	$2,000/$4,000	$250/$750	$2,000/$6,000
Annual out-of-pocket maximum (IND/FAM)	$3,500/$7,000	$6,000/$12,000	$2,500/$7,500	$6,000/$12,000
Office visits – preventive and well-child care	$0	30%*	$0	30%*
Office visits – prenatal care	$0	30%*	$0	30%*
Telehealth (phone/video)	$0	30%*	$0	30%*
Office visits – primary care	$55 ($35 enhanced benefit)	30%*	$30 ($10 enhanced benefit)	30%*
Office visits – urgent care	$110 ($60 enhanced benefit)	30%*	$30 ($10 enhanced benefit)	30%*
Office visits – specialty care	$65 ($45 enhanced benefit)	30%*	$30 ($10 enhanced benefit)	30%*
Office visits – naturopathic care	$35	30%*	$10	30%*
Lab	$35	30%*	10%*	30%*
X-ray/diagnostic tests	$35	30%*	10%*	30%*
CT, MRI, and PET scans	$50	30%*	10%*	30%*
Outpatient surgery	$150	30%*	10%*	30%*
Inpatient hospital care	$800 per admission	30%*	10%*	30%*
Emergency care	$200		$200*	
Routine eye exam	$55 ($35 enhanced benefit)	30%*	30 ($10 enhanced benefit)	30%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN A 250/15/20%/3000		☐ DUAL CHOICE PPO PLAN B 500/20/10%/3500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$250/$750	$2,000/$6,000	$500/$1,500	$2,500/$7,500
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	$6,000/$12,000	$3,500/$10,500	$7,500/$15,000
Office visits – preventive and well-child care	$0	30%*	$0	30%*
Office visits – prenatal care	$0	30%*	$0	30%*
Telehealth (phone/video)	$0	30%*	$0	30%*
Office visits – primary care	$35 ($15 enhanced benefit)	30%*	$40 ($20 enhanced benefit)	30%*
Office visits – urgent care	$55 ($35 enhanced benefit)	30%*	$80 ($40 enhanced benefit)	30%*
Office visits – specialty care	$45 ($25 enhanced benefit)	30%*	$50 ($30 enhanced benefit)	30%*
Office visits – naturopathic care	$15	30%*	$20	30%*
Lab	$15	30%*	$20	30%*
X-ray/diagnostic tests	$15	30%*	$20	30%*
CT, MRI, and PET scans	$100	30%*	$100	30%*
Outpatient surgery	20%*	30%*	10%*	30%*
Inpatient hospital care	20%*	30%*	10%*	30%*
Emergency care	20%*		10%*	
Routine eye exam	$35 ($15 enhanced benefit)	30%*	$40 ($20 enhanced benefit)	30%*

*After deductible.

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KAISER PERMANENTE®

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN B 500/10%/10%/3000		☐ DUAL CHOICE PPO PLAN B 500/10/20%/3000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	$2,500/$7,500	$500/$1,500	$2,500/$7,500
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	$7,500/$15,000	$3,000/$9,000	$7,500/$15,000
Office visits – preventive and well-child care	$0	30%*	$0	40%*
Office visits – prenatal care	$0	30%*	$0	40%*
Telehealth (phone/video)	$0	30%*	$0	40%*
Office visits – primary care	20%* (10%* enhanced benefit)	30%*	$30 ($10 enhanced benefit)	40%*
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	$30 ($10 enhanced benefit)	40%*
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	$30 ($10 enhanced benefit)	40%*
Office visits – naturopathic care	10%*	30%*	$10	40%*
Lab	10%*	30%*	20%*	40%*
X-ray/diagnostic tests	10%*	30%*	20%*	40%*
CT, MRI, and PET scans	10%*	30%*	20%*	40%*
Outpatient surgery	10%*	30%*	20%*	40%*
Inpatient hospital care	10%*	30%*	20%*	40%*
Emergency care	$200*		$200*	
Routine eye exam	20%* (10%* enhanced benefit)	30%*	$30 ($10 enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN B 500/20/20%/3500		☐ DUAL CHOICE PPO PLAN C 750/20/20%/3500 (w/SPLIT COPAYS)	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	$2,500/$7,500	$750/$2,250	$3,000/$9,000
Annual out-of-pocket maximum (IND/FAM)	$3,500/$10,500	$7,500/$15,000	$3,500/$10,500	$7,500/$22,500
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0	40%*	$0	40%*
Office visits – primary care	$40 ($20 enhanced benefit)	40%*	$40 ($20 enhanced benefit)	40%*
Office visits – urgent care	$80 ($40 enhanced benefit)	40%*	$80 ($40 enhanced benefit)	40%*
Office visits – specialty care	$50 ($30 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	40%*
Office visits – naturopathic care	$20	40%*	$20	40%*
Lab	$20	40%*	$20	40%*
X-ray/diagnostic tests	$20	40%*	$20	40%*
CT, MRI, and PET scans	$100	40%*	$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	$40 ($20 enhanced benefit)	40%*	$40 ($20 enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN C 750/20/20%/3500 (w/o SPLIT COPAYS)		☐ DUAL CHOICE PPO PLAN C 750/20%/20%/3500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$750/$2,250	$3,000/$9,000	$750/$2,250	$3,000/$9,000
Annual out-of-pocket maximum (IND/FAM)	$3,500/$10,500	$7,500/$22,500	$3,500/$10,500	$7,500/$22,500
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0	40%*	$0	40%*
Office visits – primary care	$40 ($20 enhanced benefit)	40%*	30%*(20%* enhanced benefit)	40%*
Office visits – urgent care	$40 ($20 enhanced benefit)	40%*	30%*(20%* enhanced benefit)	40%*
Office visits – specialty care	$40 ($20 enhanced benefit)	40%*	30%*(20%* enhanced benefit)	40%*
Office visits – naturopathic care	$20	40%*	20%*	40%*
Lab	20%*	40%*	20%*	40%*
X-ray/diagnostic tests	20%*	40%*	20%*	40%*
CT, MRI, and PET scans	20%*	40%*	20%*	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	$200*		$200*	
Routine eye exam	$40 ($20 enhanced benefit)	40%*	30%*(20%* enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN D 1000/20/20%/4000		☐ DUAL CHOICE PPO PLAN D 1000/25/20%/5000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$1,000/$3,000	$3,000/$9,000	$1,000/$3,000	$3,000/$9,000
Annual out-of-pocket maximum (IND/FAM)	$4,000/$12,000	$9,000/$27,000	$5,000/$15,000	$9,000/$27,000
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0	40%*	$0	40%*
Office visits – primary care	$40 ($20 enhanced benefit)	40%*	$45 ($25 enhanced benefit)	40%*
Office visits – urgent care	$40 ($20 enhanced benefit)	40%*	$90 ($45 enhanced benefit)	40%*
Office visits – specialty care	$40 ($20 enhanced benefit)	40%*	$55 ($35 enhanced benefit)	40%*
Office visits – naturopathic care	$20	40%*	$25	40%*
Lab	20%*	40%*	$25	40%*
X-ray/diagnostic tests	20%*	40%*	$25	40%*
CT, MRI, and PET scans	20%*	40%*	$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	$200*		20%*	
Routine eye exam	$40 ($20 enhanced benefit)	40%*	$45 ($25 enhanced benefit)	40%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN E 1500/25/20%/6000		☐ DUAL CHOICE PPO PLAN E 1500/20/30%/5000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$4,500	$3,500/$10,500	$1,500/$4,500	$3,500/$10,500
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$10,500/$21,000	$5,000/$12,000	$10,500/$21,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0	40%*	$0	50%*
Office visits – primary care	$45 ($25 enhanced benefit)	40%*	$40 ($20 enhanced benefit)	50%*
Office visits – urgent care	$90 ($45 enhanced benefit)	40%*	$40 ($20 enhanced benefit)	50%*
Office visits – specialty care	$55 ($35 enhanced benefit)	40%*	$40 ($20 enhanced benefit)	50%*
Office visits – naturopathic care	$25	40%*	$20	50%*
Lab	$25	40%*	30%*	50%*
X-ray/diagnostic tests	$25	40%*	30%*	50%*
CT, MRI, and PET scans	$100	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		$200*	
Routine eye exam	$45 ($25 enhanced benefit)	40%*	$40 ($20 enhanced benefit)	50%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN E 1500/30%/30%/5000		☐ DUAL CHOICE PPO PLAN F 2000/25/20%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$4,500	$3,500/$10,500	$2,000/$6,000	$4,000/$12,000
Annual out-of-pocket maximum (IND/FAM)	$5,000/$12,000	$10,500/$21,000	$6,000/$12,000	$12,000/$24,000
Office visits – preventive and well-child care	$0	50%*	$0	40%*
Office visits – prenatal care	$0	50%*	$0	40%*
Telehealth (phone/video)	$0	50%*	$0	40%*
Office visits – primary care	40%*(30%* enhanced benefit)	50%*	$45 ($25 enhanced benefit)	40%*
Office visits – urgent care	40%*(30%* enhanced benefit)	50%*	$90 ($45 enhanced benefit)	40%*
Office visits – specialty care	40%*(30%* enhanced benefit)	50%*	$55 ($35 enhanced benefit)	40%*
Office visits – naturopathic care	30%*	50%*	$25	40%*
Lab	30%*	50%*	$25	40%*
X-ray/diagnostic tests	30%*	50%*	$25	40%*
CT, MRI, and PET scans	30%*	50%*	$100	40%*
Outpatient surgery	30%*	50%*	20%*	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency care	$200*		20%*	
Routine eye exam	40%*(30%* enhanced benefit)	50%*	$45 ($25 enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN G 2500/25/20%/6000		☐ DUAL CHOICE PPO PLAN G 2500/30/30%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$7,500	$4,500/$13,500	$2,500/$5,000	$4,500/$13,500
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$13,500/$27,000	$6,000/$12,000	$13,500/$27,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0	40%*	$0	50%*
Office visits – primary care	$45 ($25 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	50%*
Office visits – urgent care	$90 ($45 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	50%*
Office visits – specialty care	$55 ($35 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	50%*
Office visits – naturopathic care	$25	40%*	$30	50%*
Lab	$25	40%*	30%*	50%*
X-ray/diagnostic tests	$25	40%*	30%*	50%*
CT, MRI, and PET scans	$100	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		$200*	
Routine eye exam	$45 ($25 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	50%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN G 2500/30%/30%/6000		☐ DUAL CHOICE PPO PLAN H 3000/30/20%/8150	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$4,500/$13,500	$3,000/$9,000	$5,000/$15,000
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$13,500/$27,000	$8,150/$16,300	$15,000/$30,000
Office visits – preventive and well-child care	$0	50%*	$0	40%*
Office visits – prenatal care	$0	50%*	$0	40%*
Telehealth (phone/video)	$0	50%*	$0	40%*
Office visits – primary care	40%* (30%* enhanced benefit)	50%*	$50 ($30 enhanced benefit)	40%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	$100 ($50 enhanced benefit)	40%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	$60 ($40 enhanced benefit)	40%*
Office visits – naturopathic care	30%*	50%*	$30	40%*
Lab	30%*	50%*	$30	40%*
X-ray/diagnostic tests	30%*	50%*	$30	40%*
CT, MRI, and PET scans	30%*	50%*	$100	40%*
Outpatient surgery	30%*	50%*	20%*	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency care	$200*		20%*	
Routine eye exam	40%* (30%* enhanced benefit)	50%*	$50 ($30 enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN H 3000/30%/30%/7000		☐ DUAL CHOICE PPO PLAN I 3500/30/20%/8000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$3,000/$6,000	$5,000/$15,000	$3,500/$10,500	$5,500/$16,500
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$15,000/$30,000	$8,000/$16,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	50%*	$0	40%*
Office visits – prenatal care	$0	50%*	$0	40%*
Telehealth (phone/video)	$0	50%*	$0	40%*
Office visits – primary care	40%* (30%* enhanced benefit)	50%*	$50 ($30 enhanced benefit)	40%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	$100 ($50 enhanced benefit)	40%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	$60 ($40 enhanced benefit)	40%*
Office visits – naturopathic care	30%*	50%*	$30	40%*
Lab	30%*	50%*	$30	40%*
X-ray/diagnostic tests	30%*	50%*	$30	40%*
CT, MRI, and PET scans	30%*	50%*	$100	40%*
Outpatient surgery	30%*	50%*	20%*	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency care	$200*		20%*	
Routine eye exam	40%* (30%* enhanced benefit)	50%*	$50 ($30 enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN J 4000/30/20%/8150		☐ DUAL CHOICE PPO PLAN K 5000/30/20%/8150	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$10,000	$6,000/$18,000	$5,000/$10,000	$6,500/$19,500
Annual out-of-pocket maximum (IND/FAM)	$8,150/$16,300	$15,000/$30,000	$8,150/$16,300	$15,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0	40%*	$0	40%*
Office visits – primary care	$50 ($30 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	40%*
Office visits – urgent care	$100 ($50 enhanced benefit)	40%*	$100 ($50 enhanced benefit)	40%*
Office visits – specialty care	$60 ($40 enhanced benefit)	40%*	$60 ($40 enhanced benefit)	40%*
Office visits – naturopathic care	$30	40%*	$30	40%*
Lab	$30	40%*	$30	40%*
X-ray/diagnostic tests	$30	40%*	$30	40%*
CT, MRI, and PET scans	$100	40%*	$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	$50 ($30 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	40%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN L 6000/35/20%/8000		☐ DUAL CHOICE PPO PLAN M 7500/35/30%/8500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$6,000/$12,000	$7,500/$18,000	$7,500/$14,500	$8,500/$19,500
Annual out-of-pocket maximum (IND/FAM)	$8,000/$16,000	$15,000/$30,000	$8,500/$17,000	$17,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0	40%*	$0	50%*
Office visits – primary care	$55 ($35 enhanced benefit)	40%*	$55 ($35 enhanced benefit)	50%*
Office visits – urgent care	$100 ($55 enhanced benefit)	40%*	$100 ($55 enhanced benefit)	50%*
Office visits – specialty care	$65 ($45 enhanced benefit)	40%*	$65 ($45 enhanced benefit)	50%*
Office visits – naturopathic care	$35	40%*	$35	50%*
Lab	$35	40%*	$35	50%*
X-ray/diagnostic tests	$35	40%*	$35	50%*
CT, MRI, and PET scans	$150	40%*	$150	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		30%*	
Routine eye exam	$55 ($35 enhanced benefit)	40%*	$55 ($35 enhanced benefit)	50%*

*After deductible.

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To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."

See plan comparisons

Reset

Dual Choice PPO Virtual Complete

Plan name	☐ DUAL CHOICE PPO PLAN VC 2500/40/20%/6500	
Network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$5,000/$15,000
Annual out-of-pocket maximum (IND/FAM)	$6,500/$13,000	$13,500/$27,000
Office visits – preventive and well-child care	$0	40%*
Office visits – prenatal care	$0	40%*
Telehealth (phone/video)	$0	40%*
Office visits – primary care	$60* ($40* enhanced benefit)[1]	40%*
Office visits – urgent care	$60* ($40* enhanced benefit)	40%*
Office visits – specialty care	$60* ($40* enhanced benefit)	40%*
Office visits – naturopathic care	$40*[1]	40%*
Lab	$15	40%*
X-ray/diagnostic tests	20%*	40%*
CT, MRI, and PET scans	20%*	40%*
Outpatient surgery	20%*	40%*
Inpatient hospital care	20%*	40%*
Emergency care	20%*	
Routine eye exam	$60* ($40* enhanced benefit)[1]	40%*
Outpatient prescription drugs	**Kaiser Permanente Pharmacies**	
	$15* generic; $40* preferred brand-name; $60* non-preferred brand-name; 20%* (up to a max of $250) specialty	Not covered
	MedImpact Pharmacies	
	$25* generic; $60* preferred brand-name; $90* non-preferred brand-name; 30%* specialty	Not covered

*After deductible.

[1]Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).

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KAISER PERMANENTE®

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To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."

See plan comparisons

Reset

Dual Choice PPO Virtual Complete

Plan name	☐ DUAL CHOICE PPO PLAN VC 3000/40/30%/7000	
Network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$3,000/$6,000	$6,000/$18,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	50%*
Office visits – prenatal care	$0	50%*
Telehealth (phone/video)	$0	50%*
Office visits – primary care	$60* ($40* enhanced benefit)[1]	50%*
Office visits – urgent care	$60* ($40* enhanced benefit)	50%*
Office visits – specialty care	$60* ($40* enhanced benefit)	50%*
Office visits – naturopathic care	$40*[1]	50%*
Lab	$15	50%*
X-ray/diagnostic tests	30%*	50%*
CT, MRI, and PET scans	30%*	50%*
Outpatient surgery	30%*	50%*
Inpatient hospital care	30%*	50%*
Emergency care	30%*	
Routine eye exam	$60* ($40* enhanced benefit)[1]	50%*
Outpatient prescription drugs	**Kaiser Permanente Pharmacies**	
	$15* generic; $40* preferred brand-name; $60* non-preferred brand-name; 30%* (up to a max of $250) specialty	Not covered
	MedImpact Pharmacies	
	$25* generic; $60* preferred brand-name; $90* non-preferred brand-name; 40%* specialty	Not covered

*After deductible.

[1]Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).

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Reset

Dual Choice PPO Virtual Complete

Plan name	☐ DUAL CHOICE PPO PLAN VC 4000/50/30%/8150	
Network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$8,000/$16,000
Annual out-of-pocket maximum (IND/FAM)	$8,150/$16,300	$15,000/$30,000
Office visits – preventive and well-child care	$0	50%*
Office visits – prenatal care	$0	50%*
Telehealth (phone/video)	$0	50%*
Office visits – primary care	$70* ($50* enhanced benefit)[1]	50%*
Office visits – urgent care	$70* ($50* enhanced benefit)	50%*
Office visits – specialty care	$70* ($50* enhanced benefit)	50%*
Office visits – naturopathic care	$50*[1]	50%*
Lab	$15	50%*
X-ray/diagnostic tests	30%*	50%*
CT, MRI, and PET scans	30%*	50%*
Outpatient surgery	30%*	50%*
Inpatient hospital care	30%*	50%*
Emergency care	30%*	
Routine eye exam	$70* ($50* enhanced benefit)[1]	50%*
Outpatient prescription drugs	**Kaiser Permanente Pharmacies**	
	$15* generic; $50* preferred brand-name; $70* non-preferred brand-name; 30%* (up to a max of $250) specialty	Not covered
	MedImpact Pharmacies	
	$25* generic; $70* preferred brand-name; $100* non-preferred brand-name; 40%* specialty	Not covered

*After deductible.

[1]Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).

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Reset

Dual Choice PPO Virtual Complete

Plan name	☐ DUAL CHOICE PPO PLAN VC 5000/50/40%/8150	
Network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$5,000/$10,000	$10,000/$20,000
Annual out-of-pocket maximum (IND/FAM)	$8,150/$16,300	$15,000/$30,000
Office visits – preventive and well-child care	$0	50%*
Office visits – prenatal care	$0	50%*
Telehealth (phone/video)	$0	50%*
Office visits – primary care	$70* ($50* enhanced benefit)[1]	50%*
Office visits – urgent care	$70* ($50* enhanced benefit)	50%*
Office visits – specialty care	$70* ($50* enhanced benefit)	50%*
Office visits – naturopathic care	$50*[1]	50%*
Lab	$15	50%*
X-ray/diagnostic tests	40%*	50%*
CT, MRI, and PET scans	40%*	50%*
Outpatient surgery	40%*	50%*
Inpatient hospital care	40%*	50%*
Emergency care	40%*	
Routine eye exam	$70* ($50* enhanced benefit)[1]	50%*
Outpatient prescription drugs	**Kaiser Permanente Pharmacies**	
	$15* generic; $50* preferred brand-name; $70* non-preferred brand-name; 40%* (up to a max of $250) specialty	Not covered
	MedImpact Pharmacies	
	$25* generic; $70* preferred brand-name; $100* non-preferred brand-name; 50%* specialty	Not covered

*After deductible.

[1]Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).

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Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN A 1500/10%/2500		☐ DUAL CHOICE PPO HDHP PLAN A 1500/20%/3500	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Aggregate		Aggregate	
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$3,000	$3,500/$9,750	$1,500/$3,000	$3,500/$9,750
Annual out-of-pocket maximum (IND/FAM)	$2,500/$5,000	$10,500/$21,000	$3,500/$7,000	$11,500/$23,000
Office visits – preventive and well-child care	$0	30%*	$0	40%*
Office visits – prenatal care	$0	30%*	$0	40%*
Telehealth (phone/video)	$0*	30%*	$0*	40%*
Office visits – primary care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – naturopathic care	10%*	30%*	20%*	40%*
Lab	10%*	30%*	20%*	40%*
X-ray/diagnostic tests	10%*	30%*	20%*	40%*
CT, MRI, and PET scans	10%*	30%*	20%*	40%*
Outpatient surgery	10%*	30%*	20%*	40%*
Inpatient hospital care	10%*	30%*	20%*	40%*
Emergency care	10%*		20%*	
Routine eye exam	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN B 2000/20%/4000		☐ DUAL CHOICE PPO HDHP PLAN B 2000/30%/4000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Aggregate		Aggregate	
Annual medical deductible (IND/FAM) (per calendar year)	$2,000/$4,000	$4,000/$12,000	$2,000/$4,000	$4,000/$12,000
Annual out-of-pocket maximum (IND/FAM)	$4,000/$8,000	$12,000/$24,000	$4,000/$8,000	$12,000/$24,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0*	40%*	$0*	50%*
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – naturopathic care	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN C 2500/20%/5000		☐ DUAL CHOICE PPO HDHP PLAN C 2500/30%/5000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Aggregate		Aggregate	
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$5,000/$15,000	$2,500/$5,000	$5,000/$15,000
Annual out-of-pocket maximum (IND/FAM)	$5,000/$7,500	$15,000/$30,000	$5,000/$7,500	$15,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0*	40%*	$0*	50%*
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – naturopathic care	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN E 3000/20%/6000		☐ DUAL CHOICE PPO HDHP PLAN E 3000/30%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$3,000/$6,000	$5,000/$15,000	$3,000/$6,000	$5,000/$15,000
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$15,000/$30,000	$6,000/$12,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0*	40%*	$0*	50%*
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – naturopathic care	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN F 3500/20%/7000		☐ DUAL CHOICE PPO HDHP PLAN F 3500/30%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$3,500/$7,000	$5,500/$16,500	$3,500/$7,000	$5,500/$16,500
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$15,000/$30,000	$7,000/$14,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0*	40%*	$0*	50%*
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – naturopathic care	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

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Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN G 4000/20%/7000		☐ DUAL CHOICE PPO HDHP PLAN G 4000/30%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$6,000/$12,000	$4,000/$8,000	$6,000/$12,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$15,000/$30,000	$7,000/$14,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0*	40%*	$0*	50%*
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – naturopathic care	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN G 4000/40%/7000		☐ DUAL CHOICE PPO HDHP PLAN H 5000/20%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$6,000/$12,000	$5,000/$10,000	$7,000/$14,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$15,000/$30,000	$7,000/$14,000	$17,000/$34,000
Office visits – preventive and well-child care	$0	50%*	$0	40%*
Office visits – prenatal care	$0	50%*	$0	40%*
Telehealth (phone/video)	$0*	50%*	$0*	40%*
Office visits – primary care	50%* (40%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – urgent care	50%* (40%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	50%* (40%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – naturopathic care	40%*	50%*	20%*	40%*
Lab	40%*	50%*	20%*	40%*
X-ray/diagnostic tests	40%*	50%*	20%*	40%*
CT, MRI, and PET scans	40%*	50%*	20%*	40%*
Outpatient surgery	40%*	50%*	20%*	40%*
Inpatient hospital care	40%*	50%*	20%*	40%*
Emergency care	40%*		20%*	
Routine eye exam	50%* (40%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN H 5000/30%/7000		☐ DUAL CHOICE PPO HDHP PLAN H 5000/40%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$5,000/$10,000	$7,000/$14,000	$5,000/$10,000	$7,000/$14,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$17,000/$34,000	$7,000/$14,000	$17,000/$34,000
Office visits – preventive and well-child care	$0	50%*	$0	50%*
Office visits – prenatal care	$0	50%*	$0	50%*
Telehealth (phone/video)	$0*	50%*	$0*	50%*
Office visits – primary care	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*
Office visits – naturopathic care	30%*	50%*	40%*	50%*
Lab	30%*	50%*	40%*	50%*
X-ray/diagnostic tests	30%*	50%*	40%*	50%*
CT, MRI, and PET scans	30%*	50%*	40%*	50%*
Outpatient surgery	30%*	50%*	40%*	50%*
Inpatient hospital care	30%*	50%*	40%*	50%*
Emergency care	30%*		40%*	
Routine eye exam	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*

*After deductible.

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See plan comparisons

Reset

OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS PLAN WDB 500/20%/2500		☐ PPO PLUS PLAN WDC 750/20%/3750	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	$750/$2,250	$750/$2,250	$1,125/$3,375
Annual out-of-pocket maximum (IND/FAM)	$2,500/$7,500	$3,500/$10,500	$3,750/$11,250	$5,250/$16,875
Office visits – preventive and well-child care	$0	35%*	$0	35%*
Office visits – prenatal care	$0	35%*	$0	35%*
Telehealth (phone/video)	$0	35%*	$0	35%*
Office visits – primary care	$30	35%*	$30	35%*
Office visits – urgent care	$50	35%*	$50	35%*
Office visits – specialty care	$40	35%*	$40	35%*
Office visits – naturopathic care	$30	35%*	$30	35%*
Lab	$30	35%*	$30	35%*
X-ray/diagnostic tests	$30	35%*	$30	35%*
CT, MRI, and PET scans	20%*	35%*	20%*	35%*
Outpatient surgery	20%*	35%*	20%*	35%*
Inpatient hospital care	20%*	35%*	20%*	35%*
Emergency care	$200*		$200*	
Routine eye exam	$30	35%*	$30	35%*

*After deductible.

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.

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals.

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."

See plan comparisons

Reset

OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS PLAN WDE 1000/30%/4750		☐ PPO PLUS PLAN WDP 1500/30%/6000	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Annual medical deductible (IND/FAM) (per calendar year)	$1,000/$3,000	$1,500/$4,500	$1,500/$4,500	$2,250/$6,750
Annual out-of-pocket maximum (IND/FAM)	$4,750/$9,500	$6,000/$12,000	$6,000/$12,000	$7,500/$15,000
Office visits – preventive and well-child care	$0	45%*	$0	45%*
Office visits – prenatal care	$0	45%*	$0	45%*
Telehealth (phone/video)	$0	45%*	$0	45%*
Office visits – primary care	$30	45%*	$30	45%*
Office visits – urgent care	$50	45%*	$50	45%*
Office visits – specialty care	$40	45%*	$40	45%*
Office visits – naturopathic care	$30	45%*	$30	45%*
Lab	$30	45%*	$30	45%*
X-ray/diagnostic tests	$30	45%*	$30	45%*
CT, MRI, and PET scans	30%*	45%*	30%*	45%*
Outpatient surgery	30%*	45%*	30%*	45%*
Inpatient hospital care	30%*	45%*	30%*	45%*
Emergency care	$200*		$200*	
Routine eye exam	$30	45%*	$30	45%*

*After deductible.

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See plan comparisons

Reset

OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS PLAN WDN 2000/30%/6000		☐ PPO PLUS PLAN WDX 3000/30%/6850	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Annual medical deductible (IND/FAM) (per calendar year)	$2,000/$6,000	$3,000/$9,000	$3,000/$9,000	$4,500/$13,500
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$7,500/$15,000	$6,850/$13,700	$8,400/$16,800
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0	40%*	$0	40%*
Office visits – primary care	$35	40%*	$35	40%*
Office visits – urgent care	$55	40%*	$55	40%*
Office visits – specialty care	$45	40%*	$45	40%*
Office visits – naturopathic care	$35	40%*	$35	40%*
Lab	$35	40%*	$35	40%*
X-ray/diagnostic tests	$35	40%*	$35	40%*
CT, MRI, and PET scans	30%*	40%*	30%*	40%*
Outpatient surgery	30%*	40%*	30%*	40%*
Inpatient hospital care	30%*	40%*	30%*	40%*
Emergency care	$200*		$200*	
Routine eye exam	$35	40%*	$35	40%*

*After deductible.

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Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals.

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See plan comparisons

Reset

OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS PLAN WDR 4000/30%/7350		☐ PPO PLUS PLAN WDS 5000/30%/7350	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$6,000/$12,000	$5,000/$10,000	$6,500/$13,000
Annual out-of-pocket maximum (IND/FAM)	$7,350/$14,700	$9,000/$18,000	$7,350/$14,700	$9,000/$18,000
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0	40%*	$0	40%*
Office visits – primary care	$35	40%*	$35	40%*
Office visits – urgent care	$55	40%*	$55	40%*
Office visits – specialty care	$45	40%*	$45	40%*
Office visits – naturopathic care	$35	40%*	$35	40%*
Lab	$35	40%*	$35	40%*
X-ray/diagnostic tests	$35	40%*	$35	40%*
CT, MRI, and PET scans	30%*	40%*	30%*	40%*
Outpatient surgery	30%*	40%*	30%*	40%*
Inpatient hospital care	30%*	40%*	30%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	$35	40%*	$35	40%*

*After deductible.

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.

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals.

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."

See plan comparisons

Reset

OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS HDHP AA PLAN WFI 1500/20%/3500		☐ PPO PLUS HDHP AA PLAN WAS 2800/20%/4000	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Accumulation type	Aggregate		Aggregate	
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$3,000	$3,500/$7,000	$2,800/$5,600	$3,500/$7,000
Annual out-of-pocket maximum (IND/FAM)	$3,500/$7,000	$6,000/$12,000	$4,000/$8,000	$7,000/$14,000
Office visits – preventive and well-child care	$0	30%*	$0	30%*
Office visits – prenatal care	$0	30%*	$0	30%*
Telehealth (phone/video)	$0*	30%*	$0*	30%*
Office visits – primary care	20%*	30%*	20%*	30%*
Office visits – urgent care	20%*	30%*	20%*	30%*
Office visits – specialty care	20%*	30%*	20%*	30%*
Office visits – naturopathic care	20%*	30%*	20%*	30%*
Lab	20%*	30%*	20%*	30%*
X-ray/diagnostic tests	20%*	30%*	20%*	30%*
CT, MRI, and PET scans	20%*	30%*	20%*	30%*
Outpatient surgery	20%*	30%*	20%*	30%*
Inpatient hospital care	20%*	30%*	20%*	30%*
Emergency care	20%*		10%*	
Routine eye exam	20%*	30%*	20%*	30%*

*After deductible.

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.

Compare plans - traditional, deductible, HDHP

Plan Options			
Annual medical deductible (IND/FAM) (per calendar year)			
Annual out-of-pocket maximum (IND/FAM)			
Office visits – preventive and well-child care			
Office visits – prenatal care			
Telehealth (phone/video)			
Office visits – primary care			
Office visits – urgent care			
Office visits – specialty care			
Office visits – naturopathic care			
Lab			
X-ray/diagnostic tests			
CT, MRI, and PET scans			
Outpatient surgery			
Inpatient hospital care			
Emergency care			
Routine eye exam			
Outpatient prescription drugs			

*After deductible.

[1]Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).

Start over

KAISER PERMANENTE®

Compare plans - Dual Choice PPO, Out-of-Area PPO Plus

Plan Options						
Annual medical deductible (IND/FAM) (per calendar year)						
Annual out-of-pocket maximum (IND/FAM)						
Office visits – preventive and well-child care						
Office visits – prenatal care						
Telehealth (phone/video)						
Office visits – primary care						
Office visits – urgent care						
Office visits – specialty care						
Office visits – naturopathic care						
Lab						
X-ray/diagnostic tests						
CT, MRI, and PET scans						
Outpatient surgery						
Inpatient hospital care						
Emergency care						
Routine eye exam						
Outpatient prescription drugs						

*After deductible.

[1]The limit of 10 covered Services does not apply.

[2]If you are temporarily out of the service area, urgent care from a non-participating provider or non-participating facility may be covered if the services are deemed necessary to prevent serious deterioration of health and that the services could not be delayed until returning to the Kaiser Permanente service area.

Start over

KAISER PERMANENTE®

SUPPLEMENTAL BENEFIT OPTIONS

OUTPATIENT PRESCRIPTION DRUGS

Traditional, deductible, and HSA-qualified HDHP plans

Below are pharmacy benefit designs available for traditional, deductible, and HSA-qualified plans. The Kaiser Permanente formulary applies to all plans below. View our formulary at **kp.org/formulary**.

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

Generic	Preferred Brand	Non Preferred Brand	Specialty	Pairs With Dual Choice
$10	$20	$40	$100	Yes
$10	$20	$40	$150	Yes
$10	$30	$60	50%	Yes
$15	$30	$50	$100	Yes
$15	$30	$50	$150	Yes
$15	$30	$50	$200	Yes
$15	$60	$80	50%	Yes
$20	$40	$60	$150	Yes
$20	$40	$60	$200	Yes

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

All cost share amounts shown for the HSA-qualified plans below are after deductible.

Generic	Preferred Brand	Non Preferred Brand	Specialty	Pairs With Dual Choice
$10	$20	$40	$100	Yes
$10	$20	$40	$150	Yes
$10	$30	$60	50%	Yes
$15	$30	$50	$100	Yes
$15	$30	$50	$150	Yes
$15	$30	$50	$200	Yes
$15	$60	$80	50%	Yes
$20	$40	$60	$150	Yes
$20	$40	$60	$200	Yes
10%	10%	10%	10%	Yes
20%	20%	20%	20%	Yes
30%	30%	30%	30%	Yes
40%	40%	40%	40%	Yes
50%	50%	50%	50%	No

A prescription drug rider for HSA-qualified high deductible health plans may also be purchased with certain preventive drugs not subject to the deductible. Contact your Kaiser Permanente sales representative or account manager for details. Note: Prescription drug cost shares apply to the medical out-of-pocket maximum.

Kaiser Permanente Plus™ Plans

This benefit covers outpatient prescriptions drugs from a Kaiser Permanente pharmacy or an out-of-network pharmacy. Out-of-network pharmacy benefits are limited to five (5) prescription fills/refills in a year. Your cost share will differ depending on which type of pharmacy you choose.

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

Kaiser Permanente Pharmacies				Out-of-Network Pharmacies (Limited to 5 prescription fills per year)			
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Generic	Preferred Brand	Non-Preferred Brand	Specialty
$10	$20	$40	$100	$30	$40	$60	$120
$10	$20	$40	$150	$30	$40	$60	$170
$10	$30	$60	50%	$30	$50	$80	50%
$15	$30	$50	$100	$35	$50	$70	$120
$15	$30	$50	$150	$35	$50	$70	$170
$15	$30	$50	$200	$35	$50	$70	$220
$15	$60	$80	50%	$35	$80	$100	50%
$20	$40	$60	$150	$40	$60	$80	$170
$20	$40	$60	$200	$40	$60	$80	$220

Note: Mail order only available through Kaiser Permanente Pharmacies.

Dual Choice PPO and HSA-qualified Dual Choice PPO plans

Below are pharmacy benefit designs available for Dual Choice plans. The pharmacy option chosen for the base plan must match the option chosen for the Dual Choice PPO plan. Dual Choice members have access to a broad national network of pharmacies through MedImpact, as well as access to Kaiser Permanente pharmacies.

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

Kaiser Permanente Pharmacies				MedImpact Pharmacies			
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Generic	Preferred Brand	Non-Preferred Brand	Specialty
$10	$20	$40	$100	$20	$40	$70	25%
$10	$20	$40	$150	$20	$40	$70	30%
$10	$30	$60	50%	$20	$50	$90	50%
$15	$30	$50	$100	$25	$50	$80	25%
$15	$30	$50	$150	$25	$50	$80	30%
$15	$30	$50	$200	$25	$50	$80	35%
$15	$60	$80	50%	$25	$80	$110	50%
$20	$40	$60	$150	$30	$60	$90	30%
$20	$40	$60	$200	$30	$60	$90	35%

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

All cost shares amounts shown for the HSA-qualified plans below are after deductible.

Kaiser Permanente Pharmacies				MedImpact Pharmacies			
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Generic	Preferred Brand	Non-Preferred Brand	Specialty
$10	$20	$40	$100	$20	$40	$70	25%
$10	$20	$40	$150	$20	$40	$70	30%
$10	$30	$60	50%	$20	$50	$90	50%
$15	$30	$50	$100	$25	$50	$80	25%
$15	$30	$50	$150	$25	$50	$80	30%
$15	$30	$50	$200	$25	$50	$80	35%
$15	$60	$80	50%	$25	$80	$110	50%
$20	$40	$60	$150	$30	$60	$90	30%
$20	$40	$60	$200	$30	$60	$90	35%
10%	10%	10%	10%	20%	20%	20%	20%
20%	20%	20%	20%	30%	30%	30%	30%
30%	30%	30%	30%	40%	40%	40%	40%
40%	40%	40%	40%	50%	50%	50%	50%

The Kaiser Permanente formulary applies to Kaiser Permanente pharmacies as a part of Dual Choice plans. View our formulary at **kp.org/formulary**. Members get up to a 30-day supply for each cost share (up to a 90-day supply of maintenance drugs for 2 copays when our mail-order pharmacy is used).*

*Specialty drugs are provided at 1 cost share (or 1 maximum) for a 30-day supply.

Out-of-Area PPO Plus and HSA-qualified Out-of-Area PPO Plus plans

PPO Plus members have access to a broad national network of pharmacies through MedImpact, as well as access to Kaiser Permanente pharmacies. Members will pay the same cost share whether they use a Kaiser Permanente or MedImpact pharmacy. Below are some examples of pharmacy benefit designs available for PPO Plus plans and HSA-qualified PPO Plus plans.

DEDUCTIBLE COST SHARE OPTIONS

Medimpact or Kaiser Permanente Pharmacies				
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Pairs With Dual Choice
$10	$20	$40	$100	Yes
$10	$20	$40	$150	Yes
$10	$30	$60	50%	Yes
$15	$30	$50	$100	Yes
$15	$30	$50	$150	Yes
$15	$30	$50	$200	Yes
$15	$60	$80	50%	Yes
$20	$40	$60	$150	Yes
$20	$40	$60	$200	Yes

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

All cost shares shown below are after deductible for HSA-qualified PPO Plus plans. The Kaiser Permanente formulary applies to Kaiser Permanente pharmacies as a part of PPO Plus plans.

MedImpact or Kaiser Permanente Pharmacies				
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Pairs With Dual Choice
$10	$20	$40	$100	Yes
$10	$20	$40	$150	Yes
$10	$30	$60	50%	Yes
$15	$30	$50	$100	Yes
$15	$30	$50	$150	Yes
$15	$30	$50	$200	Yes
$15	$60	$80	50%	Yes
$20	$40	$60	$150	Yes
$20	$40	$60	$200	Yes
10%	10%	10%	10%	Yes
20%	20%	20%	20%	Yes
30%	30%	30%	30%	Yes
40%	40%	40%	40%	Yes
50%	50%	50%	50%	No

HEARING AIDS

Traditional and deductible (including KP Plus[1]), and HSA-qualified HDHP plans

Our traditional, deductible, and HSA-qualified plans offer several options for hearing aid benefits. Members can get 1 hearing aid per ear per 36, 48, or 60 months up to a $250, $500, $1,000, or $1,500 allowance per ear.

Note: For Oregon groups, the rider only covers adults. Pediatric coverage is part of the Oregon pediatric mandate.

Dual Choice PPO, HSA-qualified Dual Choice PPO, Out-of-Area PPO Plus, and HSA-qualified Out-of-Area PPO Plus plans

Dual Choice PPO plans (including HSA-qualified plans) offer several options for hearing aid benefits. Members may purchase hearing aids through Kaiser Permanente or direct contracted providers, First Choice Health, First Health Network, or out-of-network providers. One hearing aid per ear per 36, 48, or 60 months up to a $250, $500, $1,000, or $1,500 allowance per ear.

Note: For Oregon groups, the rider only covers adults. Pediatric coverage is part of the Oregon pediatric mandate.

ALTERNATIVE CARE

OREGON

Traditional and deductible (including KP Plus[1]), and HSA-qualified HDHP plans

Self-referred naturopathic coverage is included on all plans at the primary care office visit cost share, with unlimited visits without the need to purchase a buy-up.

Buy-up self-referred alternative care benefits

Groups can choose to add self-referred care for the following services:

Self-Referred Services	Cost Share Options*	Visit Limit Options
Chiropractic	$10/$25/$40	20 or 30
Acupuncture	$10/$25/$40	12 or 24
Massage	$25	12

*Subject to deductible on HSA-qualified plans.

Services may be received from The CHP Group, a broad network of alternative care providers in the Pacific Northwest. Visit **chpgroup.com** for a list of providers.

[1]Rider benefits only available in-network

WASHINGTON

Traditional and deductible (including KP Plus[1]), and HSA-qualified HDHP plans

Self-referred coverage is included in all plans for the following services without the need to purchase a buy-up. Unlimited naturopathic visits, 12 chiropractic visits per year, and 12 acupuncture visits per year are covered at the primary or specialty cost share.

Buy-up self-referred alternative care benefits

Self-Referred Services	Cost Share*	Visit Limit
Massage	$25	12

*Subject to deductible on HSA-qualified plans.

Services may be received from The CHP Group, a broad network of alternative care providers in the Pacific Northwest. Visit **chpgroup.com** for a list of providers.

Dual Choice PPO and HSA-qualified Dual Choice PPO plans

Self-referred naturopathic coverage is included on all plans at the primary care office visit cost share, with unlimited visits without the need to purchase a buy-up.

Oregon buy-up self-referred alternative care benefits

Groups can choose to add self-referred care for the following services:

Self-Referred Services	Cost Share Options* In Network Providers	Cost Share Options* Out of Network Providers	Visit Limit Options
Chiropractic	$10/$25/$40	40%	20 or 30
Acupuncture	$10/$25/$40	40%	12 or 24
Massage	$25	40%	12

*Subject to deductible on HSA-qualified plans.

Washington buy-up self-referred alternative care benefits

Self-Referred Services	Cost Share* Select Providers	Cost Share* PPO Providers	Cost Share* Nonparticipating Providers	Visit Limit
Massage	$25	20%	40%	12

*Subject to deductible on HSA-qualified plans.

[1]Rider benefits only available in-network

Oregon and Washington Dual Choice PPO members may select:

- In-network providers from The CHP Group, First Choice Health, and First Health Network
- Out-of-network providers

Out-of-Area PPO Plus and HSA-qualified out-of-area PPO Plus plans

Oregon buy-up self-referred alternative care benefits

Self-Referred Services	Cost Share Options* PPO Providers	Cost Share Options* Nonparticipating Providers	Visit Limit Options
Chiropractic	$10/$25/$40	40%	20 or 30
Acupuncture	$10/$25/$40	40%	12 or 24
Massage	$25	40%	12

*Subject to deductible on HSA-qualified plans.

Washington buy-up self-referred alternative care benefits

Self-Referred Services	Cost Share* PPO Providers	Cost Share* Nonparticipating Providers	Visit Limit
Massage	$25	40%	12

*Subject to deductible on HSA-qualified plans.

Oregon and Washington PPO Plus members may select:

- PPO providers from First Choice Health or First Health Network
- Nonparticipating providers

VISION HARDWARE

Traditional, deductible (including KP Plus*), and HDHP plans

Eye exams are covered as a medical benefit at the applicable office visit cost share. Vision hardware must be purchased from Vision Essentials by Kaiser Permanente or participating facilities. Visit **kp2020.org** for more info.

For members 19 and older	
An allowance is provided toward the purchase of eyeglass lenses and a frame, or contact lenses.	
ALLOWANCE OPTIONS	$100, $150, $200, $250, $300, $400, or $500 every calendar year or $100, $150, $200, $250, $300, $400, or $500 every 2 calendar years

OREGON OPTIONS:

For members 18 and younger – Standard benefit	
Each calendar year, one pair of eyeglass lenses and a standard frame from a specified collection of frames, or contact lenses.	
For members 18 and younger – Enhanced benefit	
With the enhanced benefit, the member may purchase frames outside of the specified collection. An allowance is provided toward the purchase of the eyeglass lenses/frame or contact lenses.	
ALLOWANCE OPTIONS	$100, $150, $200, $250, $300, $400, or $500 every calendar year

WASHINGTON OPTION:

For members 18 and younger
Each calendar year, one pair of eyeglass lenses and a frame, or contact lenses.

Added Choice, HSA-qualified Added Choice, PPO Plus, and HSA-qualified PPO Plus plans

Eye exams are covered as a medical benefit at the applicable office visit cost share. Vision hardware must be purchased from Vision Essentials by Kaiser Permanente or select facilities. First Choice Health optical providers, First Health Network optical providers, or nonparticipating optical providers.

For members 19 and older	
An allowance is provided toward the purchase of eyeglass lenses and a frame, or contact lenses.	
ALLOWANCE OPTIONS	$100, $150, $200, $250, $300, $400, or $500 every calendar year or $100, $150, $200, $250, $300, $400, or $500 every 2 calendar years

*Rider benefits only available in-network

OREGON OPTIONS:

For members 18 and younger – Standard benefit	
Each calendar year, one pair of eyeglass lenses and a standard frame from a specified collection of frames or contact lenses is covered in full when purchased from Vision Essentials by Kaiser Permanente or select facilities and First Choice Health optical vendors and First Health Network optical vendors. Vision hardware purchased from nonparticipating optical vendors is covered at 50%.	
For members 18 and younger – Enhanced benefit	
With the enhanced benefit, the member may purchases frames outside of the specified collection. An allowance is provided toward the purchase of the eyeglass lenses/frame or contact lenses when purchased from Vision Essentials by Kaiser Permanente or select facilities and First Choice Health optical vendors and First Health Network optical vendors.	
ALLOWANCE OPTIONS	$100, $150, $200, $250, $300, $400, or $500 every calendar year

WASHINGTON OPTION:

For members 18 and younger
Each calendar year, one pair of eyeglass lenses and a frame or contact lenses is covered in full when purchased from Vision Essentials by Kaiser Permanente or select facilities and First Choice Health optical vendors and First Health Network optical vendors. Vision hardware purchased from nonparticipating optical vendors is covered at 50%.

SENIOR ADVANTAGE			
Plan Name	**Low Plan**	**Mid Plan**	**High Plan**
Annual medical deductible (per calendar year)	$0	$0	$0
Annual out-of-pocket maximum	$1,500	$1,000	$600
Office visits – preventive	$0	$0	$0
Telehealth (phone/video)	$0	$0	$0
Office visits – primary care	$20	$15	$10
Office visits – urgent care	$25	$20	$15
Office visits – specialty care	$25	$20	$15
Lab	$0	$0	$0
X-ray/diagnostic tests	$0	$0	$0
CT, MRI, and PET scans	$50	$25	$0
Outpatient surgery	$150	$100	$50
Inpatient hospital care	$250 per admission	$200 per admission	$100 per admission
Emergency care	$50	$50	$50
Ambulance	$100	$75	$50
Routine eye exam	$20	$15	$10
Outpatient prescription drugs	$15 generic; $30 preferred brand-name	$10 generic; $20 preferred brand-name	$5 generic; $10 preferred brand-name
Outside service area	$1,000 maximum per year – 20%	$1,000 maximum per year – 20%	$1,000 maximum per year – 20%

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.

kp.org/dualchoice/nw/producers

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