2024 PLANS AND PRODUCTS | OREGON



Complete Suite[™] plan comparison chart

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



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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	ETTER WAY	TO TAKE CARE	OF BUSINESS

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	TTER WAY	O TAKE CARE	OF BUSINESS
2024 Compl The list below inc list of benefits.		-		t a plan to navi	gate to the	full	Plans sel Comp	ected:
Trac	ditional			Deductible		High d	eductible hea (HDHP)	lth plan
TRAD	PLAN A 10/100	0	DED PLA	AN A 250/10/10%/2	2000	HDI	HP PLAN A 1600/	10%/2500
TRAD	PLAN B 20/150	0	DED PLA	N A 250/15/20%/2	2500	HDI	HP PLAN A 1600/	20%/3500
TRAD	PLAN C 20/200	0	DED PLA	AN B 500/20/10%/	3000	HDI	HP PLAN B 2000/	20%/4000
TRAD	PLAN D 30/250	0	DED PLA	N B 500/10%/10%	6/2000	HDI	HP PLAN B 2000/	30%/4000
TRAD	PLAN E 35/300	0	DED PLA	N B 500/10/20%/	2000	HDI	HP PLAN C 2500/	20%/5000
			DED PLA	N B 500/20/20%/	3000	HDI	HP PLAN C 2500/	30%/5000
			DED PLA	N C 750/20/20%/	3250	HDI	HP PLAN E 3200/	10%/6000
			DED PLA	N C 750/20%/20%	6/3000	HDI	HP PLAN E 3200/	20%/6000
			DED PLA	ND 1000/20/20%	6/3000	HDI	HP PLAN E 3200/	30%/6000
			DED PLA	N D 1000/25/20%	6/4000	HDI	HP PLAN F 3500/	20%/7000
			DED PLA	N E 1500/25/20%	/5500	HDI	HP PLAN F 3500/	30%/7000
			DED PLA	N E 1500/20/30%	/4000	HDI	HP PLAN G 4000/	20%/7000
			DED PLA	N F 2000/25/20%	/5000	HDI	HP PLAN G 4000/	30%/7000
			DED PLA	N G 2500/25/20%	5000	HDI	HP PLAN H 5000/	20%/7000
			DED PLA	N G 2500/30/30%	6/5000	HDI	HP PLAN H 5000/	30%/7000
			DED PLA	NH 3000/30/20%	6/7350	HDI	HP PLAN H 5000/	40%/7000
			DED PLA	NH 3000/30%/30	0%/6000	HDI	HP PLAN H 5000/	50%/7000
			DED PLA	NI3500/30/20%	/7350			
			DED PLA	N J 4000/30/20%	/7500			
			DED PLA	N K 5000/30/20%	6/7350			
			DED PLA	NL6000/35/20%	/7500			
			DED PLA	N M 7500/35/309	%/8500			

Reset

Clear all plans selected

OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	ETTER WAY	TO TAKE CARE	OF BUSINESS
2024 Comp The list below ind list of benefits,				ct a plan to navi	gate to the	full	Plans sele	ected:
							Comp	are plans

KP Plus	Dual Choice PPO
KP PLUS PLAN A 10/1000	DUAL CHOICE PPO PLAN A 10/1500
KP PLUS PLAN B 20/1500	DUAL CHOICE PPO PLAN B 20/2000
KP PLUS PLAN C 20/2000	DUAL CHOICE PPO PLAN C 20/2500
KP PLUS PLAN D 30/2500	DUAL CHOICE PPO PLAN D 30/3000
KP PLUS PLAN E 35/3000	DUAL CHOICE PPO PLAN E 35/3500
KP PLUS PLAN A 250/10/10%/2000	DUAL CHOICE PPO PLAN A 250/10/10%/2500
KP PLUS PLAN A 250/15/20%/2500	DUAL CHOICE PPO PLAN A 250/15/20%/3000
KP PLUS PLAN B 500/20/10%/3000	DUAL CHOICE PPO PLAN B 500/20/10%/3500
KP PLUS PLAN B 500/10%/10%/2000	DUAL CHOICE PPO PLAN B 500/10%/10%/3000
KP PLUS PLAN B 500/10/20%/2000	DUAL CHOICE PPO PLAN B 500/10/20%/3000
KP PLUS PLAN B 500/20/20%/3000	DUAL CHOICE PPO PLAN B 500/20/20%/3500
KP PLUS PLAN C 750/20/20%/3250	DUAL CHOICE PPO PLAN C 750/20/20%/3500
KP PLUS PLAN C 750/20%/20%/3000	DUAL CHOICE PPO PLAN C 750/20%/20%/3500
KP PLUS PLAN D 1000/20/20%/3000	DUAL CHOICE PPO PLAN D 1000/20/20%/4000
KP PLUS PLAN D 1000/25/20%/4000	DUAL CHOICE PPO PLAN D 1000/25/20%/5000
KP PLUS PLAN E 1500/25/20%/5500	DUAL CHOICE PPO PLAN E 1500/25/20%/6000
KP PLUS PLAN E 1500/20/30%/4000	DUAL CHOICE PPO PLAN E 1500/20/30%/5000
KP PLUS PLAN F 2000/25/20%/5000	DUAL CHOICE PPO PLAN F 2000/25/20%/6000
KP PLUS PLAN G 2500/25/20%/5000	DUAL CHOICE PPO PLAN G 2500/25/20%/6000
KP PLUS PLAN G 2500/30%/5000	DUAL CHOICE PPO PLAN G 2500/30/30%/6000
KP PLUS PLAN H 3000/30/20%/7350	DUAL CHOICE PPO PLAN H 3000/30/20%/8150
KP PLUS PLAN H 3000/30%/30%/6000	DUAL CHOICE PPO PLAN H 3000/30%/30%/7000
KP PLUS PLAN I 3500/30/20%/7350	DUAL CHOICE PPO PLAN I 3500/30/20%/8000
KP PLUS PLAN J 4000/30/20%/7500	DUAL CHOICE PPO PLAN J 4000/30/20%/8150
KP PLUS PLAN K 5000/30/20%/7350	DUAL CHOICE PPO PLAN K 5000/30/20%/8150
KP PLUS PLAN L 6000/35/20%/7500	DUAL CHOICE PPO PLAN L 6000/35/20%/8000
KP PLUS PLAN M 7500/35/30%/8500	DUAL CHOICE PPO PLAN M 7500/35/30%/8500

Reset

Clear all plans selected

OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	ETTER WAY	TO TAKE CARE	OF BUSINESS
2024 Comp	lete Suite	e [™] plans						
The list below in	cludes all 202	24 plan offe	erings. Seleo	ct a plan to navi	igate to the	full	Plans sel	ected:
list of benefits.							Com	oare plans
	Dual Cho	oice PPO			(Dut of Area	PPO Plus	
DUAL C	HOICE PPO HD	HP PLAN A 16	00/10%/2500	[PPO PLUS	SPLAN WDB 5	00/20%/2500	
DUALC	HOICE PPO HD	HP PLAN A 16	00/20%/3500	[PPO PLUS	S PLAN WDC 7	50/20%/3750	
DUALC	HOICE PPO HD	HP PLAN B 20	00/20%/4000	[PPO PLUS	S PLAN WDT 10	000/20%/3000	
DUALC	HOICE PPO HD	HP PLAN B 20	00/30%/4000	[PPO PLUS	S PLAN WDE 10	000/30%/4750	
DUALC	HOICE PPO HD	HP PLAN C 25	00/20%/5000	[PPO PLUS	S PLAN WDU 1	500/20%/5500	
DUAL C	HOICE PPO HD	HP PLAN C 25	00/30%/5000	[PPO PLUS	S PLAN WDP 15	500/30%/6000	

DUAL CHOICE PPO HDHP PLAN E 3200/10%/6000	PPO PLUS PLAN WDN 2000/30%/6000
DUAL CHOICE PPO HDHP PLAN E 3200/20%/6000	PPO PLUS PLAN WDX 3000/30%/6850
DUAL CHOICE PPO HDHP PLAN E 3200/30%/6000	PPO PLUS PLAN WDR 4000/30%/7350
DUAL CHOICE PPO HDHP PLAN F 3500/20%/7000	PPO PLUS PLAN WDS 5000/30%/7350
DUAL CHOICE PPO HDHP PLAN F 3500/30%/7000	PPO PLUS HDHP AA PLAN WFI 1600/20%/3500
DUAL CHOICE PPO HDHP PLAN G 4000/20%/7000	PPO PLUS HDHP AA PLAN WAS 2800/20%/4000
DUAL CHOICE PPO HDHP PLAN G 4000/30%/7000	
DUAL CHOICE PPO HDHP PLAN H 5000/20%/7000	
DUAL CHOICE PPO HDHP PLAN H 5000/30%/7000	
DUAL CHOICE PPO HDHP PLAN H 5000/40%/7000	

Reset Clear all plans selected

Complete Suite[™] plan pairings and plan comparisons

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



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

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

*In states where Kaiser Permanente operates (CA, CO, GA, HI, MD, OR, VA, WA, and D.C.), members can get care from The CHP Group and First Choice Health providers in Oregon and Washington, and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C. In all other states, members can visit the Cigna HealthcareSM PPO Network providers.

The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Healthcare Intellectual Property, Inc.



PPO

Accumulation types

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.

For services that are subject to the deductible/out-of-pocket maximum, you must pay charges for the services when you receive them until you meet your deductible/out-of-pocket maximum. If you are the only member in your family, then you must meet the member deductible/out-of-pocket maximum.

Aggregate accumulation:

If you are a member in a family of 2 or more members, you meet the deductible/out-of-pocket maximum when your entire family meets the family deductible/out-of-pocket maximum amount. Every member in your family must pay charges during the year until the entire family meets the family deductible/out-of-pocket maximum.

Embedded accumulation:

If there is at least one other member in your family, then you must each meet the member deductible/out-ofpocket maximum, or your family must meet the family deductible/out-of-pocket maximum, whichever is less. For any member of the family who has satisfied their individual deductible/out-of-pocket maximum, no further member deductible/out-of-pocket maximum will be due for that family member the remainder of the year. Each member deductible amount counts toward the family deductible/out-of-pocket maximum amount. Once the family deductible/out-of-pocket maximum is satisfied, no further member deductible/out-of-pocket maximum will be due for any family member for the remainder of the year.

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RIDERS

2024 COMPLETE SUITE[™] PAIRING GUIDE Traditional and deductible plans

Recommended product pairings when offering a Dual Choice PPO plan alongside a traditional or deductible plan. Shaded plans are appropriate to pair.

* Orange plans (*) indicate pairings that are closely benefit-aligned.

t Green plans (†) indicate more economical pairing options.

				DUAL (CHOICE PPO	PLANS	
			PPO PLAN A 10/1500	PPO PLAN B 20/2000	PPO PLAN C 20/2500	PPO PLAN D 30/3000	PPO PLAN E 35/3500
		TRAD PLAN A 10/1000	*	t			
PLUS TM	ANS	TRAD PLAN B 20/1500		*	t		
KAISER PERMANENTE PLUS TM	TRADITIONAL PLANS	TRAD PLAN C 20/2000			*	t	t
KAISER I	TRA	TRAD PLAN D 30/2500				*	t
		TRAD PLAN E 35/3000					*

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge. Only plans with Dual Choice PPO pairings are displayed.

Plans are paired using multiple factors including, but not limited to, traditional/deductible plan cost shares, deductibles, and out-of-pocket limits compared to the Dual Choice PPO plan.

All pairings assume alignment between the traditional/deductible plan and the Dual Choice PPO Kaiser Permanente pharmacy riders. Approved plan pairings include KP Plus versions of the traditional and deductible plans listed above.



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				DUAL CHOICE PPO PLANS								
			PPO PLAN A 250/10/10%/2500	PPO PLAN A 250/15/20%/3000	PPO PLAN B 500/20/10%/3500	PPO PLAN B 500/10%/10%/3000	PPO PLAN B 500/10/20%/3000	PPO PLAN B 500/20%/3500	PPO PLAN C 750/20%/3500	PPO PLAN C 750/20%/20%/3500	PPO PLAN D 1000/20/20%/4000	PPO PLAN D 1000/25/20%/5000
		DED PLAN A 250/10/10%/2000	*	†	†							
		DED PLAN A 250/15/20%/2500		*	t			t				
LUSTM	10	DED PLAN B 500/20/10%/3000			*	†		t	t			
KAISER PERMANENTE PLUS TM	DEDUCTIBLE PLANS	DED PLAN B 500/10%/10%/2000				*				+		
ER PERMA	DEDUCTIE	DED PLAN B 500/10/20%/2000					*	†	†			
KAISE		DED PLAN B 500/20/20%/3000						*	†			
		DED PLAN C 750/20/20%/3250							*	+		+
		DED PLAN C 750/20%/20%/3000								*		+

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge. Only plans with Dual Choice PPO pairings are displayed.

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2024 COMPLETE SUITE[™] PAIRING GUIDE Traditional and deductible plans

Recommended product pairings when offering a Dual Choice PPO plan alongside a traditional or deductible plan. Shaded plans are appropriate to pair.

* Orange plans (*) indicate pairings that are closely benefit-aligned.

f Green plans (†) indicate more economical pairing options.

					DUAL	CHOIC	e ppo p	LANS		
			PPO PLAN D 1000/20/20%/4000	PPO PLAN D 1000/25/20%/5000	PPO PLAN E 1500/25/20%/6000	PPO PLAN E 1500/20/30%/5000	PPO PLAN F 2000/25/20%/6000	PPO PLAN G 2500/25/20%/6000	PPO PLAN G 2500/30/30%/6000	PPO PLAN H 3000/30/20%/8150
		DED PLAN D 1000/20/20%/3000	*	t	†					
		DED PLAN D 1000/25/20%/4000		*	†					
IE PLUS TM	LANS	DED PLAN E 1500/25/20%/5500			*		†	t		
KAISER PERMANENTE PLUS TM	DEDUCTIBLE PLANS	DED PLAN E 1500/20/30%/4000				*	t	t		
KAISER PI	DEDI	DED PLAN F 2000/25/20%/5000					*	t		
		DED PLAN G 2500/25/20%/5000						*		†
		DED PLAN G 2500/30/30%/5000							*	†

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge. Only plans with Dual Choice PPO pairings are displayed.

Plans are paired using multiple factors including, but not limited to, traditional/deductible plan cost shares, deductibles, and out-of-pocket limits compared to the Dual Choice PPO plan.

All pairings assume alignment between the traditional/deductible plan and the Dual Choice PPO Kaiser Permanente pharmacy riders.

Approved plan pairings include KP Plus versions of the traditional and deductible plans listed above.



2024 COMPLETE SUITE[™] PAIRING GUIDE Traditional and deductible plans

Recommended product pairings when offering a Dual Choice PPO plan alongside a traditional or deductible plan. Shaded plans are appropriate to pair.

Orange plans (*) indicate pairings that are closely benefit-aligned.

f Green plans (†) indicate more economical pairing options.

				l	DUAL CH	OICE PP	O PLANS	5	
			PPO PLAN H 3000/30/20%/8150	PPO PLAN H 3000/30%/30%/7000	PPO PLAN I 3500/30/20%/8000	PPO PLAN J 4000/30/20%/8150	PPO PLAN K 5000/30/20%/8150	PPO PLAN L 6000/35/20%/8000	PPO PLAN M 7500/35/30%/8500
		DED PLAN H 3000/30/20%/7350	*		t	†			
		DED PLAN H 3000/30%/30%/6000		*	t				
IE PLUS™	-ANS	DED PLAN I 3500/30/20%/7350			*	†			
KAISER PERMANENTE PLUS TM	DEDUCTIBLE PLANS	DED PLAN J 4000/30/20%/7500				*	t	†	
KAISER P	DEDI	DED PLAN K 5000/30/20%/7350					*	+	+
		DED PLAN L 6000/35/20%/7500						*	†
		DED PLAN M 7500/35/30%/8500							*

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge. Only plans with Dual Choice PPO pairings are displayed.

Plans are paired using multiple factors including, but not limited to, traditional/deductible plan cost shares, deductibles, and out-of-pocket limits compared to the Dual Choice PPO plan.

All pairings assume alignment between the traditional/deductible plan and the Dual Choice PPO Kaiser Permanente pharmacy riders.

Approved plan pairings include KP Plus versions of the traditional and deductible plans listed above.



RIDERS

2024 COMPLETE SUITE[™] PAIRING GUIDE High deductible plans

Recommended product pairings when offering a Dual Choice PPO plan alongside a high deductible plan. Shaded plans are appropriate to pair.

* Orange plans (*) indicate pairings that are closely benefit-aligned.

+ Green plans (†) indicate more economical pairing options.

				DU	AL CHO	DICE PI	PO PLA	NS		
		PPO HDHP PLAN A 1600/10%/2500	PPO HDHP PLAN A 1600/20%/3500	PPO HDHP PLAN B 2000/20%/4000	PPO HDHP PLAN B 2000/30%/4000	PPO HDHP PLAN C 2500/20%/5000	PPO HDHP PLAN C 2500/30%/5000	PPO HDHP PLAN E 3200/10%/6000	PPO HDHP PLAN E 3200/20%/6000	PPO HDHP PLAN E 3200/30%/6000
ANS	HDHP PLAN A 1600/10%/2500	*	t	t						
HIGH DEDUCTIBLE HEALTH PLANS	HDHP PLAN A 1600/20%/3500		*	t						
H DEDUCTIBL	HDHP PLAN B 2000/20%/4000			*	t	t	t		t	
ЫН	HDHP PLAN B 2000/30%/4000				*		t			†

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge. Only plans with Dual Choice PPO pairings are displayed.

Plans are paired using multiple factors including, but not limited to, high deductible plan cost shares, deductibles, and out-of-pocket limits compared to the Dual Choice PPO plan.

All pairings assume alignment between the high deductible plan and the Dual Choice PPO Kaiser Permanente pharmacy riders.



RIDERS

2024 COMPLETE SUITE[™] PAIRING GUIDE High deductible plans

Recommended product pairings when offering a Dual Choice PPO plan alongside a high deductible plan. Shaded plans are appropriate to pair.

Orange plans (*) indicate pairings that are closely benefit-aligned.

t Green plans (†) indicate more economical pairing options.

					DUAI	_ СНС	DICE P		LANS			
		PPO HDHP PLAN C 2500/20%/5000	PPO HDHP PLAN C 2500/30%/5000	PPO HDHP PLAN E 3200/10%/6000	PPO HDHP PLAN E 3200/20%/6000	PPO HDHP PLAN E 3200/30%/6000	PPO HDHP PLAN F 3500/20%/7000	PPO HDHP PLAN F 3500/30%/7000	PPO HDHP PLAN G 4000/20%/7000	PPO HDHP PLAN G 4000/30%/7000	PPO HDHP PLAN H 5000/20%/7000	PPO HDHP PLAN H 5000/30%/7000
	HDHP PLAN C 2500/20%/5000	*	†	†	†	†	†					
	HDHP PLAN C 2500/30%/5000		*			t		t		t		
NLTH PLANS	HDHP PLAN E 3200/10%/6000			*	t	†	t	†	t			
CTIBLE HEA	HDHP PLAN E 3200/20%/6000				*	†	t	t	†			
HIGH DEDUCTIBLE HEALTH PLANS	HDHP PLAN E 3200/30%/6000					*		†		t		
	HDHP PLAN F 3500/20%/7000						*	†	t	†		
	HDHP PLAN F 3500/30%/7000							*		†		†

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge. Only plans with Dual Choice PPO pairings are displayed.

Plans are paired using multiple factors including, but not limited to, high deductible plan cost shares, deductibles, and out-of-pocket limits compared to the Dual Choice PPO plan.

All pairings assume alignment between the high deductible plan and the Dual Choice PPO Kaiser Permanente pharmacy riders.



PPO

RIDERS

2024 COMPLETE SUITE[™] PAIRING GUIDE High deductible plans

Recommended product pairings when offering a Dual Choice PPO plan alongside a high deductible plan. Shaded plans are appropriate to pair.

Orange plans (*) indicate pairings that are closely benefit-aligned.

f Green plans (†) indicate more economical pairing options.

			DUAL C	CHOICE PPO	PLANS	
		PPO HDHP PLAN G 4000/20%/7000	PPO HDHP PLAN G 4000/30%/7000	PPO HDHP PLAN H 5000/20%/7000	PPO HDHP PLAN H 5000/30%/7000	PPO HDHP PLAN H 5000/40%/7000
	HDHP PLAN G 4000/20%/7000	*	t	t	t	
NS	HDHP PLAN G 4000/30%/7000		*		t	
HIGH DEDUCTIBLE HEALTH PLANS	HDHP PLAN H 5000/20%/7000			*	t	t
GH DEDUCTIBI	HDHP PLAN H 5000/30%/7000				*	t
Ŧ	HDHP PLAN H 5000/40%/7000					*
	HDHP PLAN H 5000/50%/7000					*

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge. Only plans with Dual Choice PPO pairings are displayed.

Plans are paired using multiple factors including, but not limited to, high deductible plan cost shares, deductibles, and out-of-pocket limits compared to the Dual Choice PPO plan.

All pairings assume alignment between the high deductible plan and the Dual Choice PPO Kaiser Permanente pharmacy riders.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA RID	DERS SR. ADV.
Below are highlig you the flexibility business goals. To compare the k plan and then sel	to choose a	a plan that he ip to any 3 pla	lps meet ans, chec	employee r	needs and		See plan comparisons Reset
			TR	ADITION	AL		
Plan Nar	ne	TRAD PLAN # 10/1000		AD PLAN B 20/1500	TRAD PLAN C 20/2000	TRAD PLAN D 30/2500	0 TRAD PLAN E 35/3000
Annual medical dec (IND/FAM) (per cale		\$0/\$0		\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0
Annual out-of-pock maximum (IND/FAN		\$1,000/\$2,00	0 \$1,!	500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000	0 \$3,000/\$6,000
Office visits – preve well-child care	ntive and	\$0		\$0	\$0	\$0	\$0
Office visits - prena	tal care	\$0		\$0	\$0	\$0	\$0
Telehealth (phone/	video)	\$0*		\$0*	\$0*	\$0*	\$0*
Office visits – prima	ry care	\$5 for the first visits; then \$10		or the first 3 s; then \$20*	\$5 for the first 3 visits; then \$20*	\$5 for the first visits; then \$30	
Office visits - urgen	it care	\$30		\$40	\$40	\$50	\$60
Office visits - specia	alty care	\$20		\$30	\$30	\$40	\$45
Office visits - nature	opathic care	\$5 for the first visits; then \$10		or the first 3 s; then \$20*	\$5 for the first 3 visits; then \$20*	\$5 for the first visits; then \$30	
Lab		\$10		\$20	\$20	\$30	\$35
X-ray/diagnostic tes	sts	\$10		\$20	\$20	\$30	\$35
CT, MRI, and PET sca	ans	\$50		\$50	\$50	\$50	\$50
Outpatient surgery		\$50		\$50	\$50	\$100	\$150
Inpatient hospital o	are	\$100 per day \$500 per admission		00 per day, \$500 per dmission	\$200 per day, \$1,000 per admission	\$200 per day, \$1,000 per admission	4 \$800 per admission
Emergency care		\$100		\$100	\$200	\$200	\$200
Routine eye exam		\$10		\$20	\$20	\$30	\$35

*First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

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

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). To get a copy of the EOC, please visit account.kp.org or contact your Kaiser Permanente representative.

OVERVIEW TRAD	DED	HDHP	KP PLUS	PPO	OOA R	IDERS	SR. ADV.
Below are highlights of the you the flexibility to choose business goals. To compare the benefits of plan and then select "See p	a plan that up to any 3	helps mee plans, che isons."	t employee needs	and			omparisons eset
		L	DEDUCTIBLE				
Plan Name	DED P 250/10/1	LAN A 0%/2000	DED PLAN A 250/15/20%/2500		DED PLAN B 500/20/10%/3000		PLAN B /10%/2000
Annual medical deductible (IND/FAM) (per calendar year)	\$250,	/\$750	\$250/\$750		\$500/\$1,500	\$500	/\$1,500
Annual out-of-pocket maximum (IND/FAM)	\$2,000/	/\$6,000	\$2,500/\$7,500		\$3,000/\$6,000	\$2,000/\$6,000	
Office visits – preventive and well-child care	\$	0	\$0		\$0		\$0
Office visits - prenatal care	\$	0	\$0	\$0			\$0
Telehealth (phone/video)	\$	0 ¹	\$0 ¹		\$0 ¹		\$0 ¹
Office visits - primary care	\$5 for the f then		\$5 for the first 3 visits; then \$151		\$5 for the first 3 visits; then \$201		first 3 visits; 10%*1
Office visits – urgent care	\$`	10	\$35		\$40	1	0%*
Office visits – specialty care	\$`	10	\$25		\$30	1	0%*
Office visits – naturopathic care	\$5 for the f then		\$5 for the first 3 visit then \$151	s;	\$5 for the first 3 visits; then \$201		first 3 visits; 10%*1
Lab	10	%*	\$15		\$20	1	0%*
X-ray/diagnostic tests	10	%*	\$15		\$20	1	0%*
CT, MRI, and PET scans	10	%*	\$100		\$100	1	0%*
Outpatient surgery	10	%*	20%*		10%*	1	0%*
Inpatient hospital care	10	%*	20%*		10%*	1	0%*
Emergency care	\$20)0*	20%*		10%*	\$2	200*
Routine eye exam	\$	10	\$15		\$20	1	0%*

*After deductible.

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.



OVERVIEW T	RAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.				
you the flexibility to business goals. To compare the ben	To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."											
			C	EDUCTIBLE								
Plan Name		DED P 500/10/2		DED PLAN B 500/20/20%/3000	7	DED PLAN C 50/20/20%/3250		D PLAN C %/20%/3000				
Annual medical deduct (IND/FAM) (per calenda		\$500/\$	51,500	\$500/\$1,500		\$750/\$2,250	\$75	50/\$2,250				
Annual out-of-pocket maximum (IND/FAM)		\$2,000/	\$6,000	\$3,000/\$9,000	\$3,000/\$9,000 \$3,2			00/\$9,000				
Office visits – preventiv well-child care	e and	\$	0	\$0		\$0		\$0				
Office visits – prenatal o	are	\$	0	\$0		\$0		\$0				
Telehealth (phone/vide	o)	\$() ¹	\$0 ¹		\$0 ¹		\$0 ¹				
Office visits – primary ca	are	\$5 for the fi then		\$5 for the first 3 visits; then \$201		for the first 3 visits then \$201		ne first 3 visits; en 20%*1				
Office visits – urgent ca	re	\$1	0	\$40		\$40		20%*				
Office visits - specialty	care	\$1	0	\$30		\$30		20%*				
Office visits – naturopat	hic care	\$5 for the fi then		\$5 for the first 3 visits then \$201	; \$5	for the first 3 visits then \$201		ne first 3 visits; en 20%*1				
Lab		20	%*	\$20		\$20		20%*				
X-ray/diagnostic tests		20	%*	\$20		\$20		20%*				
CT, MRI, and PET scans		20	%*	\$100		\$100		20%*				
Outpatient surgery		20	%*	20%*		20%*		20%*				
Inpatient hospital care		20	%*	20%*		20%*		20%*				
Emergency care		\$20)0*	20%*		20%*		\$200*				
Routine eye exam		\$1	0	\$20		\$20		20%*				

*After deductible.

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.



OVERVIEW TRAD	DED	HDHP	KP PLUS	PPO	OOA R	IDERS SR.	ADV.					
you the flexibility to choose business goals. To compare the benefits of	To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."											
		D	EDUCTIBLE									
Plan Name	DED P 1000/20/2	LAN D 20%/3000	DED PLAN D 1000/25/20%/4000	0	DED PLAN E 1500/25/20%/5500	DED PLAN 1500/20/30%/						
Annual medical deductible (IND/FAM) (per calendar year)	\$1,000,	/\$3,000	\$1,000/\$3,000		\$1,500/\$4,500	\$1,500/\$4,5	00					
Annual out-of-pocket maximum (IND/FAM)	\$3,000	/\$9,000	\$4,000/\$12,000		\$5,500/\$11,000	\$4,000/\$12,000						
Office visits - preventive and well-child care	\$	0	\$0	D \$0		\$0						
Office visits - prenatal care	\$	0	\$0		\$0	\$0						
Telehealth (phone/video)	\$	0 ¹	\$0 ¹		\$0 ¹	\$0 ¹						
Office visits – primary care	\$5 for the f then	irst 3 visits; \$201	\$5 for the first 3 visits; then \$251		\$5 for the first 3 visits; then \$251	\$5 for the first 3 then \$20 ¹	-					
Office visits – urgent care	\$2	20	\$45		\$45	\$20						
Office visits – specialty care	\$2	20	\$35		\$35	\$20						
Office visits – naturopathic care		irst 3 visits; \$201	\$5 for the first 3 visits then \$251	s;	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 then \$20 ¹						
Lab	20	%*	\$25		\$25	30%*						
X-ray/diagnostic tests	20	%*	\$25		\$25	30%*						
CT, MRI, and PET scans	20	%*	\$100		\$100	30%*						
Outpatient surgery	20	%*	20%*		20%*	30%*						
Inpatient hospital care	20	%*	20%*		20%*	30%*						
Emergency care	\$20)0*	20%*		20%*	\$200*						
Routine eye exam	\$2	20	\$25		\$25	\$20						

*After deductible.

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.



OVERVIEW TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights of the you the flexibility to choose business goals. To compare the benefits of plan and then select "See p	e a plan that up to any 3	helps mee plans, che	t employee needs	and			comparisons Reset
		C	DEDUCTIBLE				
Plan Name	DED P 2000/25/2	PLAN F 20%/5000	DED PLAN G 2500/25/20%/5000	25	DED PLAN G 00/30/30%/5000		D PLAN H 80/20%/7350
Annual medical deductible (IND/FAM) (per calendar year)	\$2,000	/\$6,000	\$2,500/\$7,500		\$2,500/\$5,000	\$3,0	00/\$9,000
Annual out-of-pocket maximum (IND/FAM)	\$5,000/	\$10,000	\$5,000/\$10,000	4	\$5,000/\$10,000	\$7,3	50/\$14,700
Office visits - preventive and well-child care	\$	0	\$0		\$0		\$0
Office visits – prenatal care	\$	0	\$0		\$0		\$0
Telehealth (phone/video)	\$	0 ¹	\$0 ¹		\$0 ¹		\$0 ¹
Office visits – primary care	\$5 for the f then	irst 3 visits; \$251	\$5 for the first 3 visits then \$25 ¹	; \$5 f	for the first 3 visits; then \$30 ¹		ne first 3 visits; nen \$301
Office visits – urgent care	\$4	45	\$45		\$30		\$50
Office visits - specialty care	\$3	35	\$35		\$30		\$40
Office visits – naturopathic care		irst 3 visits; \$25¹	\$5 for the first 3 visits then \$25 ¹	; \$5 f	for the first 3 visits; then \$30 ¹		ne first 3 visits; nen \$301
Lab	\$2	25	\$25		30%*		\$30
X-ray/diagnostic tests	\$2	25	\$25		30%*		\$30
CT, MRI, and PET scans	\$1	00	\$100		30%*		\$100
Outpatient surgery	20	%*	20%*		30%*		20%*
Inpatient hospital care	20	%*	20%*		30%*		20%*
Emergency care	20	%*	20%*		\$200*		20%*
Routine eye exam	\$2	25	\$25		\$30		\$30

*After deductible.

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.



OVERVIEW TRAD	DED	HDHP	KP PLUS	PPO	OOA R	IDERS	SR. ADV.
Below are highlights of the you the flexibility to choos business goals. To compare the benefits o plan and then select "See	e a plan that f up to any 3	helps mee plans, che	t employee needs	and			comparisons eset
		D	EDUCTIBLE				
Plan Name	DED P 3000/30%	LAN H /30%/6000	DED PLAN I 3500/30/20%/7350)	DED PLAN J 4000/30/20%/7500		PLAN K D/20%/7350
Annual medical deductible (IND/FAM) (per calendar year)	\$3,000	/\$6,000	\$3,500/\$10,500		\$4,000/\$10,000	\$5,00	0/\$10,000
Annual out-of-pocket maximum (IND/FAM)	\$6,000/	\$12,000	\$7,350/\$14,700		\$7,500/\$15,000	\$7,35	0/\$14,700
Office visits – preventive and well-child care	\$	0	\$0	\$0			\$0
Office visits - prenatal care	\$	0	\$0		\$0		\$0
Telehealth (phone/video)	\$	0 ¹	\$0 ¹		\$0 ¹		\$0 ¹
Office visits – primary care	0% for the f then		\$5 for the first 3 visits; then \$301		55 for the first 3 visits; then \$301		e first 3 visits; en \$301
Office visits – urgent care	30	%*	\$50		\$50		\$50
Office visits - specialty care	30	%*	\$40		\$40		\$40
Office visits – naturopathic care	0% for the f then	irst 3 visits; 30%¹	\$5 for the first 3 visits then \$301	s; \$	55 for the first 3 visits; then \$30 ¹		e first 3 visits; en \$301
Lab	30	%*	\$30		\$30		\$30
X-ray/diagnostic tests	30	%*	\$30		\$30		\$30
CT, MRI, and PET scans	30	%*	\$100		\$100		\$100
Outpatient surgery	30	%*	20%*		20%*		20%*
Inpatient hospital care	30	%*	20%*		20%*		20%*
Emergency care	\$20)0*	20%*		20%*		20%*
Routine eye exam	30	%*	\$30		\$30		\$30

*After deductible.

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.		
Below are highlight you the flexibility to business goals.	o choose a	a plan that	helps meet	employee nee	eds and			comparisons Reset		
To compare the be plan and then selec				k the checkbo	xes next to	each		lesel		
			D	EDUCTIBLI	E					
Plan Name DED PLAN L DED PLAN M 6000/35/20%/7500 7500/35/30%/8500										
Annual medical dedu (IND/FAM) (per calend			\$6,000/\$	12,000		\$	7,500/\$14,500			
Annual out-of-pocket maximum (IND/FAM)			\$7,500/\$	15,000		\$8,500/\$17,000				
Office visits – preventi well-child care	ive and		\$0				\$0			
Office visits - prenatal	l care		\$0				\$0			
Telehealth (phone/vid	leo)		\$0	I			\$0 ¹			
Office visits - primary	care		\$5 for the fir then \$			\$5 fo	or the first 3 visits, then \$351			
Office visits – urgent c	are		\$55	5			\$55			
Office visits – specialty	y care		\$45	5			\$45			
Office visits – naturop	athic care		\$5 for the fir then \$			\$5 fo	or the first 3 visits; then \$351	;		
Lab			\$3	-)			\$35			
X-ray/diagnostic tests			\$35	5			\$35			
CT, MRI, and PET scans	S		\$15	0		\$150				
Outpatient surgery		20%*					30%*			
Inpatient hospital car	e	20%*					30%*			
Emergency care		20%*					30%*			
Routine eye exam			\$3!	5		\$35				

*After deductible.

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
you the flexibility business goals.	to choose a	a plan that	helps meet	A variety of optio t employee needs ck the checkboxes	s and		See pla	n comparisons Reset
plan and then se								
		HIG	H DEDU	CTIBLE HEAL	.TH I	PLAN		
Plan Na	me		PLAN A 0%/2500	HDHP PLAN A 1600/20%/3500		HDHP PLAN B 2000/20%/4000		DHP PLAN B 00/30%/4000
Accumulation type		Aggr	egate	Aggregate		Aggregate		Aggregate
Annual medical de (IND/FAM) (per cale		\$1,600,	/\$3,200	\$1,600/\$3,200		\$2,000/\$4,000	\$2	,000/\$4,000
Annual out-of-pock maximum (IND/FA		\$2,500/\$5,000		\$3,500/\$7,000		\$4,000/\$8,000	\$4	,000/\$8,000
Office visits – preve well-child care	entive and	\$	0	\$0		\$0		\$0
Office visits – pren	atal care	\$	0	\$0		\$0		\$0
Telehealth (phone/	video)	\$0) *1	\$0*1		\$0* ¹		\$0* ¹
Office visits – prima	ary care	\$5* for the then	-	\$5* for the first 3 visits; then 20%*1		\$5* for the first 3 visit then 20%*1		r the first 3 visits; hen 30%*1
Office visits – urger	nt care	10	%*	20%*		20%*		30%*
Office visits – speci	alty care	10	%*	20%*		20%*		30%*
Office visits - natur	ropathic care	\$5* for the then	first 3 visits; 10%*1	\$5* for the first 3 visi then 20%*1	its;	\$5* for the first 3 visit then 20%*1		r the first 3 visits; hen 30%*1
Lab		10	%*	20%*		20%*		30%*
X-ray/diagnostic te	sts	10	%*	20%*		20%*		30%*
CT, MRI, and PET sc	ans	10	%*	20%*		20%*		30%*
Outpatient surgery	1	10	%*	20%*		20%*		30%*
Inpatient hospital	care	10	%*	20%*		20%*		30%*
Emergency care		10%*		20%*		20%*		30%*
i								

Routine eye exam

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

10%*

20%*

20%*

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
you the flexibility business goals.	to choose	a plan that	helps meet	A variety of optior employee needs	and			i comparisons Reset
Io compare the l plan and then se			•	k the checkboxes	next to	each		heser
	•	•				A N I		
		HIG	H DEDU	CTIBLE HEAL		AN		
Plan Na	me		PLAN C 0%/5000	HDHP PLAN C 2500/30%/5000		HDHP PLAN E 200/10%/6000		HP PLAN E)/20%/6000
Accumulation type		Aggr	egate	Aggregate		Embedded	Ei	mbedded
Annual medical de (IND/FAM) (per cale		\$2,500	/\$5,000	\$2,500/\$5,000	0	\$3,200/\$6,400		200/\$6,000
Annual out-of-pock maximum (IND/FA		\$5,000	/\$7,500	\$5,000/\$7,500		\$6,000/\$9,000	\$6,0	00/\$12,000
Office visits – prevo well-child care	entive and	4	0	\$0		\$0		\$0
Office visits – pren	atal care	\$	0	\$0		\$0		\$0
Telehealth (phone/	video)	\$()*1	\$0* ¹		\$0* ¹		\$0* ¹
Office visits – prima	ary care		first 3 visits; 20%*1	\$5* for the first 3 visit then 30%*1	s; \$5**	for the first 3 visits then 10%*1	-	the first 3 visits; en 20%*1
Office visits – urger	nt care	20	%*	30%*		10%*		20%*
Office visits – speci	alty care	20	%*	30%*		10%*		20%*
Office visits – natur	opathic care		first 3 visits; 20%*1	\$5* for the first 3 visit then 30%*1	s; \$5**	for the first 3 visits then 10%*1		the first 3 visits; en 20%*1
Lab		20	%*	30%*		10%*		20%*
X-ray/diagnostic te	sts	20	%*	30%*		10%*		20%*
CT, MRI, and PET sc	ans	20	%*	30%*		10%*		20%*
Outpatient surgery		20	%*	30%*		10%*		20%*
Inpatient hospital	care	20	%*	30%*		10%*		20%*

Emergency care

Routine eye exam

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

30%*

30%*

10%*

10%*

20%*

20%*

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20%*

OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.		
Below are highligh you the flexibility t business goals.					-	/es		n comparisons		
To compare the be plan and then sele				ck the checkboxe	es next	to each		Reset		
				CTIBLE HEA	LTH I	PLAN				
Plan Nam	16	HDHP 3200/30	PLAN E 0%/6000	HDHP PLAN F 3500/20%/700	0	HDHP PLAN F 3500/30%/7000		HP PLAN G D/20%/7000		
Accumulation type		Embe	dded	Embedded		Embedded	E	mbedded		
Annual medical ded (IND/FAM) (per calen		\$3,200	/\$6,000	\$3,500/\$7,000		\$3,500/\$7,000	\$4,0	000/\$8,000		
Annual out-of-pocke maximum (IND/FAM		\$6,000/\$12,000		\$7,000/\$14,000)	\$7,000/\$14,000	\$7,0	00/\$14,000		
Office visits – prever well-child care	itive and	\$	0	\$0		\$0		\$0		
Office visits – prenat	al care	\$	0	\$0		\$0		\$0		
Telehealth (phone/vi	ideo)	\$0)*1	\$0* ¹		\$0* ¹		\$0* ¹		
Office visits - primar	y care	\$5* for the then S		\$5* for the first 3 visits; then 20%*1		\$5* for the first 3 visits then 30%*1	-	the first 3 visits; en 20%*1		
Office visits – urgent	care	30	%*	20%*		30%*		20%*		
Office visits – special	ty care	30	%*	20%*		30%*		20%*		
Office visits - naturo	pathic care	\$5* for the then 3		\$5* for the first 3 vi then 20%*1	sits;	\$5* for the first 3 visits then 30%*1		the first 3 visits; en 20%*1		
Lab		30	%*	20%*		30%*		20%*		
X-ray/diagnostic test	S	30	%*	20%*		30%*		20%*		
CT, MRI, and PET sca	ns	30	%*	20%*		30%*		20%*		
Outpatient surgery		30	%*	20%*		30%*		20%*		
Inpatient hospital ca	ire	30	%*	20%*		30%*		20%*		
Emergency care		30%*		20%*		30%*		20%*		

Routine eye exam

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

20%*

30%*

30%*

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KP PLUS OVERVIEW TRAD HDHP PPO OOA **RIDERS** SR. ADV. DED Below are highlights of the benefits for each plan. A variety of options gives See plan comparisons you the flexibility to choose a plan that helps meet employee needs and business goals. Reset To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons." HIGH DEDUCTIBLE HEALTH PLAN **Plan Name** HDHP PLAN G HDHP PLAN H HDHP PLAN H 5000/20%/7000 4000/30%/7000 5000/30%/7000 Accumulation type Embedded Embedded Embedded Annual medical deductible \$4,000/\$8,000 \$5,000/\$10,000 \$5,000/\$10,000 (IND/FAM) (per calendar year) Annual out-of-pocket \$7,000/\$14,000 \$7,000/\$14,000 \$7,000/\$14,000 maximum (IND/FAM) Office visits - preventive and \$0 \$0 \$0 well-child care Office visits – prenatal care \$0 \$0 \$0 \$0*1 \$0*1 \$0*1 Telehealth (phone/video) \$5* for the first 3 visits; \$5* for the first 3 visits; \$5* for the first 3 visits; Office visits - primary care then 30%*1 then 20%*1 then 30%*1 Office visits - urgent care 30%* 20%* 30%* Office visits - specialty care 30%* 20%* 30%* \$5* for the first 3 visits; \$5* for the first 3 visits; \$5* for the first 3 visits; Office visits - naturopathic care then 30%*1 then 20%*1 then 30%*1 30%* 20%* 30%*

*After deductible.

Emergency care

Routine eye exam

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

Outpatient surgery

Lab

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

20%*

20%*

20%*

20%*

20%*

20%*

30%*

30%*

30%*

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% after deductible of the actual fee. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills.

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30%*

30%*

30%*

30%*

30%*

OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.		
Below are highli you the flexibility			•		-	6	See plan	comparisons		
business goals. To compare the plan and then se			•	the checkbo	xes next to	each		Reset		
		HIG	H DEDUO	CTIBLE HE	alth Pl	AN.				
Plan Na	me		HDHP PL 5000/40%				HDHP PLAN H 000/50%/7000			
Accumulation type			Embed	ded			Embedded			
Annual medical de (IND/FAM) (per cal			\$5,000/\$1	0,000		\$5,000/\$10,000				
Annual out-of-pock maximum (IND/FA			\$7,000/\$1	4,000		\$7,000/\$14,000				
Office visits – prev well-child care	entive and		\$0				\$0			
Office visits – pren	atal care		\$0				\$0			
Telehealth (phone	video)		\$0*	1			\$0* ¹			
Office visits – prim	ary care		\$5* for the fir then 40			\$5*	for the first 3 visits then 50%*1	5,		
Office visits – urge	nt care		40%	*			50%*			
Office visits – speci	alty care		40%	*			50%*			
Office visits – natu	opathic care		\$5* for the fir then 40			\$5*	for the first 3 visits then 50%*1	<i>;</i>		
Lab			40%	*			50%*			
X-ray/diagnostic te	sts		40%	*		50%*				
CT, MRI, and PET so	ans		40%	*			50%*			
Outpatient surgery	1		40%	*			50%*			
Inpatient hospital	care		40%*			50%*				
Emergency care			40%	*		50%*				
Routine eye exam			40%	*		50%*				

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

These plans 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.



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 yea	ır								
Services	Out-of-Network coverage								
Medical Visits PCP Office Visit Specialty Office Visit Outpatient Mental Health and Substance Use Disorder Services Physical Therapy, Occupational Therapy, Speech Therapy, and Labs/X-Rays	\$20 higher copay (or 10% higher coinsurance) than in-network 10 visits per member per year								
Pharmacy Fills Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty Kaiser Permanente mail-order pharmacy: 90-day supply for 2 copays	\$20 higher copay (or 10% higher coinsurance) than in-network 5 pharmacy fills per member per year Mail-order pharmacy is not covered out of network.								
Hospital Inpatient Outpatient surgery Skilled nursing facilities Maternity care	Not covered out-of-network								



OVERVIEW TRA	D DED	HDHP	KP PLUS	PPC	OOA	RIDERS	SR. ADV.		
Below are highlights of you the flexibility to cho business goals. To compare the benefit plan and then select "So	pose a plan that is of up to any	at helps mee 3 plans, che	et employee need	ls and			comparisons Reset		
			KP Plus						
Plan name		KP PLUS PI	LAN A 10/1000		KP PLU	S PLAN B 20/	1500		
Network	ln-n	ietwork	Out-of-network (limited to 10 covered ser per year, combined)	vices	Out-of-network In-network (limited to 10 covered so per year, combined				
Annual medical deductible (IND/FAM) (per calendar ye		N/A	N/A		N/A		N/A		
Annual out-of-pocket maximum (IND/FAM)	\$1,00	0/\$2,000	N/A		\$1,500/\$3,000		N/A		
Office visits – preventive an well-child care	nd	\$0	\$0		\$0		\$0		
Office visits – prenatal care		\$0	\$0		\$0		\$0		
Telehealth (phone/video)		\$0 ¹	Cost share applicable to service when provided person.		\$0 ¹		e applicable to the vhen provided in person.		
Office visits – primary care		e first 3 visits; en \$101	\$30		\$5 for the first 3 visits; then \$20 ¹		\$40		
Office visits – urgent care		\$30	Not covered, except for services recei outside the service area		\$40	except for	ot covered, services received he service area ^{2,3}		
Office visits – specialty care		\$20	\$40		\$30		\$50		
Office visits – naturopathic		e first 3 visits; en \$101	\$30		\$5 for the first 3 visits; then \$201		\$40		
Lab		\$10	\$30		\$20		\$40		
X-ray/diagnostic tests		\$10	\$30		\$20		\$40		
CT, MRI, and PET scans		\$50	Not covered		\$50	N	ot covered		
Outpatient surgery		\$50	Not covered		\$50	N	ot covered		
Inpatient hospital care		day, \$500 per nission	Not covered		\$100 per day, \$500 per admission	N	ot covered		
Emergency care	\$	5100	Covered at the in-netwo cost share ¹	ork	\$100		at the in-network ost share¹		
Routine eye exam		\$10	\$30		\$20		\$40		
Outpatient prescription dru	ugs 📃 🚽	ietwork	Out-of-network (limited prescription fills per ye	ar)	In-network	prescript	twork (limited to 5 tion fills per year)		
*After deductible.	A pharmac	zy rider must be pu	rchased with all KP Plus plar	ns	A pharmacy rider must b	e purchased with	all KP Plus plans		

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OVERVIEW TR.	AD	DED	HDHP	KP PLUS	PP	O OOA	RIDERS	SR. ADV.			
Below are highlights o you the flexibility to ch business goals. To compare the benef plan and then select "S	oose its of (a plan that up to any 3	helps mee plans, che	t employee nee	ds and	b	See p	an comparisons Reset			
				KP Plus							
Plan name KP PLUS PLAN C 20/2000 KP PLUS PLAN D 30/2500											
Network		In-net	work	Out-of-network (limited to 10 covered se per year, combined		Out-of-network In-network (limited to 10 covered se per year, combined					
Annual medical deductibl (IND/FAM) (per calendar y		N//	Į	N/A		N/A		N/A			
Annual out-of-pocket maximum (IND/FAM)		\$2,000/\$	54,000	N/A		\$2,500/\$5,000		N/A			
Office visits – preventive a well-child care	and	\$0)	\$0		\$0		\$0			
Office visits – prenatal car	e	\$0)	\$0		\$0		\$0			
Telehealth (phone/video)		\$0	1	Cost share applicable t service when provide person.		\$0 ¹		nare applicable to the ce when provided in person.			
Office visits – primary care	è	\$5 for the fir then \$		\$40		\$5 for the first 3 visit then \$301	ts;	\$50			
Office visits – urgent care		\$4	D	Not covered, except for services rece outside the service ar		\$50		Not covered, for services received de the service area ^{2,3}			
Office visits – specialty ca	re	\$3	0	\$50		\$40		\$60			
Office visits – naturopathi	c care	\$5 for the fir then \$		\$40		\$5 for the first 3 visit then \$301	ts;	\$50			
Lab		\$2	D	\$40		\$30		\$50			
X-ray/diagnostic tests		\$2	0	\$40		\$30		\$50			
CT, MRI, and PET scans		\$5	D	Not covered		\$50		Not covered			
Outpatient surgery		\$5	0	Not covered		\$100		Not covered			
Inpatient hospital care	_	\$200 per day, admis		Not covered		\$200 per day, \$1,000 admission	per	Not covered			
Emergency care		\$20	0	Covered at the in-netw cost share ¹	vork	\$200	Cover	ed at the in-network cost share¹			
Routine eye exam		\$2	D	\$40		\$30		\$50			
Outpatient prescription d	rugs	In-net	work	Out-of-network (limited prescription fills per y		In-network		network (limited to 5 ription fills per year)			
*After deductible.		A pharmacy r	ider must be pur	chased with all KP Plus pl	ans	A pharmacy rider mus	st be purchased w	ith all KP Plus plans			

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	AOO C	RIDERS	SR. ADV.			
Below are highlight you the flexibility to business goals. To compare the ber plan and then selec	choose nefits of u	a plan that up to any 3	helps mee ^r plans, cheo	t employee need	ds and		See pl	an comparisons Reset			
				KP Plus							
Plan nameKP PLUS PLAN E 35/3000KP PLUS PLAN A 250/10/10%/2000											
Network		In-net	work	Out-of-network (limited to 10 covered se per year, combined		Out-of-network In-network (limited to 10 covered ser per year, combined)					
Annual medical deduc (IND/FAM) (per calenda		N//	ł	N/A		\$250/\$750		N/A			
Annual out-of-pocket maximum (IND/FAM)		\$3,000/\$	56,000	N/A		\$2,000/\$6,000		N/A			
Office visits – preventi well-child care	ve and	\$C		\$0		\$0		\$0			
Office visits – prenatal	care	\$C		\$0		\$0		\$0			
Telehealth (phone/vide	eo)	\$0	1	Cost share applicable to service when provideo person.		\$0 ¹		are applicable to the ce when provided in person.			
Office visits – primary	care	\$5 for the fir then \$		\$55		\$5 for the first 3 visit then \$101	S;	\$30			
Office visits – urgent c	are	\$6		Not covered, except for se received outside the se area ^{2,3}		\$10		red, except for services ed outside the service area ^{2,3}			
Office visits – specialty	care	\$4		\$65		\$10		\$30			
Office visits – naturopa	athic care	\$5 for the fir then \$		\$55		\$5 for the first 3 visit then \$10 ¹	s;	\$30			
Lab		\$3	5	\$55		10%*		20%			
X-ray/diagnostic tests		\$3	5	\$55		10%*		20%			
CT, MRI, and PET scans		\$50	0	Not covered		10%*		Not covered			
Outpatient surgery		\$15	0	Not covered		10%*		Not covered			
Inpatient hospital care		\$800 per a	dmission	Not covered		10%*		Not covered			
Emergency care		\$20	0	Covered at the in-netw cost share ¹	/ork	\$200*	Cover	ed at the in-network cost share ¹			
Routine eye exam		\$3	5	\$55		\$10		\$30			
Outpatient prescriptio	n druas	In-net	work	Out-of-network (limited prescription fills per ye		In-network		network (limited to 5 ription fills per year)			
*After deductible.		A pharmacy r	ider must be purc	chased with all KP Plus pla	ans	A pharmacy rider mus	st be purchased w	ith all KP Plus plans			

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	DOOA	RIDEF	RS SR. A	DV.		
Below are highlight you the flexibility to				, i	0		See	e plan compariso	ons		
business goals. To compare the bei plan and then selec	nefits of	up to any 3	, plans, cheo					Reset			
				KP Plus							
Plan name KP PLUS PLAN A 250/15/20%/2500 KP PLUS PLAN B 500/20/10%/3000											
Network		In-net	work	Out-of-network (limited to 10 covered se per year, combined)		Out-of-network In-network (limited to 10 covered se per year, combined					
Annual medical deduc (IND/FAM) (per calend		\$250/\$	5750	N/A		\$500/\$1,500		N/A			
Annual out-of-pocket maximum (IND/FAM)		\$2,500/	\$7,500	N/A		\$3,000/\$6,000		N/A			
Office visits – preventi well-child care	ive and	\$0		\$0		\$0		\$0			
Office visits – prenatal	care	\$0		\$0		\$0		\$0			
Telehealth (phone/vid	eo)	\$0	1	Cost share applicable to service when provided person.		\$0 ¹		st share applicable to ervice when provideo person.			
Office visits – primary	care	\$5 for the fir then S	515 ¹	\$35		\$5 for the first 3 visi then \$201	ts;	\$40			
Office visits – urgent c	are	\$3		Not covered, except for se received outside the ser area ^{2,3}		\$40		overed, except for se eived outside the se area ^{2,3}			
Office visits – specialty	y care	\$2		\$45		\$30		\$50			
Office visits – naturop	athic care	\$5 for the fir then S		\$35		\$5 for the first 3 visi then \$201	ts;	\$40			
Lab		\$1	5	\$35		\$20		\$40			
X-ray/diagnostic tests		\$1	5	\$35		\$20		\$40			
CT, MRI, and PET scans	;	\$10	0	Not covered		\$100		Not covered			
Outpatient surgery		20%	ʻ5*	Not covered		10%*		Not covered			
Inpatient hospital care	e	20%	b*	Not covered		10%*		Not covered			
Emergency care		20%	b*	Covered at the in-netw cost share ¹	ork	10%*	Co	overed at the in-netw cost share ¹	vork		
Routine eye exam		\$1	5	\$35		\$20		\$40			
Outpatient prescriptio	on druas	In-net	work	Out-of-network (limited prescription fills per ye		In-network		t-of-network (limited escription fills per ye			
*After deductible.	5	A pharmacy r	ider must be purc	chased with all KP Plus pla	ns	A pharmacy rider mu	st be purchase	d with all KP Plus pla	ans		

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	DOOA	RIDERS	SR. ADV.			
				-							
Below are highlight you the flexibility to				, i	•		See plar	comparisons			
business goals. To compare the be	nefits of	up to any 3	plans, cheo	ck the checkbox	es nex	t to each		Reset			
plan and then selec		-									
				KP Plus							
Plan name KP PLUS PLAN B 500/10%/10%/2000 KP PLUS PLAN B 500/10/20%/2000											
Network		In-net	vork	Out-of-network (limited to 10 covered se per year, combined		5 In-network (limited to 10 covered s per year, combined					
Annual medical deduc (IND/FAM) (per calend		\$500/\$	1,500	N/A		\$500/\$1,500		N/A			
Annual out-of-pocket maximum (IND/FAM)		\$2,000/\$	6,000	N/A		\$2,000/\$6,000		N/A			
Office visits – prevent well-child care	ive and	\$0		\$0		\$0		\$0			
Office visits – prenata	care	\$C		\$0		\$0		\$0			
Telehealth (phone/vid	eo)	\$0	1	Cost share applicable to service when provided person.		\$0 ¹		e applicable to the vhen provided in person.			
Office visits – primary	care	\$5 for the fir then 1		20%		\$5 for the first 3 visits then \$101	,	\$30			
Office visits – urgent o	are	10%		Not covered, except for se received outside the se area ^{2,3}	ervices rvice	\$10		l, except for services butside the service area ^{2,3}			
Office visits – specialty	y care	10%	*	20%		\$10		\$30			
Office visits – naturop	athic care	\$5 for the fir then 1		20%		\$5 for the first 3 visits then \$101	;	\$30			
Lab		10%	*	20%		20%*		30%			
X-ray/diagnostic tests		10%	*	20%		20%*		30%			
CT, MRI, and PET scans	;	10%	*	Not covered		20%*	N	ot covered			
Outpatient surgery		10%	*	Not covered		20%*	N	ot covered			
Inpatient hospital care	9	10%	*	Not covered		20%*		ot covered			
Emergency care		\$20)*	Covered at the in-netw cost share ¹	vork	\$200*		at the in-network ost share ¹			
Routine eye exam		10%)*	20%		\$10		\$30			
Outpatient prescriptio	on drugs	In-net	vork	Out-of-network (limited prescription fills per y		In-network		twork (limited to 5 tion fills per year)			
*After deductible.		A pharmacy r	ider must be purc	hased with all KP Plus pla	ans	A pharmacy rider must	be purchased with	all KP Plus plans			

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	D OOA	RIDER	S S	SR. ADV.		
Below are highligh you the flexibility t business goals.			•		-		See	See plan comparisons			
To compare the be plan and then sele		1		ck the checkbox	es nex	t to each		Rese	t		
				KP Plus							
Plan name KP PLUS PLAN B 500/20/20%/3000 KP PLUS PLAN C 750/20/20%/3250											
Network		In-net	work	Out-of-network (limited to 10 covered se per year, combined)		5 In-network (limited to 10 covered so per year, combined					
Annual medical dedu (IND/FAM) (per calen		\$500/\$	1,500	N/A		\$750/\$2,250		N/A			
Annual out-of-pocket maximum (IND/FAM)	\$3,000/	\$9,000	N/A		\$3,250/\$9,750		N/A			
Office visits – preven well-child care	tive and	\$0		\$0		\$0		\$0			
Office visits – prenat	al care	\$0		\$0		\$0		\$0			
Telehealth (phone/vi	deo)	\$0	1	Cost share applicable to service when provided person.		\$0 ¹		st share appli rvice when p perso	provided in		
Office visits – primar	y care	\$5 for the fir then \$	520 ¹	\$40		\$5 for the first 3 visi then \$201	its;	\$40			
Office visits – urgent	care	\$4		Not covered, except for se received outside the ser area ^{2,3}		\$40		overed, exce eived outside area ²			
Office visits – special	ty care	\$3)	\$50		\$30		\$50			
Office visits – naturo	pathic care	\$5 for the fir then \$		\$40		\$5 for the first 3 visi then \$201	its;	\$40			
Lab		\$2)	\$40		\$20		\$40			
X-ray/diagnostic test	S	\$2)	\$40		\$20		\$40			
CT, MRI, and PET scar	ns	\$10	0	Not covered		\$100		Not cove	ered		
Outpatient surgery		20%	b*	Not covered		20%*		Not cove	ered		
Inpatient hospital ca	re	20%	b*	Not covered		20%*		Not cove	ered		
Emergency care		20%	b*	Covered at the in-netw cost share ¹	ork	20%*	Со	vered at the cost sha			
Routine eye exam		\$2)	\$40		\$20		\$40			
Outpatient prescript	ion druas	In-net	work	Out-of-network (limited prescription fills per ye		In-network		of-network escription fil			
*After deductible.		A pharmacy r	ider must be pure	chased with all KP Plus pla	ns	A pharmacy rider mu	ist be purchase	d with all KP	Plus plans		

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	OOA	RIDERS	SR. ADV.			
Below are highlig you the flexibility				, i	· ·	ves	See plar	comparisons			
business goals. To compare the b	enefits of	up to any 3	plans, cheo	ck the checkbox	es next	t to each		Reset			
plan and then sele	ect "See pl	lan compari	sons."								
				KP Plus							
Plan name KP PLUS PLAN C 750/20%/20%/3000 KP PLUS PLAN D 1000/20/20%/3000											
Network		In-net [,]	work	Out-of-network (limited to 10 covered se per year, combined)		In-network	(limited to	t-of-network 10 covered services ear, combined)			
Annual medical ded (IND/FAM) (per caler		\$750/\$	2,250	N/A		\$1,000/\$3,000		N/A			
Annual out-of-pocke maximum (IND/FAM		\$3,000/	\$9,000	N/A		\$3,000/\$9,000		N/A			
Office visits – prever well-child care	ntive and	\$0		\$0		\$0		\$0			
Office visits – prenat	tal care	\$0		\$0		\$0		\$0			
Telehealth (phone/v	ideo)	\$0	1	Cost share applicable to service when provideo person.		\$0 ¹		e applicable to the vhen provided in person.			
Office visits – prima	ry care	\$5 for the fir then 2		30%		\$5 for the first 3 visits; then \$20 ¹		\$40			
Office visits – urgen	t care	20%		Not covered, except for se received outside the se area ^{2,3}	ervices rvice	\$20		l, except for services butside the service area ^{2,3}			
Office visits – specia	lty care	20%		30%		\$20		\$40			
Office visits – naturo	opathic care	\$5 for the fir then 2		30%		\$5 for the first 3 visits; then \$201		\$40			
Lab		20%	b*	30%		20%*		30%			
X-ray/diagnostic test	ts	20%	b*	30%		20%*		30%			
CT, MRI, and PET sca	ns	20%	b*	Not covered		20%*	N	ot covered			
Outpatient surgery		20%	b*	Not covered		20%*	N	ot covered			
Inpatient hospital ca	are	20%	b*	Not covered		20%*	N	ot covered			
Emergency care		\$20)*	Covered at the in-netw cost share ¹	ork	\$200*		at the in-network ost share ¹			
Routine eye exam		20%	b*	30%		\$20		\$40			
Outpatient prescript	tion drugs	In-net		Out-of-network (limited prescription fills per ye	ear)	In-network		twork (limited to 5 tion fills per year)			
*After deductible.	Ĵ	A pharmacy r	ider must be purc	hased with all KP Plus pla	ns	A pharmacy rider must	be purchased with	all KP Plus plans			

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	OOA	RIDERS	SR. ADV.			
Below are highligh you the flexibility to			•		-		See pla	an comparisons			
business goals.	5 010030		neips meet								
To compare the be			-	ck the checkbox	es nex	t to each		Reset			
plan and then sele	ct "See pl	lan compari	sons."								
				KP Plus							
Plan name KP PLUS PLAN D 1000/25/20%/4000 KP PLUS PLAN E 1500/25/20%/5500											
Network		In-net	work	Out-of-network (limited to 10 covered se per year, combined)		In-network	(limited	ut-of-network o 10 covered services year, combined)			
Annual medical dedu (IND/FAM) (per calend		\$1,000/\$	53,000	N/A		\$1,500/\$4,500		N/A			
Annual out-of-pocket maximum (IND/FAM)		\$4,000/\$	12,000	N/A		\$5,500/\$11,000		N/A			
Office visits – prevent well-child care	tive and	\$0		\$0		\$0		\$0			
Office visits – prenata	l care	\$0		\$0		\$0		\$0			
Telehealth (phone/vio	deo)	\$0	1	Cost share applicable to service when provided person.		\$0 ¹		are applicable to the e when provided in person.			
Office visits – primary	/ care	\$5 for the fir then \$		\$45		\$5 for the first 3 visits then \$251	5;	\$45			
Office visits – urgent	care	\$4		Not covered, except for se received outside the set area ^{2,3}	ervices rvice	\$45		ed, except for services d outside the service area ^{2,3}			
Office visits – specialt	ty care	\$3		\$55		\$35		\$55			
Office visits – naturop	oathic care	\$5 for the fir then S		\$45		\$5 for the first 3 visits then \$25 ¹	5;	\$45			
Lab		\$2	5	\$45		\$25		\$45			
X-ray/diagnostic tests		\$2	5	\$45		\$25		\$45			
CT, MRI, and PET scan	S	\$10	0	Not covered		\$100		Not covered			
Outpatient surgery		20%	b*	Not covered		20%*		Not covered			
Inpatient hospital car	e	20%	b*	Not covered		20%*		Not covered			
Emergency care		20%	b*	Covered at the in-netw cost share ¹	ork	20%*	Covere	d at the in-network cost share ¹			
Routine eye exam		\$2	5	\$45		\$25		\$45			
Outpatient prescription	on drugs	In-net		Out-of-network (limited prescription fills per ye	ear)	In-network	prescr	network (limited to 5 iption fills per year)			
*After deductible.		A pharmacy r	ider must be purc	hased with all KP Plus pla	ns	A pharmacy rider mus	t be purchased wi	h all KP Plus plans			

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	DOOA	RIDER	S SR. ADV.			
Below are highligh you the flexibility t			•		-		See	plan comparisons			
business goals. To compare the be plan and then sele				ck the checkboxe	es nex	t to each		Reset			
				KP Plus							
Plan name KP PLUS PLAN E 1500/20/30%/4000 KP PLUS PLAN F 2000/25/20%/5000											
Network		In-net	work	Out-of-network (limited to 10 covered ser per year, combined)	vices	Out-of-network In-network (limited to 10 covered ser per year, combined)					
Annual medical ded (IND/FAM) (per calen		\$1,500/\$	54,500	N/A		\$2,000/\$6,000		N/A			
Annual out-of-pocket maximum (IND/FAM)	\$4,000/\$	12,000	N/A		\$5,000/\$10,000		N/A			
Office visits – preven well-child care	itive and	\$0)	\$0		\$0		\$0			
Office visits – prenat	al care	\$0		\$0		\$0		\$0			
Telehealth (phone/vi	deo)	\$0	1	Cost share applicable to service when provided person.		\$0 ¹		share applicable to the vice when provided in person.			
Office visits – primar	y care	\$5 for the fin then S		\$40		\$5 for the first 3 visi then \$251		\$45			
Office visits – urgent	care	\$2		Not covered, except for se received outside the ser area ^{2,3}		\$45		vered, except for services ived outside the service area ^{2,3}			
Office visits – special	ty care	\$2		\$40		\$35		\$55			
Office visits – naturo	pathic care	\$5 for the fin then S		\$40		\$5 for the first 3 visi then \$251	ts;	\$45			
Lab		30%	(* 0	40%		\$25		\$45			
X-ray/diagnostic test	s	30%	ʻo*	40%		\$25		\$45			
CT, MRI, and PET scar	ıs	30%	′°*	Not covered		\$100		Not covered			
Outpatient surgery		30%	ʻo*	Not covered		20%*		Not covered			
Inpatient hospital ca	re	30%	′°*	Not covered		20%*		Not covered			
Emergency care		\$20	0*	Covered at the in-netwo cost share ¹	ork	20%*	Cov	ered at the in-network cost share ¹			
Routine eye exam		\$2	D	\$40		\$25		\$45			
Outpatient prescript	ion drugs	In-net	work	Out-of-network (limited prescription fills per ye		In-network		of-network (limited to 5 scription fills per year)			
*After deductible.		A pharmacy r	ider must be purc	hased with all KP Plus plan	ns	A pharmacy rider mu	st be purchased	with all KP Plus plans			

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	D OOA	RIC	DERS	SR. ADV.
Below are highligh	nts of the	benefits for	each plan.	A variety of opti	ons g	ives		See nlan	comparisons
you the flexibility t business goals. To compare the be plan and then sele	enefits of	up to any 3	plans, che						leset
	et seep	ian compan	150115.	KP Plus					
Plan name	9	KP P	PLUS PLAN G	2500/25/20%/5000		KP PLUS	PLAN G 2	2500/30/3	80%/5000
Network		In-net [,]	work	Out-of-network (limited to 10 covered ser per year, combined)		In-network		(limited to 1	of-network O covered services rr, combined)
Annual medical dedu (IND/FAM) (per calen		\$2,500/	\$7,500	N/A		\$2,500/\$5,000	0		N/A
Annual out-of-pocket maximum (IND/FAM)		\$5,000/\$	10,000	N/A		\$5,000/\$10,00	0		N/A
Office visits – preven well-child care	tive and	\$0)	\$0		\$0			\$0
Office visits – prenata	al care	\$0)	\$0		\$0			\$0
Telehealth (phone/vi	deo)	\$0	1	Cost share applicable to service when provided person.		\$0 ¹		service w	applicable to the hen provided in person.
Office visits – primar	y care	\$5 for the fir then S	\$25 ¹	\$45		\$5 for the first 3 vi then \$301	sits;		\$50
Office visits – urgent	care	\$4		Not covered, except for se received outside the ser area ^{2,3}		\$30	1	received or	except for services utside the service area ^{2,3}
Office visits – special	ty care	\$3	5	\$55		\$30			\$50
Office visits – naturo	pathic care	\$5 for the fir then \$		\$45		\$5 for the first 3 vi then \$30 ¹	sits;		\$50
Lab		\$2	5	\$45		30%*			40%
X-ray/diagnostic test	S	\$2	5	\$45		30%*			40%
CT, MRI, and PET scar	ıs	\$10	0	Not covered		30%*		No	t covered
Outpatient surgery		20%	′°*	Not covered		30%*		No	t covered
Inpatient hospital ca	re	20%	(* 0 [*]	Not covered		30%*		No	t covered
Emergency care		20%	(*	Covered at the in-netwo cost share ¹	ork	\$200*			t the in-network st share¹
Routine eye exam		\$2	5	\$45		\$30			\$50
Outpatient prescripti	ion druas	In-net	work	Out-of-network (limited prescription fills per ye		In-network			work (limited to 5 on fills per year)
*After deductible.		A pharmacy r	ider must be pur	chased with all KP Plus pla	ns	A pharmacy rider m	nust be purc	hased with a	ll KP Plus plans

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	D OOA	RIDERS	SR. ADV.
Below are highlig you the flexibility business goals. To compare the l plan and then se	to choose benefits of	a plan that up to any 3	helps mee plans, cheo	t employee need	ds and		See pla	n comparisons Reset
				KP Plus				
Plan nar	ne	KP F	LUS PLAN H	3000/30/20%/7350)	KP PLUS PL/	AN H 3000/309	%/30%/6000
Network		In-net	work	Out-of-network (limited to 10 covered se per year, combined		In-network	(limited to	ut-of-network 0 10 covered services rear, combined)
Annual medical de (IND/FAM) (per cale		\$3,000/	\$9,000	N/A		\$3,000/\$6,000		N/A
Annual out-of-pock maximum (IND/FA		\$7,350/\$	514,700	N/A		\$6,000/\$12,000		N/A
Office visits – preve well-child care	entive and	\$0)	\$0		\$0		\$0
Office visits – pren	atal care	\$()	\$0		\$0		\$0
Telehealth (phone/	/video)	\$0	1	Cost share applicable to service when provideo person.		\$0 ¹		re applicable to the when provided in person.
Office visits – prim	ary care	\$5 for the fi then S		\$50		\$5 for the first 3 visit then 30% ¹	s;	40%
Office visits – urge	nt care	\$5	0	Not covered, except for se received outside the se area ^{2,3}		30%*		d, except for services outside the service area ^{2,3}
Office visits – speci	ialty care	\$4	-	\$60		30%*		40%
Office visits – natu	ropathic care	\$5 for the find then s		\$50		\$5 for the first 3 visit then 30% ¹	s;	40%
Lab		\$3	0	\$50		30%*		40%
X-ray/diagnostic te	sts	\$3	0	\$50		30%*		40%
CT, MRI, and PET sc	ans	\$10	00	Not covered		30%*		Not covered
Outpatient surgery	1	20%	6*	Not covered		30%*		Not covered
Inpatient hospital	care	20%	6*	Not covered		30%*		Not covered
Emergency care		209	6*	Covered at the in-netw cost share ¹	/ork	\$200*		l at the in-network cost share¹
Routine eye exam		\$3	0	\$50		30%*		40%
Outpatient prescri	otion drugs	In-net		Out-of-network (limited prescription fills per ye	ear)	In-network	prescri	etwork (limited to 5 otion fills per year)
*After deductible.		A pharmacy r	ider must be pur	chased with all KP Plus pla	ans	A pharmacy rider mus	t be purchased wit	n all KP Plus plans

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	AOO C	RIDERS	SR. ADV.	
Below are highligh you the flexibility t business goals. To compare the be plan and then sele	to choose enefits of	a plan that up to any 3	helps meet plans, cheo	t employee need	ds and	ł	See pl	an comparisons Reset	
				KP Plus					
Plan nam	e	KP I	PLUS PLAN I 3	500/30/20%/7350		KP PLUS P	LAN J 4000/3	0/20%/7500	
Network		In-net [,]	work	Out-of-network (limited to 10 covered ser per year, combined)		In-network	(limited	Dut-of-network to 10 covered services year, combined)	
Annual medical ded (IND/FAM) (per calen		\$3,500/\$	10,500	N/A		\$4,000/\$10,000		N/A	
Annual out-of-pocket maximum (IND/FAM		\$7,350/\$	14,700	N/A		\$7,500/\$15,000		N/A	
Office visits – preven well-child care	itive and	\$0		\$0		\$0		\$0	
Office visits – prenat	al care	\$0		\$0		\$0		\$0	
Telehealth (phone/vi	deo)	\$0	1	Cost share applicable to service when provided person.		\$0 ¹		are applicable to the e when provided in person.	
Office visits – primar	y care	\$5 for the fir then \$		\$50		\$5 for the first 3 visi then \$301	ts;	\$50	
Office visits – urgent	care	\$5		Not covered, except for se received outside the ser area ^{2,3}		\$50		red, except for services d outside the service area ^{2,3}	
Office visits – special	ty care	\$4	-	\$60		\$40		\$60	
Office visits – naturo	pathic care	\$5 for the fir then \$		\$50		\$5 for the first 3 visi then \$301	ts;	\$50	
Lab		\$3	0	\$50		\$30		\$50	
X-ray/diagnostic test	S	\$3	0	\$50		\$30		\$50	
CT, MRI, and PET scar	15	\$10	0	Not covered		\$100		Not covered	
Outpatient surgery		20%	b*	Not covered		20%*		Not covered	
Inpatient hospital ca	re	20%	b*	Not covered		20%*		Not covered	
Emergency care		20%	b*	Covered at the in-netwo cost share ¹	ork	20%*	Cover	ed at the in-network cost share ¹	
Routine eye exam		\$3	D	\$50		\$30		\$50	
Outpatient prescript	ion drugs	In-net	work	Out-of-network (limited prescription fills per ye		In-network		network (limited to 5 ription fills per year)	
*After deductible.	A pharmacy rider must be purchased with all KP Plus plans A pharmacy rider must be purchased with all KP Plus plans								

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PP	AOO C	RIDERS	SR. ADV.
Below are highligh you the flexibility t business goals. To compare the be plan and then sele	o choose enefits of	a plan that up to any 3	helps meet	t employee need	ds and	ł	See pla	n comparisons Reset
				KP Plus				
Plan name	9	KP F	LUS PLAN K	5000/30/20%/7350		KP PLUS PI	LAN L 6000/35	/20%/7500
Network		In-net [,]	work	Out-of-network (limited to 10 covered se per year, combined)		In-network	(limited to	it-of-network 10 covered services ear, combined)
Annual medical dedu (IND/FAM) (per calen		\$5,000/\$	10,000	N/A		\$6,000/\$12,000		N/A
Annual out-of-pocket maximum (IND/FAM		\$7,350/\$	14,700	N/A		\$7,500/\$15,000		N/A
Office visits – preven well-child care	tive and	\$0		\$0		\$0		\$0
Office visits – prenata	al care	\$0		\$0		\$0		\$0
Telehealth (phone/vi	deo)	\$0	1	Cost share applicable to service when provideo person.		\$0 ¹		re applicable to the when provided in person.
Office visits – primar	y care	\$5 for the fir then \$		\$50		\$5 for the first 3 visit then \$351	s;	\$55
Office visits – urgent	care	\$5		Not covered, except for se received outside the set area ^{2,3}		\$55		d, except for services outside the service area ^{2,3}
Office visits – special	ty care	\$4	-	\$60		\$45		\$65
Office visits – naturo	pathic care	\$5 for the fir then \$		\$50		\$5 for the first 3 visit then \$35 ¹	s;	\$55
Lab		\$3	0	\$50		\$35		\$55
X-ray/diagnostic tests	5	\$3	0	\$50		\$35		\$55
CT, MRI, and PET scar	ıs	\$10	0	Not covered		\$150	1	lot covered
Outpatient surgery		20%	[′] [′] [×]	Not covered		20%*	1	lot covered
Inpatient hospital ca	re	20%	⁶ *	Not covered		20%*	1	lot covered
Emergency care		20%	[′] ⁰ *	Covered at the in-netw cost share ¹	vork	20%*		l at the in-network cost share¹
Routine eye exam		\$3	0	\$50		\$35		\$55
Outpatient prescripti	on drugs	In-net		Out-of-network (limited prescription fills per ye	ear)	In-network	prescrip	etwork (limited to 5 otion fills per year)
*After deductible.		A pharmacy r	ider must be purc	chased with all KP Plus pla	ins	A pharmacy rider mus	t be purchased with	n all KP Plus plans

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.			
Below are highligh you the flexibility t					-	5	See plan	comparisons			
business goals.	<i>c</i> , <i>c</i>						F	Reset			
To compare the be plan and then sele		, ,		the checkbo	xes next to	each					
				KP Plus							
Plan name KP PLUS PLAN M 7500/35/30%/8500											
Network			In-netwo	rk		N M 7500/35/30%/8500 Out-of-network (limited to 10 covered services per year, combined) N/A N/A					
Annual medical ded (IND/FAM) (per calen	dar year)		\$7,500/\$14	,500							
Annual out-of-pocket maximum (IND/FAM			\$8,500/\$17	7,000			N/A				
Office visits – preven well-child care	tive and		\$0				\$0				
Office visits – prenat	al care		\$0				\$0				
Telehealth (phone/vi	deo)		\$0 ¹		Cost	share applicable t	o the service when pr	ovided in person.			
Office visits – primar	y care		\$5 for the first then \$3			\$55					
Office visits – urgent	care	\$55			Not	Not covered, except for services received outside the service area ^{2,3}					
Office visits – special	ty care		\$45			\$65					
Office visits – naturo	pathic care		\$5 for the first then \$3	'			\$55				
Lab			\$35				\$55				
X-ray/diagnostic test	s		\$35				\$55				
CT, MRI, and PET scar	ıs		\$150				Not covered				
Outpatient surgery			30%*				Not covered				
Inpatient hospital ca	re					Not covered					
Emergency care			30%*			Covered at the in-network cost share ¹					
Routine eye exam			\$35				\$55				
Outpatient prescript	ion drugs		In-netwo	rk	(Out-of-network (limited to 5 prescription fills per year)					
*After deductible	ion uruys			A pharmacy rider m	ust be purchased	with all KP Plus pl	ans				

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlight you the flexibility to ousiness goals. To compare the ber olan and then selec	o choose nefits of	a plan that up to any 3	helps meet plans, cheo	employee nee	ds and			n comparisons Reset
	i see p			al Choice PF	0			
Plan name		DUAL (CHOICE PPO F	PLAN A 10/1500		DUAL CHOICE I	PPO PLAN B	20/2000
Network		In-netw	ork	Out-of-network		In-network	Out	-of-network
Annual medical deduc (IND/FAM) (per calend		\$0/\$0)	\$1,500/\$3,000		\$0/\$0	\$2,	000/\$4,000
Annual out-of-pocket maximum (IND/FAM)		\$1,500/\$3	3,000	\$4,500/\$9,000		\$2,000/\$4,000	\$6,0	00/\$12,000
Office visits – preventi well-child care	ive and	\$0		30%*		\$0		30%*
Office visits – prenatal	care	\$0		30%*		\$0		30%*
Telehealth (phone/vid	eo)	\$0 ¹		30%*		\$0 ¹		30%*
Office visits – primary	care	\$5 for the firs then \$30 (\$10 benefit	enhanced	30%*		for the first 3 visits; 1 \$40 (\$20 enhancec benefit) ¹	1	30%*
Office visits – urgent c	are	\$60 (\$30 en benefi		30%*	\$	80 (\$40 enhanced benefit)		30%*
Office visits – specialty	y care	\$40 (\$20 en benefi		30%*	\$	50 (\$30 enhanced benefit)		30%*
Office visits – naturopa care	athic	\$5 for the firs then \$1		30%*	\$5	for the first 3 visits; then \$201		30%*
Lab		\$10		30%*		\$20		30%*
X-ray/diagnostic tests		\$10		30%*		\$20		30%*
CT, MRI, and PET scans	;	\$50		30%*		\$50		30%*
Outpatient surgery		\$50		30%*		\$50		30%*
Inpatient hospital care	9	\$100 per day, admissi		30%*	\$10	00 per day, \$500 per admission		30%*
Emergency care			\$100)			\$100	
Routine eye exam		\$30 (\$10 en benefi		30%*	\$	40 (\$20 enhanced benefit)		30%*

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV
Below are highlight you the flexibility to ousiness goals. Fo compare the ber	choose	a plan that l	nelps meet	t employee nee	ds and			i comparisons Reset
blan and then selec	t "See p	lan compari		al Choice PF	20			
Plan name		DUAL C		PLAN C 20/2500		DUAL CHOICE I	PPO PLAN D	30/3000
Network		In-netwo	ork	Out-of-network		In-network	Out	of-network
Annual medical deduc (IND/FAM) (per calend		\$0/\$0		\$2,000/\$4,000		\$0/\$0	\$2,	000/\$4,000
Annual out-of-pocket maximum (IND/FAM)		\$2,500/\$5	,000	\$6,000/\$12,000		\$3,000/\$6,000	\$6,0	00/\$12,000
Office visits – preventi well-child care	ve and	\$0		30%*		\$0		30%*
Office visits – prenatal	care	\$0		30%*		\$0		30%*
Telehealth (phone/vid	eo)	\$0 ¹		30%*		\$0 ¹		30%*
Office visits – primary	care	\$5 for the first then \$40 (\$20 benefit	enhanced	30%*		for the first 3 visits; 1 \$50 (\$30 enhanced benefit) ¹	3	30%*
Office visits – urgent c	are	\$80 (\$40 en benefi		30%*	\$1	100 (\$50 enhanced benefit)		30%*
Office visits – specialty	/ care	\$50 (\$30 en benefi		30%*	\$	60 (\$40 enhanced benefit)		30%*
Office visits – naturopa care	athic	\$5 for the first then \$2		30%*	\$5	for the first 3 visits; then \$301		30%*
Lab		\$20		30%*		\$30		30%*
X-ray/diagnostic tests		\$20		30%*		\$30		30%*
CT, MRI, and PET scans		\$50		30%*		\$50		30%*
Outpatient surgery		\$50		30%*		\$100		30%*
Inpatient hospital care)	\$200 per day, \$ admissi		30%*	\$20	0 per day, \$1,000 pe admission	r	30%*
Emergency care			\$200)			\$200	
Routine eye exam		\$40 (\$20 en benefi		30%*	\$	50 (\$30 enhanced benefit)		30%*

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highligh	ate of the	honofits for		A variaty of opt	ions aivo			
you the flexibility t business goals.	o choose	a plan that h	nelps meet	employee nee	ds and		See plai	n comparisons Reset
To compare the be plan and then sele				ck the checkbox	es next to	o each		
			Dua	l Choice PF	° 0			
Plan name)	DUAL C	HOICE PPO F	PLAN E 35/3500	D	UAL CHOICE PPO	PLAN A 250/*	10/10%/2500
Network		In-netwo	ork	Out-of-network		In-network	Ou	t-of-network
Annual medical ded (IND/FAM) (per calen		\$0/\$0		\$2,000/\$4,000		\$250/\$750	\$2,	000/\$6,000
Annual out-of-pocket maximum (IND/FAM		\$3,500/\$7	,000	\$6,000/\$12,000		\$2,500/\$7,500	\$6,0	000/\$12,000
Office visits – preven well-child care	itive and	\$0		30%*		\$0		30%*
Office visits – prenat	al care	\$0		30%*		\$0		30%*
Telehealth (phone/vi	deo)	\$0 ¹		30%*		\$0 ¹		30%*
Office visits – primar	y care	\$5 for the first then \$55 (\$35 e benefitj	enhanced	30%*		5 for the first 3 visits n \$30 (\$10 enhance benefit) ¹		30%*
Office visits – urgent	care	\$110 (\$60 en benefit		30%*		\$30 (\$10 enhanced benefit)		30%*
Office visits – special	ty care	\$65 (\$45 enł benefit		30%*	(\$*	\$30 10 enhanced benefit	:)	30%*
Office visits – naturo care	pathic	\$5 for the first then \$3		30%*	\$!	5 for the first 3 visits then \$101	;	30%*
Lab		\$35		30%*		10%*		30%*
X-ray/diagnostic test	S	\$35		30%*		10%*		30%*
CT, MRI, and PET scar	ns	\$50		30%*		10%*		30%*
Outpatient surgery		\$150		30%*		10%*		30%*
Inpatient hospital ca	re	\$800 per adn	nission	30%*		10%*		30%*
Emergency care			\$200				\$200*	
Routine eye exam		\$55 (\$35 enł benefit		30%*	30 (\$10 enhanced bene	fit)	30%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highligh you the flexibility to business goals. To compare the be plan and then sele	o choose enefits of	a plan that ł up to any 3 إ	nelps meet olans, chec	employee nee	ds and			i comparisons Reset
			Dua	l Choice PF	0			
Plan name		DUAL CHOIC	E PPO PLAN	A 250/15/20%/300	00	DUAL CHOICE PPO I	PLAN B 500/2	20/10%/3500
Network		In-netwo	ork	Out-of-network		In-network	Out	-of-network
Annual medical dedu (IND/FAM) (per calend		\$250/\$7	50	\$2,000/\$6,000		\$500/\$1,500	\$2,	500/\$7,500
Annual out-of-pocket maximum (IND/FAM)		\$3,000/\$9	,000	\$6,000/\$12,000		\$3,500/\$10,500	\$7,5	00/\$15,000
Office visits – prevent well-child care	tive and	\$0		30%*		\$0		30%*
Office visits – prenata	al care	\$0		30%*		\$0		30%*
Telehealth (phone/vio	deo)	\$0 ¹		30%*		\$0 ¹		30%*
Office visits – primary	y care	\$5 for the first then \$35 (\$15 e benefit	enhanced	30%*		\$5 for the first 3 visits; hen \$40 (\$20 enhanced benefit) ¹	Ŀ	30%*
Office visits – urgent	care	\$55 (\$35 enł benefit		30%*		\$80 (\$40 enhanced benefit)		30%*
Office visits – special	ty care	\$45 (\$25 enł benefit		30%*		\$50 (\$30 enhanced benefit)		30%*
Office visits – naturop care	pathic	\$5 for the first then \$1		30%*		\$5 for the first 3 visits; then \$201		30%*
Lab		\$15		30%*		\$20		30%*
X-ray/diagnostic tests	5	\$15		30%*		\$20		30%*
CT, MRI, and PET scan	IS	\$100		30%*		\$100		30%*
Outpatient surgery		20%*		30%*		10%*		30%*
Inpatient hospital car	re	20%*		30%*		10%*		30%*
Emergency care			20%*				10%*	
Routine eye exam		\$35 (\$15 enł benefit		30%*		\$40 (\$20 enhanced benefit)		30%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV
Below are highlight you the flexibility to business goals. To compare the be blan and then selec	o choose nefits of	e a plan that h up to any 3	nelps meet olans, chec	employee nee	ds and		See plan	n comparisons Reset
			Dua	I Choice PF	0			
Plan name		DUAL CHOIC	E PPO PLAN E	3 500/10%/10%/30	00	DUAL CHOICE PPO	PLAN B 500/	10/20%/3000
Network		In-netwo	ork	Out-of-network		In-network	Ou	t-of-network
Annual medical dedu (IND/FAM) (per calend		\$500/\$1,	500	\$2,500/\$7,500		\$500/\$1,500	\$2,	500/\$7,500
Annual out-of-pocket maximum (IND/FAM)		\$3,000/\$9	,000	\$7,500/\$15,000		\$3,000/\$9,000	\$7,5	500/\$15,000
Office visits – prevent well-child care	ive and	\$0		30%*		\$0		40%*
Office visits – prenata	l care	\$0		30%*		\$0		40%*
Telehealth (phone/vid	leo)	\$0 ¹		30%*		\$0 ¹		40%*
Office visits – primary	care	\$5 for the first then 20% (10% benefit	enhanced	30%*		\$5 for the first 3 visits hen \$30 (\$10 enhance benefit) ¹		40%*
Office visits – urgent o	care	20%* (10%* e benefit		30%*		\$30 (\$10 enhanced benefit)		40%*
Office visits – specialt	y care	20%* (10%* e benefit		30%*		\$30 (\$10 enhanced benefit)		40%*
Office visits – naturop care	oathic	\$5 for the first then 10		30%*		\$5 for the first 3 visits then \$10 ¹	;	40%*
Lab		10%*		30%*		20%*		40%*
X-ray/diagnostic tests		10%*		30%*		20%*		40%*
CT, MRI, and PET scans	S	10%*		30%*		20%*		40%*
Outpatient surgery		10%*		30%*		20%*		40%*
Inpatient hospital care	e	10%*		30%*		20%*		40%*
Emergency care			\$200	*			\$200*	
Routine eye exam		20%* (10%* e benefit		30%*		\$30 (\$10 enhanced benefit)		40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.		
Below are highlights you the flexibility to business goals. To compare the ber plan and then selec:	choose nefits of	a plan that up to any 3	helps meet plans, cheo	employee nee	ds and		See plan	n comparisons Reset		
			Dua	al Choice PF	0					
Plan name DUAL CHOICE PPO PLAN B 500/20/20%/3500 DUAL CHOICE PPO PLAN C 750/20/20%/3500										
Network		In-netw	ork	Out-of-network		In-network	Ou	t-of-network		
Annual medical deduc (IND/FAM) (per calenda		\$500/\$1	.500	\$2,500/\$7,500		\$750/\$2,250	\$3,	000/\$9,000		
Annual out-of-pocket maximum (IND/FAM)		\$3,500/\$1	0,500	\$7,500/\$15,000		\$3,500/\$10,500	\$7,5	500/\$22,500		
Office visits – preventiv well-child care	ve and	\$0		40%*		\$0		40%*		
Office visits – prenatal	care	\$0		40%*		\$0		40%*		
Telehealth (phone/vide	eo)	\$0 ¹		40%*		\$0 ¹		40%*		
Office visits – primary o	care	\$5 for the firs then \$40 (\$20 benefi	enhanced	40%*		5 for the first 3 visits, en \$40 (\$20 enhance benefit) ¹		40%*		
Office visits – urgent ca	are	\$80 (\$40 en benef		40%*		\$80 (\$40 enhanced benefit)		40%*		
Office visits – specialty	care	\$50 (\$30 en benef		40%*		\$50 (\$30 enhanced benefit)		40%*		
Office visits – naturopa care	athic	\$5 for the firs then \$2		40%*	\$	5 for the first 3 visits, then \$201	;	40%*		
Lab		\$20		40%*		\$20		40%*		
X-ray/diagnostic tests		\$20		40%*		\$20		40%*		
CT, MRI, and PET scans		\$100)	40%*		\$100		40%*		
Outpatient surgery		20%*	۲	40%*		20%*		40%*		
Inpatient hospital care		20%	r III	40%*		20%*		40%*		
Emergency care			20%*	r			20%*			
Routine eye exam		\$40 (\$20 en benef		40%*		\$40 (\$20 enhanced benefit)		40%*		

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW TF	RAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights of you the flexibility to c business goals. To compare the bene	hoose fits of	a plan that he up to any 3 pla	lps meet ans, cheo	t employee nee	ds and		See pla	n comparisons Reset
plan and then select '	'See p	lan compariso		al Choice PF				
Plan name		DUAL CHOICE P		C 750/20%/20%/35		JAL CHOICE PPO P	LAN D 1000/	20/20%/4000
Network		In-network		Out-of-network		In-network	Ou	-of-network
Annual medical deductik (IND/FAM) (per calendar year)		\$750/\$2,250)	\$3,000/\$9,000		\$1,000/\$3,000	\$3,	000/\$9,000
Annual out-of-pocket maximum (IND/FAM)		\$3,500/\$10,50	00	\$7,500/\$22,500		\$4,000/\$12,000	\$9,0	000/\$27,000
Office visits – preventive well-child care	and	\$0		40%*		\$0		40%*
Office visits – prenatal ca	are	\$0		40%*		\$0		40%*
Telehealth (phone/video)	\$0 ¹		40%*		\$0 ¹		40%*
Office visits – primary ca	re	\$5 for the first 3 v then 30% (20% enh benefit) ¹		40%*		5 for the first 3 visits; n \$40 (\$20 enhanced benefit)1	ł	40%*
Office visits – urgent care	e	30%*(20%* enha benefit)	nced	40%*	(\$40 (\$20 enhanced benefit)		40%*
Office visits – specialty ca	are	30%*(20%* enha benefit)	nced	40%*		\$40 (\$20 enhanced benefit)		40%*
Office visits – naturopath care	nic	\$5 for the first 3 v then 20% ¹	visits;	40%*	\$5	5 for the first 3 visits; then \$201		40%*
Lab		20%*		40%*		20%*		40%*
X-ray/diagnostic tests		20%*		40%*		20%*		40%*
CT, MRI, and PET scans		20%*		40%*		20%*		40%*
Outpatient surgery		20%*		40%*		20%*		40%*
Inpatient hospital care		20%*		40%*		20%*		40%*
Emergency care			\$200	*			\$200*	
Routine eye exam		30%*(20%* enha benefit)	nced	40%*		\$40 (\$20 enhanced benefit)		40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights you the flexibility to business goals. To compare the ber plan and then selec	choose nefits of	a plan that up to any 3	helps meet plans, chec	employee nee	ds and		See pla	n comparisons Reset
			Dua	al Choice PF	0			
Plan name		DUAL CHOIC	E PPO PLAN I	D 1000/25/20%/50	00 [DUAL CHOICE PPO	PLAN E 1500/	25/20%/6000
Network		In-netw	ork	Out-of-network		In-network	Ou	t-of-network
Annual medical deduc (IND/FAM) (per calenda		\$1,000/\$3	5,000	\$3,000/\$9,000		\$1,500/\$4,500	\$3,5	500/\$10,500
Annual out-of-pocket maximum (IND/FAM)		\$5,000/\$1	5,000	\$9,000/\$27,000		\$6,000/\$12,000	\$10,	500/\$21,000
Office visits – preventiv well-child care	ve and	\$0		40%*		\$0		40%*
Office visits – prenatal	care	\$0		40%*		\$0		40%*
Telehealth (phone/vide	eo)	\$0 ¹		40%*		\$0 ¹		40%*
Office visits – primary (care	\$5 for the firs then \$45 (\$25 benefit	enhanced	40%*		\$5 for the first 3 visits; nen \$45 (\$25 enhance benefit) ¹		40%*
Office visits – urgent ca	are	\$90 (\$45 en benefi		40%*		\$90 (\$45 enhanced benefit)		40%*
Office visits – specialty	care	\$55 (\$35 en benefi		40%*		\$55 (\$35 enhanced benefit)		40%*
Office visits – naturopa care	athic	\$5 for the firs then \$2		40%*		\$5 for the first 3 visits; then \$251	:	40%*
Lab		\$25		40%*		\$25		40%*
X-ray/diagnostic tests		\$25		40%*		\$25		40%*
CT, MRI, and PET scans		\$100		40%*		\$100		40%*
Outpatient surgery		20%*		40%*		20%*		40%*
Inpatient hospital care		20%* 40%*				20%*		40%*
Emergency care			20%*	c			20%*	
Routine eye exam		\$45 (\$25 en benefi		40%*		\$45 (\$25 enhanced benefit)		40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highligh you the flexibility t business goals. To compare the be plan and then sele	o choose enefits of	a plan that up to any 3	helps meet plans, chec	employee nee	ds and			n comparisons Reset
			Dua	al Choice PF	0			
Plan name	:	DUAL CHOIC	CE PPO PLAN	E 1500/20/30%/50	00	DUAL CHOICE PPO I	PLAN F 2000/	25/20%/6000
Network		In-netw	ork	Out-of-network		In-network	Out	-of-network
Annual medical ded (IND/FAM) (per calen		\$1,500/\$4	4,500	\$3,500/\$10,500		\$2,000/\$6,000	\$4,0	000/\$12,000
Annual out-of-pocket maximum (IND/FAM		\$5,000/\$1	2,000	\$10,500/\$21,000		\$6,000/\$12,000	\$12,	000/\$24,000
Office visits – preven well-child care	tive and	\$0		50%*		\$0		40%*
Office visits – prenat	al care	\$0		50%*		\$0		40%*
Telehealth (phone/vi	deo)	\$0 ¹		50%*		\$0 ¹		40%*
Office visits – primar	y care	\$5 for the firs then \$40 (\$20 benefi	enhanced	50%*	t	\$5 for the first 3 visits; hen \$45 (\$25 enhance, benefit)1		40%*
Office visits – urgent	care	\$40 (\$20 en benef		50%*		\$90 (\$45 enhanced benefit)		40%*
Office visits – special	ty care	\$40 (\$20 en benef		50%*		\$55 (\$35 enhanced benefit)		40%*
Office visits – naturo care	pathic	\$5 for the firs then \$2		50%*		\$5 for the first 3 visits; then \$251		40%*
Lab		30%	*	50%*		\$25		40%*
X-ray/diagnostic test	S	30%	*	50%*		\$25		40%*
CT, MRI, and PET scar	ıs	30%'	*	50%*		\$100		40%*
Outpatient surgery		30%3	*	50%*		20%*		40%*
Inpatient hospital ca	re	30%* 50%*				20%*		40%*
Emergency care			\$200	*			20%*	
Routine eye exam		\$40 (\$20 en benef		50%*		\$45 (\$25 enhanced benefit)		40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlight you the flexibility to business goals. To compare the ber plan and then selec	choose nefits of	a plan that l up to any 3	nelps meet plans, cheo	employee nee	ds and		See pla	n comparisons Reset
			Dua	al Choice PF	0			
Plan name		DUAL CHOIC	E PPO PLAN (G 2500/25/20%/60	00 1	DUAL CHOICE PPO	PLAN G 2500/	/30/30%/6000
Network		In-netwo	ork	Out-of-network		In-network	Ou	t-of-network
Annual medical deduc (IND/FAM) (per calenda		\$2,500/\$7	,500	\$4,500/\$13,500		\$2,500/\$5,000	\$4,	500/\$13,500
Annual out-of-pocket maximum (IND/FAM)		\$6,000/\$1	2,000	\$13,500/\$27,000		\$6,000/\$12,000	\$13,	500/\$27,000
Office visits – preventi well-child care	ve and	\$0		40%*		\$0	\$0	
Office visits – prenatal	care	\$0		40%*		\$0		50%*
Telehealth (phone/vide	eo)	\$0 ¹		40%*		\$0 ¹		50%*
Office visits – primary	care	\$5 for the first then \$45 (\$25 benefit	enhanced	40%*		\$5 for the first 3 visits hen \$50 (\$30 enhance benefit) ¹		50%*
Office visits – urgent ca	are	\$90 (\$45 en benefi		40%*		\$50 (\$30 enhanced benefit)		50%*
Office visits – specialty	/ care	\$55 (\$35 en benefi		40%*		\$50 (\$30 enhanced benefit)		50%*
Office visits – naturopa care	athic	\$5 for the first then \$2		40%*		\$5 for the first 3 visits then \$301	;	50%*
Lab		\$25		40%*		30%*		50%*
X-ray/diagnostic tests		\$25		40%*		30%*		50%*
CT, MRI, and PET scans		\$100		40%*		30%*		50%*
Outpatient surgery		20%*		40%*		30%*		50%*
Inpatient hospital care	•	20%* 40%*				30%*		50%*
Emergency care			20%*	k			\$200*	
Routine eye exam		\$45 (\$25 en benefi		40%*		\$50 (\$30 enhanced benefit)		50%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	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 penefits of	a plan that h up to any 3 p	nelps meet plans, chec	employee nee	ds and		See pla	n comparisons Reset
			Dua	al Choice PF	PO			
Plan nan	ne	DUAL CHOIC	E PPO PLAN	H 3000/30/20%/81	150 D	UAL CHOICE PPO I	PLAN H 3000/	30%/30%/7000
Network		In-netwo	ork	Out-of-network		In-network	Οι	t-of-network
Annual medical de (IND/FAM) (per cale		\$3,000/\$9	2,000	\$5,000/\$15,000		\$3,000/\$6,000	\$5,	000/\$15,000
Annual out-of-pock maximum (IND/FAI		\$8,150/\$16	5,300	\$15,000/\$30,000)	\$7,000/\$14,000	\$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 ¹		40%*		\$0 ¹		50%*
Office visits – prima	ary care	\$5 for the first then \$50 (\$30 benefit	enhanced	40%*	t	\$5 for the first 3 visit hen 40% (30% enhan benefit) ¹		50%*
Office visits – urger	nt care	\$100 (\$50 en benefi		40%*		40%* (30%* enhance benefit)	ed 🛛	50%*
Office visits – speci	alty care	\$60 (\$40 en benefi		40%*		40%* (30%* enhance benefit)	ed	50%*
Office visits – natu	ropathic care	\$5 for the first then \$3		40%*		\$5 for the first 3 visit then 30% ¹	s;	50%*
Lab		\$30		40%*		30%*		50%*
X-ray/diagnostic tes	sts	\$30		40%*		30%*		50%*
CT, MRI, and PET sc	ans	\$100		40%*		30%*		50%*
Outpatient surgery		20%*		40%*		30%*		50%*
Inpatient hospital of	care	20%*		40%*		30%*		50%*
Emergency care			20%	*			\$200*	
Routine eye exam		\$50 (\$30 en benefi		40%*		40%* (30%* enhance benefit)	ed .	50%*
*After deductible.	I		I					

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highligh you the flexibility to ousiness goals. To compare the be olan and then seled	o choose nefits of	a plan that up to any 3	helps meet plans, cheo	employee nee	ds and			n comparisons Reset
			Dua	al Choice PF	0			
Plan name		DUAL CHOIC	CE PPO PLAN	I 3500/30/20%/80	00	DUAL CHOICE PPO F	PLAN J 4000/	30/20%/8150
Network		In-netw	ork	Out-of-network		In-network	Out	t-of-network
Annual medical dedu (IND/FAM) (per calenc		\$3,500/\$1	0,500	\$5,500/\$16,500		\$4,000/\$10,000	\$6,0	000/\$18,000
Annual out-of-pocket maximum (IND/FAM)		\$8,000/\$1	6,000	\$15,000/\$30,000		\$8,150/\$16,300	\$15,	000/\$30,000
Office visits – prevent well-child care	ive and	\$0		40%*		\$0		40%*
Office visits – prenata	l care	\$0		40%*		\$0		40%*
Telehealth (phone/vid	leo)	\$0 ¹		40%*		\$0 ¹		40%*
Office visits – primary	r care	\$5 for the firs then \$50 (\$30 benefi	enhanced	40%*		\$5 for the first 3 visits; hen \$50 (\$30 enhance benefit) ¹		40%*
Office visits – urgent o	care	\$100 (\$50 er benefi		40%*		\$100 (\$50 enhanced benefit)		40%*
Office visits – specialt	y care	\$60 (\$40 en benefi		40%*		\$60 (\$40 enhanced benefit)		40%*
Office visits – naturop care	oathic	\$5 for the firs then \$3		40%*		\$5 for the first 3 visits; then \$30 ¹		40%*
Lab		\$30		40%*		\$30		40%*
X-ray/diagnostic tests		\$30		40%*		\$30		40%*
CT, MRI, and PET scan	s	\$100		40%*		\$100		40%*
Outpatient surgery		20%*	r	40%*		20%*		40%*
Inpatient hospital car	e	20%* 40%*				20%*		40%*
Emergency care			20%*	< compared by the second s			20%*	
Routine eye exam		\$50 (\$30 en benefi		40%*		\$50 (\$30 enhanced benefit)		40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highligh you the flexibility to business goals. To compare the be plan and then seled	o choose enefits of	e a plan that l up to any 3	nelps meet plans, cheo	employee nee	ds and		See plan	n comparisons Reset
			Dua	al Choice PF	0			
Plan name		DUAL CHOIC	E PPO PLAN	K 5000/30/20%/81	50 I	DUAL CHOICE PPO I	PLAN L 6000/	35/20%/8000
Network		In-netwo	ork	Out-of-network		In-network	Ou	t-of-network
Annual medical dedu (IND/FAM) (per calenc		\$5,000/\$10	0,000	\$6,500/\$19,500		\$6,000/\$12,000	\$7,5	500/\$18,000
Annual out-of-pocket maximum (IND/FAM)		\$8,150/\$16	5,300	\$15,000/\$30,000		\$8,000/\$16,000	\$15,	000/\$30,000
Office visits – prevent well-child care	tive and	\$0		40%*		\$0		40%*
Office visits – prenata	l care	\$0		40%*		\$0		40%*
Telehealth (phone/vio	deo)	\$0 ¹		40%*		\$0 ¹		40%*
Office visits – primary	/ care	\$5 for the first then \$50 (\$30 benefit	enhanced	40%*		\$5 for the first 3 visits; hen \$55 (\$35 enhance benefit) ¹		40%*
Office visits – urgent	care	\$100 (\$50 en benefi		40%*		\$100 (\$55 enhanced benefit)		40%*
Office visits – specialt	ty care	\$60 (\$40 en benefi		40%*		\$65 (\$45 enhanced benefit)		40%*
Office visits – naturop care	oathic	\$5 for the first then \$3		40%*		\$5 for the first 3 visits; then \$35 ¹		40%*
Lab		\$30		40%*		\$35		40%*
X-ray/diagnostic tests		\$30		40%*		\$35		40%*
CT, MRI, and PET scan	S	\$100		40%*		\$150		40%*
Outpatient surgery		20%*		40%*		20%*		40%*
Inpatient hospital car	re	20%* 40%*				20%*		40%*
Emergency care			20%*	*			20%*	
Routine eye exam		\$50 (\$30 en benefi		40%*		\$55 (\$35 enhanced benefit)		40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.			
Below are highlig you the flexibility business goals.	y to choose a	a plan that	helps meet	employee nee	ds and			comparisons Reset			
To compare the plan and then se				< the checkbo>	tes next to	each					
			Dua	l Choice Pl	P0						
Pla	an name			DUAL CHO	ICE PPO PLA	N M 7500/35/	30%/8500				
Network				In-network			Out-of-network				
Annual medical de calendar year)	eductible (IND/I	FAM) (per		\$7,500/\$14,500			\$8,500/\$19,500)			
Annual out-of-pock	ket maximum ((IND/FAM)		\$8,500/\$17,000			\$17,000/\$30,00	0			
Office visits – prev	entive and wel	l-child care		\$0			50%*				
Office visits – pren	atal care			\$0			50%*				
Telehealth (phone/	/video)			\$0 ¹			50%*				
Office visits – prim	ce visits – primary care		\$5 for the first	3 visits; then \$55 (\$ benefit)1	35 enhanced		50%*				
Office visits – urge	nt care		\$100	(\$55 enhanced ben	efit)		50%*				
Office visits – spec	ialty care		9	665 (\$45 enhanced benefit)			50%*				
Office visits – natu	ropathic care		\$5	5 for the first 3 visits; then \$351			50%*				
Lab				\$35			50%*				
X-ray/diagnostic te	ests			\$35			50%*				
CT, MRI, and PET so	ans			\$150			50%*				
Outpatient surgery	/			30%*			50%*				
Inpatient hospital	care			30%*		50%*					
Emergency care					30)%*					
Routine eye exam			\$55 (\$35 enhanced bene	fit)		50%*				

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	D OOA	RIDERS	SR. ADV
Below are highlig you the flexibility pusiness goals. To compare the b	to choose penefits of	e a plan that up to any 3	helps meet	t employee need	ds and		See pla	n comparisons Reset
blan and then sel	ect "See p	olan compari		al Choice PP	0			
Plan nam	e	DUAL CHOICE		PLAN A 1600/10%/2		DUAL CHOICE PPO F	IDHP PLAN A	1600/20%/350
Network		In-netv	vork	Out-of-network		In-network	01	ıt-of-network
Accumulation type			Aggree	jate			Aggregate	
Annual medical dec (IND/FAM) (per cale		\$1,600/\$	3,200	\$3,500/\$9,750		\$1,600/\$3,200	\$3	500/\$9,750
Annual out-of-pock maximum (IND/FAN		\$2,500/\$	5,000	\$10,500/\$21,000		\$3,500/\$7,000	\$11	,500/\$23,000
Office visits – preve well-child care	ntive and	\$0		30%*		\$0		40%*
Office visits – prena	tal care	\$0		30%*		\$0		40%*
Telehealth (phone/\	video)	\$0*	1	30%*		\$0* ¹		40%*
Office visits – prima	ry care	\$5 for the firs then 20%* enhanced k	* (10%*	30%*		\$5 for the first 3 visit then 30%* (20%* enhanced benefit) ¹		40%*
Office visits – urgen	t care	20%* (10%* benet		30%*		30%* (20%* enhance benefit)	ed	40%*
Office visits – specia	alty care	20%* (10%* benet		30%*		30%* (20%* enhance benefit)	ed	40%*
Office visits – natur	opathic care	\$5 for the firs then 10		30%*		\$5 for the first 3 visit then 20%*1	s;	40%*
Lab		10%	*	30%*		20%*		40%*
X-ray/diagnostic tes	ts	10%	*	30%*		20%*		40%*
CT, MRI, and PET sca	ins	10%	*	30%*		20%*		40%*
Outpatient surgery		10%	*	30%*		20%*		40%*
Inpatient hospital c	are	10%	*	30%*		20%*		40%*
Emergency care			10%	*			20%*	
Routine eye exam		20%* (10%* benet		30%*		30%* (20%* enhance benefit)	ed	40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	D OOA	RIDERS	SR. ADV.
Below are highligh you the flexibility t business goals. To compare the be olan and then sele	o choose enefits of	a plan that up to any 3	helps meet plans, cheo	t employee need	ds and		See pl	an comparisons Reset
				al Choice PP	0			
Plan name	;	DUAL CHOICE	PPO HDHP P	PLAN B 2000/20%/4	000	DUAL CHOICE PPO	HDHP PLAN B	2000/30%/4000
Network		In-netv	vork	Out-of-network		In-network	0	ut-of-network
Accumulation type			Aggreg	gate			Aggregate	
Annual medical ded (IND/FAM) (per calen		\$2,000/\$	4,000	\$4,000/\$12,000		\$2,000/\$4,000	\$4	l,000/\$12,000
Annual out-of-pocket maximum (IND/FAM		\$4,000/\$	8,000	\$12,000/\$24,000		\$4,000/\$8,000	\$1.	2,000/\$24,000
Office visits – preven well-child care	tive and	\$0		40%*		\$0		50%*
Office visits – prenat	al care	\$0		40%*		\$0		50%*
Telehealth (phone/vi	deo)	\$0*	1	40%*		\$0* ¹		50%*
Office visits – primar	y care	\$5 for the firs then 30%* enhanced k	(20%*	40%*		\$5 for the first 3 vis then 40%* (30% ³ enhanced benefit	k	50%*
Office visits – urgent	care	30%* (20%* benet		40%*		40%* (30%* enhan benefit)	ced	50%*
Office visits – special	ty care	30%* (20%* benet		40%*		40%* (30%* enhan benefit)	ced	50%*
Office visits – naturo	pathic care	\$5 for the firs then 20		40%*		\$5 for the first 3 vis then 30%*1	its;	50%*
Lab		20%	*	40%*		30%*		50%*
X-ray/diagnostic test	S	20%	*	40%*		30%*		50%*
CT, MRI, and PET scar	ıs	20%	*	40%*		30%*		50%*
Outpatient surgery		20%	*	40%*		30%*		50%*
Inpatient hospital ca	re	20%	*	40%*		30%*		50%*
Emergency care			20%	*			30%*	
Routine eye exam		30%* (20%* benet		40%*		40%* (30%* enhan benefit)	ced	50%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PP	0 00	A RIDE	RS	SR. ADV.
Below are highligh you the flexibility to business goals.	o choose	a plan that	helps meet	employee need	ds and	k	S		omparisons eset
To compare the be plan and then sele				k the checkbox	es nez	kt to each		I.C.	
			Dua	al Choice PP	0				
Plan name)	DUAL CHOIC	E PPO HDHP I	PLAN C 2500/20%/5	5000	DUAL CHOICE	PPO HDHP PL	AN C 25(00/30%/5000
Network		In-netv	work	Out-of-network		In-netw	vork	Out-o	f-network
Accumulation type			Aggree	gate			Aggrega	te	
Annual medical dedu (IND/FAM) (per calend		\$2,500/\$	5,000	\$5,000/\$15,000		\$2,500/\$	5,000	\$5,00	0/\$15,000
Annual out-of-pocket maximum (IND/FAM)		\$5,000/\$	57,500	\$15,000/\$30,000)	\$5,000/\$	7,500	\$15,00	0/\$30,000
Office visits – prevent well-child care	tive and	\$0		40%*		\$0		Ľ	50%*
Office visits – prenata	al care	\$0		40%*		\$0		50%*	
Telehealth (phone/vi	deo)	\$0*	:1	40%*		\$0*	1	50%*	
Office visits – primary	/ care	\$5 for the fir then 30% enhanced	* (20%*	40%*		\$5 for the firs then 40%* enhanced b	(30%*	Ę	50%*
Office visits – urgent	care	30%* (20%* bene		40%*		40%* (30%* benef		Ľ	50%*
Office visits – special	ty care	30%* (20%* bene		40%*		40%* (30%* benef		[50%*
Office visits – naturop	oathic care	\$5 for the fir then 20		40%*		\$5 for the firs then 30		Ę	50%*
Lab		20%	*	40%*		30%	*	Ę	50%*
X-ray/diagnostic tests	;	20%	*	40%*		30%	*	Ľ	50%*
CT, MRI, and PET scan	S	20%)*	40%*		30%	*	Ę	50%*
Outpatient surgery		20%)*	40%*		30%	*	Ę	50%*
Inpatient hospital ca	re	20%)*	40%*		30%	*	Ę	50%*
Emergency care			20%)*	30%*				
Routine eye exam		30%* (20%* bene		40%*		40%* (30%* benef		[50%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PP	0 00	DA RIDE	ERS	SR. ADV.
Below are highligł you the flexibility t business goals.	o choose	a plan that	helps meet	employee need	ds and	k	S		comparisons eset
To compare the be plan and then sele		1		k the checkbox	es nez	kt to each		K	-561
			Dua	I Choice PP	0				
Plan name	9	DUAL CHOIC	E PPO HDHP I	PLAN E 3200/10%/6	6000	DUAL CHOIC	E PPO HDHP PI	.AN E 32	00/20%/6000
Network		In-net	work	Out-of-network		In-net	work	Out-o	of-network
Accumulation type			Embed	ded			Embedd	ed	
Annual medical ded (IND/FAM) (per calen		\$3,200/5	\$6,400	\$5,000/\$15,000		\$3,200/5	\$6,000	\$5,00	0/\$15,000
Annual out-of-pocket maximum (IND/FAM		\$6,000/	\$9,000	\$15,000/\$30,000)	\$6,000/\$	12,000	\$15,00	00/\$30,000
Office visits – preven well-child care	tive and	\$0)	30%*		\$0)	40%*	
Office visits – prenat	al care	\$0)	30%*		\$0)	40%*	
Telehealth (phone/vi	deo)	\$0;	k 1	30%*		\$03	k1	40%*	
Office visits – primar	y care	\$5 for the fin then 20% enhanced	* (10%*	30%*		\$5 for the fir then 30% enhanced	* (20%*	2	40%*
Office visits – urgent	care	20%* (10%* bene		30%*		30%* (20%* bene		2	40%*
Office visits – special	ty care	20%* (10%* bene		30%*		30%* (20%* bene		2	40%*
Office visits – naturo	pathic care	\$5 for the fin then 1		30%*		\$5 for the fir then 2		2	40%*
Lab		10%	6*	30%*		20%	6*	4	40%*
X-ray/diagnostic test	S	10%	/*	30%*		20%	/*	2	40%*
CT, MRI, and PET scar	IS	10%	/*	30%*		20%	(* 0 [*]	2	40%*
Outpatient surgery	tient surgery 10%*		/* 0 [*]	30%*		20%	/* 0	2	40%*
Inpatient hospital care 10%* 30%*		20%	/* 0	2	40%*				
Emergency care			10%	*	20%*				
Routine eye exam		20%* (10%* bene		30%*		30%* (20%* bene			40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PP	0 00	DA RID	ERS	SR. ADV.
Below are highligh you the flexibility to business goals. To compare the be	o choose	a plan that	helps meet	employee need	ds and	b	S		comparisons eset
plan and then sele		1	isons."	al Choice PP					
Plan name	;	DUAL CHOIC		PLAN E 3200/30%/6		DUAL CHOI	CE PPO HDHP P	LAN F 35	00/20%/7000
Network		In-net	work	Out-of-network		In-ne	twork	Out-	of-network
Accumulation type			Embec	lded			Embedo	led	
Annual medical dedu (IND/FAM) (per calend		\$3,200/5	\$6,000	\$5,000/\$15,000		\$3,500	/\$7,000	\$5,50	0/\$16,500
Annual out-of-pocket maximum (IND/FAM)		\$6,000/\$	512,000	\$15,000/\$30,000	D	\$7,000/	\$14,000	\$15,00	00/\$30,000
Office visits – preven well-child care	tive and	\$0)	50%*		\$	0		40%*
Office visits – prenata	al care	\$0)	50%*		\$	0	40%*	
Telehealth (phone/vi	deo)	\$03	*1	50%*		\$0)*1		40%*
Office visits – primar	y care	\$5 for the fin then 40% enhanced	* (30%*	50%*		then 30%	irst 3 visits; %* (20%* I benefit)1		40%*
Office visits – urgent	care	40%* (30%* bene		50%*		30%* (20% ben	* enhanced efit)		40%*
Office visits – special	ty care	40%* (30%* bene		50%*		•	* enhanced efit)		40%*
Office visits – naturo	pathic care	\$5 for the fin then 3		50%*			irst 3 visits; 20%*1		40%*
Lab		30%	%*	50%*		20	%*		40%*
X-ray/diagnostic tests	5	30%	%*	50%*		20	%*		40%*
CT, MRI, and PET scan	IS	30%	6*	50%*		20	%*		40%*
Outpatient surgery		30%	6*	50%*		20	%*		40%*
Inpatient hospital ca	re	30%	6*	50%*		20	%*		40%*
Emergency care			30%	ʻo*	20%*				
Routine eye exam		40%* (30%* bene		50%*			* enhanced efit)		40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED HD	HP KP PLUS	PP	OOA	RIDERS	SR. ADV.
Dolouworo bioblic	bto of the	hanafita far asah r	lon Averiative for				
you the flexibility	•		blan. A variety of op meet employee ne			See plan	comparisons
ousiness goals. To compare the k	penefits of	up to any 3 plans,	check the checkbo	oxes ne	ext to each	R	leset
•		lan comparisons."					
			Dual Choice P	PO			
Plan nam	ne	DUAL CHOICE PPO H	DHP PLAN F 3500/30%	/7000	DUAL CHOICE PPO H	IDHP PLAN G 40	00/20%/7000
Network		In-network	Out-of-networ	k	In-network	Out-o	of-network
Accumulation type		E	mbedded			Embedded	
Annual medical de (IND/FAM) (per cale		\$3,500/\$7,000	\$5,500/\$16,50	0	\$4,000/\$8,000	\$6,00	00/\$12,000
Annual out-of-pock maximum (IND/FAI		\$7,000/\$14,000	\$15,000/\$30,00	00	\$7,000/\$14,000	\$15,00	00/\$30,000
Office visits – preve well-child care	entive and	\$0	50%*		\$0		40%*
Office visits – prena	atal care	\$0	50%*		\$0		40%*
Telehealth (phone/	video)	\$ 0 *1	50%*		\$0* ¹		40%*
Office visits – prima	ary care	\$5 for the first 3 visits; th 40%* (30%* enhanced benefit) ¹			\$5 for the first 3 visits then 30%* (20%* enhanced benefit) ¹		40%*
Office visits – urger	nt care	40%* (30%* enhanced benefit)	50%*		30%* (20%* enhance benefit)	ed	40%*
Office visits – speci	alty care	40%* (30%* enhanced benefit)	50%*		30%* (20%* enhance benefit)	ed .	40%*
Office visits – natur	opathic care	\$5 for the first 3 visits; th 30%*1	nen 50%*		\$5 for the first 3 visit then 20%*1	s;	40%*
Lab		30%*	50%*		20%*		40%*
X-ray/diagnostic tes	sts	30%*	50%*		20%*		40%*
CT, MRI, and PET sca	ans	30%*	50%*		20%*		40%*
Outpatient surgery		30%*	50%*		20%*		40%*
Inpatient hospital o	are	30%*	50%*		20%*		40%*
Emergency care			30%*			20%*	
Routine eye exam		40%* (30%* enhanced benefit)	50%*		30%* (20%* enhance benefit)	ed .	40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	D OOA	RIDERS	SR. ADV.
Below are highligh you the flexibility to business goals.					-		See pl	an comparisons
To compare the be plan and then seled			•	k the checkbox	es nex	t to each		Reset
			Dua	al Choice PP	0			
Plan name		DUAL CHOICE	PPO HDHP P	LAN G 4000/30%/7	000	DUAL CHOICE PPO F	IDHP PLAN H	5000/20%/7000
Network		In-netw	vork	Out-of-network		In-network	0	ut-of-network
Accumulation type			Embed	ded			Embedded	
Annual medical dedu (IND/FAM) (per calenc		\$4,000/\$	8,000	\$6,000/\$12,000		\$5,000/\$10,000	\$7	7,000/\$14,000
Annual out-of-pocket maximum (IND/FAM)		\$7,000/\$1	4,000	\$15,000/\$30,000		\$7,000/\$14,000	\$1	7,000/\$34,000
Office visits – prevent well-child care	ive and	\$0		50%*		\$0		40%*
Office visits – prenata	l care	\$0		50%*		\$0		40%*
Telehealth (phone/vid	leo)	\$0*	1	50%*		\$0*1		40%*
Office visits – primary	care	\$5 for the firs then 40%* enhanced b	(30%*	50%*		\$5 for the first 3 visit then 30%* (20%* enhanced benefit)		40%*
Office visits – urgent o	care	40%* (30%* benef		50%*		30%* (20%* enhance benefit)	ed	40%*
Office visits – specialt	y care	40%* (30%* benef		50%*		30%* (20%* enhance benefit)	ed	40%*
Office visits – naturop	athic care	\$5 for the firs then 30		50%*		\$5 for the first 3 visit then 20%*1	is;	40%*
Lab		30%	*	50%*		20%*		40%*
X-ray/diagnostic tests		30%	*	50%*		20%*		40%*
CT, MRI, and PET scan	S	30%	*	50%*		20%*		40%*
Outpatient surgery		30%	*	50%*		20%*		40%*
Inpatient hospital car	е	30%	*	50%*		20%*		40%*
Emergency care			30%	*			20%*	
Routine eye exam		40%* (30%* benef		50%*		30%* (20%* enhanc benefit)	ed	40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPC	D OOA	RIDERS	SR. ADV.
Below are highligh you the flexibility to business goals.			•		-		See pla	in comparisons
To compare the be plan and then seled			isons."			t to each		Reset
			Dua	al Choice PP	0			
Plan name		DUAL CHOICE	E PPO HDHP P	LAN H 5000/30%/7	000	DUAL CHOICE PPO F	IDHP PLAN H	5000/40%/7000
Network		In-netv	vork	Out-of-network		In-network	0	ut-of-network
Accumulation type			Embed	ded			Embedded	
Annual medical dedu (IND/FAM) (per calenc		\$5,000/\$7	10,000	\$7,000/\$14,000		\$5,000/\$10,000	\$7	,000/\$14,000
Annual out-of-pocket maximum (IND/FAM)		\$7,000/\$1	14,000	\$17,000/\$34,000		\$7,000/\$14,000	\$17	7,000/\$34,000
Office visits – prevent well-child care	ive and	\$0		50%*		\$0		50%*
Office visits – prenata	l care	\$0		50%*		\$0		50%*
Telehealth (phone/vid	leo)	\$0*	1	50%*		\$0* ¹		50%*
Office visits – primary	care	\$5 for the firs then 40% enhanced b	* (30%*	50%*		\$5 for the first 3 visit then 50%* (40%* enhanced benefit)		50%*
Office visits – urgent o	care	40%* (30%* bene		50%*		50%* (40%* enhanc benefit)	ed	50%*
Office visits – specialt	y care	40%* (30%* bene		50%*		50%* (40%* enhanc benefit)	ed	50%*
Office visits – naturop	athic care	\$5 for the firs then 30		50%*		\$5 for the first 3 visit then 40%*1	is;	50%*
Lab		30%	*	50%*		40%*		50%*
X-ray/diagnostic tests		30%	*	50%*		40%*		50%*
CT, MRI, and PET scans	5	30%	*	50%*		40%*		50%*
Outpatient surgery		30%	*	50%*		40%*		50%*
Inpatient hospital car	e	30%	*	50%*		40%*		50%*
Emergency care			30%	*			40%*	
Routine eye exam		40%* (30%* bene		50%*		50%* (40%* enhanc benefit)	ed	50%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.			
						-					
Below are highlig you the flexibility business goals. To compare the l	to choose	a plan that he	elps meet	employee nee	ds and		See pl	an comparisons Reset			
plan and then se											
		(OUT-OF	-AREA PPO	PLUS						
Plan nar	Plan name PPO PLUS PLAN WDB 500/20%/2500 PPO PLUS PLAN WDC 750/20%/3750										
Network		PPO provi	ders	Nonparticipatin providers	g	PPO providers	No	nparticipating providers			
Annual medical de (IND/FAM) (per cale		\$500/\$1,	500	\$750/\$2,250		\$750/\$2,250	\$	1,125/\$3,375			
Annual out-of-pock maximum (IND/FA		\$2,500/\$7	,500	\$3,500/\$10,50	0	\$3,750/\$11,250		5,250/\$16,875			
Office visits – prevo well-child care	entive and	\$0		35%*		\$0		35%*			
Office visits – pren	atal care	\$0		35%*		\$0		35%*			
Telehealth (phone/	video)	\$0 ¹		35%*		\$0 ¹		35%*			
Office visits – prim	ary care	\$5 for the first then \$3		35%*	\$5	5 for the first 3 vi then \$301	sits;	35%*			
Office visits – urge	nt care	\$50		35%*		\$50		35%*			
Office visits – speci	alty care	\$40		35%*		\$40		35%*			
Office visits – natu	ropathic care	\$5 for the first then \$3		35%*	\$5	5 for the first 3 vi then \$301	sits;	35%*			
Lab		\$30		35%*		\$30		35%*			
X-ray/diagnostic te	sts	\$30		35%*		\$30		35%*			
CT, MRI, and PET sc	ans	20%*		35%*		20%*		35%*			
Outpatient surgery	1	20%*		35%*		20%*		35%*			
Inpatient hospital	care	20%* 35%*				20%*		35%*			
Emergency care			\$200	0*			\$200*				
Routine eye exam		\$30		35%*		\$30		35%*			

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
						_		
Below are highlig you the flexibility business goals. To compare the	to choose	a plan that he	elps meet	employee nee	ds and		See pla	n comparisons Reset
plan and then se								
			OUT-OF	-AREA PPO	PLUS			
Plan naı	ne	PPO PLU	S PLAN WD	T 1000/20%/3000		PPO PLUS PL	AN WDE 1000/	30%/4750
Network		PPO provi	ders	Nonparticipatin providers	Ig	PPO providers		participating providers
Annual medical de (IND/FAM) (per cal		\$1,000/\$3	,000	\$1,500/\$4,500)	\$1,000/\$3,000) \$1,	500/\$4,500
Annual out-of-pock maximum (IND/FA		\$3,000/\$9	,000	\$6,000/\$12,00	0	\$4,750/\$9,500		000/\$12,000
Office visits – prev well-child care	entive and	\$0		45%*		\$0		45%*
Office visits – pren	atal care	\$0		45%*		\$0		45%*
Telehealth (phone	video)	\$0 ¹		45%*		\$0 ¹		45%*
Office visits – prim	ary care	\$5 for the first then \$2		45%*	\$	5 for the first 3 vi then \$301	sits;	45%*
Office visits – urge	nt care	\$20		45%*		\$50		45%*
Office visits – spec	ialty care	\$20		45%*		\$40		45%*
Office visits – natu	ropathic care	\$5 for the first then \$2		45%*	\$	5 for the first 3 vi then \$301	sits;	45%*
Lab		20%*		45%*		\$30		45%*
X-ray/diagnostic te	sts	20%*		45%*		\$30		45%*
CT, MRI, and PET so	ans	20%*		45%*		30%*		45%*
Outpatient surgery	1	20%*		45%*		30%*		45%*
Inpatient hospital	care	20%*		45%*		30%*		45%*
Emergency care			\$20	0*			\$200*	
Routine eye exam		\$20		45%*		\$30		45%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED HD	OHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.			
Below are highlig you the flexibility business goals. To compare the	to choose benefits of u	a plan that helps	meet e , check	mployee nee	ds and		See pl	an comparisons Reset			
	iect see pi										
		00	1-0F-	AREA PPO	PLUS						
Plan nai	Plan name PPO PLUS PLAN WDU 1500/20%/5500 PPO PLUS PLAN WDP 1500/30%/6000										
Network		PPO providers		Nonparticipatir providers	ıg	PPO provider	5 No	onparticipating providers			
Annual medical de (IND/FAM) (per calo		\$1,500/\$4,500		\$2,250/\$6,750)	\$1,500/\$4,50	0 \$	2,250/\$6,750			
Annual out-of-pock maximum (IND/FA		\$5,500/\$11,000)	\$7,500/\$15,00	0	\$6,000/\$12,000		7,500/\$15,000			
Office visits – preve well-child care	entive and	\$0		45%*		\$0		45%*			
Office visits – pren	atal care	\$0		45%*		\$0		45%*			
Telehealth (phone/	video)	\$0 ¹		45%*		\$0 ¹		45%*			
Office visits – prim	ary care	\$5 for the first 3 vis then \$25 ¹	sits;	45%*	\$5	for the first 3 v then \$301	isits;	45%*			
Office visits – urge	nt care	\$45		45%*		\$50		45%*			
Office visits – speci	ialty care	\$35		45%*		\$40		45%*			
Office visits – natu	ropathic care	\$5 for the first 3 vis then \$25 ¹	sits;	45%*	\$5	for the first 3 v then \$301	isits;	45%*			
Lab		\$25		45%*		\$30		45%*			
X-ray/diagnostic te	sts	\$25		45%*		\$30		45%*			
CT, MRI, and PET sc	ans	\$100		45%*		30%*		45%*			
Outpatient surgery	1	20%*		45%*		30%*		45%*			
Inpatient hospital	care	20%*		45%*		30%*		45%*			
Emergency care			20%				\$200*				
Routine eye exam		\$25		45%*		\$30		45%*			

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
						-		
Below are highlig you the flexibility business goals. To compare the l plan and then se	to choose	a plan that he up to any 3 pl	elps meet ans, cheo	t employee nee	ds and		See pla	n comparisons Reset
		-		-AREA PPO	PILIS			
Plan nar	ne	PPO PLUS	PLAN WD	N 2000/30%/6000		PPO PLUS PL	AN WDX 3000	/30%/6850
Network		PPO provid	ders	Nonparticipatin providers	g	PPO providers	Nor	nparticipating providers
Annual medical de (IND/FAM) (per cale		\$2,000/\$6,	000	\$3,000/\$9,000)	\$3,000/\$9,000) \$4,	500/\$13,500
Annual out-of-pock maximum (IND/FA		\$6,000/\$12	,000	\$7,500/\$15,00	0	\$6,850/\$13,700		400/\$16,800
Office visits – preve well-child care	entive and	\$0		40%*		\$0		40%*
Office visits – pren	atal care	\$0		40%*		\$0		40%*
Telehealth (phone/	video)	\$0 ¹		40%*		\$0 ¹		40%*
Office visits – prim	ary care	\$5 for the first then \$3		40%*	\$5	for the first 3 vi then \$351	sits;	40%*
Office visits – urge	nt care	\$55		40%*		\$55		40%*
Office visits – speci	ialty care	\$45		40%*		\$45		40%*
Office visits – natu	ropathic care	\$5 for the first then \$3		40%*	\$5	for the first 3 vi then \$351	sits;	40%*
Lab		\$35		40%*		\$35		40%*
X-ray/diagnostic te	sts	\$35		40%*		\$35		40%*
CT, MRI, and PET sc	ans	30%*		40%*		30%*		40%*
Outpatient surgery	1	30%*		40%*		30%*		40%*
Inpatient hospital	care	30%*		40%*		30%*		40%*
Emergency care			\$20	0*			\$200*	
Routine eye exam		\$35		40%*		\$35		40%*

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.			
						-					
Below are highlig you the flexibility business goals. To compare the	to choose	a plan that he up to any 3 pla	lps meet ans, cheo	t employee nee	ds and		See pla	nn comparisons Reset			
plan and then se	liect See pi	·									
		C	OUT-OF	-AREA PPO	PLUS						
Plan nar	Plan name PPO PLUS PLAN WDR 4000/30%/7350 PPO PLUS PLAN WDS 5000/30%/7350										
Network		PPO provid	ers	Nonparticipatin providers	g	PPO providers	No	nparticipating providers			
Annual medical de (IND/FAM) (per cale		\$4,000/\$8,	000	\$6,000/\$12,00	0	\$5,000/\$10,00	0 \$6	500/\$13,000			
Annual out-of-pock maximum (IND/FA		\$7,350/\$14,	700	\$9,000/\$18,00	0	\$7,350/\$14,700		000/\$18,000			
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 ¹		40%*		\$0 ¹		40%*			
Office visits – prim	ary care	\$5 for the first 3 then \$35		40%*	\$5	5 for the first 3 vi then \$351	sits;	40%*			
Office visits – urge	nt care	\$55		40%*		\$55		40%*			
Office visits – speci	ialty care	\$45		40%*		\$45		40%*			
Office visits – natu	ropathic care	\$5 for the first 3 then \$35		40%*	\$5	5 for the first 3 vi then \$351	sits;	40%*			
Lab		\$35		40%*		\$35		40%*			
X-ray/diagnostic te	sts	\$35		40%*		\$35		40%*			
CT, MRI, and PET sc	ans	30%*		40%*		30%*		40%*			
Outpatient surgery	1	30%*		40%*		30%*		40%*			
Inpatient hospital	care	30%*		40%*		30%*		40%*			
Emergency care			20%	/ * 0			20%*				
Routine eye exam		\$35		40%*		\$35		40%*			

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED H	IDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.			
						_					
Below are highlig you the flexibility business goals.	to choose	a plan that help	os meet	employee nee	ds and		See pla	n comparisons Reset			
To compare the l plan and then se				ck the checkbox	tes next	to each		Neset			
		O	UT-OF	-AREA PPO	PLUS	5					
Plan nar	Plan name PPO PLUS HDHP AA PLAN WFI 1600/20%/3500 PPO PLUS HDHP AA PLAN WAS 2800/20%/4000										
Network		PPO provider	ſS	Nonparticipatin providers	g	PPO providers	Nor	nparticipating providers			
Accumulation type			Aggre	gate			Aggregate				
Annual medical de (IND/FAM) (per cale		\$1,600/\$3,20	00	\$3,500/\$7,000)	\$2,800/\$5,600) \$3	,500/\$7,000			
Annual out-of-pock maximum (IND/FA		\$3,500/\$7,00	0	\$6,000/\$12,000	0	\$4,000/\$8,000) \$7,	000/\$14,000			
Office visits – preve well-child care	entive and	\$0		30%*		\$0		30%*			
Office visits – prena	atal care	\$0		30%*		\$0		30%*			
Telehealth (phone/	video)	\$0* ¹		30%*		\$0* ¹		30%*			
Office visits – prim	ary care	\$5 for the first 3 v then 20%*1	visits;	30%*		\$5 for the first 3 vi then 20%*1	sits;	30%*			
Office visits – urge	nt care	20%*		30%*		20%*		30%*			
Office visits – speci	alty care	20%*		30%*		20%*		30%*			
Office visits – natu	ropathic care	\$5 for the first 3 v then 20%*1		30%*		\$5 for the first 3 vi then 20%*1	sits;	30%*			
Lab		20%*		30%*		20%*		30%*			
X-ray/diagnostic te	sts	20%*		30%*		20%*		30%*			
CT, MRI, and PET sc	ans	20%*		30%*		20%*		30%*			
Outpatient surgery	,	20%*		30%*		20%*		30%*			
Inpatient hospital	care	20%* 30%*				20%*		30%*			
Emergency care			20%	b*			10%*				
Routine eye exam		20%*		30%*		20%*		30%*			

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.



OVERVIEW	TRAD	DED	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.

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.





OVERVIEW	TRAD	DED	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.

¹First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.

²The limit of 10 covered services does not apply.

³If 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



TRAD

PPO OOA SR. ADV.

RIDERS

SUPPLEMENTAL BENEFIT OPTIONS **OUTPATIENT PRESCRIPTION DRUGS**

Traditional, deductible, and HSA-qualified, HDHP plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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

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



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	TTER WAY	TO TAKE CARE	OF BUSINESS

Kaiser Permanente Plus[™] Plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

	Kaiser Perman	ente Pharmacie	95	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	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BI	ETTER WAY	TO TAKE CARE	OF BUSINESS

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 Kaiser Permanente pharmacies and a broad national network of pharmacies through MedImpact.

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

	Kaiser Perman	ente Pharmacie	S	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%	



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	TTER WAY	TO 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 Perman	ente Pharmacie	S	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	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	ETTER WAY	TO TAKE CARE	OF BUSINESS

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

	Kaiser Permanente or MedImpact 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.

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



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	TTER WAY	TO TAKE CARE	OF BUSINESS

HEARING AIDS

Traditional and deductible (including KP Plus¹), 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: 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, in-network/PPO providers, or out-of-network/nonparticipating 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.

Dual Choice PPO and PPO Plus members may purchase hearing aids from:

In-network/PPO providers

In states where Kaiser Permanente operates, members can get care from Kaiser Permanente providers and First Choice Health providers in Oregon and Washington, and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C.² In all other states, members can visit the Cigna Healthcare PPO Network providers.³

Out-of-network/nonparticipating providers

Members can also get care from an out-of-network provider of their choice.

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

ALTERNATIVE CARE

Traditional and deductible (including KP Plus¹), 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.

¹Rider benefits only available in-network

²Kaiser Permanente states: California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Healthcare Intellectual Property, Inc.



³The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	ETTER WAY	TO TAKE CARE	OF BUSINESS

Buy-up self-referred alternative care benefits

Groups can choose to add self-referred alternative 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.

PPO Plus, 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.

Buy-up self-referred alternative care benefits

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

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

*Subject to deductible on HSA-qualified, plans.

Dual Choice PPO and PPO Plus members can get care from:

In-network/PPO providers

Dual Choice PPO members can get care from The CHP Group, a broad network of alternative care providers in the Pacific Northwest. Visit **chpgroup.com** for a list of providers.

In states where Kaiser Permanente operates, members can get care from First Choice Health providers in Oregon and Washington, and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C.¹ In all other states, members can visit The Cigna Healthcare PPO Network providers.²

¹Kaiser Permanente states: California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

²The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

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OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	TTER WAY	TO TAKE CARE	OF BUSINESS

Out-of-network/nonparticipating providers

Members can also get care from an out-of-network provider of their choice.

VISION HARDWARE

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

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

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

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

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 may be purchased from Vision Essentials by Kaiser Permanente, 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 for KP Plus plans.



OVERVIEW	TRAD	DED	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
					A BE	TTER WAY	TO TAKE CARE	OF BUSINESS

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

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

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



