## 2023 PLANS AND PRODUCTS | OREGON AND WASHINGTON



# Complete Suite<sup>™</sup> 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





OVERVIEW TRAD DED VC HDHP KP PLUS PPO OOA RIDERS SR.
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A BETTER WAY TO TAKE CARE OF BUSINESS

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# **Complete Suite**<sup>™</sup> plan pairings and plan comparisons

Dual Choice PPO<sup>®</sup> 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<sup>®</sup> 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.

<sup>\*</sup>In-network providers for Dual Choice PPO plans include First Choice Health and First Health Network providers.



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.



Annual medical deductible (IND/FAM) (per calendar year) Annual out-of-pocket maximum (IND/FAM)	\$250/\$750 \$2,000/\$6,000	\$250/\$750 \$2,500/\$7,500	\$500/\$1,500	\$500/\$1,500
maximum (IND/FAM)	\$2,000/\$6,000	\$2,500/\$7,500	\$3.000/\$6.000	¢2,000/¢4,000
			<i><i><i><i>ϕ</i>ϕϕϕϕϕϕϕϕϕϕϕ</i></i></i>	\$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%*
hese plans include limited coverage fo ervices, the member pays 20% of the a After deductible.				

#### 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.

VC

**HDHP** 

**KP PLUS** 

**DEDUCTIBLE** 

**DED PLAN A** 

PPO

OOA

**DED PLAN B** 

DED

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

**DED PLAN A** 

See plan comparisons

Reset

**DED PLAN B** 

**Plan Name** 

TRAD

**RIDERS** SR. ADV.

KAISER PERMANENTE®

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
hese plans include limited coverage ervices, the member pays 20% of th After deductible.				
hese plans are subject to exclusions oget a copy of the EOC, please con			nitations is included in the E	vidence of Coverage (EOC)
6			KAIS	ER PERMANENTE

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

**DED PLAN B** 

500/10/20%/2000

VC

**HDHP** 

**KP PLUS** 

**DEDUCTIBLE** 

**DED PLAN B** 

500/20/20%/3000

PPO

DED

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.

See plan comparisons

**DED PLAN C** 

750/20/20%/3000

Reset

**DED PLAN C** 

750/20/20%/3250

**OVERVIEW** 

**Plan Name** 

TRAD

OOA **RIDERS**  SR. ADV.

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	

To compare the benefits of up to any 3 plans, check the checkboxes next to each

VC

**HDHP** 

**KP PLUS** 

DEDUCTIBLE

PPO

OOA

DED

**OVERVIEW** 

TRAD

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.

plan and then select "See plan comparisons."

See plan comparisons

SR. ADV.

**RIDERS** 

Reset



7

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

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.

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

DEDUCTIBLE

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

VC

DED

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.

**HDHP** 

**KP PLUS** 

PPO

OOA

See plan comparisons

SR. ADV.

**RIDERS** 

Reset

**OVERVIEW** 

TRAD

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%/600						
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 vell-child care	\$0	\$0	\$0	\$0						
Office visits – prenatal care	\$0	\$0	\$0	\$0						
elehealth (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%*						
ab	30%*	30%*	\$30	30%*						
(-ray/diagnostic tests	30%*	30%*	\$30	30%*						
CT, MRI, and PET scans	30%*	30%*	\$100	30%*						
Dutpatient surgery	30%*	30%*	20%*	30%*						
npatient hospital care	30%*	30%*	20%*	30%*						
Emergency care	\$200*	\$200*	20%*	\$200*						
Routine eye exam	\$30	30%*	\$30	30%*						
nese plans include limited coverage ervices, the member pays 20% of the After deductible.	for dependent children ou	tside the Kaiser Foundation I	Health Plan of the Northwe	st service area. For cove						

OOA

**RIDERS** 

SR. ADV.

See plan comparisons

PPO

VC

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

**HDHP** 

**KP PLUS** 

DED

**OVERVIEW** 

TRAD



OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	PPO	004	A RIDERS	SR. ADV.			
	-										
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."											
DEDUCTIBLE											
Plan Name	DED PLA	N I 3500/3	0/20%/7350	DED PLAN J	1000/30/20	%/7500	DED PLAN K 50	00/30/20%/7350			
Annual medical deductible (IND/FAM) (per calendar year	)	\$3,500/\$10	,500	\$4,0	00/\$10,000		\$5,000	/\$10,000			
Annual out-of-pocket maximum (IND/FAM)		\$7,350/\$14	700	\$7,5	\$7,500/\$15,000			/\$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 ca	re	\$30			\$30		\$	30			
Lab		\$30			\$30		\$	30			
X-ray/diagnostic tests		\$30			\$30		\$	30			
CT, MRI, and PET scans		\$100			\$100		\$1	00			
Outpatient surgery		20%*			20%*		20	)%*			
Inpatient hospital care		20%*			20%*		20	)%*			
Emergency care		20%*			20%*		20	)%*			
Routine eye exam		\$30			\$30		\$	30			

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.



OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	РРО	OOA	RIDERS	SR. ADV.		
Below are highlights of the benefits for each plan. A variety of options gives See plan comparisons										
you the flexibility to choo business goals.	ose a plan tł	nat helps	s meet emp	loyee needs	and					
	To compare the benefits of up to any 3 plans, check the checkboxes next to each Reset plan and then select "See plan comparisons."									
DEDUCTIBLE										
Plan Name			N L 6000/35/2	0%/7500		DED PLAN N	л 7500/35/30%	/8500		
Annual medical deductible (IND/FAM) (per calendar yea	r)	\$	6,000/\$12,00	0		\$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 ca	are	\$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.



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highl	Below are highlights of the benefits for each plan. A variety of options gives you the								comparisons
flexibility to choose a plan that helps meet employee needs and business goals. Dual								See plan	comparisons
Choice PPO plan options are available to pair with Virtual Complete plans.									

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

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* <sup>1</sup>	\$50* <sup>1</sup>						
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* <sup>1</sup>	\$50* <sup>1</sup>						
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* <sup>1</sup>	\$50* <sup>1</sup>						
Outpatient prescription drugs	\$15 generic; \$40* preferred brand-name; \$60* non-preferred brand-name; 20%* (up to	\$15 generic; \$40* preferred brand-name; \$60* non-preferred brand-name; 30%* (up to	\$15 generic; \$50* preferred brand-name; \$70* non-preferred brand-name; 30%* (up to	\$15 generic; \$50* preferred brand-name; \$70* non-preferred brand-name; 40%* (up to						
	a max of \$250) specialty									

\*After deductible.

<sup>1</sup>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).

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.



Reset

OVERVIEW TRAD	DED VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlights of the you the flexibility to choose business goals.		•		-		See plan	comparisons					
To compare the benefits of	up to any 3 plans	s, check the	checkboxes r	next to ea	ch	Reset						
plan and then select "See p	lan comparisons.											
HIGH DEDUCTIBLE HEALTH PLAN												
Plan Name	HDHP PLAN # 1500/10%/250		HDHP PLAN A 500/20%/3500		HP PLAN B D/20%/4000		IP PLAN B '30%/4000					
Accumulation type	Aggregate		Aggregate	A	ggregate	Ag	gregate					
Annual medical deductible (IND/FAM) (per calendar year)	\$1,500/\$3,000	0 \$	1,500/\$3,000	\$2,0	000/\$4,000	\$2,00	00/\$4,000					
Annual out-of-pocket maximum (IND/FAM)	\$2,500/\$5,000	0 \$	3,500/\$7,000	\$4,0	000/\$8,000	\$4,0	00/\$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	eye exam 10%* 20%* 20%* 30%*											

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.



OVERVIEW	TRAD	DED	VC НD		JS PP	AOO C	RIDERS	SR. ADV.				
Below are highl you the flexibilit business goals.	0			, ,	0	S	See plar	comparisons				
To compare the	benefits of u	ip to any 3	plans, chec	k the checkbo	oxes next to	o each		Reset				
plan and then se	elect "See pla	an compari	sons."									
HIGH DEDUCTIBLE HEALTH PLAN												
Plan Name HDHP PLAN C HDHP PLAN C HDHP PLAN C HDHP PLAN E HDHP PLAN C 3000/20%/6000 3000/30%												
Accumulation typ	e	Aggre	egate	Aggregate		Embedded	E	mbedded				
Annual medical d (IND/FAM) (per ca		\$2,500/	/\$5,000	\$2,500/\$5,0	00	\$3,000/\$6,00	0 \$3,0	000/\$6,000				
Annual out-of-poo maximum (IND/F/		\$5,000/	/\$7,500	\$5,000/\$7,5	00	\$6,000/\$12,00	00 \$6,0	00/\$12,000				
Office visits – prev well-child care	ventive and	\$	0	\$0		\$0		\$0				
Office visits – prer	natal care	\$	0	\$0		\$0		\$0				
Telehealth (phone	e/video)	\$0	)*	\$0*		\$0*		\$0*				
Office visits – prin	nary care	20	%*	30%*		20%*		30%*				
Office visits – urge	ent care	20	%*	30%*		20%*		30%*				
Office visits – spec	cialty care	20	%*	30%*		20%*		30%*				
Office visits – natu	uropathic care	20	%*	30%*		20%*		30%*				
Lab		20	%*	30%*		20%*		30%*				
X-ray/diagnostic to	ests	20	%*	30%*		20%*		30%*				
CT, MRI, and PET s	cans	20	%*	30%*		20%*		30%*				
Outpatient surger	ŷ	20	%*	30%*		20%*		30%*				
Inpatient hospital	care	20	%*	30%*		20%*		30%*				
Emergency care		20	%*	30%*		20%*		30%*				
Denting		20	0/+	200/*		200/*		200/*				

Routine eye exam

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.

30%\*

20%\*

20%\*

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OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.		
Below are highl you the flexibilit pusiness goals.	-				· ·	-		See plan	comparisons		
o compare the			•	heck the	checkboxes r	next to ea	ch	F	Reset		
		HI	GH DEI	DUCTIE	BLE HEALT	h plai	N				
Plan NameHDHP PLAN FHDHP PLAN FHDHP PLAN G3500/20%/70003500/30%/70004000/20%/7000											
Accumulation typ	e	Em	bedded		Embedded	E	mbedded	Em	nbedded		
Annual medical d (IND/FAM) (per ca		\$3,50	0/\$7,000	\$	3,500/\$7,000	\$4,	000/\$8,000	\$4,00	00/\$8,000		
Annual out-of-poo maximum (IND/F/		\$7,00	0/\$14,000	\$7	7,000/\$14,000	\$7,0	000/\$14,000	\$7,00	00/\$14,000		
Office visits – prev well-child care	ventive and		\$0		\$0		\$0		\$0		
Office visits – prei	natal care		\$0		\$0		\$0		\$0		
Telehealth (phone	e/video)		\$0*		\$0*		\$0*		\$0*		
Office visits – prin	nary care		20%*		30%*		20%*		30%*		
Office visits – urg	ent care		20%*		30%*		20%*		30%*		
Office visits – spe	cialty care		20%*		30%*		20%*		30%*		
Office visits – natu	uropathic care		20%*		30%*		20%*		30%*		
Lab			20%*		30%*		20%*		30%*		
X-ray/diagnostic t	ests		20%*		30%*		20%*		30%*		
CT, MRI, and PET s	cans		20%*		30%*		20%*	30%*			
Outpatient surger	ry		20%*		30%*		20%*		30%*		
Inpatient hospital	care		20%*		30%*		20%*		30%*		
Emergency care			20%*		30%*		20%*		30%*		
Denter			200/*		200/+		200/*		200/+		

Routine eye exam

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.

30%\*

20%\*

20%\*

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OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	A RIE	DERS	SR. ADV.			
you the flexibilit business goals. To compare the	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." <b>HIGH DEDUCTIBLE HEALTH PLAN</b>												
HIGH DEDUCTIBLE HEALTH PLAN													
Plan Na	Plan Name HDHP PLAN G 4000/40%/7000 HDHP PLAN H 5000/20%/7000 HDHP PLAN H												
Accumulation typ	е		Embedo	ed	Ei	nbedded			Embedo	bed			
Annual medical d (IND/FAM) (per ca			\$4,000/\$8	8,000	\$5,0	00/\$10,000		\$	0,000				
Annual out-of-poo maximum (IND/F/		9	\$7,000/\$14	4,000	\$7,0	\$7,000/\$14,000			\$7,000/\$14,000				
Office visits – prev well-child care	ventive and		\$0			\$0			\$0				
Office visits – prer	natal care	\$0 \$0							\$0				
Telehealth (phone	e/video)	\$0* \$0*							\$0*				
Office visits – prin	nary care		40%*			20%*			30%	٢			
Office visits – urge	ent care		40%*			20%*		30%*					
Office visits – spec	cialty care	re 40%* 20%*							30%*				

**Emergency care** 

Routine eye exam

Lab

**Office visits – naturopathic care** 

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

**Outpatient surgery** 

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.

20%\*

20%\*

20%\*

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20%\*

20%\*

20%\*

40%\*

40%\*

40%\*

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40%\*

40%\*

40%\*

40%\*

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.



30%\* 30%\*

30%\*

30%\*

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30%\*

OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.			
Below are highl you the flexibilit business goals.	to choose	a plan th	at helps	s meet emp	loyee needs	and			comparisons Reset			
To compare the plan and then se					checkboxes	next to ea	ach		leser			
		H	IGH D	EDUCTIE	BLE HEALT	H PLA	N					
Plan Na	ame		HDHP PLAN H 5000/40%/7000 HDHP PLAN H 5000/50%/7000									
Accumulation typ	e			Embedded				Embedded				
Annual medical d (IND/FAM) (per ca			\$	5,000/\$10,000	0		\$5,	,000/\$10,000				
Annual out-of-poo maximum (IND/F/			\$	7,000/\$14,000	)		\$7,	000/\$14,000				
Office visits – prev well-child care	ventive and			\$0								
Office visits – prei	natal care			\$0				\$0				
Telehealth (phone	e/video)			\$0*				\$0*				
Office visits – prin	nary care			40%*		50%*						
Office visits – urge	ent care			40%*		50%*						
Office visits – spe	cialty care			40%*		50%*						
Office visits – natu	uropathic care			40%*		50%*						
Lab				40%*		50%*						

Emergency care Routine eye exam

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

**Outpatient surgery** 

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.

40%\*

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40%\*

40%\*

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.



50%\*

50%\*

50%\*

50%\*

50%\*

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

OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
				_									
Below are highlights of the you the flexibility to choos business goals.				<b>y</b>	0		See plan	comparisons					
To compare the benefits o	f up to any	/ 3 plans, d	check the	checkboxes n	ext to ea	ch	F	Reset					
plan and then select "See		•											
KP Plus													
Plan name		KP PLU	S PLAN A 1	0/1000		KP PLUS	PLAN B 20/1	500					
Network	In-	network	(limi	ut-of-network ted to 10 covered per year, combined)		n-network	(limited	of-network to 10 covered r year, combined)					
Annual medical deductible (IND/FAM) (per calendar year)		N/A		N/A		N/A		N/A					
Annual out-of-pocket	\$1,0	00/\$2,000	500/\$3,000		N/A								
maximum (IND/FAM) Office visits – preventive and						-							
well-child care		\$0		\$0		\$0		\$0					
Office visits – prenatal care		\$0		\$0		\$0		\$0					
Telehealth (phone/video)		\$0		are applicable to the e when provided in person.		\$0	service w	applicable to the hen provided in person.					
Office visits – primary care		\$10		\$30	\$20			\$40					
Office visits – urgent care		\$30	services	overed, except for received outside the service area <sup>1,2</sup>	2	\$40		ered, except for ceived outside the vice area <sup>1,2</sup>					
Office visits – specialty care		\$20		\$40		\$30	\$50						
Office visits – naturopathic care	e	\$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	No	t covered					
Outpatient surgery		\$50		Not covered		\$50	No	t covered					
Inpatient hospital care		day, \$500 pe mission		Not covered		er day, \$500 per idmission	No	t covered					
Emergency care		\$100	Covere	ed at the in-network cost share <sup>1</sup>		\$100		at the in-network ost share <sup>1</sup>					
Routine eye exam		\$10		\$30		\$20		\$40					
Outpatient prescription drugs	In-network				Ir	n-network	Out-of-network (limited to 5 prescription fills per year)						
- stranger broombrion and go	A pharmac	A pharmacy rider must be purchased with all KP Plus plan											

<sup>1</sup>The limit of 10 covered Services does not apply.

<sup>2</sup>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.



OVERVIEW TRAD	DED	VC F	IDHP	KP PLUS PPO OOA		OOA	RIDERS	SR. ADV.
Below are highlights of the you the flexibility to choose business goals. To compare the benefits of	e a plan th f up to any	at helps me v 3 plans, ch	eet emp	loyee needs a	nd	ch		comparisons Reset
plan and then select "See <sub>l</sub>	olan comp	barisons.	ΚD	Plus				
Plan name		KP PLUS				KP PLUS	PLAN D 30/3	
Network	In-	network	(limi	ut-of-network ted to 10 covered per year, combined)	n-network	(limited	-of-network d to 10 covered er 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)	\$2,0	00/\$4,000		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		are applicable to the e when provided in person.		\$0	service w	e applicable to the /hen provided in person.
Office visits – primary care		\$20		\$40	\$30			\$50
Office visits – urgent care		\$40	services	Not covered, except for services received outside the service area <sup>1,2</sup>			Not covered, except f services received outsid service area <sup>1,2</sup>	
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	No	ot covered
Outpatient surgery		\$50		Not covered		\$100	No	ot covered
Inpatient hospital care		day, \$1,000 per mission		Not covered		r day, \$1,000 per admission	N	ot covered
Emergency care		\$200	Covere	ed at the in-network cost share <sup>1</sup>		\$200		at the in-network ost share <sup>1</sup>
Routine eye exam	\$20			\$40		\$30		\$50
Outpatient prescription drugs	In-network					n-network	Out-of-network (limited to 5 prescription fills per year)	
*After deductible	A pharmac	y rider must be p	ourchased w	vith all KP Plus plans	A pharma	icy rider must be p	ourchased wit	h all KP Plus plans

<sup>1</sup>The limit of 10 covered Services does not apply.

<sup>2</sup>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.



OVERVIEW	FRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.			
Below are highligh you the flexibility to business goals.					· ·	-			comparisons			
To compare the be plan and then seled			•		checkboxes n	ext to ea	ich		Reset			
KP Plus												
Plan name			KP PL	US PLAN E 3	5/3000		KP PLUS PL	AN A 250/10/1	0%/2000			
Network		In-	network	(limi	)ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network I to 10 covered er year, combined)			
Annual medical dedu (IND/FAM) (per calenc			N/A		N/A	\$	250/\$750		N/A			
Annual out-of-pocket maximum (IND/FAM)		\$3,0	00/\$6,000		N/A	\$2,	000/\$6,000		N/A			
Office visits – prevent well-child care	ive and		\$0		\$0		\$0		\$0			
Office visits – prenata	l care	\$0 \$0 \$0						\$0				
Telehealth (phone/vic	leo)		\$0		are applicable to the e when provided in person.		\$0	service w	applicable to the hen provided in provided in			
Office visits – primary	r care		\$35		\$55		\$10	\$30				
Office visits – urgent (	care		\$60	services	overed, except for received outside the service area <sup>1,2</sup>	e	\$10	services re	ered, except for ceived outside the vice area <sup>1,2</sup>			
Office visits – specialt	y care		\$45		\$65		\$10		\$30			
Office visits – naturop	athic care		\$35		\$55		\$10		\$30			
Lab			\$35		\$55		10%*		20%			
X-ray/diagnostic tests			\$35		\$55		10%*		20%			
CT, MRI, and PET scan	S		\$50		Not covered		10%*	No	it covered			
Outpatient surgery			\$150		Not covered		10%*	No	it covered			
Inpatient hospital car	e	\$800 p	er admissior	1	Not covered		10%*	No	it covered			
Emergency care			\$200	Covere	ed at the in-network cost share <sup>1</sup>		\$200*		at the in-network ost share <sup>1</sup>			
Routine eye exam			\$35		\$55		\$10	0 \$30				
Outpatient prescription	on drugs	In-	network		network (limited to ription fills per year)		n-network		twork (limited to tion fills per year)			
*After deductible	5	A pharmac	y rider must l	be purchased v	vith all KP Plus plans	A pharma	acy rider must b	e purchased with	n all KP Plus plans			

<sup>1</sup>The limit of 10 covered Services does not apply.

<sup>2</sup>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.



OVERVIEW TR	RAD	DED	VC	HDHP KP PLUS PPO OOA		OOA	RIDERS	SR. ADV.					
Below are highlights you the flexibility to o business goals.			-		-	-			comparisons				
To compare the bend plan and then select			-	check the	checkboxes n	ext to ea	ich	F	Reset				
	KP Plus												
Plan name			KP PLUS PL	AN A 250/15	/20%/2500		KP PLUS PL	AN B 500/20/1	0%/3000				
Network		In-	network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)				
Annual medical deducti (IND/FAM) (per calendar		\$2	50/\$750		500/\$1,500		N/A						
Annual out-of-pocket maximum (IND/FAM)		\$2,5	00/\$7,500		N/A								
Office visits – preventive well-child care	e and		\$0 \$0 \$0						\$0				
Office visits – prenatal c	are	\$0 \$0							\$0				
Telehealth (phone/video	0)		\$0		are applicable to the when provided in person.		\$0	service w	applicable to the nen provided in person.				
Office visits – primary ca	are		\$15		\$35		\$20	\$40					
Office visits – urgent ca	re		\$35	services	overed, except for received outside the ervice area <sup>1,2</sup>	ġ	\$40	services rec	red, except for eived outside the rice area <sup>1,2</sup>				
Office visits – specialty	care		\$25		\$45		\$30		\$50				
Office visits – naturopat	hic 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	No	t covered				
Outpatient surgery			20%*		Not covered		10%*	No	t covered				
Inpatient hospital care		20%* Not covered					10%*	No	t covered				
Emergency care			20%*	Covere	d at the in-network cost share <sup>1</sup>		10%*		t the in-network st share <sup>1</sup>				
Routine eye exam			\$15		\$35		\$20	\$20 \$40					
Outpatient prescription	drugs	In-	network		network (limited to ription fills per year)		n-network	Out-of-network (limited to 5 prescription fills per year)					
	3	A pharmacy	y rider must b	e purchased w	rith all KP Plus plans	A pharma	acy rider must be purchased with all KP Plus plans						

<sup>1</sup>The limit of 10 covered Services does not apply.

<sup>2</sup>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.



OVERVIEW TR	RAD	DED	VC	HDHP	IDHP KP PLUS PPO OOA		OOA	RIDERS	SR. ADV.					
Below are highlights you the flexibility to o business goals.	choose	a plan th	at helps r	neet emp	loyee needs a	nd			comparisons					
To compare the bene plan and then select			-	check the	checkboxes n	ext to ea	ich	ſ	Reset					
1	T	1		KP	Plus									
Plan name		К	P PLUS PLA	N B 500/10 <sup>6</sup>	%/10%/2000		KP PLUS PLA	N B 500/10/2	0%/2000					
Network		In-	network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)					
Annual medical deducti (IND/FAM) (per calendar		\$50	0/\$1,500		500/\$1,500		N/A							
Annual out-of-pocket maximum (IND/FAM)	-	\$2,00	00/\$6,000		N/A	\$2,	000/\$6,000		N/A					
Office visits – preventive well-child care	e and		\$0		\$0		\$0		\$0					
Office visits – prenatal c	are	\$0 \$0 \$0							\$0					
Telehealth (phone/video	0)		\$0		are applicable to the when provided in person.		\$0	service w	applicable to the nen provided in person.					
Office visits – primary ca	are		10%*		20%		\$10	\$30						
Office visits – urgent ca	re		10%*	services	overed, except for received outside the ervice area <sup>1,2</sup>	9	\$10	services rec	red, except for eived outside the rice area <sup>1,2</sup>					
Office visits – specialty	care		10%*		20%		\$10		\$30					
Office visits – naturopat	hic 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%*	No	t covered					
Outpatient surgery			10%*		Not covered		20%*	No	t covered					
Inpatient hospital care		10%* Not covered 20%*					20%*	No	t covered					
Emergency care		4	\$200*	Covere	d at the in-network cost share <sup>1</sup>		\$200*		t the in-network st share <sup>1</sup>					
Routine eye exam			10%*		20%		\$10	\$10 \$30						
Outpatient prescription	druas	In-	network		network (limited to ription fills per year)		n-network		Out-of-network (limited to 5 prescription fills per year)					
		A pharmacy	y rider must b	A pharmacy rider must be purchased with all KP Plus plans A pharmacy rider must be p										

<sup>1</sup>The limit of 10 covered Services does not apply.

<sup>2</sup>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.



OVERVIEW TRA	٨D	DED	VC	HDHP	KP PLUS	KP PLUS PPO OOA		RIDERS	SR. ADV.	
Below are highlights c you the flexibility to ch					<b>,</b>	•		See plan	comparisons	
business goals.								, in the second s	leset	
To compare the benef			-	check the	checkboxes n	ext to ea	ach	ſ	lesel	
plan and then select "	See p	ian comp	arisons.							
				KP	Plus					
Plan name		l	(P PLUS PL	AN B 500/20	/20%/3000		KP PLUS PL	AN C 750/20/2	0%/3250	
Network		In-	network	(limi	ut-of-network ed to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)	
Annual medical deductib (IND/FAM) (per calendar y		\$50	0/\$1,500	750/\$2,250		N/A				
Annual out-of-pocket maximum (IND/FAM)		\$3,0	00/\$9,000		N/A	\$3	,250/\$9,750		N/A	
Office visits – preventive well-child care	and		\$0		\$0		\$0		\$0	
Office visits – prenatal ca	re		\$0		\$0		\$0		\$0	
Telehealth (phone/video)			\$0		ere applicable to the when provided in person.		\$0	service w	applicable to the nen provided in person.	
Office visits – primary car	e		\$20		\$40		\$20 \$40			
Office visits – urgent care	1		\$40	services	overed, except for received outside the ervice area <sup>1,2</sup>	e	\$40	services rec	red, except for eived outside the rice area <sup>1,2</sup>	
Office visits – specialty ca	re		\$30		\$50		\$30		\$50	
Office visits – naturopath	ic 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	No	t covered	
Outpatient surgery			20%*		Not covered		20%*	No	t covered	
Inpatient hospital care		20%* Not covered 20%*					20%*	No	t covered	
Emergency care			20%*	Covere	d at the in-network cost share <sup>1</sup>		20%*		t the in-network st share <sup>1</sup>	
Routine eye exam			\$20		\$40		\$20	\$20 \$40		
Outpatient prescription d	ruas	In-	network		network (limited to iption fills per year)		n-network	Out-of-network (limited to 5 prescription fills per year)		
	<b>J</b> .	A pharmac	ith all KP Plus plans	lans A pharmacy rider must be purchased with all KP Plus pla						

<sup>1</sup>The limit of 10 covered Services does not apply.

<sup>2</sup>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.



OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlights of th you the flexibility to choos business goals. To compare the benefits of plan and then select "See	se a plan th of up to any	nat helps n v 3 plans, o	neet emp	loyee needs a	nd	ach		comparisons Reset					
KP Plus													
Plan name		KP PLUS PLA	N C 750/20%/	20%/3000									
Network	In	network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)					
Annual medical deductible (IND/FAM) (per calendar year)	\$75	0/\$2,250		N/A	\$7	750/\$2,250		N/A					
Annual out-of-pocket maximum (IND/FAM)	\$3,0	00/\$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		are applicable to the when provided in person.	2	\$0	service w	applicable to the hen provided in person.					
Office visits – primary care		\$20		\$40		20%*		30%					
Office visits – urgent care		\$20	services	overed, except for received outside th recrvice area <sup>1,2</sup>	e	20%*	services rec	red, except for eived outside the rice area <sup>1,2</sup>					
Office visits – specialty care		\$20		\$40		20%*		30%					
Office visits – naturopathic car	re 🛛	\$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%*	No	t covered					
Outpatient surgery		20%*		Not covered		20%*	No	t covered					
Inpatient hospital care		20%*		Not covered		20%*	No	t covered					
Emergency care		\$200*	Covere	d at the in-network cost share <sup>1</sup>		\$200*		t the in-network st share <sup>1</sup>					
Routine eye exam		\$20		\$40		20%*		30%					
Outpatient prescription drugs	In-network			network (limited to ription fills per year)		n-network	Out-of-network (limited to 5 prescription fills per year)						
		y rider must b	e purchased w	vith all KP Plus plans	A pharma	acy rider must b	e purchased with	all KP Plus plans					

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OVERVIEW TR	RAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights you the flexibility to o business goals. To compare the bend	choose	a plan th	at helps r	neet emp	loyee needs a	nd	ch		comparisons Reset
plan and then select			•	check the	CHECKDOXES	ext to ea	ich		
				KP	Plus				
Plan name			KP PLUS PLA	N D 1000/25/2	20%/4000				
Network		In-	network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)
Annual medical deducti (IND/FAM) (per calendar		\$1,00	00/\$3,000		N/A	\$1,	000/\$3,000		N/A
Annual out-of-pocket maximum (IND/FAM)		\$3,00	00/\$9,000		N/A	\$4,	000/\$12,000		N/A
Office visits – preventive well-child care	e and		\$0		\$0		\$0		\$0
Office visits – prenatal o	are		\$0		\$0		\$0		\$0
Telehealth (phone/video	0)		\$0		are applicable to the when provided in person.		\$0	service w	applicable to the hen provided in person.
Office visits – primary c	are		\$20		\$40		\$25		\$45
Office visits – urgent ca	re		\$20	services	overed, except for received outside the ervice area <sup>1,2</sup>	9	\$45	services rec	ered, except for reived outside the vice area <sup>1,2</sup>
Office visits – specialty	care		\$20		\$40		\$35		\$55
Office visits – naturopat	thic 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	No	t covered
Outpatient surgery			20%*		Not covered		20%*	No	t covered
Inpatient hospital care			20%*		Not covered		20%*	No	t covered
Emergency care		4	\$200*	Covere	d at the in-network cost share <sup>1</sup>		20%*		t the in-network st share <sup>1</sup>
Routine eye exam			\$20		\$40		\$25		\$45
Outpatient prescription	In-network Out-of-network (limited to 5 prescription fills per year)		n-network	Out-of-network (limite 5 prescription fills per					
		A pharmacy	y rider must b	e purchased w	rith all KP Plus plans	A pharma	acy rider must be	e purchased with	all KP Plus plans

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OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlights of th you the flexibility to choo business goals. To compare the benefits plan and then select "See	se a plan th of up to any	hat helps n v 3 plans, o	neet emp	loyee needs a	nd	ich		comparisons Reset					
KP Plus													
Plan name	ŀ	5/20%/5500		KP PLUS PLA	N E 1500/20/3	0%/4000							
Network	In	network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)					
Annual medical deductible (IND/FAM) (per calendar year	<b>)</b> \$1,5	00/\$4,500		N/A	\$1,	500/\$4,500		N/A					
Annual out-of-pocket maximum (IND/FAM)	\$5,50	00/\$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		are applicable to the when provided in person.	!	\$0	service w	applicable to the hen provided in person.					
Office visits – primary care		\$25		\$45		\$20		\$40					
Office visits – urgent care		\$45	services	overed, except for received outside the ervice area <sup>1,2</sup>	e	\$20	services rec	red, except for eived outside the rice area <sup>1,2</sup>					
Office visits – specialty care		\$35		\$55		\$20		\$40					
Office visits – naturopathic ca	re	\$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%*	No	t covered					
Outpatient surgery		20%*		Not covered		30%*	No	t covered					
Inpatient hospital care		20%*		Not covered		30%*	No	t covered					
Emergency care		20%*	Covere	d at the in-network cost share <sup>1</sup>		\$200*		t the in-network st share <sup>1</sup>					
Routine eye exam		\$25		\$45		\$20		\$40					
Outpatient prescription drug	drugs		I	In-network		work (limited to ion fills per year)							
		y rider must be	e purchased w	vith all KP Plus plans	A pharma	acy rider must be	e purchased with	all KP Plus plans					

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OVERVIEW TR	AD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.				
Below are highlights you the flexibility to c business goals.			-			-			comparisons				
To compare the bene plan and then select '			-	check the	checkboxes r	ext to ea	ach	ł	Reset				
KP Plus													
Plan name		К	P PLUS PLA	N E 1500/30	%/30%/4000		KP PLUS PLA	N F 2000/25/2	20%/5000				
Network		In-	network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)				
Annual medical deductil (IND/FAM) (per calendar		\$1,50	00/\$4,500		N/A	\$2,	.000/\$6,000		N/A				
Annual out-of-pocket maximum (IND/FAM)	-	\$4,00	00/\$12,000		N/A	\$5,	000/\$10,000		N/A				
Office visits – preventive well-child care	and		\$0		\$0		\$0		\$0				
Office visits – prenatal ca	are		\$0		\$0		\$0		\$0				
Telehealth (phone/video	)		\$0		are applicable to the when provided in person.	!	\$0	service w	applicable to the hen provided in person.				
Office visits – primary ca	re		30%*		40%		\$25		\$45				
Office visits – urgent care	е		30%*	services	overed, except for received outside the service area <sup>1,2</sup>	e	\$45	services rec	ered, except for reived outside the vice area <sup>1,2</sup>				
Office visits – specialty ca	are		30%*		40%		\$35		\$55				
Office visits – naturopath	nic 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	No	t covered				
Outpatient surgery			30%*		Not covered		20%*	No	t covered				
Inpatient hospital care			30%*		Not covered		20%*	No	t covered				
Emergency care			\$200*	Covere	d at the in-network cost share <sup>1</sup>		20%*		t the in-network st share <sup>1</sup>				
Routine eye exam			30%*		40%		\$25		\$45				
Outpatient prescription	-		In-network Out-of-network (limited to 5 prescription fills per year)						twork (limited to ion fills per year)				
	5-	A pharmac	y rider must b	e purchased w	vith all KP Plus plans	A pharma	acy rider must b	e purchased with	all KP Plus plans				

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OVERVIEW TRAD	D DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights of you the flexibility to cho business goals. To compare the benefit plan and then select "Se	oose a plan t s of up to an	hat helps i by 3 plans,	meet emp	loyee needs a	nd	ch		comparisons Reset
	·	1	KP	Plus				
Plan name		KP PLUS PL	AN G 2500/2	5/20%/5000		KP PLUS PLA	N G 2500/30/3	30%/5000
Network	Ir	n-network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r 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)	\$5,0	000/\$10,000		N/A	\$5,(	000/\$10,000		N/A
Office visits – preventive ar well-child care	nd	\$0		\$0		\$0		\$0
Office visits – prenatal care		\$0		\$0		\$0		\$0
Telehealth (phone/video)		\$0		are applicable to the when provided in person.		\$0	service w	applicable to the hen provided in person.
Office visits – primary care		\$25		\$45		\$30		\$50
Office visits – urgent care		\$45	services	overed, except for received outside the ervice area <sup>1,2</sup>	e	\$30	services rec	red, except for eived outside the vice area <sup>1,2</sup>
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%*	No	t covered
Outpatient surgery		20%*		Not covered		30%*	No	t covered
Inpatient hospital care		20%*		Not covered		30%*	No	t covered
Emergency care		20%*	Covere	d at the in-network cost share <sup>1</sup>		\$200*		t the in-network st share <sup>1</sup>
Routine eye exam		\$25		\$45		\$30		\$50
Outpatient prescription dru	In-network E preservintion fi		network (limited to ription fills per year)	In-network			work (limited to ion fills per year)	
		cy rider must k	pe purchased w	vith all KP Plus plans	A pharma	cy rider must be	e purchased with	all KP Plus plans

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OVERVIEW TI	RAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.				
Below are highlights you the flexibility to business goals. To compare the ben	choose nefits of u	a plan th up to any	at helps i 3 plans,	meet emp	loyee needs a	nd	ach		comparisons Reset				
lan and then select "See plan comparisons." <b>KP Plus</b>													
Plan name KP PLUS PLAN G 2500/30%/30%/5000 KP PLUS PLAN H 3000/30/20%/73													
Network		In-	network	(limi	ut-of-network ed to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)				
Annual medical deduct (IND/FAM) (per calenda		\$2,50	00/\$5,000		N/A	\$3	,000/\$9,000		N/A				
Annual out-of-pocket maximum (IND/FAM)		\$5,00	0/\$10,000		N/A	\$7,	350/\$14,700		N/A				
Office visits – preventiv well-child care			\$0		\$0		\$0		\$0				
Office visits – prenatal	care		\$0		\$0		\$0		\$0				
Telehealth (phone/vide	90)		\$0		are applicable to the when provided in person.	•	\$0	service w	applicable to the hen provided in person.				
Office visits – primary of	care		30%*		40%		\$30		\$50				
Office visits – urgent ca	are		30%*	services	overed, except for received outside the ervice area <sup>1,2</sup>	e	\$50	services rec	ered, except for ceived outside the vice area <sup>1,2</sup>				
Office visits – specialty	care		30%*		40%		\$40		\$60				
Office visits – naturopa	thic 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	No	t covered				
Outpatient surgery			30%*		Not covered		20%*	No	t covered				
Inpatient hospital care			30%*		Not covered		20%*	No	t covered				
Emergency care		4	\$200*	Covere	d at the in-network cost share <sup>1</sup>		20%*		t the in-network st share <sup>1</sup>				
Routine eye exam			30%*		40%		\$30		\$50				
Outpatient prescription	In-network Out-of-network (limited to 5 prescription fills per year)			In-network		twork (limited to tion fills per year)							
	5	A pharmacy	y rider must b	e purchased w	rith all KP Plus plans	A pharma	acy rider must be	e purchased with	all KP Plus plans				

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OVERVIEW T	RAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlights you the flexibility to business goals. To compare the ber	choose	a plan th	at helps r	neet emp	loyee needs a	nd	ach		comparisons Reset					
plan and then select	lan and then select "See plan comparisons."													
				KP	Plus									
Plan name	NI3500/30/2	20%/7350												
Network		In-	network	(limi	ut-of-network ed to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)					
Annual medical deduct (IND/FAM) (per calenda		\$3,00	00/\$6,000		N/A	\$3,	500/\$10,500		N/A					
Annual out-of-pocket maximum (IND/FAM)		\$6,00	0/\$12,000		N/A	\$7,	350/\$14,700		N/A					
Office visits – preventiv well-child care	ve and		\$0		\$0		\$0		\$0					
Office visits – prenatal	care		\$0		\$0		\$0		\$0					
Telehealth (phone/vide	90)		\$0		ere applicable to the when provided in person.		\$0	service w	applicable to the hen provided in person.					
Office visits – primary	care		30%*		40%		\$30		\$50					
Office visits – urgent ca	are		30%*	services	overed, except for received outside the ervice area <sup>1,2</sup>	e	\$50	services ree	ered, except for ceived outside the vice area <sup>1,2</sup>					
Office visits – specialty	care		30%*		40%		\$40		\$60					
Office visits – naturopa	thic 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	No	t covered					
Outpatient surgery			30%*		Not covered		20%*	No	t covered					
Inpatient hospital care			30%*		Not covered		20%*	No	t covered					
Emergency care		\$	5200*	Covere	d at the in-network cost share <sup>1</sup>		20%*		t the in-network st share <sup>1</sup>					
Routine eye exam			30%*		40%		\$30		\$50					
Outpatient prescription	n drugs	In-	network		network (limited to ription fills per year)				twork (limited to tion fills per year)					
	•	A pharmacy	/ rider must b	e purchased w	ith all KP Plus plans	A pharm	acy rider must b	e purchased with	all KP Plus plans					

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OVERVIEW TR	RAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.				
Below are highlights you the flexibility to business goals. To compare the ben	choose	a plan tha	at helps	meet emp	loyee needs a	nd	ach		comparisons Reset				
plan and then select			•										
KP Plus													
Plan name		К	P PLUS PL	AN J 4000/3	0/20%/7500		KP PLUS PLA	N K 5000/30/2	20%/7350				
Network		In-r	network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)				
Annual medical deduct (IND/FAM) (per calenda		\$4,00	0/\$10,000		N/A	\$5,	000/\$10,000		N/A				
Annual out-of-pocket maximum (IND/FAM)		\$7,50	0/\$15,000		N/A	\$7,	350/\$14,700		N/A				
Office visits – preventiv well-child care	e and		\$0		\$0		\$0		\$0				
Office visits – prenatal of	care		\$0		\$0		\$0		\$0				
Telehealth (phone/vide	o)		\$0		are applicable to the e when provided in person.		\$0	service w	applicable to the hen provided in person.				
Office visits – primary c	are		\$30		\$50		\$30		\$50				
Office visits – urgent ca	re		\$50	services	overed, except for received outside the service area <sup>1,2</sup>	9	\$50	services rec	ered, except for ceived outside the vice area <sup>1,2</sup>				
Office visits – specialty	care		\$40		\$60		\$40		\$60				
Office visits – naturopa	thic 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	No	t covered				
Outpatient surgery		2	20%*		Not covered		20%*	No	t covered				
Inpatient hospital care		2	20%*		Not covered		20%*	No	t covered				
Emergency care		2	20%*	Covere	ed at the in-network cost share <sup>1</sup>		20%*		nt the in-network ost share <sup>1</sup>				
Routine eye exam			\$30		\$50		\$30		\$50				
Outpatient prescription	-		In-network Out-of-network (limited to 5 prescription fills per year)				n-network	Out-of-network (limited to 5 prescription fills per year)					
		A pharmacy	rider must l	be purchased w	vith all KP Plus plans	A pharma	acy rider must be	e purchased with	all KP Plus plans				

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OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlights of you the flexibility to cho business goals. To compare the benefits	ose a plan tl s of up to an	hat helps r y 3 plans,	neet emp	loyee needs a	nd	ch		comparisons Reset					
lan and then select "See plan comparisons." <b>KP Plus</b>													
Plan name	KP PLUS PLAI	N M 7500/35/3	30%/8500										
Network	In	n-network	(limi	ut-of-network ed to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)					
Annual medical deductible (IND/FAM) (per calendar yea	\$6,0	00/\$12,000		N/A	\$7,5	500/\$14,500		N/A					
Annual out-of-pocket maximum (IND/FAM)	\$7,5	00/\$15,000		N/A	\$8,	500/\$17,000		N/A					
Office visits – preventive an well-child care	d	\$0		\$0		\$0		\$0					
Office visits – prenatal care		\$0		\$0		\$0		\$0					
Telehealth (phone/video)		\$0		are applicable to the when provided in person.		\$0	service w	applicable to the hen provided in person.					
Office visits – primary care		\$35		\$55		\$35		\$55					
Office visits – urgent care		\$55	services	overed, except for received outside th ervice area <sup>1,2</sup>	e	\$55	services rec	red, except for eived outside the vice area <sup>1,2</sup>					
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	No	t covered					
Outpatient surgery		20%*		Not covered		30%*	No	t covered					
Inpatient hospital care		20%*		Not covered		30%*	No	t covered					
Emergency care		20%*	Covere	d at the in-network cost share <sup>1</sup>		30%*		t the in-network st share <sup>1</sup>					
Routine eye exam		\$35		\$55		\$35		\$55					
Outpatient prescription dru	In-network Out-of-network (limited to 5 prescription fills per yea			In-network			work (limited to ion fills per year)						
		cy rider must b	e purchased w	rith all KP Plus plans	A pharma	icy rider must be	e purchased with	all KP Plus plans					

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OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights of th you the flexibility to choos business goals. To compare the benefits of plan and then select "See	se a plan th of up to any	at helps m 3 plans, c	neet emp	loyee needs a	and	ach		comparisons Reset
		٦	Dual Ch	noice PPO				
Plan name	D	UAL CHOICE	PPO PLAN	A 10/1500		DUAL CHOIC	E PPO PLAN B	20/2000
Network	In-n	etwork	Οι	ıt-of-network	lı	n-network	Out-	of-network
Annual medical deductible (IND/FAM) (per calendar year)	\$(	0/\$0	\$1	,500/\$3,000		\$0/\$0	\$2,0	00/\$4,000
Annual out-of-pocket maximum (IND/FAM)	\$1,500	0/\$3,000	\$4	,500/\$9,000	\$2,	000/\$4,000	\$6,00	00/\$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		) enhanced nefit)		30%*	\$40 (	\$20 enhanced benefit)		30%*
Office visits – urgent care		) enhanced nefit)		30%*	\$80 (	\$40 enhanced benefit)		30%*
Office visits – specialty care		) enhanced nefit)		30%*	\$50 (	\$30 enhanced benefit)		30%*
Office visits – naturopathic care	9	\$10		30%*		\$20		30%*
Lab	4	\$10		30%*		\$20		30%*
X-ray/diagnostic tests	4	\$10		30%*		\$20		30%*
CT, MRI, and PET scans	\$	50		30%*		\$50		30%*
Outpatient surgery	\$	550		30%*		\$50		30%*
Inpatient hospital care		lay, \$500 pen nission	r	30%*		er day, \$500 pe admission	r	30%*
Emergency care			\$100				\$100	
Routine eye exam		) enhanced nefit)		30%*	\$40 (	\$20 enhanced benefit)		30%*



OVERVIEW TRA	D DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights o you the flexibility to ch business goals. To compare the benefi plan and then select "S	pose a plan ts of up to a	that helps any 3 plans,	meet emp check the	loyee needs a	and	ach		comparisons Reset
			Dual Cl	noice PPO				
Plan name		DUAL CHOI	CE PPO PLAN	C 20/2500		DUAL CHOIC	E PPO PLAN D	30/3000
Network	1	n-network	Οι	ıt-of-network	Ir	n-network	Out-	of-network
Annual medical deductibl (IND/FAM) (per calendar y		\$0/\$0	\$2	,000/\$4,000		\$0/\$0	\$2,0	00/\$4,000
Annual out-of-pocket maximum (IND/FAM)	\$2,	500/\$5,000	\$6,	000/\$12,000	\$3,	000/\$6,000	\$6,00	00/\$12,000
Office visits – preventive a well-child care	nd	\$0		30%*		\$0		30%*
Office visits – prenatal car	;	\$0		30%*		\$0		30%*
Telehealth (phone/video)		\$0		30%*		\$0		30%*
Office visits – primary care	\$40 (	\$20 enhanced benefit)		30%*		\$30 enhanced benefit)		30%*
Office visits – urgent care	\$80 (	\$40 enhanced benefit)		30%*	\$100(	\$50 enhanced benefit)		30%*
Office visits – specialty car	<b>e</b> \$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		per day, \$1,00 r admission	0	30%*		per day, \$1,000 r admission	)	30%*
Emergency care			\$200				\$200	
Routine eye exam	\$40(	\$20 enhanced benefit)		30%*	\$50 (	\$30 enhanced benefit)		30%*



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highli you the flexibility business goals. To compare the plan and then se	y to choos benefits o	e a plan th f up to any	nat helps / 3 plans,	meet emp check the	loyee needs a	and	ich		comparisons Reset
				Dual Cl	noice PPO				
Plan nar	ne	D	UAL CHOI	CE PPO PLAN	I E 35/3500	DUA	L CHOICE PP	0 PLAN A 250	/10/10%/2500
Network		ln-n	etwork	0.	ut-of-network	Ir	n-network	Out-	of-network
Annual medical de (IND/FAM) (per cal		\$	0/\$0	\$2	,000/\$4,000	\$2	250/\$750	\$2,0	00/\$6,000
Annual out-of-poc maximum (IND/FA		\$3,50	0/\$7,000	\$6,	.000/\$12,000	\$2,	500/\$7,500	\$6,0	00/\$12,000
Office visits – prev well-child care	entive and		\$0		30%*		\$0		30%*
Office visits – pren	atal care		\$0		30%*		\$0		30%*
Telehealth (phone	/video)		\$0		30%*		\$0		30%*
Office visits – prim	ary care		5 enhanced mefit)		30%*		510 enhanced benefit)		30%*
Office visits – urge	ent care		0 enhanceo enefit)	k	30%*		510 enhanced benefit)		30%*
Office visits – spec	ialty care		5 enhanced enefit)		30%*		510 enhanced benefit)		30%*
Office visits – natu care	ropathic		\$35		30%*		\$10		30%*
Lab			\$35		30%*		10%*		30%*
X-ray/diagnostic te	ests		\$35		30%*		10%*		30%*
CT, MRI, and PET so	cans		\$50		30%*		10%*		30%*
Outpatient surger	у	\$	5150		30%*		10%*		30%*
Inpatient hospital	care	\$800 pe	r admissior	1	30%*		10%*		30%*
Emergency care				\$200				\$200*	
Routine eye exam			5 enhanced enefit)		30%*		10 enhanced benefit)		30%*


OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.														
Below are highlig you the flexibility business goals. To compare the plan and then se	y to choos benefits o	e a plan th f up to any	nat helps / 3 plans,	meet emp check the	loyee needs a	nd	ich		comparisons Reset														
				Dual Cl	noice PPO																		
Plan nan	ne	DUAL	CHOICE PP	O PLAN A 25	50/15/20%/3000	DUA	L CHOICE PPC	PLAN B 500/	20/10%/3500														
Network		ln-n	etwork	0.	ıt-of-network	Ir	n-network	Out-	of-network														
Annual medical de (IND/FAM) (per cal		\$25	0/\$750	\$2	,000/\$6,000	\$5	00/\$1,500	\$2,5	00/\$7,500														
Annual out-of-pock maximum (IND/FA		\$3,00	0/\$9,000	\$6	.000/\$12,000	\$3,5	00/\$10,500	\$7,50	0/\$15,000														
Office visits – prevo well-child care	entive and		\$0		30%*		\$0		30%*														
Office visits – pren	atal care		\$0		30%*		\$0		30%*														
Telehealth (phone/	/video)		\$0		30%*		\$0		30%*														
Office visits – prim	ary care		5 enhanced enefit)		30%*		520 enhanced benefit)		30%*														
Office visits – urge	nt care		5 enhanced enefit)		30%*		\$80 (\$40 enhanced benefit)		30%*														
Office visits – spec	ialty care		5 enhanced enefit)		30%*		\$50 (\$30 enhanced benefit)		30%*														
Office visits – natu care	ropathic		\$15		30%* \$20		\$20		\$20		\$20		\$20		\$20		\$20		\$20		\$20		30%*
Lab			\$15		30%*		\$20		30%*														
X-ray/diagnostic te	sts		\$15		30%*		\$20		30%*														
CT, MRI, and PET sc	ans	\$	5100		30%*		\$100		30%*														
Outpatient surgery	1	2	0%*		30%*		10%*		30%*														
Inpatient hospital	care	2	0%*		30%*		30%*																
Emergency care				20%*		10%*																	
Routine eye exam			5 enhanced enefit)		30%*		\$20 enhanced benefit)		30%*														



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlig you the flexibility business goals. To compare the	y to choose	e a plan th	at helps	meet emp	loyee needs a	and	ich		comparisons Reset					
plan and then se	elect "See p	olan comp												
				Dual Cr	oice PPO									
Plan nan	Plan name   DUAL CHOICE PPO PLAN B 500/10%/10%/3000   DUAL CHOICE PPO PLAN B 500/10/20%/3000													
Network		ln-ne	etwork	Οι	t-of-network	Ir	n-network	Out-	of-network					
Annual medical de (IND/FAM) (per cale		\$500/	/\$1,500	\$2	,500/\$7,500	\$5	00/\$1,500	\$2,5	00/\$7,500					
Annual out-of-pock maximum (IND/FA		\$3,000	)/\$9,000	\$7,	500/\$15,000	\$3,	000/\$9,000	\$7,5	00/\$15,000					
Office visits – prevo well-child care	entive and	(	\$0		30%*		\$0		40%*					
Office visits – pren	atal care		\$0		30%*		\$0		40%*					
Telehealth (phone/	/video)		\$0		30%*		\$0		40%*					
Office visits – prim	ary care	20%* (10% bei	6* enhance nefit)	d	30%*		510 enhanced benefit)		40%*					
Office visits – urge	nt care	20%* (10% bei	6* enhance nefit)	d	30%*		\$10 enhanced benefit)		40%*					
Office visits – speci	ialty care		6* enhance nefit)	d	30%*		510 enhanced benefit)		40%*					
Office visits – natu care	ropathic	10	)%*		30%*		\$10		40%*					
Lab		1(	)%*		30%*		20%*		40%*					
X-ray/diagnostic te	sts	1(	)%*		30%*		20%*		40%*					
CT, MRI, and PET sc	ans	1(	)%*		30%*		20%*		40%*					
Outpatient surgery	/	1(	)%*		30%*		20%*		40%*					
Inpatient hospital	care	1(	)%*		30%*		20%*		40%*					
Emergency care				\$200*				\$200*						
Routine eye exam		20%* (10% bei	6* enhance nefit)	d	30%*		510 enhanced benefit)		40%*					



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.		
Below are highlig you the flexibility business goals. To compare the b	to choose	e a plan th	at helps	meet emp	loyee needs a	and	ch		comparisons Reset		
plan and then sel			arisons."	,							
		_		Dual Ch	oice PPO						
Plan nam	e			HOICE PPO F 20/20%/350		DUA		O PLAN C 750 PLIT COPAYS)	/20/20%/3500		
Network		ln-n	etwork	Ou	t-of-network	lr	n-network	of-network			
Annual medical ded (IND/FAM) (per cale		\$500	/\$1,500	\$2	,500/\$7,500	\$7	50/\$2,250	\$3,0	000/\$9,000		
Annual out-of-pocke maximum (IND/FAN		\$3,500	)/\$10,500	\$7,	500/\$15,000	\$3,5	00/\$10,500	\$7,5	00/\$22,500		
Office visits – prever well-child care	ntive and		\$0		40%*		\$0		40%*		
Office visits – prena	tal care		\$0		40%*		\$0		40%*		
Telehealth (phone/v	video)		\$0		40%*		\$0		40%*		
Office visits – prima	iry care		) enhanced nefit)		40%*		520 enhanced benefit)		40%*		
Office visits – urgen	it care		) enhancec nefit)	1	40%*		540 enhanced benefit)		40%*		
Office visits – specia	alty care		) enhanced nefit)		40%*		530 enhanced benefit)		40%*		
Office visits – nature care	opathic	0	\$20		40%*		\$20		40%*		
Lab		(	\$20		40%*		\$20		40%*		
X-ray/diagnostic tes	ts	C.	\$20		40%*		\$20		40%*		
CT, MRI, and PET sca	ins	\$	100		40%*		\$100	40%*			
Outpatient surgery		2	0%*		40%*		20%* 40%				
Inpatient hospital ca	are	2	0%*		40%*		20%*		40%*		
Emergency care				20%*				20%*			
Routine eye exam			) enhanced nefit)		40%*		520 enhanced benefit)		40%*		



OVERVIEW TR	RAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlights you the flexibility to business goals.					<b>y</b>	0			comparisons					
To compare the ben plan and then select			-		checkboxes n	ext to ea	ch		Reset					
				Dual Ch	oice PPO									
Plan name	(w/o SPLIT COPAYS) 750/20%/20%/3500													
Network		In-n	etwork	Ou	t-of-network	In	-network	Out	of-network					
Annual medical deduct (IND/FAM) (per calenda		\$750	/\$2,250	\$3	,000/\$9,000	\$7	50/\$2,250	\$3,0	000/\$9,000					
Annual out-of-pocket maximum (IND/FAM)		\$3,500	)/\$10,500	\$7,	500/\$22,500	\$3,5	00/\$10,500	\$7,5	00/\$22,500					
Office visits – preventiv well-child care	e and		\$0		40%*		\$0		40%*					
Office visits – prenatal o	care		\$0		40%*		\$0		40%*					
Telehealth (phone/vide	o)		\$0		40%*		\$0		40%*					
Office visits – primary c	are	•	) enhanceo nefit)	1	40%*		0%* enhanced benefit)	b	40%*					
Office visits – urgent ca	re		) enhanceo nefit)	1	40%*		0%* enhanced benefit)	b	40%*					
Office visits – specialty	care	•	) enhanceo nefit)	1	40%*		0%* enhanced benefit)	b	40%*					
Office visits – naturopat care	thic	4	520		40%*		20%*		40%*					
Lab		2	0%*		40%*		20%*		40%*					
X-ray/diagnostic tests		2	0%*		40%*		20%*		40%*					
CT, MRI, and PET scans		2	0%*		40%*		20%*		40%*					
Outpatient surgery		2	0%*		40%*		20%*		40%*					
Inpatient hospital care	Inpatient hospital care				40%*		20%*		40%*					
Emergency care				\$200*				\$200*						
Routine eye exam			) enhanceo nefit)	1	40%*		0%* enhanced benefit)	b	40%*					



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlig you the flexibility business goals. To compare the	/ to choose benefits of	e a plan th <sup>:</sup> up to any	nat helps y 3 plans,	meet emp check the	loyee needs a	nd	ich		comparisons Reset
plan and then se	elect "See p	olan comp							
Plan nan	ne	DUAL CH			noice PPO	DUAL (	CHOICE PPO F	PLAN D 1000//	25/20%/5000
Network		ln-n	etwork	Οι	it-of-network	Ir	ı-network	Out	of-network
Annual medical de (IND/FAM) (per cal		\$1,00	0/\$3,000	\$3	,000/\$9,000	\$1,0	000/\$3,000	\$3,0	00/\$9,000
Annual out-of-pock maximum (IND/FA		\$4,000	0/\$12,000	\$9,	000/\$27,000	\$5,0	00/\$15,000	\$9,0	00/\$27,000
Office visits – prevo well-child care	entive and		\$0		40%*		\$0		40%*
Office visits – pren	atal care		\$0		40%*		\$0		40%*
Telehealth (phone/	/video)		\$0		40%*		\$0		40%*
Office visits – prim	ary care	•	0 enhanced enefit)		40%*		525 enhanced benefit)		40%*
Office visits – urge	nt care		0 enhanced enefit)		40%*		545 enhanced benefit)		40%*
Office visits – speci	ialty care		0 enhanced enefit)		40%*		535 enhanced benefit)		40%*
Office visits – natu care	ropathic		\$20		40%*		\$25		40%*
Lab		2	0%*		40%*		\$25		40%*
X-ray/diagnostic te	sts	2	0%*		40%*		\$25		40%*
CT, MRI, and PET sc	ans	2	0%*		40%*		\$100		40%*
Outpatient surgery	1	2	0%*		40%*		20%*		40%*
Inpatient hospital	care	2	0%*		40%*		20%*		40%*
Emergency care				\$200*				20%*	
Routine eye exam		•	0 enhanced enefit)		40%*		525 enhanced benefit)		40%*



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	OOA	RIDERS	SR. ADV.	
Below are highlig you the flexibility business goals. To compare the b	to choose enefits of	e a plan th <sup>:</sup> up to any	nat helps v 3 plans	s meet emp s, check the	loyee needs a	and	ach		comparisons Reset
plan and then sele	ect "See p	olan comp	barisons		noice PPO				
Plan name	9	DUAL CH	IOICE PPC		/25/20%/6000	DUAL	CHOICE PPO F	PLAN E 1500/2	20/30%/5000
Network		ln-n	etwork	Οι	ıt-of-network	Ir	n-network	Out-	of-network
Annual medical ded (IND/FAM) (per caler		\$1,50	0/\$4,500	\$3,	500/\$10,500	\$1,5	500/\$4,500	\$3,5	00/\$10,500
Annual out-of-pocke maximum (IND/FAM		\$6,000	0/\$12,000	\$10	,500/\$21,000	\$5,0	00/\$12,000	\$10,5	00/\$21,000
Office visits – prever well-child care	ntive and		\$0		40%*		\$0		50%*
Office visits – prenat	tal care		\$0		40%*		\$0		50%*
Telehealth (phone/v	ideo)		\$0		40%*		\$0		50%*
Office visits – prima	ry care	•	5 enhance enefit)	d	40%*		\$20 enhanced benefit)		50%*
Office visits – urgen	t care		5 enhance enefit)	d	40%*		\$20 enhanced benefit)		50%*
Office visits – specia	lty care		5 enhance enefit)	d	40%*		\$20 enhanced benefit)		50%*
Office visits – naturo care	opathic	:	\$25		40%*		\$20		50%*
Lab			\$25		40%*		30%*		50%*
X-ray/diagnostic test	ts		\$25		40%*		30%*		50%*
CT, MRI, and PET sca	ns	\$	5100		40%*		30%*		50%*
Outpatient surgery		2	0%*		40%*		30%*		50%*
Inpatient hospital ca	are	2	0%*		40%*		30%*		50%*
Emergency care				20%*				\$200*	
Routine eye exam			5 enhance enefit)	d	40%*		\$20 enhanced benefit)		50%*



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	OOA	RIDERS	SR. ADV.						
Below are highli you the flexibility business goals. To compare the plan and then se	y to choose benefits of	e a plan th f up to any	at helps i v 3 plans,	meet emp	loyee needs a	nd	ch		comparisons Reset					
	Dual Choice PPO													
Plan nar	ne	DUAL CHO			30%/30%/5000	DUAL (	CHOICE PPO I	PLAN F 2000/2	25/20%/6000					
Network		ln-n	etwork	Ou	t-of-network	In	-network	Out	of-network					
Annual medical de (IND/FAM) (per cal		\$1,500	0/\$4,500	\$3,	500/\$10,500	\$2,0	000/\$6,000	\$4,0	00/\$12,000					
Annual out-of-poc maximum (IND/FA		\$5,000	)/\$12,000	\$10	500/\$21,000	\$6,0	00/\$12,000	\$12,0	00/\$24,000					
Office visits – prev well-child care	entive and		\$0		50%*		\$0		40%*					
Office visits – pren	atal care		\$0		50%*		\$0		40%*					
Telehealth (phone	/video)		\$0		50%*		\$0		40%*					
Office visits – prim	ary care		%* enhance nefit)	d	50%*		525 enhanced benefit)		40%*					
Office visits – urge	ent care		%* enhance nefit)	d	50%*		645 enhanced benefit)		40%*					
Office visits – spec	ialty care		%* enhance nefit)	d	50%*		35 enhanced benefit)		40%*					
Office visits – natu care	ropathic	3	0%*		50%*		\$25		40%*					
Lab		3	0%*		50%*		\$25		40%*					
X-ray/diagnostic te	ests	3	0%*		50%*		\$25		40%*					
CT, MRI, and PET so	cans	3	0%*		50%*		\$100		40%*					
Outpatient surgery	y	3	0%*		50%*		20%* 40%*							
Inpatient hospital	care	3	0%*		50%*		20%*		40%*					
Emergency care				\$200*				20%*						
Routine eye exam			%* enhance nefit)	b	50%*		525 enhanced benefit)		40%*					



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.	
Below are highli you the flexibility business goals. To compare the	y to choose	e a plan th	nat helps	meet emp	loyee needs a	nd	ch		n comparisons Reset	
plan and then se				,						
 Plan nar	ne	DUAL CH	OICE PPO		10ice PPO	DUAL (	CHOICE PPO F	PLAN G 2500/	30/30%/6000	
Network		ln-n	ietwork	Ou	t-of-network	In	-network	Out	-of-network	
Annual medical de (IND/FAM) (per cal		\$2,50	0/\$7,500	\$4,	500/\$13,500	\$2,5	500/\$5,000	\$4,5	00/\$13,500	
Annual out-of-poc maximum (IND/FA		\$6,000	0/\$12,000	\$13	,500/\$27,000	\$6,0	00/\$12,000	\$13,5	500/\$27,000	
Office visits – prev well-child care	entive and		\$0		40%*		\$0		50%*	
Office visits – pren	atal care		\$0		40%*		\$0		50%*	
Telehealth (phone	/video)		\$0		40%*		\$0		50%*	
Office visits – prim	ary care		5 enhancec enefit)		40%*		530 enhanced benefit)		50%*	
Office visits – urge	nt care		5 enhancec enefit)		40%*		530 enhanced benefit)		50%*	
Office visits – spec	ialty care		5 enhancec enefit)		40%*		530 enhanced benefit)		50%*	
Office visits – natu care	ropathic		\$25		40%*		\$30		50%*	
Lab			\$25		40%*		30%*		50%*	
X-ray/diagnostic te	ests		\$25		40%*		30%*		50%*	
CT, MRI, and PET so	ans	\$	5100		40%*		30%*		50%*	
Outpatient surgery	/	2	20%*		40%*		30%*		50%*	
Inpatient hospital	care	2	20%*		40%*		30%*		50%*	
Emergency care				20%*				\$200*		
Routine eye exam			5 enhancec enefit)		40%*		530 enhanced benefit)		50%*	



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlig you the flexibility business goals.						-			comparisons					
To compare the k plan and then sel				heck the	checkboxes r	ext to ea	ich		Reset					
Dual Choice PPO														
Plan nam	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													
Network	In-network Out-of-network In-network Out-of-													
Annual medical dec (IND/FAM) (per cale		\$2,500	0/\$5,000	\$4,	500/\$13,500	\$3,0	000/\$9,000	\$5,0	00/\$15,000					
Annual out-of-pock maximum (IND/FAN		\$6,000	)/\$12,000	\$13,	,500/\$27,000	\$8,1	50/\$16,300	\$15,0	00/\$30,000					
Office visits – preve well-child care	ntive and		\$0		50%*		\$0		40%*					
Office visits – prena	ital care		\$0		50%*		\$0		40%*					
Telehealth (phone/v	video)		\$0		50%*		\$0		40%*					
Office visits – prima	ary care		%* enhanced nefit)		50%*		530 enhanced benefit)		40%*					
Office visits – urger	nt care		%* enhanced nefit)		50%*		\$50 enhanced benefit)		40%*					
Office visits – specia	alty care		%* enhanced nefit)		50%*		540 enhanced benefit)		40%*					
Office visits – natur care	opathic	3	0%*		50%*		\$30		40%*					
Lab		3	0%*		50%*		\$30		40%*					
X-ray/diagnostic tes	its	3	0%*		50%*		\$30		40%*					
CT, MRI, and PET sca	ans	3	0%*		50%*		\$100		40%*					
Outpatient surgery		3	0%*		50%*		20%* 40%*							
Inpatient hospital c	are	3	0%*		50%*		20%*		40%*					
Emergency care			\$	5200*				20%*						
Routine eye exam			%* enhanced nefit)		50%*		530 enhanced benefit)		40%*					



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlig you the flexibility business goals. To compare the	, to choose benefits of	e a plan th f up to any	at helps m <sup>,</sup> 3 plans, c	neet emp	loyee needs a	nd	ch		comparisons Reset					
plan and then se	lect "See p	olan comp												
Dual Choice PPO														
Plan nan	Plan name DUAL CHOICE PPO PLAN H 3000/30%/30%/7000 DUAL CHOICE PPO PLAN I 3500/30/20%/8000													
Network		In-n	etwork	Ou	t-of-network	In	-network	Out-	of-network					
Annual medical de (IND/FAM) (per cale		\$3,000	0/\$6,000	\$5,	000/\$15,000	\$3,5	00/\$10,500	\$5,5	00/\$16,500					
Annual out-of-pock maximum (IND/FA		\$7,000	/\$14,000	\$15,	000/\$30,000	\$8,0	00/\$16,000	\$15,0	00/\$30,000					
Office visits – prevo well-child care	entive and		\$0		50%*		\$0		40%*					
Office visits – pren	atal care		\$0		50%*		\$0		40%*					
Telehealth (phone/	/video)		\$0		50%*		\$0		40%*					
Office visits – prim	ary care		%* enhanced nefit)		50%*		30 enhanced benefit)		40%*					
Office visits – urge	nt care		%* enhanced nefit)		50%*		\$50 enhanced benefit)		40%*					
Office visits – speci	ialty care		%* enhanced nefit)		50%*		540 enhanced benefit)		40%*					
Office visits – natu care	ropathic	3	0%*		50%*		\$30		40%*					
Lab		3	0%*		50%*		\$30		40%*					
X-ray/diagnostic te	sts	3	0%*		50%*		\$30		40%*					
CT, MRI, and PET sc	ans	3	0%*		50%*		\$100		40%*					
Outpatient surgery	1	3	0%*		50%*		20%* 40%*							
Inpatient hospital	care	3	0%*		50%*		20%*		40%*					
Emergency care			\$	\$200*				20%*						
Routine eye exam			%* enhanced nefit)		50%*		530 enhanced benefit)		40%*					



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.				
Below are highlig you the flexibility business goals. To compare the b	to choose	e a plan th	at helps r	neet emp	loyee needs a	nd	ich		comparisons Reset				
plan and then se			arisons."										
Dual Choice PPO     Plan name   DUAL CHOICE PPO PLAN J 4000/30/20%/8150   DUAL CHOICE PPO PLAN K 5000/30/20%/8150													
Network			etwork		t-of-network		-network		of-network				
Annual medical de (IND/FAM) (per cale		\$4,000	)/\$10,000	\$6,	000/\$18,000	\$5,0	00/\$10,000	\$6,5	00/\$19,500				
Annual out-of-pock maximum (IND/FAI		\$8,150	)/\$16,300	\$15,	000/\$30,000	\$8,1	50/\$16,300	\$15,0	00/\$30,000				
Office visits – preve well-child care	entive and		\$0		40%*		\$0		40%*				
Office visits – prena	atal care		\$0		40%*		\$0		40%*				
Telehealth (phone/	video)		\$0		40%*		\$0		40%*				
Office visits – prima	ary care		D enhanced nefit)		40%*		530 enhanced benefit)		40%*				
Office visits – urgei	nt care	•	0 enhanced nefit)		40%*		\$50 enhanced benefit)		40%*				
Office visits – speci	alty care		0 enhanced nefit)		40%*		540 enhanced benefit)		40%*				
Office visits – natur care	ropathic	(	\$30		40%*		\$30		40%*				
Lab		(	\$30		40%*		\$30		40%*				
X-ray/diagnostic te	sts	(	\$30		40%*		\$30		40%*				
CT, MRI, and PET sc	ans	\$	100		40%*		\$100		40%*				
Outpatient surgery		2	0%*		40%*		20%*		40%*				
Inpatient hospital of	care	2	0%*		40%*		20%*		40%*				
Emergency care				20%*				20%*					
Routine eye exam\$50 (\$30 enhanced benefit)40%*\$50 (\$30 enhanced benefit)40%*													



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlig you the flexibility business goals. To compare the k plan and then se	to choose	e a plan th <sup>f</sup> up to any	at helps i v 3 plans,	meet emp	loyee needs a	nd	ach		comparisons Reset					
	Dual Choice PPO													
Plan nam	ie	DUAL CH			/35/20%/8000	DUAL (	CHOICE PPO P	LAN M 7500/	35/30%/8500					
Network		ln-n	etwork	Ou	t-of-network	Ir	n-network	Out-	of-network					
Annual medical de (IND/FAM) (per cale		\$6,000	)/\$12,000	\$7,5	500/\$18,000	\$7,5	00/\$14,500	\$8,5	00/\$19,500					
Annual out-of-pock maximum (IND/FAI		\$8,000	)/\$16,000	\$15,	000/\$30,000	\$8,5	500/\$17,000	\$17,0	00/\$30,000					
Office visits – preve well-child care	entive and		\$0		40%*		\$0		50%*					
Office visits – prena	atal care		\$0		40%*		\$0		50%*					
Telehealth (phone/	video)		\$0		40%*		\$0		50%*					
Office visits – prima	ary care		5 enhanced nefit)		40%*		\$35 enhanced benefit)		50%*					
Office visits – urger	nt care		5 enhanced nefit)		40%*		\$55 enhanced benefit)		50%*					
Office visits – speci	alty care		5 enhanced nefit)		40%*		\$45 enhanced benefit)		50%*					
Office visits – natur care	opathic	ç	\$35		40%*		\$35		50%*					
Lab		ç	\$35		40%*		\$35		50%*					
X-ray/diagnostic tes	sts	Ç	\$35		40%*		\$35		50%*					
CT, MRI, and PET sca	ans	\$	150		40%*		\$150		50%*					
Outpatient surgery		2	0%*		40%*		30%*		50%*					
Inpatient hospital of	are	2	0%*		40%*		30%*		50%*					
Emergency care				20%*				30%*						
Routine eye exam			5 enhanced nefit)		40%*		\$35 enhanced benefit)		50%*					



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.	
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. PPO plans designated "VC" are designed to pair with our Virtual Complete plans. To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."										
		Du	ial Cho	oice PPC	) Virtual C	omple	te			
	Plan nai	ne			DUAL C	HOICE PPO	PLAN VC 25	00/40/20%/650	00	
Network					In-network			Out-of-netw	ork	
Annual medical d	eductible (IND	/FAM) (per d	calendar ye	ear)	\$2,500/\$5,0	00		\$5,000/\$15,000		
Annual out-of-poo	ket maximur	n (IND/FAM)	)		\$6,500/\$13,0	00		\$13,500/\$27,000		
Office visits – prev	ventive and w	ell-child car	e		\$0			40%*		
Office visits – pre	natal care				\$0			40%*		
Telehealth (phone	e/video)				\$0			40%*		

\$0	40%*				
\$0	40%*				
\$60* (\$40* enhanced benefit) <sup>1</sup>	40%*				
\$60* (\$40* enhanced benefit)	40%*				
\$60* (\$40* enhanced benefit)	40%*				
\$40*1	40%*				
\$15	40%*				
20%*	40%*				
20%*	40%*				
20%*	40%*				
20%*	40%*				
20%*					
\$60* (\$40* enhanced benefit) <sup>1</sup>	40%*				
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 Pha	rmacies				
\$25* generic; \$60* preferred brand- name; \$90* non-preferred brand- name; 30%* specialty	Not covered				
	\$0     \$0       \$60* (\$40* enhanced benefit)1     \$60* (\$40* enhanced benefit)1       \$60* (\$40* enhanced benefit)     \$60* (\$40* enhanced benefit)1       \$60* (\$40* enhanced benefit)     \$60* (\$40* enhanced benefit)1       \$60* (\$40* enhanced benefit)     \$60* (\$40* enhanced benefit)1       \$15     20%*       20%*     20%*       20%*     20%*       \$60* (\$40* enhanced benefit)1     \$60* (\$40* enhanced benefit)1       \$15* generic; \$40* preferred brand-name; 20%* (up to a max of \$250) specialty     \$60* (up to a max of \$250) specialty       \$25* generic; \$60* preferred brand-name; \$25* generic; \$60* preferred brand-name				

<sup>1</sup>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).



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.		
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. PPO plans designated "VC" are designed to pair with our Virtual Complete plans. To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."											
		Du	ial Ch	oice PPC	) Virtual C	omple	te				
	Plan na	me			DUAL C	HOICE PPO	PLAN VC 30	00/40/30%/70	00		
Network					In-network	(		Out-of-netw	ork		
Annual medical d	eductible (IND	)/FAM) (per o	calendar y	ear)	\$3,000/\$6,0	00		\$6,000/\$18,	000		
Annual out-of-pocket maximum (IND/FAM) \$7,000/\$14,000 \$15,000/\$30,000									,000		
Office visits – prev	preventive and well-child care \$0 50%*										
Office visits – pre	natal care				\$0			50%*			
Talahaalth (nhan	o/video)				¢Ο			E00/*			

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) <sup>1</sup>	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) <sup>1</sup>	50%*			
Outpatient prescription drugs	Kaiser Permane	nte 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			

<sup>1</sup>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).



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.	
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. PPO plans designated "VC" are designed to pair with our Virtual Complete plans. To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."										
		Du	ial Cho	oice PP(	) Virtual C	omple	te			
	Plan na	me			DUAL C	HOICE PPO	PLAN VC 40	00/50/30%/81	50	
Network					In-network			Out-of-netw	ork	
Annual medical d	eductible (IND	)/FAM) (per o	calendar ye	ear)	\$4,000/\$8,0	00		\$8,000/\$16,	000	
Annual out-of-po	cket maximu	m (IND/FAM	)		\$8,150/\$16,3	00		\$15,000/\$30	,000	
Office visits – pre	ventive and w	ell-child car	'е		\$0			50%*		
Office visits – pre	natal care				\$0			50%*		
Telehealth (phon	e/video)				\$0			50%*		

Office visits – prenatal care	\$0	50%*
Telehealth (phone/video)	\$0	50%*
Office visits – primary care	\$70* (\$50* enhanced benefit) <sup>1</sup>	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) <sup>1</sup>	50%*
Outpatient prescription drugs	Kaiser Permanent	e Pharmacies
	\$15* generic; \$50* preferred brand- name; \$70* non-preferred brand-name; 30%* (up to a max of \$250) specialty	Not covered
	MedImpact Ph	armacies
	\$25* generic; \$70* preferred brand- name; \$100* non-preferred brand- name; 40%* specialty	Not covered

<sup>1</sup>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).



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.		
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. PPO plans designated "VC" are designed to pair with our Virtual Complete plans. To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."											
		Du	ial Cho	oice PP(	) Virtual C	omple	te				
	Plan na	me			DUAL C	HOICE PPO	PLAN VC 50	00/50/40%/81	50		
Network					In-network	(		Out-of-netw	ork		
Annual medical d	eductible (INE	)/FAM) (per o	calendar y	ear)	\$5,000/\$10,0	000		\$10,000/\$20	,000		
Annual out-of-pocket maximum (IND/FAM) \$8,150/\$16,300 \$15,000/\$30,000									,000		
Office visits – prev	ventive and w	and well-child care \$0 50%*									
Office visits – pre	natal care				\$0			50%*			
Tolohoalth (nhon	wideo)				¢0			50%*			

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) <sup>1</sup>	50%*
Office visits – urgent care	\$70* (\$50* enhanced benefit)	50%*
Office visits – specialty care	\$70* (\$50* enhanced benefit)	50%*
Office visits – naturopathic care	\$50* <sup>1</sup>	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) <sup>1</sup>	50%*
Outpatient prescription drugs	Kaiser Permane	ente 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

<sup>1</sup>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).



OVERVIEW	TRAD	DED	VC I	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.	
Below are highlig you the flexibility						-		See pla	n comparisons	
business goals. To compare the b	enefits of I	up to any	3 nlans cl	neck the	checkboxes	next to ea	ach		Reset	
plan and then sel										
			D	ual Ch	oice PPO					
Plan nam	e		DUAL CHOIC 1500/				ICE PPO HDF 0/20%/3500	IP PLAN A		
Network		In-	network	0ι	ıt-of-network	I	n-network	Ou	t-of-network	
Accumulation type			Ag	gregate			Д	ggregate		
Annual medical ded (IND/FAM) (per cale		\$1,50	00/\$3,000	\$3	8,500/\$9,750	\$1,	500/\$3,000	\$3	,500/\$9,750	
Annual out-of-pocke maximum (IND/FAM		\$2,50	00/\$5,000	\$10	,500/\$21,000	\$3	,500/\$7,000	\$11,	500/\$23,000	
Office visits – prever well-child care	ntive and		\$0		30%*		\$0		40%*	
Office visits – prena	tal care		\$0		30%*		\$0		40%*	
Telehealth (phone/v	ideo)		\$0*		30%*		\$0*		40%*	
Office visits – prima	ry care		)%* enhanced enefit)		30%*	30%* (	20%* enhance benefit)	d	40%*	
Office visits – urgen	t care		)%* enhanced enefit)		30%*		20%* enhance benefit)	d	40%*	
Office visits – specia	lty care	•	)%* enhanced enefit)		30%*	30%* (	20%* enhance benefit)	d	40%*	
Office visits – nature	opathic care		10%*		30%*		20%*		40%*	
Lab			10%*		30%*		20%*		40%*	
X-ray/diagnostic tes	ts		10%*		30%*		20%*		40%*	
CT, MRI, and PET sca	ns		10%*		30%*		20%*		40%*	
Outpatient surgery			10%*	30%*			20%*		40%*	
Inpatient hospital ca	are		10%*		30%*		20%*		40%*	
Emergency care				10%*				20%*		
Routine eye exam			)%* enhanced enefit)		30%*	30%* (	20%* enhance benefit)	d	40%*	



OVERVIEW	TRAD	DED	VC F	IDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlig you the flexibility business goals.	-					-		See pla	n comparisons
To compare the l plan and then se				neck the	checkboxes r	next to ea	ach		Reset
			D	ual Ch	oice PPO				
Plan nar	ne		DUAL CHOIC 2000/	E PPO HD 20%/4000				ICE PPO HDF 0/30%/4000	
Network		In-	network	0ι	ıt-of-network	I	n-network	Ou	t-of-network
Accumulation type			Ag	gregate			Д	ggregate	
Annual medical de (IND/FAM) (per cale		\$2,00	00/\$4,000	\$4	.000/\$12,000	\$2,	000/\$4,000	\$4,	000/\$12,000
Annual out-of-pock maximum (IND/FA		\$4,00	00/\$8,000	\$12	,000/\$24,000	\$4,	000/\$8,000	\$12,	.000/\$24,000
Office visits – preve well-child care	entive and		\$0		40%*		\$0		50%*
Office visits – prena	atal care		\$0		40%*		\$0		50%*
Telehealth (phone/	video)		\$0*		40%*		\$0*		50%*
Office visits – prima	ary care		)%* enhanced enefit)		40%*	40%* (	30%* enhance benefit)	ed	50%*
Office visits – urge	nt care		)%* enhanced enefit)		40%*		30%* enhance benefit)	ed	50%*
Office visits – speci	alty care		)%* enhanced enefit)		40%*	40%* (	30%* enhance benefit)	d	50%*
Office visits – natur	ropathic care		20%*		40%*		30%*		50%*
Lab			20%*		40%*		30%*		50%*
X-ray/diagnostic te	sts	:	20%*		40%*		30%*		50%*
CT, MRI, and PET sc	ans		20%*		40%*		30%*		50%*
Outpatient surgery	,		20%*		40%*		30%*		50%*
Inpatient hospital	care		20%*		40%*		30%*		50%*
Emergency care				20%*				30%*	
Routine eye exam			)%* enhanced enefit)		40%*	40%* (	30%* enhance benefit)	ed	50%*



OVERVIEW	TRAD	DED	VC F	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlig you the flexibility					5	0		See pla	n comparisons
business goals. To compare the k	penefits of t	up to anv	3 plans, cł	neck the	checkboxes r	next to ea	ach		Reset
plan and then se		1							
			D	ual Ch	oice PPO				
Plan nan	ne			ICE PPO HDI 0/30%/5000					
Network		In-r	network	0ι	ut-of-network		n-network	Ου	t-of-network
Accumulation type			Age	gregate			Д	ggregate	
Annual medical de (IND/FAM) (per cale		\$2,50	0/\$5,000	\$5,	,000/\$15,000	\$2,	500/\$5,000	\$5,	000/\$15,000
Annual out-of-pock maximum (IND/FAI		\$5,00	0/\$7,500	\$15	,000/\$30,000	\$5	,000/\$7,500	\$15	000/\$30,000
Office visits – preve well-child care	entive and		\$0		40%*		\$0		50%*
Office visits – prena	atal care		\$0		40%*		\$0		50%*
Telehealth (phone/	video)		\$0*		40%*		\$0*		50%*
Office visits – prima	ary care		%* enhanced enefit)		40%*	40%* (	30%* enhance benefit)	ed	50%*
Office visits – urger	nt care		%* enhanced enefit)		40%*		30%* enhance benefit)	ed .	50%*
Office visits – speci	alty care		%* enhanced enefit)		40%*	40%* (	30%* enhance benefit)	d	50%*
Office visits – natur	opathic care		20%*		40%*		30%*		50%*
Lab		2	20%*		40%*		30%*		50%*
X-ray/diagnostic tes	sts	2	20%*		40%*		30%*		50%*
CT, MRI, and PET sca	ans		20%*		40%*		30%*		50%*
Outpatient surgery			20%*		40%*		30%*		50%*
Inpatient hospital o	are		20%*		40%*		30%*		50%*
Emergency care			2	20%*				30%*	
Routine eye exam			%* enhanced enefit)		40%*	40%* (	30%* enhance benefit)	ed	50%*



OVERVIEW	TRAD	DED	VC F	IDHP	KP PLUS	PPO	OOA	RIDER	S SR. ADV.		
					<i>.</i> .						
Below are highlig you the flexibility business goals. To compare the b	to choose	a plan th	at helps me	eet empl	oyee needs a	nd	ach	See p	lan comparisons Reset		
plan and then sel					checkboxesi						
			D	ual Ch	oice PPO						
Plan nam	Plan nameDUAL CHOICE PPO HDHP PLAN E 3000/20%/6000DUAL CHOICE PPO HDHP PLAN 3000/30%/6000										
Network		In-	network	0ι	ut-of-network	I	n-network	C	out-of-network		
Accumulation type			Em	bedded			E	mbedded			
Annual medical dec (IND/FAM) (per cale		\$3,00	00/\$6,000	\$5,	.000/\$15,000	\$3,	000/\$6,000	\$!	5,000/\$15,000		
Annual out-of-pocke maximum (IND/FAN		\$6,00	0/\$12,000	\$15	,000/\$30,000	\$6,	000/\$12,000	\$1	5,000/\$30,000		
Office visits – preve well-child care	ntive and		\$0		40%*		\$0	50%*			
Office visits – prena	tal care		\$0		40%*		\$0		50%*		
Telehealth (phone/v	/ideo)		\$0*		40%*		\$0*		50%*		
Office visits – prima	iry care		)%* enhanced enefit)		40%*	40%* (	30%* enhance benefit)	ed	50%*		
Office visits – urgen	it care		)%* enhanced enefit)		40%*		30%* enhance benefit)	ed	50%*		
Office visits – specia	alty care		)%* enhanced enefit)		40%*	40%* (	30%* enhance benefit)	ed	50%*		
Office visits – nature	opathic care		20%*		40%*		30%*		50%*		
Lab			20%*		40%*		30%*		50%*		
X-ray/diagnostic tes	ts		20%*		40%*		30%*		50%*		
CT, MRI, and PET sca	ins		20%*		40%*		30%*		50%*		
Outpatient surgery			20%*		40%*		30%*		50%*		
Inpatient hospital c	are		20%*		40%*		30%*		50%*		
Emergency care			2	20%*				30%*			
Routine eye exam			)%* enhanced enefit)		40%*	40%* (	30%* enhance benefit)	ed	50%*		



OVERVIEW	TRAD	DED	VC H	DHP	KP PLUS	PPO	OOA	RIDERS	S SR. ADV.	
Below are highlig you the flexibility business goals.	•					-		See p	an comparisons	
To compare the k plan and then sel				eck the	checkboxes r	next to ea	ach		Reset	
				ual Ch	oice PPO					
Plan nameDUAL CHOICE PPO HDHP PLAN F 3500/20%/7000DUAL CHOICE PPO HDH 3500/30%/7000										
Network		ln-ı	network	0ι	ıt-of-network		n-network	C	ut-of-network	
Accumulation type			Emb	edded			E	Embedded		
Annual medical dec (IND/FAM) (per cale		\$3,50	00/\$7,000	\$5,	500/\$16,500	\$3,	500/\$7,000	\$5	5,500/\$16,500	
Annual out-of-pock maximum (IND/FAI		\$7,00	0/\$14,000	\$15	,000/\$30,000	\$7,0	000/\$14,000	\$1	5,000/\$30,000	
Office visits – preve well-child care	entive and		\$0		40%*		\$0		50%*	
Office visits – prena	ital care		\$0		40%*		\$0		50%*	
Telehealth (phone/	video)		\$0*		40%*		\$0*		50%*	
Office visits – prima	ary care	,	)%* enhanced enefit)		40%*	40%* (	30%* enhanc benefit)	ed	50%*	
Office visits – urger	nt care		)%* enhanced enefit)		40%*		30%* enhanc benefit)	ed	50%*	
Office visits – speci	alty care		)%* enhanced enefit)		40%*	40%* (	30%* enhanc benefit)	ed	50%*	
Office visits – natur	opathic care		20%*		40%*		30%*		50%*	
Lab			20%*		40%*		30%*		50%*	
X-ray/diagnostic tes	sts		20%*		40%*		30%*		50%*	
CT, MRI, and PET sca	ans		20%*		40%*		30%*		50%*	
Outpatient surgery			20%*		40%*		30%*		50%*	
Inpatient hospital o	are		20%*		40%*		30%*		50%*	
Emergency care			2	0%*				30%*		
Routine eye exam			)%* enhanced enefit)		40%*	40%* (	30%* enhanc benefit)	ed	50%*	



OVERVIEW	TRAD	DED	VC ł	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.	
Below are highligh you the flexibility t business goals.			•			-		See pl	an comparisons	
To compare the b plan and then sele			•	neck the	checkboxes r	next to ea	ach		Reset	
			D	ual Ch	oice PPO					
Plan name DUAL CHOICE PPO HDHP PLAN G 4000/20%/7000								0ICE PPO HD 0/30%/7000		
Network		In-	network	01	ut-of-network	I	n-network	0	ut-of-network	
Accumulation type			Em	bedded			E	mbedded		
Annual medical ded (IND/FAM) (per caler		\$4,00	00/\$8,000	\$6	,000/\$12,000	\$4	,000/\$8,000	\$6	,000/\$12,000	
Annual out-of-pocke maximum (IND/FAM		\$7,00	0/\$14,000	\$15	,000/\$30,000	\$7,	000/\$14,000	\$15	5,000/\$30,000	
Office visits – prever well-child care	ntive and		\$0		40%*		\$0		50%*	
Office visits – prenat	al care		\$0		40%*		\$0		50%*	
Telehealth (phone/v	ideo)		\$0*		40%*		\$0*		50%*	
Office visits – prima	ry care		)%* enhanced enefit)		40%*	40%* (	(30%* enhanc benefit)	ed	50%*	
Office visits – urgent	t care		)%* enhanced enefit)		40%*		(30%* enhanc benefit)	ed	50%*	
Office visits – specia	lty care	•	)%* enhanced enefit)		40%*	40%* (	(30%* enhanc benefit)	ed	50%*	
Office visits – naturo	pathic care		20%*		40%*		30%*		50%*	
Lab		:	20%*		40%*		30%*		50%*	
X-ray/diagnostic test	s	:	20%*		40%*		30%*		50%*	
CT, MRI, and PET sca	ns		20%*		40%*		30%*		50%*	
Outpatient surgery			20%*		40%*		30%*		50%*	
Inpatient hospital ca	are		20%*		40%*		30%*		50%*	
Emergency care			2	20%*		30%*				
Routine eye exam			)%* enhanced enefit)		40%*	40%* (	(30%* enhanc benefit)	ed	50%*	



OVERVIEW	TRAD	DED	VC F	IDHP	KP PLUS	PPO	OOA	RIDERS	S SR. ADV.	
Below are highligh you the flexibility to business goals. To compare the be plan and then sele	o choose enefits of u	a plan th up to any	at helps me v 3 plans, ch	eet emp	oyee needs a	nd	ich	See p	an comparisons Reset	
			D	ual Ch	oice PPO					
Plan name	Plan nameDUAL CHOICE PPO HDHP PLAN G 4000/40%/7000DUAL CHOICE PPO HDHP 5000/20%/7000									
Network		In-	network	0ι	ıt-of-network		n-network	C	ut-of-network	
Accumulation type			Eml	pedded			E	Embedded		
Annual medical dedu (IND/FAM) (per calend		\$4,00	00/\$8,000	\$6	.000/\$12,000	\$5,0	000/\$10,000	\$7	7,000/\$14,000	
Annual out-of-pocket maximum (IND/FAM)		\$7,00	0/\$14,000	\$15	,000/\$30,000	\$7,0	000/\$14,000	\$1	7,000/\$34,000	
Office visits – prevent well-child care	tive and		\$0		50%*		\$0		40%*	
Office visits – prenata	al care		\$0		50%*		\$0		40%*	
Telehealth (phone/vio	deo)		\$0*		50%*		\$0*		40%*	
Office visits – primary	y care		)%* enhanced enefit)		50%*	30%* (	20%* enhanco benefit)	ed	40%*	
Office visits – urgent	care	•	)%* enhanced enefit)		50%*		20%* enhanco benefit)	ed	40%*	
Office visits – special	ty care	•	)%* enhanced enefit)		50%*	30%* (	20%* enhanco benefit)	ed	40%*	
Office visits – naturop	oathic care	L	40%*		50%*		20%*		40%*	
Lab		4	40%*		50%*		20%*		40%*	
X-ray/diagnostic tests	;		40%*		50%*		20%*		40%*	
CT, MRI, and PET scan	S		40%*		50%*		20%*		40%*	
Outpatient surgery			40%*		50%*		20%*		40%*	
Inpatient hospital car	re		40%*		50%*		20%*		40%*	
Emergency care			4	0%*				20%*		
Routine eye exam		•	)%* enhanced enefit)		50%*	30%* (	20%* enhanco benefit)	ed	40%*	



OVERVIEW	TRAD	DED	VC F	IDHP	KP PLUS	PPO	OOA	RIDERS	S SR. ADV.	
Below are highlig you the flexibility business goals.					5 1	0		See p	an comparisons	
To compare the b plan and then sel			-	neck the	checkboxes r	next to ea	ich		Reset	
			D	ual Ch	oice PPO					
Plan nameDUAL CHOICE PPO HDHP PLAN H 5000/30%/7000DUAL CHOICE PPO HDH 5000/40%/7000										
Network		In-	network	01	ut-of-network	l	n-network	C	ut-of-network	
Accumulation type			Em	bedded			E	mbedded		
Annual medical dec (IND/FAM) (per cale		\$5,00	0/\$10,000	\$7,	000/\$14,000	\$5,(	000/\$10,000	\$7	7,000/\$14,000	
Annual out-of-pocke maximum (IND/FAN		\$7,00	0/\$14,000	\$17	,000/\$34,000	\$7,0	000/\$14,000	\$1	7,000/\$34,000	
Office visits – preve well-child care	ntive and		\$0		50%*		\$0		50%*	
Office visits – prena	tal care		\$0		50%*		\$0		50%*	
Telehealth (phone/v	/ideo)		\$0*		50%*		\$0*		50%*	
Office visits – prima	ary care		)%* enhanced enefit)		50%*	50%* (	40%* enhanco benefit)	ed	50%*	
Office visits – urgen	it care		)%* enhanced enefit)		50%*		40%* enhanco benefit)	ed	50%*	
Office visits – specia	alty care		)%* enhanced enefit)		50%*	50%* (	40%* enhanco benefit)	ed	50%*	
Office visits – nature	opathic care		30%*		50%*		40%*		50%*	
Lab			30%*		50%*		40%*		50%*	
X-ray/diagnostic tes	its		30%*		50%*		40%*		50%*	
CT, MRI, and PET sca	ins		30%*		50%*		40%*		50%*	
Outpatient surgery			30%*		50%*		40%*		50%*	
Inpatient hospital c	are		30%*		50%*		40%*		50%*	
Emergency care			3	30%*		40%*				
Routine eye exam		•	)%* enhanced enefit)		50%*	50%* (	40%* enhanco benefit)	ed	50%*	



\$30	35%*	\$30	35%*
20%*	35%*	20%*	35%*
20%*	35%*	20%*	35%*
20%*	35%*	20%*	35%*
\$20	)0*	\$20	)0*
\$30	35%*	\$30	35%*
s and limitations. A comple EOC, please contact your	ete list of the exclusions and sales executive or account i	limitations is included in th manager.	e Evidence of

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	\$20	)0*	\$20	)0*								
Routine eye exam	\$30	35%*	\$30	35%*								

business goals.

These plans are subject to exclusions Coverage (EOC). To get a copy of the



**IDERS** 

Reset

SR. ADV.

Below are highlights of the benefits for each plan. A variety of options gives

To compare the benefits of up to any 3 plans, check the checkboxes next to each

you the flexibility to choose a plan that helps meet employee needs and

plan and then select "See plan comparisons."

#### 61

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."

VC

DED

**HDHP** 

**KP PLUS** 

PPO

OOA

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	750/\$9,500 \$6,000/\$12,000 \$6,0		\$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	\$2	200*	\$20	00*							
Routine eye exam	\$30	45%*	\$30	45%*							

\*After deductible.

**OVERVIEW** 

TRAD

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.

See plan comparisons

SR. ADV.

Reset

**RIDERS** 

you the flexibility to choose	elow are highlights of the benefits for each plan. A variety of options gives u the flexibility to choose a plan that helps meet employee needs and usiness goals.								
To compare the benefits of upper the select "See pl		eck the checkboxes ne	ext to each	Reset					
	OUT-O	F-AREA PPO PLU	US						
Plan name	PPO PLUS PLAN V	VDN 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%*					

40%\*

40%\*

40%\*

30%\*

30%\*

\$35

\$200\*

PPO

OOA

**KP PLUS** 

**RIDERS** 

SR. ADV.

VC

**HDHP** 

DED

\*After deductible.

**Emergency care** 

Routine eye exam

**Outpatient surgery** 

Inpatient hospital care

**OVERVIEW** 

TRAD

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.

\$200\*

30%\*

30%\*

\$35



40%\*

40%\*

40%\*

OVERVIEW TRA	D DE	D VC H	IDHP KP PLUS	РРО	OOA I	RIDERS	SR. ADV.				
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 blan and then select "See plan comparisons."											
OUT-OF-AREA PPO PLUS											
Plan name	Plan name PPO PLUS PLAN WDR 4000/30%/7350 PPO PLUS PLAN WDS 5000/30%/7350										
Network		PPO providers	Nonparticipating providers	РРО р	roviders		rticipating oviders				
Annual medical deductibl (IND/FAM) (per calendar y		\$4,000/\$8,000	\$6,000/\$12,000	\$5,000	/\$10,000	\$6,50	0/\$13,000				
Annual out-of-pocket maximum (IND/FAM)		\$7,350/\$14,700	\$9,000/\$18,000	\$7,350	/\$14,700	\$9,00	0/\$18,000				
Office visits – preventive a well-child care	and	\$0	40%*		\$0		10%*				
Office visits – prenatal car	e	\$0	40%*		\$0		10%*				
Telehealth (phone/video)		\$0	40%*		\$0	4	10%*				
Office visits – primary care	9	\$35	40%*	\$	535	4	10%*				
Office visits – urgent care		\$55	40%*	\$	555		10%*				
Office visits – specialty ca	re	\$45	40%*	\$	545		10%*				
Office visits – naturopathi	c care	\$35	40%*	\$	535		10%*				
Lab		\$35	40%*	\$	535		10%*				
X-ray/diagnostic tests		\$35	40%*	\$	535		10%*				

40%\*

40%\*

40%\*

40%\*

30%\*

30%\*

30%\*

\$35

20%\*

\*After deductible.

**Emergency care** 

Routine eye exam

CT, MRI, and PET scans

Inpatient hospital care

**Outpatient surgery** 

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.

20%\*

30%\*

30%\*

30%\*

\$35



40%\*

40%\*

40%\*

40%\*

OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.	
Below are highli you the flexibility business goals.	-				-	-		See pla	n comparisons	
To compare the plan and then se				heck the	checkboxes ı	next to ea	ach		Reset	
			OUT-	OF-AR	EA PPO PI	LUS				
PPO PLUS HDHP AA PLAN WFI PPO PLUS HD 1500/20%/3500 2800/20						S HDHP AA PL )0/20%/4000	AN WAS			
Network		PPO	providers	No	nparticipating providers	PP	PPO providers PPO provide			
Accumulation type	;		Ag	ggregate				Aggregate		
Annual medical de (IND/FAM) (per cal		\$1,50	00/\$3,000	\$3	3,500/\$7,000	\$2,	800/\$5,600	,600 \$3,500/\$7,		
Annual out-of-poc maximum (IND/FA		\$3,50	00/\$7,000	\$6	,000/\$12,000	\$4,	000/\$8,000	\$7,0	000/\$14,000	
Office visits – prev well-child care	entive and		\$0		30%*		\$0		30%*	
Office visits – pren	atal care		\$0		30%*		\$0		30%*	
Telehealth (phone	/video)		\$0*		30%*		\$0*		30%*	
Office visits – prim	ary care		20%*		30%*		20%*		30%*	
Office visits – urge	ent care	2	20%*		30%*		20%*		30%*	
Office visits – spec	ialty care		20%*		30%*		20%*		30%*	
Office visits – natu	ropathic care		20%*		30%*		20%*		30%*	
Lab		2	20%*		30%*		20%*		30%*	
X-ray/diagnostic te	ests		20%*		30%*		20%*		30%*	
CT, MRI, and PET so	cans		20%*		30%*		20%*	30%*		
Outpatient surger	у		20%*		30%*		20%*		30%*	
Inpatient hospital	care		20%*		30%*		20%*		30%*	
Emergency care				20%*				10%*		
Routine eye exam			20%*		30%*		20%*		30%*	



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.

## 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		

\*After deductible.

<sup>1</sup>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



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.

## 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.

<sup>1</sup>The limit of 10 covered Services does not apply.

<sup>2</sup>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



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## SUPPLEMENTAL BENEFIT OPTIONS OUTPATIENT PRESCRIPTION DRUGS

VC

## 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.



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
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## Kaiser Permanente Plus<sup>™</sup> 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 Pei	rmanente Ph	armacies	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.



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
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## **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 Pei	rmanente Ph	armacies	MedImpact Pharmacies					
Generic	Preferred Brand	Non- Preferred Brand	Specialty	Preferred Generic 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%		

OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
						A BETT	ER WAY TO	O TAKE CARE	OF BUSINESS

#### HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

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

	Kaiser Pe	rmanente Ph	armacies	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.

OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
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## **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	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	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						



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.

#### A BETTER WAY TO TAKE CARE OF BUSINESS

## **HEARING AIDS**

## Traditional and deductible (including KP Plus<sup>1</sup>), 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<sup>1</sup>), 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.

<sup>1</sup>Rider benefits only available in-network



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
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#### WASHINGTON

## Traditional and deductible (including KP Plus<sup>1</sup>), 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			Visit Limit
Massage	\$25	20%	40%	12

\*Subject to deductible on HSA-qualified plans.

<sup>1</sup>Rider benefits only available in-network

OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
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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

OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
						A BETT	TER WAY TO	O TAKE CARE	OF BUSINESS

## **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	meml	bers	19	and	ol	der
				unu		

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



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
						A BET	TER WAY TO	O TAKE CARE	OF BUSINESS

### **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%.

OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.

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%					





kp.org/dualchoice/nw/producers

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