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.

KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

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Table of contents

2024 Complete Suite™ plans

The list below includes all 2024 plan offerings. Select a plan to navigate to the full list of benefits.

Plans selected:

Compare plans

Traditional	Deductible	High deductible health plan (HDHP)
TRAD PLAN A 10/1000	DED PLAN A 250/10/10%/2000	HDHP PLAN A 1600/10%/2500
TRAD PLAN B 20/1500	DED PLAN A 250/15/20%/2500	HDHP PLAN A 1600/20%/3500
TRAD PLAN C 20/2000	DED PLAN B 500/20/10%/3000	HDHP PLAN B 2000/20%/4000
TRAD PLAN D 30/2500	DED PLAN B 500/10%/10%/2000	HDHP PLAN B 2000/30%/4000
TRAD PLAN E 35/3000	DED PLAN B 500/10/20%/2000	HDHP PLAN C 2500/20%/5000
	DED PLAN B 500/20/20%/3000	HDHP PLAN C 2500/30%/5000
	DED PLAN C 750/20/20%/3250	HDHP PLAN E 3200/10%/6000
	DED PLAN C 750/20%/20%/3000	HDHP PLAN E 3200/20%/6000
	DED PLAN D 1000/20/20%/3000	HDHP PLAN E 3200/30%/6000
	DED PLAN D 1000/25/20%/4000	HDHP PLAN F 3500/20%/7000
	DED PLAN E 1500/25/20%/5500	HDHP PLAN F 3500/30%/7000
	DED PLAN E 1500/20/30%/4000	HDHP PLAN G 4000/20%/7000
	DED PLAN F 2000/25/20%/5000	HDHP PLAN G 4000/30%/7000
	DED PLAN G 2500/25/20%/5000	HDHP PLAN H 5000/20%/7000
	DED PLAN G 2500/30/30%/5000	HDHP PLAN H 5000/30%/7000
	DED PLAN H 3000/30/20%/7350	HDHP PLAN H 5000/40%/7000
	DED PLAN H 3000/30%/30%/6000	HDHP PLAN H 5000/50%/7000
	DED PLAN I 3500/30/20%/7350	
	DED PLAN J 4000/30/20%/7500	
	DED PLAN K 5000/30/20%/7350	
	DED PLAN L 6000/35/20%/7500	
	DED PLAN M 7500/35/30%/8500	

Reset

Clear all plans selected

2024 Complete Suite™ plans

The list below includes all 2024 plan offerings. Select a plan to navigate to the full list of benefits.

Plans selected: ☐

Compare 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 2500/30/30%/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

2024 Complete Suite™ plans

The list below includes all 2024 plan offerings. Select a plan to navigate to the full list of benefits.

Plans selected: ☐

Compare plans

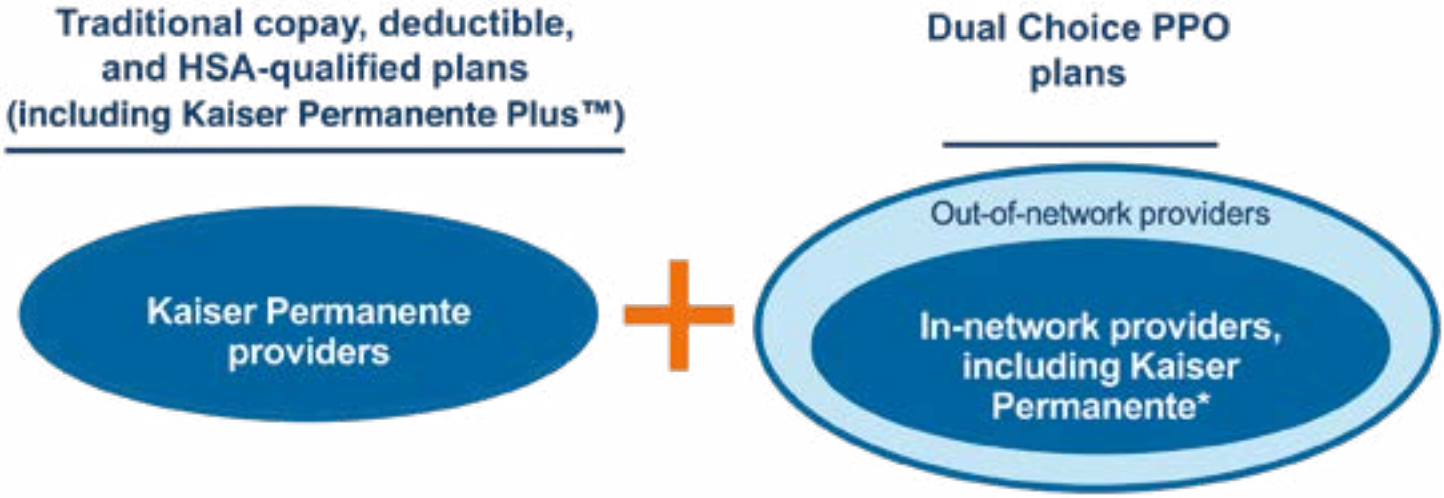
Dual Choice PPO	Out of Area PPO Plus
☐ DUAL CHOICE PPO HDHP PLAN A 1600/10%/2500	☐ PPO PLUS PLAN WDB 500/20%/2500
☐ DUAL CHOICE PPO HDHP PLAN A 1600/20%/3500	☐ PPO PLUS PLAN WDC 750/20%/3750
☐ DUAL CHOICE PPO HDHP PLAN B 2000/20%/4000	☐ PPO PLUS PLAN WDT 1000/20%/3000
☐ DUAL CHOICE PPO HDHP PLAN B 2000/30%/4000	☐ PPO PLUS PLAN WDE 1000/30%/4750
☐ DUAL CHOICE PPO HDHP PLAN C 2500/20%/5000	☐ PPO PLUS PLAN WDU 1500/20%/5500
☐ DUAL CHOICE PPO HDHP PLAN C 2500/30%/5000	☐ PPO PLUS PLAN WDP 1500/30%/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 Healthcare℠ 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.

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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-of-pocket 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.

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.

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

KAISER PERMANENTE PLUS™ TRADITIONAL PLANS	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	*	†			
TRAD PLAN B 20/1500		*	†		
TRAD PLAN C 20/2000			*	†	†
TRAD PLAN D 30/2500				*	†
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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KAISER PERMANENTE PLUS™ DEDUCTIBLE PLANS	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 500/20/20%/3500	PPO PLAN C 750/20/20%/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		*	†			†				
DED PLAN B 500/20/10%/3000			*	†		†	†			
DED PLAN B 500/10%/10%/2000				*				†		
DED PLAN B 500/10/20%/2000					*	†	†			
DED PLAN B 500/20/20%/3000						*	†			
DED PLAN C 750/20/20%/3250							*	†		†
DED PLAN C 750/20%/20%/3000								*		†

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KAISER PERMANENTE PLUS™ DEDUCTIBLE PLANS	DUAL CHOICE PPO PLANS							
	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	*	†	†					
DED PLAN D 1000/25/20%/4000		*	†					
DED PLAN E 1500/25/20%/5500			*		†	†		
DED PLAN E 1500/20/30%/4000				*	†	†		
DED PLAN F 2000/25/20%/5000					*	†		
DED PLAN G 2500/25/20%/5000						*		†
DED PLAN G 2500/30/30%/5000							*	†

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KAISER PERMANENTE PLUS™ DEDUCTIBLE PLANS	DUAL CHOICE PPO PLANS						
	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	*		†	†			
DED PLAN H 3000/30%/30%/6000		*	†				
DED PLAN I 3500/30/20%/7350			*	†			
DED PLAN J 4000/30/20%/7500				*	†	†	
DED PLAN K 5000/30/20%/7350					*	†	†
DED PLAN L 6000/35/20%/7500						*	†
DED PLAN M 7500/35/30%/8500							*

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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.

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		DUAL CHOICE PPO PLANS								
		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
HIGH DEDUCTIBLE HEALTH PLANS	HDHP PLAN A 1600/10%/2500	*	†	†						
	HDHP PLAN A 1600/20%/3500		*	†						
	HDHP PLAN B 2000/20%/4000			*	†	†	†		†	
	HDHP PLAN B 2000/30%/4000				*		†			†

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.

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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.

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		DUAL CHOICE PPO PLANS										
		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
HIGH DEDUCTIBLE HEALTH PLANS	HDHP PLAN C 2500/20%/5000	*	†	†	†	†	†					
	HDHP PLAN C 2500/30%/5000		*			†		†		†		
	HDHP PLAN E 3200/10%/6000			*	†	†	†	†	†			
	HDHP PLAN E 3200/20%/6000				*	†	†	†	†			
	HDHP PLAN E 3200/30%/6000					*		†		†		
	HDHP PLAN F 3500/20%/7000						*	†	†	†		
	HDHP PLAN F 3500/30%/7000							*		†		†

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2024 COMPLETE SUITE™ PAIRING GUIDE

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

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HIGH DEDUCTIBLE HEALTH PLANS	DUAL 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	*	†	†	†	
HDHP PLAN G 4000/30%/7000		*		†	
HDHP PLAN H 5000/20%/7000			*	†	†
HDHP PLAN H 5000/30%/7000				*	†
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.

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

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

See plan comparisons

Reset

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

*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.

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

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

See plan comparisons

Reset

DEDUCTIBLE				
Plan Name	☐ DED PLAN A 250/10/10%/2000	☐ DED PLAN A 250/15/20%/2500	☐ DED PLAN B 500/20/10%/3000	☐ DED PLAN B 500/10%/10%/2000
Annual medical deductible (IND/FAM) (per calendar year)	$250/$750	$250/$750	$500/$1,500	$500/$1,500
Annual out-of-pocket maximum (IND/FAM)	$2,000/$6,000	$2,500/$7,500	$3,000/$6,000	$2,000/$6,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	$0[1]	$0[1]	$0[1]
Office visits – primary care	$5 for the first 3 visits; then $10[1]	$5 for the first 3 visits; then $15[1]	$5 for the first 3 visits; then $20[1]	$5 for the first 3 visits; then 10%*[1]
Office visits – urgent care	$10	$35	$40	10%*
Office visits – specialty care	$10	$25	$30	10%*
Office visits – naturopathic care	$5 for the first 3 visits; then $10[1]	$5 for the first 3 visits; then $15[1]	$5 for the first 3 visits; then $20[1]	$5 for the first 3 visits; then 10%*[1]
Lab	10%*	$15	$20	10%*
X-ray/diagnostic tests	10%*	$15	$20	10%*
CT, MRI, and PET scans	10%*	$100	$100	10%*
Outpatient surgery	10%*	20%*	10%*	10%*
Inpatient hospital care	10%*	20%*	10%*	10%*
Emergency care	$200*	20%*	10%*	$200*
Routine eye exam	$10	$15	$20	10%*

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*After deductible.

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See plan comparisons

Reset

DEDUCTIBLE				
Plan Name	☐ DED PLAN B 500/10/20%/2000	☐ DED PLAN B 500/20/20%/3000	☐ DED PLAN C 750/20/20%/3250	☐ DED PLAN C 750/20%/20%/3000
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	$500/$1,500	$750/$2,250	$750/$2,250
Annual out-of-pocket maximum (IND/FAM)	$2,000/$6,000	$3,000/$9,000	$3,250/$9,750	$3,000/$9,000
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 first 3 visits; then $10[1]	$5 for the first 3 visits; then $20[1]	$5 for the first 3 visits; then $20[1]	$5 for the first 3 visits; then 20%*[1]
Office visits – urgent care	$10	$40	$40	20%*
Office visits – specialty care	$10	$30	$30	20%*
Office visits – naturopathic care	$5 for the first 3 visits; then $10[1]	$5 for the first 3 visits; then $20[1]	$5 for the first 3 visits; then $20[1]	$5 for the first 3 visits; then 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	$200*	20%*	20%*	$200*
Routine eye exam	$10	$20	$20	20%*

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Reset

DEDUCTIBLE				
Plan Name	☐ DED PLAN D 1000/20/20%/3000	☐ DED PLAN D 1000/25/20%/4000	☐ DED PLAN E 1500/25/20%/5500	☐ DED PLAN E 1500/20/30%/4000
Annual medical deductible (IND/FAM) (per calendar year)	$1,000/$3,000	$1,000/$3,000	$1,500/$4,500	$1,500/$4,500
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	$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 first 3 visits; then $20[1]	$5 for the first 3 visits; then $25[1]	$5 for the first 3 visits; then $25[1]	$5 for the first 3 visits; then $20[1]
Office visits – urgent care	$20	$45	$45	$20
Office visits – specialty care	$20	$35	$35	$20
Office visits – naturopathic care	$5 for the first 3 visits; then $20[1]	$5 for the first 3 visits; then $25[1]	$5 for the first 3 visits; then $25[1]	$5 for the first 3 visits; 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	$200*	20%*	20%*	$200*
Routine eye exam	$20	$25	$25	$20

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See plan comparisons

Reset

DEDUCTIBLE				
Plan Name	☐ DED PLAN F 2000/25/20%/5000	☐ DED PLAN G 2500/25/20%/5000	☐ DED PLAN G 2500/30/30%/5000	☐ DED PLAN H 3000/30/20%/7350
Annual medical deductible (IND/FAM) (per calendar year)	$2,000/$6,000	$2,500/$7,500	$2,500/$5,000	$3,000/$9,000
Annual out-of-pocket maximum (IND/FAM)	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000	$7,350/$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 first 3 visits; then $25[1]	$5 for the first 3 visits; then $25[1]	$5 for the first 3 visits; then $30[1]	$5 for the first 3 visits; then $30[1]
Office visits – urgent care	$45	$45	$30	$50
Office visits – specialty care	$35	$35	$30	$40
Office visits – naturopathic care	$5 for the first 3 visits; then $25[1]	$5 for the first 3 visits; then $25[1]	$5 for the first 3 visits; then $30[1]	$5 for the first 3 visits; then $30[1]
Lab	$25	$25	30%*	$30
X-ray/diagnostic tests	$25	$25	30%*	$30
CT, MRI, and PET scans	$100	$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	$25	$25	$30	$30

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See plan comparisons

Reset

DEDUCTIBLE				
Plan Name	☐ DED PLAN H 3000/30%/30%/6000	☐ DED PLAN I 3500/30/20%/7350	☐ DED PLAN J 4000/30/20%/7500	☐ DED PLAN K 5000/30/20%/7350
Annual medical deductible (IND/FAM) (per calendar year)	$3,000/$6,000	$3,500/$10,500	$4,000/$10,000	$5,000/$10,000
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$7,350/$14,700	$7,500/$15,000	$7,350/$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 first 3 visits; then 30%[1]	$5 for the first 3 visits; then $30[1]	$5 for the first 3 visits; then $30[1]	$5 for the first 3 visits; then $30[1]
Office visits – urgent care	30%*	$50	$50	$50
Office visits – specialty care	30%*	$40	$40	$40
Office visits – naturopathic care	0% for the first 3 visits; then 30%[1]	$5 for the first 3 visits; then $30[1]	$5 for the first 3 visits; then $30[1]	$5 for the first 3 visits; then $30[1]
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	$200*	20%*	20%*	20%*
Routine eye exam	30%*	$30	$30	$30

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See plan comparisons

Reset

DEDUCTIBLE		
Plan Name	☐ **DED PLAN L 6000/35/20%/7500**	☐ **DED PLAN M 7500/35/30%/8500**
Annual medical deductible (IND/FAM) (per calendar year)	$6,000/$12,000	$7,500/$14,500
Annual out-of-pocket maximum (IND/FAM)	$7,500/$15,000	$8,500/$17,000
Office visits – preventive and well-child care	$0	$0
Office visits – prenatal care	$0	$0
Telehealth (phone/video)	$0[1]	$0[1]
Office visits – primary care	$5 for the first 3 visits; then $35[1]	$5 for the first 3 visits; then $35[1]
Office visits – urgent care	$55	$55
Office visits – specialty care	$45	$45
Office visits – naturopathic care	$5 for the first 3 visits; then $35[1]	$5 for the first 3 visits; then $35[1]
Lab	$35	$35
X-ray/diagnostic tests	$35	$35
CT, MRI, and PET scans	$150	$150
Outpatient surgery	20%*	30%*
Inpatient hospital care	20%*	30%*
Emergency care	20%*	30%*
Routine eye exam	$35	$35

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Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN A 1600/10%/2500	☐ HDHP PLAN A 1600/20%/3500	☐ HDHP PLAN B 2000/20%/4000	☐ HDHP PLAN B 2000/30%/4000
Accumulation type	Aggregate	Aggregate	Aggregate	Aggregate
Annual medical deductible (IND/FAM) (per calendar year)	$1,600/$3,200	$1,600/$3,200	$2,000/$4,000	$2,000/$4,000
Annual out-of-pocket maximum (IND/FAM)	$2,500/$5,000	$3,500/$7,000	$4,000/$8,000	$4,000/$8,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0*[1]	$0*[1]	$0*[1]	$0*[1]
Office visits – primary care	$5* for the first 3 visits; then 10%*[1]	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 30%*[1]
Office visits – urgent care	10%*	20%*	20%*	30%*
Office visits – specialty care	10%*	20%*	20%*	30%*
Office visits – naturopathic care	$5* for the first 3 visits; then 10%*[1]	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 30%*[1]
Lab	10%*	20%*	20%*	30%*
X-ray/diagnostic tests	10%*	20%*	20%*	30%*
CT, MRI, and PET scans	10%*	20%*	20%*	30%*
Outpatient surgery	10%*	20%*	20%*	30%*
Inpatient hospital care	10%*	20%*	20%*	30%*
Emergency care	10%*	20%*	20%*	30%*
Routine eye exam	10%*	20%*	20%*	30%*

*After deductible.

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See plan comparisons

Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN C 2500/20%/5000	☐ HDHP PLAN C 2500/30%/5000	☐ HDHP PLAN E 3200/10%/6000	☐ HDHP PLAN E 3200/20%/6000
Accumulation type	Aggregate	Aggregate	Embedded	Embedded
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$2,500/$5,000	$3,200/$6,400	$3,200/$6,000
Annual out-of-pocket maximum (IND/FAM)	$5,000/$7,500	$5,000/$7,500	$6,000/$9,000	$6,000/$12,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0*[1]	$0*[1]	$0*[1]	$0*[1]
Office visits – primary care	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 30%*[1]	$5* for the first 3 visits; then 10%*[1]	$5* for the first 3 visits; then 20%*[1]
Office visits – urgent care	20%*	30%*	10%*	20%*
Office visits – specialty care	20%*	30%*	10%*	20%*
Office visits – naturopathic care	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 30%*[1]	$5* for the first 3 visits; then 10%*[1]	$5* for the first 3 visits; then 20%*[1]
Lab	20%*	30%*	10%*	20%*
X-ray/diagnostic tests	20%*	30%*	10%*	20%*
CT, MRI, and PET scans	20%*	30%*	10%*	20%*
Outpatient surgery	20%*	30%*	10%*	20%*
Inpatient hospital care	20%*	30%*	10%*	20%*
Emergency care	20%*	30%*	10%*	20%*
Routine eye exam	20%*	30%*	10%*	20%*

*After deductible.

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Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN E 3200/30%/6000	☐ HDHP PLAN F 3500/20%/7000	☐ HDHP PLAN F 3500/30%/7000	☐ HDHP PLAN G 4000/20%/7000
Accumulation type	Embedded	Embedded	Embedded	Embedded
Annual medical deductible (IND/FAM) (per calendar year)	$3,200/$6,000	$3,500/$7,000	$3,500/$7,000	$4,000/$8,000
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0*[1]	$0*[1]	$0*[1]	$0*[1]
Office visits – primary care	$5* for the first 3 visits; then 30%*[1]	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 30%*[1]	$5* for the first 3 visits; then 20%*[1]
Office visits – urgent care	30%*	20%*	30%*	20%*
Office visits – specialty care	30%*	20%*	30%*	20%*
Office visits – naturopathic care	$5* for the first 3 visits; then 30%*[1]	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 30%*[1]	$5* for the first 3 visits; then 20%*[1]
Lab	30%*	20%*	30%*	20%*
X-ray/diagnostic tests	30%*	20%*	30%*	20%*
CT, MRI, and PET scans	30%*	20%*	30%*	20%*
Outpatient surgery	30%*	20%*	30%*	20%*
Inpatient hospital care	30%*	20%*	30%*	20%*
Emergency care	30%*	20%*	30%*	20%*
Routine eye exam	30%*	20%*	30%*	20%*

*After deductible.

[1]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.

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HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN G 4000/30%/7000	☐ HDHP PLAN H 5000/20%/7000	☐ HDHP PLAN H 5000/30%/7000
Accumulation type	Embedded	Embedded	Embedded
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$5,000/$10,000	$5,000/$10,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000
Office visits – preventive and well-child care	$0	$0	$0
Office visits – prenatal care	$0	$0	$0
Telehealth (phone/video)	$0*[1]	$0*[1]	$0*[1]
Office visits – primary care	$5* for the first 3 visits; then 30%*[1]	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 30%*[1]
Office visits – urgent care	30%*	20%*	30%*
Office visits – specialty care	30%*	20%*	30%*
Office visits – naturopathic care	$5* for the first 3 visits; then 30%*[1]	$5* for the first 3 visits; then 20%*[1]	$5* for the first 3 visits; then 30%*[1]
Lab	30%*	20%*	30%*
X-ray/diagnostic tests	30%*	20%*	30%*
CT, MRI, and PET scans	30%*	20%*	30%*
Outpatient surgery	30%*	20%*	30%*
Inpatient hospital care	30%*	20%*	30%*
Emergency care	30%*	20%*	30%*
Routine eye exam	30%*	20%*	30%*

*After deductible.

[1]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.

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Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	☐ HDHP PLAN H 5000/40%/7000	☐ HDHP PLAN H 5000/50%/7000
Accumulation type	Embedded	Embedded
Annual medical deductible (IND/FAM) (per calendar year)	$5,000/$10,000	$5,000/$10,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$7,000/$14,000
Office visits – preventive and well-child care	$0	$0
Office visits – prenatal care	$0	$0
Telehealth (phone/video)	$0*[1]	$0*[1]
Office visits – primary care	$5* for the first 3 visits; then 40%*[1]	$5* for the first 3 visits; then 50%*[1]
Office visits – urgent care	40%*	50%*
Office visits – specialty care	40%*	50%*
Office visits – naturopathic care	$5* for the first 3 visits; then 40%*[1]	$5* for the first 3 visits; then 50%*[1]
Lab	40%*	50%*
X-ray/diagnostic tests	40%*	50%*
CT, MRI, and PET scans	40%*	50%*
Outpatient surgery	40%*	50%*
Inpatient hospital care	40%*	50%*
Emergency care	40%*	50%*
Routine eye exam	40%*	50%*

*After deductible.

[1]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% after deductible 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.

KP PLUS PLANS

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

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

KP Plus Benefit Design Summary

Limited to 10 medical services and 5 pharmacy fills per year

Services	Out-of-Network coverage
Medical Visits PCP Office Visit Specialty Office Visit Outpatient Mental Health and Substance Use Disorder Services Physical Therapy, Occupational Therapy, Speech Therapy, and Labs/X-Rays	$20 higher copay (or 10% higher coinsurance) than in-network 10 visits per member per year
Pharmacy Fills Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty 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

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See plan comparisons

Reset

KP Plus

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

*After deductible.

[1]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 from all contracted providers combined.

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

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

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Reset

KP Plus

Plan name	☐ KP PLUS PLAN C 20/2000		☐ KP PLUS PLAN D 30/2500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	N/A	N/A	N/A	N/A
Annual out-of-pocket maximum (IND/FAM)	$2,000/$4,000	N/A	$2,500/$5,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then $20[1]	$40	$5 for the first 3 visits; then $30[1]	$50
Office visits – urgent care	$40	Not covered, except for services received outside the service area[2,3]	$50	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	$30	$50	$40	$60
Office visits – naturopathic care	$5 for the first 3 visits; then $20[1]	$40	$5 for the first 3 visits; then $30[1]	$50
Lab	$20	$40	$30	$50
X-ray/diagnostic tests	$20	$40	$30	$50
CT, MRI, and PET scans	$50	Not covered	$50	Not covered
Outpatient surgery	$50	Not covered	$100	Not covered
Inpatient hospital care	$200 per day, $1,000 per admission	Not covered	$200 per day, $1,000 per admission	Not covered
Emergency care	$200	Covered at the in-network cost share[1]	$200	Covered at the in-network cost share[1]
Routine eye exam	$20	$40	$30	$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

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See plan comparisons

Reset

KP Plus

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

*After deductible.

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See plan comparisons

Reset

KP Plus

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

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Reset

KP Plus

Plan name	☐ KP PLUS PLAN B 500/10%/10%/2000		☐ KP PLUS PLAN B 500/10/20%/2000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	N/A	$500/$1,500	N/A
Annual out-of-pocket maximum (IND/FAM)	$2,000/$6,000	N/A	$2,000/$6,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then 10%[1]	20%	$5 for the first 3 visits; then $10[1]	$30
Office visits – urgent care	10%*	Not covered, except for services received outside the service area[2,3]	$10	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	10%*	20%	$10	$30
Office visits – naturopathic care	$5 for the first 3 visits; then 10%[1]	20%	$5 for the first 3 visits; then $10[1]	$30
Lab	10%*	20%	20%*	30%
X-ray/diagnostic tests	10%*	20%	20%*	30%
CT, MRI, and PET scans	10%*	Not covered	20%*	Not covered
Outpatient surgery	10%*	Not covered	20%*	Not covered
Inpatient hospital care	10%*	Not covered	20%*	Not covered
Emergency care	$200*	Covered at the in-network cost share[1]	$200*	Covered at the in-network cost share[1]
Routine eye exam	10%*	20%	$10	$30
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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See plan comparisons

Reset

KP Plus

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

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN C 750/20%/20%/3000		☐ KP PLUS PLAN D 1000/20/20%/3000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$750/$2,250	N/A	$1,000/$3,000	N/A
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	N/A	$3,000/$9,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then 20%[1]	30%	$5 for the first 3 visits; then $20[1]	$40
Office visits – urgent care	20%*	Not covered, except for services received outside the service area[2,3]	$20	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	20%*	30%	$20	$40
Office visits – naturopathic care	$5 for the first 3 visits; then 20%[1]	30%	$5 for the first 3 visits; then $20[1]	$40
Lab	20%*	30%	20%*	30%
X-ray/diagnostic tests	20%*	30%	20%*	30%
CT, MRI, and PET scans	20%*	Not covered	20%*	Not covered
Outpatient surgery	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency care	$200*	Covered at the in-network cost share[1]	$200*	Covered at the in-network cost share[1]
Routine eye exam	20%*	30%	$20	$40
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN D 1000/25/20%/4000		☐ KP PLUS PLAN E 1500/25/20%/5500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$1,000/$3,000	N/A	$1,500/$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 – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then $25[1]	$45	$5 for the first 3 visits; then $25[1]	$45
Office visits – urgent care	$45	Not covered, except for services received outside the service area[2,3]	$45	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	$35	$55	$35	$55
Office visits – naturopathic care	$5 for the first 3 visits; then $25[1]	$45	$5 for the first 3 visits; then $25[1]	$45
Lab	$25	$45	$25	$45
X-ray/diagnostic tests	$25	$45	$25	$45
CT, MRI, and PET scans	$100	Not covered	$100	Not covered
Outpatient surgery	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	$25	$45	$25	$45
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN E 1500/20/30%/4000		☐ KP PLUS PLAN F 2000/25/20%/5000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$4,500	N/A	$2,000/$6,000	N/A
Annual out-of-pocket maximum (IND/FAM)	$4,000/$12,000	N/A	$5,000/$10,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then $20[1]	$40	$5 for the first 3 visits; then $25[1]	$45
Office visits – urgent care	$20	Not covered, except for services received outside the service area[2,3]	$45	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	$20	$40	$35	$55
Office visits – naturopathic care	$5 for the first 3 visits; then $20[1]	$40	$5 for the first 3 visits; then $25[1]	$45
Lab	30%*	40%	$25	$45
X-ray/diagnostic tests	30%*	40%	$25	$45
CT, MRI, and PET scans	30%*	Not covered	$100	Not covered
Outpatient surgery	30%*	Not covered	20%*	Not covered
Inpatient hospital care	30%*	Not covered	20%*	Not covered
Emergency care	$200*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	$20	$40	$25	$45
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

[1]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 from all contracted providers combined.

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

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

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN G 2500/25/20%/5000		☐ KP PLUS PLAN G 2500/30/30%/5000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$7,500	N/A	$2,500/$5,000	N/A
Annual out-of-pocket maximum (IND/FAM)	$5,000/$10,000	N/A	$5,000/$10,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then $25[1]	$45	$5 for the first 3 visits; then $30[1]	$50
Office visits – urgent care	$45	Not covered, except for services received outside the service area[2,3]	$30	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	$35	$55	$30	$50
Office visits – naturopathic care	$5 for the first 3 visits; then $25[1]	$45	$5 for the first 3 visits; then $30[1]	$50
Lab	$25	$45	30%*	40%
X-ray/diagnostic tests	$25	$45	30%*	40%
CT, MRI, and PET scans	$100	Not covered	30%*	Not covered
Outpatient surgery	20%*	Not covered	30%*	Not covered
Inpatient hospital care	20%*	Not covered	30%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	$200*	Covered at the in-network cost share[1]
Routine eye exam	$25	$45	$30	$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN H 3000/30/20%/7350		☐ KP PLUS PLAN H 3000/30%/30%/6000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$3,000/$9,000	N/A	$3,000/$6,000	N/A
Annual out-of-pocket maximum (IND/FAM)	$7,350/$14,700	N/A	$6,000/$12,000	N/A
Office visits – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then $30[1]	$50	$5 for the first 3 visits; then 30%[1]	40%
Office visits – urgent care	$50	Not covered, except for services received outside the service area[2,3]	30%*	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	$40	$60	30%*	40%
Office visits – naturopathic care	$5 for the first 3 visits; then $30[1]	$50	$5 for the first 3 visits; then 30%[1]	40%
Lab	$30	$50	30%*	40%
X-ray/diagnostic tests	$30	$50	30%*	40%
CT, MRI, and PET scans	$100	Not covered	30%*	Not covered
Outpatient surgery	20%*	Not covered	30%*	Not covered
Inpatient hospital care	20%*	Not covered	30%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	$200*	Covered at the in-network cost share[1]
Routine eye exam	$30	$50	30%*	40%
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN I 3500/30/20%/7350		☐ KP PLUS PLAN J 4000/30/20%/7500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$3,500/$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 – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then $30[1]	$50	$5 for the first 3 visits; then $30[1]	$50
Office visits – urgent care	$50	Not covered, except for services received outside the service area[2,3]	$50	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	$40	$60	$40	$60
Office visits – naturopathic care	$5 for the first 3 visits; then $30[1]	$50	$5 for the first 3 visits; then $30[1]	$50
Lab	$30	$50	$30	$50
X-ray/diagnostic tests	$30	$50	$30	$50
CT, MRI, and PET scans	$100	Not covered	$100	Not covered
Outpatient surgery	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	$30	$50	$30	$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

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See plan comparisons

Reset

KP Plus

Plan name	☐ KP PLUS PLAN K 5000/30/20%/7350		☐ KP PLUS PLAN L 6000/35/20%/7500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$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 – preventive and well-child care	$0	$0	$0	$0
Office visits – prenatal care	$0	$0	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then $30[1]	$50	$5 for the first 3 visits; then $35[1]	$55
Office visits – urgent care	$50	Not covered, except for services received outside the service area[2,3]	$55	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	$40	$60	$45	$65
Office visits – naturopathic care	$5 for the first 3 visits; then $30[1]	$50	$5 for the first 3 visits; then $35[1]	$55
Lab	$30	$50	$35	$55
X-ray/diagnostic tests	$30	$50	$35	$55
CT, MRI, and PET scans	$100	Not covered	$150	Not covered
Outpatient surgery	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency care	20%*	Covered at the in-network cost share[1]	20%*	Covered at the in-network cost share[1]
Routine eye exam	$30	$50	$35	$55
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

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See plan comparisons

Reset

KP Plus		
Plan name	☐ **KP PLUS PLAN M 7500/35/30%/8500**	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual medical deductible (IND/FAM) (per calendar year)	$7,500/$14,500	N/A
Annual out-of-pocket maximum (IND/FAM)	$8,500/$17,000	N/A
Office visits – preventive and well-child care	$0	$0
Office visits – prenatal care	$0	$0
Telehealth (phone/video)	$0[1]	Cost share applicable to the service when provided in person.
Office visits – primary care	$5 for the first 3 visits; then $35[1]	$55
Office visits – urgent care	$55	Not covered, except for services received outside the service area[2,3]
Office visits – specialty care	$45	$65
Office visits – naturopathic care	$5 for the first 3 visits; then $35[1]	$55
Lab	$35	$55
X-ray/diagnostic tests	$35	$55
CT, MRI, and PET scans	$150	Not covered
Outpatient surgery	30%*	Not covered
Inpatient hospital care	30%*	Not covered
Emergency care	30%*	Covered at the in-network cost share[1]
Routine eye exam	$35	$55
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO PLAN A 10/1500		DUAL CHOICE PPO PLAN B 20/2000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$0/$0	$1,500/$3,000	$0/$0	$2,000/$4,000
Annual out-of-pocket maximum (IND/FAM)	$1,500/$3,000	$4,500/$9,000	$2,000/$4,000	$6,000/$12,000
Office visits – preventive and well-child care	$0	30%*	$0	30%*
Office visits – prenatal care	$0	30%*	$0	30%*
Telehealth (phone/video)	$0[1]	30%*	$0[1]	30%*
Office visits – primary care	$5 for the first 3 visits; then $30 ($10 enhanced benefit)[1]	30%*	$5 for the first 3 visits; then $40 ($20 enhanced benefit)[1]	30%*
Office visits – urgent care	$60 ($30 enhanced benefit)	30%*	$80 ($40 enhanced benefit)	30%*
Office visits – specialty care	$40 ($20 enhanced benefit)	30%*	$50 ($30 enhanced benefit)	30%*
Office visits – naturopathic care	$5 for the first 3 visits; then $10[1]	30%*	$5 for the first 3 visits; then $20[1]	30%*
Lab	$10	30%*	$20	30%*
X-ray/diagnostic tests	$10	30%*	$20	30%*
CT, MRI, and PET scans	$50	30%*	$50	30%*
Outpatient surgery	$50	30%*	$50	30%*
Inpatient hospital care	$100 per day, $500 per admission	30%*	$100 per day, $500 per admission	30%*
Emergency care	$100		$100	
Routine eye exam	$30 ($10 enhanced benefit)	30%*	$40 ($20 enhanced benefit)	30%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

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

*After deductible.

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Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO PLAN E 35/3500		DUAL CHOICE PPO PLAN A 250/10/10%/2500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$0/$0	$2,000/$4,000	$250/$750	$2,000/$6,000
Annual out-of-pocket maximum (IND/FAM)	$3,500/$7,000	$6,000/$12,000	$2,500/$7,500	$6,000/$12,000
Office visits – preventive and well-child care	$0	30%*	$0	30%*
Office visits – prenatal care	$0	30%*	$0	30%*
Telehealth (phone/video)	$0[1]	30%*	$0[1]	30%*
Office visits – primary care	$5 for the first 3 visits; then $55 ($35 enhanced benefit)[1]	30%*	$5 for the first 3 visits; then $30 ($10 enhanced benefit)[1]	30%*
Office visits – urgent care	$110 ($60 enhanced benefit)	30%*	$30 ($10 enhanced benefit)	30%*
Office visits – specialty care	$65 ($45 enhanced benefit)	30%*	$30 ($10 enhanced benefit)	30%*
Office visits – naturopathic care	$5 for the first 3 visits; then $35[1]	30%*	$5 for the first 3 visits; then $10[1]	30%*
Lab	$35	30%*	10%*	30%*
X-ray/diagnostic tests	$35	30%*	10%*	30%*
CT, MRI, and PET scans	$50	30%*	10%*	30%*
Outpatient surgery	$150	30%*	10%*	30%*
Inpatient hospital care	$800 per admission	30%*	10%*	30%*
Emergency care	$200		$200*	
Routine eye exam	$55 ($35 enhanced benefit)	30%*	30 ($10 enhanced benefit)	30%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO PLAN A 250/15/20%/3000		DUAL CHOICE PPO PLAN B 500/20/10%/3500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$250/$750	$2,000/$6,000	$500/$1,500	$2,500/$7,500
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	$6,000/$12,000	$3,500/$10,500	$7,500/$15,000
Office visits – preventive and well-child care	$0	30%*	$0	30%*
Office visits – prenatal care	$0	30%*	$0	30%*
Telehealth (phone/video)	$0[1]	30%*	$0[1]	30%*
Office visits – primary care	$5 for the first 3 visits; then $35 ($15 enhanced benefit)[1]	30%*	$5 for the first 3 visits; then $40 ($20 enhanced benefit)[1]	30%*
Office visits – urgent care	$55 ($35 enhanced benefit)	30%*	$80 ($40 enhanced benefit)	30%*
Office visits – specialty care	$45 ($25 enhanced benefit)	30%*	$50 ($30 enhanced benefit)	30%*
Office visits – naturopathic care	$5 for the first 3 visits; then $15[1]	30%*	$5 for the first 3 visits; then $20[1]	30%*
Lab	$15	30%*	$20	30%*
X-ray/diagnostic tests	$15	30%*	$20	30%*
CT, MRI, and PET scans	$100	30%*	$100	30%*
Outpatient surgery	20%*	30%*	10%*	30%*
Inpatient hospital care	20%*	30%*	10%*	30%*
Emergency care	20%*		10%*	
Routine eye exam	$35 ($15 enhanced benefit)	30%*	$40 ($20 enhanced benefit)	30%*

*After deductible.

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Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO PLAN B 500/10%/10%/3000		DUAL CHOICE PPO PLAN B 500/10/20%/3000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	$2,500/$7,500	$500/$1,500	$2,500/$7,500
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	$7,500/$15,000	$3,000/$9,000	$7,500/$15,000
Office visits – preventive and well-child care	$0	30%*	$0	40%*
Office visits – prenatal care	$0	30%*	$0	40%*
Telehealth (phone/video)	$0[1]	30%*	$0[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then 20% (10% enhanced benefit)[1]	30%*	$5 for the first 3 visits; then $30 ($10 enhanced benefit)[1]	40%*
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	$30 ($10 enhanced benefit)	40%*
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	$30 ($10 enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then 10%[1]	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	10%*	30%*	20%*	40%*
Outpatient surgery	10%*	30%*	20%*	40%*
Inpatient hospital care	10%*	30%*	20%*	40%*
Emergency care	$200*		$200*	
Routine eye exam	20%* (10%* enhanced benefit)	30%*	$30 ($10 enhanced benefit)	40%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO PLAN B 500/20/20%/3500		DUAL CHOICE PPO PLAN C 750/20/20%/3500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$500/$1,500	$2,500/$7,500	$750/$2,250	$3,000/$9,000
Annual out-of-pocket maximum (IND/FAM)	$3,500/$10,500	$7,500/$15,000	$3,500/$10,500	$7,500/$22,500
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0[1]	40%*	$0[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then $40 ($20 enhanced benefit)[1]	40%*	$5 for the first 3 visits; then $40 ($20 enhanced benefit)[1]	40%*
Office visits – urgent care	$80 ($40 enhanced benefit)	40%*	$80 ($40 enhanced benefit)	40%*
Office visits – specialty care	$50 ($30 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then $20[1]	40%*	$5 for the first 3 visits; then $20[1]	40%*
Lab	$20	40%*	$20	40%*
X-ray/diagnostic tests	$20	40%*	$20	40%*
CT, MRI, and PET scans	$100	40%*	$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	$40 ($20 enhanced benefit)	40%*	$40 ($20 enhanced benefit)	40%*

*After deductible.

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Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN C 750/20%/20%/3500		☐ DUAL CHOICE PPO PLAN D 1000/20/20%/4000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$750/$2,250	$3,000/$9,000	$1,000/$3,000	$3,000/$9,000
Annual out-of-pocket maximum (IND/FAM)	$3,500/$10,500	$7,500/$22,500	$4,000/$12,000	$9,000/$27,000
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0[1]	40%*	$0[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then 30% (20% enhanced benefit)[1]	40%*	$5 for the first 3 visits; then $40 ($20 enhanced benefit)[1]	40%*
Office visits – urgent care	30%*(20%* enhanced benefit)	40%*	$40 ($20 enhanced benefit)	40%*
Office visits – specialty care	30%*(20%* enhanced benefit)	40%*	$40 ($20 enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then 20%[1]	40%*	$5 for the first 3 visits; then $20[1]	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%* enhanced benefit)	40%*	$40 ($20 enhanced benefit)	40%*

*After deductible.

[1]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 from all contracted providers combined.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN D 1000/25/20%/5000		☐ DUAL CHOICE PPO PLAN E 1500/25/20%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$1,000/$3,000	$3,000/$9,000	$1,500/$4,500	$3,500/$10,500
Annual out-of-pocket maximum (IND/FAM)	$5,000/$15,000	$9,000/$27,000	$6,000/$12,000	$10,500/$21,000
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0[1]	40%*	$0[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then $45 ($25 enhanced benefit)[1]	40%*	$5 for the first 3 visits; then $45 ($25 enhanced benefit)[1]	40%*
Office visits – urgent care	$90 ($45 enhanced benefit)	40%*	$90 ($45 enhanced benefit)	40%*
Office visits – specialty care	$55 ($35 enhanced benefit)	40%*	$55 ($35 enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then $25[1]	40%*	$5 for the first 3 visits; then $25[1]	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%*		20%*	
Routine eye exam	$45 ($25 enhanced benefit)	40%*	$45 ($25 enhanced benefit)	40%*

*After deductible.

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Reset

Dual Choice PPO

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

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO PLAN G 2500/25/20%/6000		DUAL CHOICE PPO PLAN G 2500/30/30%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$7,500	$4,500/$13,500	$2,500/$5,000	$4,500/$13,500
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$13,500/$27,000	$6,000/$12,000	$13,500/$27,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0[1]	40%*	$0[1]	50%*
Office visits – primary care	$5 for the first 3 visits; then $45 ($25 enhanced benefit)[1]	40%*	$5 for the first 3 visits; then $50 ($30 enhanced benefit)[1]	50%*
Office visits – urgent care	$90 ($45 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	50%*
Office visits – specialty care	$55 ($35 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	50%*
Office visits – naturopathic care	$5 for the first 3 visits; then $25[1]	40%*	$5 for the first 3 visits; then $30[1]	50%*
Lab	$25	40%*	30%*	50%*
X-ray/diagnostic tests	$25	40%*	30%*	50%*
CT, MRI, and PET scans	$100	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		$200*	
Routine eye exam	$45 ($25 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	50%*

*After deductible.

[1]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 from all contracted providers combined.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO PLAN H 3000/30/20%/8150		DUAL CHOICE PPO PLAN H 3000/30%/30%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$3,000/$9,000	$5,000/$15,000	$3,000/$6,000	$5,000/$15,000
Annual out-of-pocket maximum (IND/FAM)	$8,150/$16,300	$15,000/$30,000	$7,000/$14,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0[1]	40%*	$0[1]	50%*
Office visits – primary care	$5 for the first 3 visits; then $50 ($30 enhanced benefit)[1]	40%*	$5 for the first 3 visits; then 40% (30% enhanced benefit)[1]	50%*
Office visits – urgent care	$100 ($50 enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	$60 ($40 enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – naturopathic care	$5 for the first 3 visits; then $30[1]	40%*	$5 for the first 3 visits; then 30%[1]	50%*
Lab	$30	40%*	30%*	50%*
X-ray/diagnostic tests	$30	40%*	30%*	50%*
CT, MRI, and PET scans	$100	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		$200*	
Routine eye exam	$50 ($30 enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

*After deductible.

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Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO PLAN I 3500/30/20%/8000		DUAL CHOICE PPO PLAN J 4000/30/20%/8150	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$3,500/$10,500	$5,500/$16,500	$4,000/$10,000	$6,000/$18,000
Annual out-of-pocket maximum (IND/FAM)	$8,000/$16,000	$15,000/$30,000	$8,150/$16,300	$15,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0[1]	40%*	$0[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then $50 ($30 enhanced benefit)[1]	40%*	$5 for the first 3 visits; then $50 ($30 enhanced benefit)[1]	40%*
Office visits – urgent care	$100 ($50 enhanced benefit)	40%*	$100 ($50 enhanced benefit)	40%*
Office visits – specialty care	$60 ($40 enhanced benefit)	40%*	$60 ($40 enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then $30[1]	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 scans	$100	40%*	$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	$50 ($30 enhanced benefit)	40%*	$50 ($30 enhanced benefit)	40%*

*After deductible.

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Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO PLAN K 5000/30/20%/8150		DUAL CHOICE PPO PLAN L 6000/35/20%/8000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$5,000/$10,000	$6,500/$19,500	$6,000/$12,000	$7,500/$18,000
Annual out-of-pocket maximum (IND/FAM)	$8,150/$16,300	$15,000/$30,000	$8,000/$16,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0[1]	40%*	$0[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then $50 ($30 enhanced benefit)[1]	40%*	$5 for the first 3 visits; then $55 ($35 enhanced benefit)[1]	40%*
Office visits – urgent care	$100 ($50 enhanced benefit)	40%*	$100 ($55 enhanced benefit)	40%*
Office visits – specialty care	$60 ($40 enhanced benefit)	40%*	$65 ($45 enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then $30[1]	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 scans	$100	40%*	$150	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	$50 ($30 enhanced benefit)	40%*	$55 ($35 enhanced benefit)	40%*

*After deductible.

[1]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 from all contracted providers combined.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO PLAN M 7500/35/30%/8500	
Network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	$7,500/$14,500	$8,500/$19,500
Annual out-of-pocket maximum (IND/FAM)	$8,500/$17,000	$17,000/$30,000
Office visits – preventive and well-child care	$0	50%*
Office visits – prenatal care	$0	50%*
Telehealth (phone/video)	$0[1]	50%*
Office visits – primary care	$5 for the first 3 visits; then $55 ($35 enhanced benefit)[1]	50%*
Office visits – urgent care	$100 ($55 enhanced benefit)	50%*
Office visits – specialty care	$65 ($45 enhanced benefit)	50%*
Office visits – naturopathic care	$5 for the first 3 visits; then $35[1]	50%*
Lab	$35	50%*
X-ray/diagnostic tests	$35	50%*
CT, MRI, and PET scans	$150	50%*
Outpatient surgery	30%*	50%*
Inpatient hospital care	30%*	50%*
Emergency care	30%*	
Routine eye exam	$55 ($35 enhanced benefit)	50%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN A 1600/10%/2500		☐ DUAL CHOICE PPO HDHP PLAN A 1600/20%/3500	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Aggregate		Aggregate	
Annual medical deductible (IND/FAM) (per calendar year)	$1,600/$3,200	$3,500/$9,750	$1,600/$3,200	$3,500/$9,750
Annual out-of-pocket maximum (IND/FAM)	$2,500/$5,000	$10,500/$21,000	$3,500/$7,000	$11,500/$23,000
Office visits – preventive and well-child care	$0	30%*	$0	40%*
Office visits – prenatal care	$0	30%*	$0	40%*
Telehealth (phone/video)	$0*[1]	30%*	$0*[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then 20%* (10%* enhanced benefit)[1]	30%*	$5 for the first 3 visits; then 30%* (20%* enhanced benefit)[1]	40%*
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then 10%*[1]	30%*	$5 for the first 3 visits; then 20%*[1]	40%*
Lab	10%*	30%*	20%*	40%*
X-ray/diagnostic tests	10%*	30%*	20%*	40%*
CT, MRI, and PET scans	10%*	30%*	20%*	40%*
Outpatient surgery	10%*	30%*	20%*	40%*
Inpatient hospital care	10%*	30%*	20%*	40%*
Emergency care	10%*		20%*	
Routine eye exam	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN B 2000/20%/4000		☐ DUAL CHOICE PPO HDHP PLAN B 2000/30%/4000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Aggregate		Aggregate	
Annual medical deductible (IND/FAM) (per calendar year)	$2,000/$4,000	$4,000/$12,000	$2,000/$4,000	$4,000/$12,000
Annual out-of-pocket maximum (IND/FAM)	$4,000/$8,000	$12,000/$24,000	$4,000/$8,000	$12,000/$24,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0*[1]	40%*	$0*[1]	50%*
Office visits – primary care	$5 for the first 3 visits; then 30%* (20%* enhanced benefit)[1]	40%*	$5 for the first 3 visits; then 40%* (30%* enhanced benefit)[1]	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – naturopathic care	$5 for the first 3 visits; then 20%*[1]	40%*	$5 for the first 3 visits; then 30%*[1]	50%*
Lab	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

*After deductible.

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Dual Choice PPO

Plan name	DUAL CHOICE PPO HDHP PLAN C 2500/20%/5000		DUAL CHOICE PPO HDHP PLAN C 2500/30%/5000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Aggregate		Aggregate	
Annual medical deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$5,000/$15,000	$2,500/$5,000	$5,000/$15,000
Annual out-of-pocket maximum (IND/FAM)	$5,000/$7,500	$15,000/$30,000	$5,000/$7,500	$15,000/$30,000
Office visits – preventive and well-child care	$0	40%*	$0	50%*
Office visits – prenatal care	$0	40%*	$0	50%*
Telehealth (phone/video)	$0*[1]	40%*	$0*[1]	50%*
Office visits – primary care	$5 for the first 3 visits; then 30%* (20%* enhanced benefit)[1]	40%*	$5 for the first 3 visits; then 40%* (30%* enhanced benefit)[1]	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – naturopathic care	$5 for the first 3 visits; then 20%*[1]	40%*	$5 for the first 3 visits; then 30%*[1]	50%*
Lab	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

*After deductible.

[1]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 from all contracted providers combined.

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Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN E 3200/10%/6000		☐ DUAL CHOICE PPO HDHP PLAN E 3200/20%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$3,200/$6,400	$5,000/$15,000	$3,200/$6,000	$5,000/$15,000
Annual out-of-pocket maximum (IND/FAM)	$6,000/$9,000	$15,000/$30,000	$6,000/$12,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	30%*	$0	40%*
Office visits – prenatal care	$0	30%*	$0	40%*
Telehealth (phone/video)	$0*[1]	30%*	$0*[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then 20%* (10%* enhanced benefit)[1]	30%*	$5 for the first 3 visits; then 30%* (20%* enhanced benefit)[1]	40%*
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then 10%*[1]	30%*	$5 for the first 3 visits; then 20%*[1]	40%*
Lab	10%*	30%*	20%*	40%*
X-ray/diagnostic tests	10%*	30%*	20%*	40%*
CT, MRI, and PET scans	10%*	30%*	20%*	40%*
Outpatient surgery	10%*	30%*	20%*	40%*
Inpatient hospital care	10%*	30%*	20%*	40%*
Emergency care	10%*		20%*	
Routine eye exam	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*

*After deductible.

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Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN E 3200/30%/6000		☐ DUAL CHOICE PPO HDHP PLAN F 3500/20%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$3,200/$6,000	$5,000/$15,000	$3,500/$7,000	$5,500/$16,500
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$15,000/$30,000	$7,000/$14,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	50%*	$0	40%*
Office visits – prenatal care	$0	50%*	$0	40%*
Telehealth (phone/video)	$0*[1]	50%*	$0*[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then 40%* (30%* enhanced benefit)[1]	50%*	$5 for the first 3 visits; then 30%* (20%* enhanced benefit)[1]	40%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then 30%*[1]	50%*	$5 for the first 3 visits; then 20%*[1]	40%*
Lab	30%*	50%*	20%*	40%*
X-ray/diagnostic tests	30%*	50%*	20%*	40%*
CT, MRI, and PET scans	30%*	50%*	20%*	40%*
Outpatient surgery	30%*	50%*	20%*	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency care	30%*		20%*	
Routine eye exam	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*

*After deductible.

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Reset

Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN F 3500/30%/7000		☐ DUAL CHOICE PPO HDHP PLAN G 4000/20%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$3,500/$7,000	$5,500/$16,500	$4,000/$8,000	$6,000/$12,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$15,000/$30,000	$7,000/$14,000	$15,000/$30,000
Office visits – preventive and well-child care	$0	50%*	$0	40%*
Office visits – prenatal care	$0	50%*	$0	40%*
Telehealth (phone/video)	$0*[1]	50%*	$0*[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then 40%* (30%* enhanced benefit)[1]	50%*	$5 for the first 3 visits; then 30%* (20%* enhanced benefit)[1]	40%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then 30%*[1]	50%*	$5 for the first 3 visits; then 20%*[1]	40%*
Lab	30%*	50%*	20%*	40%*
X-ray/diagnostic tests	30%*	50%*	20%*	40%*
CT, MRI, and PET scans	30%*	50%*	20%*	40%*
Outpatient surgery	30%*	50%*	20%*	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency care	30%*		20%*	
Routine eye exam	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*

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Reset

Dual Choice PPO

Plan name	DUAL CHOICE PPO HDHP PLAN G 4000/30%/7000		DUAL CHOICE PPO HDHP PLAN H 5000/20%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$6,000/$12,000	$5,000/$10,000	$7,000/$14,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$15,000/$30,000	$7,000/$14,000	$17,000/$34,000
Office visits – preventive and well-child care	$0	50%*	$0	40%*
Office visits – prenatal care	$0	50%*	$0	40%*
Telehealth (phone/video)	$0*[1]	50%*	$0*[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then 40%* (30%* enhanced benefit)[1]	50%*	$5 for the first 3 visits; then 30%* (20%* enhanced benefit)[1]	40%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then 30%*[1]	50%*	$5 for the first 3 visits; then 20%*[1]	40%*
Lab	30%*	50%*	20%*	40%*
X-ray/diagnostic tests	30%*	50%*	20%*	40%*
CT, MRI, and PET scans	30%*	50%*	20%*	40%*
Outpatient surgery	30%*	50%*	20%*	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency care	30%*		20%*	
Routine eye exam	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*

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Dual Choice PPO

Plan name	☐ DUAL CHOICE PPO HDHP PLAN H 5000/30%/7000		☐ DUAL CHOICE PPO HDHP PLAN H 5000/40%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embedded		Embedded	
Annual medical deductible (IND/FAM) (per calendar year)	$5,000/$10,000	$7,000/$14,000	$5,000/$10,000	$7,000/$14,000
Annual out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$17,000/$34,000	$7,000/$14,000	$17,000/$34,000
Office visits – preventive and well-child care	$0	50%*	$0	50%*
Office visits – prenatal care	$0	50%*	$0	50%*
Telehealth (phone/video)	$0*[1]	50%*	$0*[1]	50%*
Office visits – primary care	$5 for the first 3 visits; then 40%* (30%* enhanced benefit)[1]	50%*	$5 for the first 3 visits; then 50%* (40%* enhanced benefit)[1]	50%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*
Office visits – naturopathic care	$5 for the first 3 visits; then 30%*[1]	50%*	$5 for the first 3 visits; then 40%*[1]	50%*
Lab	30%*	50%*	40%*	50%*
X-ray/diagnostic tests	30%*	50%*	40%*	50%*
CT, MRI, and PET scans	30%*	50%*	40%*	50%*
Outpatient surgery	30%*	50%*	40%*	50%*
Inpatient hospital care	30%*	50%*	40%*	50%*
Emergency care	30%*		40%*	
Routine eye exam	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*

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Reset

OUT-OF-AREA PPO PLUS

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

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OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS PLAN WDT 1000/20%/3000		☐ PPO PLUS PLAN WDE 1000/30%/4750	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Annual medical deductible (IND/FAM) (per calendar year)	$1,000/$3,000	$1,500/$4,500	$1,000/$3,000	$1,500/$4,500
Annual out-of-pocket maximum (IND/FAM)	$3,000/$9,000	$6,000/$12,000	$4,750/$9,500	$6,000/$12,000
Office visits – preventive and well-child care	$0	45%*	$0	45%*
Office visits – prenatal care	$0	45%*	$0	45%*
Telehealth (phone/video)	$0[1]	45%*	$0[1]	45%*
Office visits – primary care	$5 for the first 3 visits; then $20[1]	45%*	$5 for the first 3 visits; then $30[1]	45%*
Office visits – urgent care	$20	45%*	$50	45%*
Office visits – specialty care	$20	45%*	$40	45%*
Office visits – naturopathic care	$5 for the first 3 visits; then $20[1]	45%*	$5 for the first 3 visits; then $30[1]	45%*
Lab	20%*	45%*	$30	45%*
X-ray/diagnostic tests	20%*	45%*	$30	45%*
CT, MRI, and PET scans	20%*	45%*	30%*	45%*
Outpatient surgery	20%*	45%*	30%*	45%*
Inpatient hospital care	20%*	45%*	30%*	45%*
Emergency care	$200*		$200*	
Routine eye exam	$20	45%*	$30	45%*

*After deductible.

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OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS PLAN WDU 1500/20%/5500		☐ PPO PLUS PLAN WDP 1500/30%/6000	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Annual medical deductible (IND/FAM) (per calendar year)	$1,500/$4,500	$2,250/$6,750	$1,500/$4,500	$2,250/$6,750
Annual out-of-pocket maximum (IND/FAM)	$5,500/$11,000	$7,500/$15,000	$6,000/$12,000	$7,500/$15,000
Office visits – preventive and well-child care	$0	45%*	$0	45%*
Office visits – prenatal care	$0	45%*	$0	45%*
Telehealth (phone/video)	$0[1]	45%*	$0[1]	45%*
Office visits – primary care	$5 for the first 3 visits; then $25[1]	45%*	$5 for the first 3 visits; then $30[1]	45%*
Office visits – urgent care	$45	45%*	$50	45%*
Office visits – specialty care	$35	45%*	$40	45%*
Office visits – naturopathic care	$5 for the first 3 visits; then $25[1]	45%*	$5 for the first 3 visits; then $30[1]	45%*
Lab	$25	45%*	$30	45%*
X-ray/diagnostic tests	$25	45%*	$30	45%*
CT, MRI, and PET scans	$100	45%*	30%*	45%*
Outpatient surgery	20%*	45%*	30%*	45%*
Inpatient hospital care	20%*	45%*	30%*	45%*
Emergency care	20%		$200*	
Routine eye exam	$25	45%*	$30	45%*

*After deductible.

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OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS PLAN WDN 2000/30%/6000		☐ PPO PLUS PLAN WDX 3000/30%/6850	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Annual medical deductible (IND/FAM) (per calendar year)	$2,000/$6,000	$3,000/$9,000	$3,000/$9,000	$4,500/$13,500
Annual out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$7,500/$15,000	$6,850/$13,700	$8,400/$16,800
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0[1]	40%*	$0[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then $35[1]	40%*	$5 for the first 3 visits; then $35[1]	40%*
Office visits – urgent care	$55	40%*	$55	40%*
Office visits – specialty care	$45	40%*	$45	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then $35[1]	40%*	$5 for the first 3 visits; then $35[1]	40%*
Lab	$35	40%*	$35	40%*
X-ray/diagnostic tests	$35	40%*	$35	40%*
CT, MRI, and PET scans	30%*	40%*	30%*	40%*
Outpatient surgery	30%*	40%*	30%*	40%*
Inpatient hospital care	30%*	40%*	30%*	40%*
Emergency care	$200*		$200*	
Routine eye exam	$35	40%*	$35	40%*

*After deductible.

[1]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 from all contracted providers combined.

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.

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

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

See plan comparisons

Reset

OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS PLAN WDR 4000/30%/7350		☐ PPO PLUS PLAN WDS 5000/30%/7350	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Annual medical deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$6,000/$12,000	$5,000/$10,000	$6,500/$13,000
Annual out-of-pocket maximum (IND/FAM)	$7,350/$14,700	$9,000/$18,000	$7,350/$14,700	$9,000/$18,000
Office visits – preventive and well-child care	$0	40%*	$0	40%*
Office visits – prenatal care	$0	40%*	$0	40%*
Telehealth (phone/video)	$0[1]	40%*	$0[1]	40%*
Office visits – primary care	$5 for the first 3 visits; then $35[1]	40%*	$5 for the first 3 visits; then $35[1]	40%*
Office visits – urgent care	$55	40%*	$55	40%*
Office visits – specialty care	$45	40%*	$45	40%*
Office visits – naturopathic care	$5 for the first 3 visits; then $35[1]	40%*	$5 for the first 3 visits; then $35[1]	40%*
Lab	$35	40%*	$35	40%*
X-ray/diagnostic tests	$35	40%*	$35	40%*
CT, MRI, and PET scans	30%*	40%*	30%*	40%*
Outpatient surgery	30%*	40%*	30%*	40%*
Inpatient hospital care	30%*	40%*	30%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	$35	40%*	$35	40%*

*After deductible.

[1]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 from all contracted providers combined.

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.

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

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See plan comparisons

Reset

OUT-OF-AREA PPO PLUS

Plan name	☐ PPO PLUS HDHP AA PLAN WFI 1600/20%/3500		☐ PPO PLUS HDHP AA PLAN WAS 2800/20%/4000	
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Accumulation type	Aggregate		Aggregate	
Annual medical deductible (IND/FAM) (per calendar year)	$1,600/$3,200	$3,500/$7,000	$2,800/$5,600	$3,500/$7,000
Annual out-of-pocket maximum (IND/FAM)	$3,500/$7,000	$6,000/$12,000	$4,000/$8,000	$7,000/$14,000
Office visits – preventive and well-child care	$0	30%*	$0	30%*
Office visits – prenatal care	$0	30%*	$0	30%*
Telehealth (phone/video)	$0*[1]	30%*	$0*[1]	30%*
Office visits – primary care	$5 for the first 3 visits; then 20%*[1]	30%*	$5 for the first 3 visits; then 20%*[1]	30%*
Office visits – urgent care	20%*	30%*	20%*	30%*
Office visits – specialty care	20%*	30%*	20%*	30%*
Office visits – naturopathic care	$5 for the first 3 visits; then 20%*[1]	30%*	$5 for the first 3 visits; then 20%*[1]	30%*
Lab	20%*	30%*	20%*	30%*
X-ray/diagnostic tests	20%*	30%*	20%*	30%*
CT, MRI, and PET scans	20%*	30%*	20%*	30%*
Outpatient surgery	20%*	30%*	20%*	30%*
Inpatient hospital care	20%*	30%*	20%*	30%*
Emergency care	20%*		10%*	
Routine eye exam	20%*	30%*	20%*	30%*

*After deductible.

[1]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 from all contracted providers combined.

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.

Compare plans - traditional, deductible, HDHP

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

*After deductible.

[1]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.

Start over

KAISER PERMANENTE®

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

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

*After deductible.

[1]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 from all contracted providers combined.

[2]The limit of 10 covered services does not apply.

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

Start over

SUPPLEMENTAL BENEFIT OPTIONS

OUTPATIENT PRESCRIPTION DRUGS

Traditional, deductible, and HSA-qualified, HDHP plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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

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

Kaiser Permanente Plus™ Plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

Note: Mail order only available through Kaiser Permanente Pharmacies.

Dual Choice PPO and HSA-qualified, Dual Choice PPO plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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

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

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

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

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

DEDUCTIBLE COST SHARE OPTIONS

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

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

HEARING AIDS

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

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

Note: 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 Plus[1]), and HSA-qualified, HDHP plans

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

[1]Rider benefits only available in-network

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

[3]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.

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

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

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

*Subject to deductible on HSA-qualified, plans.

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]

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

[2]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.

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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.

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

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.

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