



2024 PLANS AND PRODUCTS | WASHINGTON



Complete Suite™ plan comparison chart

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



Table of contents

2024 Complete Suite™ Plans..... 3

Complete Suite™ portfolio overview 6

Accumulation types..... 7

Complete Suite™ Pairing Guide 8

Traditional plans 16

Deductible plans 17

Virtual Complete™ 23

HSA-qualified, high deductible plans (HDHP) 24

Kaiser Permanente Plus™ plans 29

Dual Choice PPO® 44

Dual Choice PPO® HSA-qualified, HDHP plans 62

Out-of-Area PPO Plus® plans..... 70

Supplemental benefit options: Outpatient prescription drugs 78

Supplemental benefit options: Alternative care 83

Supplemental benefit options: Vision hardware..... 84

Senior Advantage plans 86

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 Copay	Deductible	Virtual Complete
<input type="checkbox"/> TRAD PLAN A 10/1000	<input type="checkbox"/> DED PLAN A 250/10/10%/2000	<input type="checkbox"/> DED PLAN VC 2500/40/20%/5500
<input type="checkbox"/> TRAD PLAN B 20/1500	<input type="checkbox"/> DED PLAN A 250/15/20%/2500	<input type="checkbox"/> DED PLAN VC 3000/40/30%/6000
<input type="checkbox"/> TRAD PLAN C 20/2000	<input type="checkbox"/> DED PLAN B 500/20/10%/3000	<input type="checkbox"/> DED PLAN VC 4000/50/30%/7000
<input type="checkbox"/> TRAD PLAN D 30/2500	<input type="checkbox"/> DED PLAN B 500/10%/10%/2000	<input type="checkbox"/> DED PLAN VC 5000/50/40%/8000
<input type="checkbox"/> TRAD PLAN E 35/3000	<input type="checkbox"/> DED PLAN B 500/10/20%/2000	
	<input type="checkbox"/> DED PLAN B 500/20/20%/3000	
	<input type="checkbox"/> DED PLAN C 750/20/20%/3250	
	<input type="checkbox"/> DED PLAN C 750/20%/20%/3000	
	<input type="checkbox"/> DED PLAN D 1000/20/20%/3000	
	<input type="checkbox"/> DED PLAN D 1000/25/20%/4000	
	<input type="checkbox"/> DED PLAN E 1500/25/20%/5500	
	<input type="checkbox"/> DED PLAN E 1500/20/30%/4000	
	<input type="checkbox"/> DED PLAN F 2000/25/20%/5000	
	<input type="checkbox"/> DED PLAN G 2500/25/20%/5000	
	<input type="checkbox"/> DED PLAN G 2500/30/30%/5000	
	<input type="checkbox"/> DED PLAN H 3000/30/20%/7350	
	<input type="checkbox"/> DED PLAN H 3000/30%/30%/6000	
	<input type="checkbox"/> DED PLAN I 3500/30/20%/7350	
	<input type="checkbox"/> DED PLAN J 4000/30/20%/7500	
	<input type="checkbox"/> DED PLAN K 5000/30/20%/7350	
	<input type="checkbox"/> DED PLAN L 6000/35/20%/7500	
	<input type="checkbox"/> 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

High deductible health plan (HDHP)	KP Plus	Dual Choice PPO
<input type="checkbox"/> HDHP PLAN A 1600/10%/2500	<input type="checkbox"/> KP PLUS PLAN A 10/1000	<input type="checkbox"/> DUAL CHOICE PPO PLAN A 10/1500
<input type="checkbox"/> HDHP PLAN A 1600/20%/3500	<input type="checkbox"/> KP PLUS PLAN B 20/1500	<input type="checkbox"/> DUAL CHOICE PPO PLAN B 20/2000
<input type="checkbox"/> HDHP PLAN B 2000/20%/4000	<input type="checkbox"/> KP PLUS PLAN C 20/2000	<input type="checkbox"/> DUAL CHOICE PPO PLAN C 20/2500
<input type="checkbox"/> HDHP PLAN B 2000/30%/4000	<input type="checkbox"/> KP PLUS PLAN D 30/2500	<input type="checkbox"/> DUAL CHOICE PPO PLAN D 30/3000
<input type="checkbox"/> HDHP PLAN C 2500/20%/5000	<input type="checkbox"/> KP PLUS PLAN E 35/3000	<input type="checkbox"/> DUAL CHOICE PPO PLAN E 35/3500
<input type="checkbox"/> HDHP PLAN C 2500/30%/5000	<input type="checkbox"/> KP PLUS PLAN A 250/10/10%/2000	<input type="checkbox"/> DUAL CHOICE PPO PLAN A 250/10/10%/2500
<input type="checkbox"/> HDHP PLAN E 3200/10%/6000	<input type="checkbox"/> KP PLUS PLAN A 250/15/20%/2500	<input type="checkbox"/> DUAL CHOICE PPO PLAN A 250/15/20%/3000
<input type="checkbox"/> HDHP PLAN E 3200/20%/6000	<input type="checkbox"/> KP PLUS PLAN B 500/20/10%/3000	<input type="checkbox"/> DUAL CHOICE PPO PLAN B 500/20/10%/3500
<input type="checkbox"/> HDHP PLAN E 3200/30%/6000	<input type="checkbox"/> KP PLUS PLAN B 500/10%/10%/2000	<input type="checkbox"/> DUAL CHOICE PPO PLAN B 500/10%/10%/3000
<input type="checkbox"/> HDHP PLAN F 3500/20%/7000	<input type="checkbox"/> KP PLUS PLAN B 500/10/20%/2000	<input type="checkbox"/> DUAL CHOICE PPO PLAN B 500/10/20%/3000
<input type="checkbox"/> HDHP PLAN F 3500/30%/7000	<input type="checkbox"/> KP PLUS PLAN B 500/20/20%/3000	<input type="checkbox"/> DUAL CHOICE PPO PLAN B 500/20/20%/3500
<input type="checkbox"/> HDHP PLAN G 4000/20%/7000	<input type="checkbox"/> KP PLUS PLAN C 750/20/20%/3250	<input type="checkbox"/> DUAL CHOICE PPO PLAN C 750/20/20%/3500
<input type="checkbox"/> HDHP PLAN G 4000/30%/7000	<input type="checkbox"/> KP PLUS PLAN C 750/20%/20%/3000	<input type="checkbox"/> DUAL CHOICE PPO PLAN C 750/20%/20%/3500
<input type="checkbox"/> HDHP PLAN H 5000/20%/7000	<input type="checkbox"/> KP PLUS PLAN D 1000/20/20%/3000	<input type="checkbox"/> DUAL CHOICE PPO PLAN D 1000/20/20%/4000
<input type="checkbox"/> HDHP PLAN H 5000/30%/7000	<input type="checkbox"/> KP PLUS PLAN D 1000/25/20%/4000	<input type="checkbox"/> DUAL CHOICE PPO PLAN D 1000/25/20%/5000
<input type="checkbox"/> HDHP PLAN H 5000/40%/7000	<input type="checkbox"/> KP PLUS PLAN E 1500/25/20%/5500	<input type="checkbox"/> DUAL CHOICE PPO PLAN E 1500/25/20%/6000
<input type="checkbox"/> HDHP PLAN H 5000/50%/7000	<input type="checkbox"/> KP PLUS PLAN E 1500/20/30%/4000	<input type="checkbox"/> DUAL CHOICE PPO PLAN E 1500/20/30%/5000
	<input type="checkbox"/> KP PLUS PLAN F 2000/25/20%/5000	<input type="checkbox"/> DUAL CHOICE PPO PLAN F 2000/25/20%/6000
	<input type="checkbox"/> KP PLUS PLAN G 2500/25/20%/5000	<input type="checkbox"/> DUAL CHOICE PPO PLAN G 2500/25/20%/6000
	<input type="checkbox"/> KP PLUS PLAN G 2500/30/30%/5000	<input type="checkbox"/> DUAL CHOICE PPO PLAN G 2500/30/30%/6000
	<input type="checkbox"/> KP PLUS PLAN H 3000/30/20%/7350	<input type="checkbox"/> DUAL CHOICE PPO PLAN H 3000/30/20%/8150
	<input type="checkbox"/> KP PLUS PLAN H 3000/30%/30%/6000	<input type="checkbox"/> DUAL CHOICE PPO PLAN H 3000/30%/30%/7000
	<input type="checkbox"/> KP PLUS PLAN I 3500/30/20%/7350	<input type="checkbox"/> DUAL CHOICE PPO PLAN I 3500/30/20%/8000
	<input type="checkbox"/> KP PLUS PLAN J 4000/30/20%/7500	<input type="checkbox"/> DUAL CHOICE PPO PLAN J 4000/30/20%/8150
	<input type="checkbox"/> KP PLUS PLAN K 5000/30/20%/7350	<input type="checkbox"/> DUAL CHOICE PPO PLAN K 5000/30/20%/8150
	<input type="checkbox"/> KP PLUS PLAN L 6000/35/20%/7500	<input type="checkbox"/> DUAL CHOICE PPO PLAN L 6000/35/20%/8000
	<input type="checkbox"/> KP PLUS PLAN M 7500/35/30%/8500	<input type="checkbox"/> 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

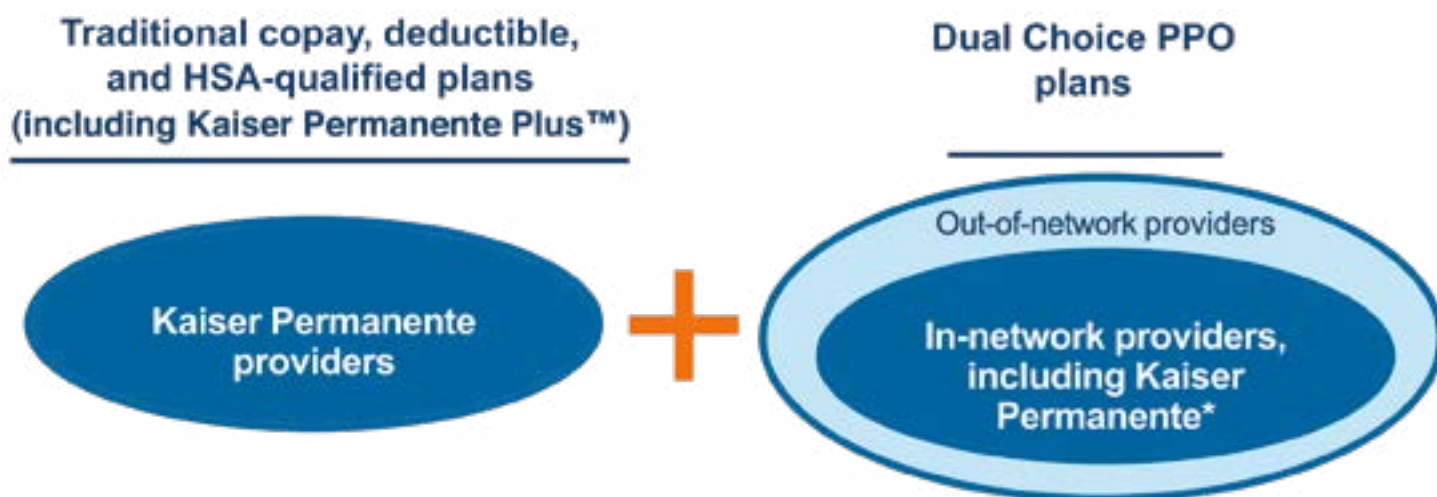
Dual Choice PPO	Out of Area PPO Plus
<input type="checkbox"/> DUAL CHOICE PPO PLAN VC 2500/40/20%/6500	<input type="checkbox"/> PPO PLUS PLAN WDB 500/20%/2500
<input type="checkbox"/> DUAL CHOICE PPO PLAN VC 3000/40/30%/7000	<input type="checkbox"/> PPO PLUS PLAN WDC 750/20%/3750
<input type="checkbox"/> DUAL CHOICE PPO PLAN VC 4000/50/30%/8150	<input type="checkbox"/> PPO PLUS PLAN WDT 1000/20%/3000
<input type="checkbox"/> DUAL CHOICE PPO PLAN VC 5000/50/40%/8150	<input type="checkbox"/> PPO PLUS PLAN WDE 1000/30%/4750
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN A 1600/10%/2500	<input type="checkbox"/> PPO PLUS PLAN WDU 1500/20%/5500
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN A 1600/20%/3500	<input type="checkbox"/> PPO PLUS PLAN WDP 1500/30%/6000
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN B 2000/20%/4000	<input type="checkbox"/> PPO PLUS PLAN WDN 2000/30%/6000
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN B 2000/30%/4000	<input type="checkbox"/> PPO PLUS PLAN WDX 3000/30%/6850
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN C 2500/20%/5000	<input type="checkbox"/> PPO PLUS PLAN WDR 4000/30%/7350
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN C 2500/30%/5000	<input type="checkbox"/> PPO PLUS PLAN WDS 5000/30%/7350
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN E 3200/10%/6000	<input type="checkbox"/> PPO PLUS HDHP AA PLAN WFI 1600/20%/3500
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN E 3200/20%/6000	<input type="checkbox"/> PPO PLUS HDHP AA PLAN WAS 2800/20%/4000
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN E 3200/30%/6000	
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN F 3500/20%/7000	
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN F 3500/30%/7000	
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN G 4000/20%/7000	
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN G 4000/30%/7000	
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN H 5000/20%/7000	
<input type="checkbox"/> DUAL CHOICE PPO HDHP PLAN H 5000/30%/7000	
<input type="checkbox"/> 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-network providers for Dual Choice PPO plans include First Choice Health and First Health Network providers.

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.

		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
KAISER PERMANENTE PLUS™	TRADITIONAL PLANS	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.

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.

		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
KAISER PERMANENTE PLUS™	DEDUCTIBLE PLANS	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								*	†

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

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

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

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

2024 COMPLETE SUITE™

PAIRING GUIDE

Traditional and deductible plans

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

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

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

		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
KAISER PERMANENTE PLUS™	DEDUCTIBLE PLANS	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						*	†

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

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

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

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

2024 COMPLETE SUITE™ PAIRING GUIDE

Traditional and deductible plans

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

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

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

		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
KAISER PERMANENTE PLUS™	DEDUCTIBLE PLANS	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						*

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

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

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

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

2024 COMPLETE SUITE™

PAIRING GUIDE

High deductible plans

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

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

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

		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.

2024 COMPLETE SUITE™

PAIRING GUIDE

High deductible plans

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

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

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

		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							*		†		†

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.

2024 COMPLETE SUITE™

PAIRING GUIDE

High deductible plans

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

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

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

		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
HIGH DEDUCTIBLE HEALTH PLANS	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.

2024 COMPLETE SUITE™

PAIRING GUIDE

Virtual Complete™ plans

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

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

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

		DUAL CHOICE PPO PLANS			
		PPO PLAN VC 2500/40/20%/6500	PPO PLAN VC 3000/40/30%/7000	PPO PLAN VC 4000/50/30%/8150	PPO PLAN VC 5000/50/40%/8150
VIRTUAL COMPLETE PLANS	DED PLAN VC 2500/40/20%/5500	*	†		
	DED PLAN VC 3000/40/30%/6000		*	†	
	DED PLAN VC 4000/50/30%/7000			*	†
	DED PLAN VC 5000/50/40%/8000				*

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.

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

[See plan comparisons](#)

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

[Reset](#)

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

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

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

[See plan comparisons](#)

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

[Reset](#)

DEDUCTIBLE

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

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

*After deductible.

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.

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	\$0	\$0	\$0
Office visits – primary care	\$10	\$20	\$20	20%*
Office visits – urgent care	\$10	\$40	\$40	20%*
Office visits – specialty care	\$10	\$30	\$30	20%*
Office visits – naturopathic care	\$10	\$20	\$20	20%*
Lab	20%*	\$20	\$20	20%*
X-ray/diagnostic tests	20%*	\$20	\$20	20%*
CT, MRI, and PET scans	20%*	\$100	\$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%*

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

*After deductible.

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.

[See plan comparisons](#)

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

[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	\$0	\$0	\$0
Office visits – primary care	\$20	\$25	\$25	\$20
Office visits – urgent care	\$20	\$45	\$45	\$20
Office visits – specialty care	\$20	\$35	\$35	\$20
Office visits – naturopathic care	\$20	\$25	\$25	\$20
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

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

*After deductible.

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.

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	\$0	\$0	\$0
Office visits – primary care	\$25	\$25	\$30	\$30
Office visits – urgent care	\$45	\$45	\$30	\$50
Office visits – specialty care	\$35	\$35	\$30	\$40
Office visits – naturopathic care	\$25	\$25	\$30	\$30
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

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

*After deductible.

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.

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	\$0	\$0	\$0
Office visits – primary care	30%*	\$30	\$30	\$30
Office visits – urgent care	30%*	\$50	\$50	\$50
Office visits – specialty care	30%*	\$40	\$40	\$40
Office visits – naturopathic care	30%*	\$30	\$30	\$30
Lab	30%*	\$30	\$30	\$30
X-ray/diagnostic tests	30%*	\$30	\$30	\$30
CT, MRI, and PET scans	30%*	\$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

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

*After deductible.

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.

[See plan comparisons](#)

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

[Reset](#)

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

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

*After deductible.

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. Dual Choice PPO plan options are available to pair with Virtual Complete plans.

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

[See plan comparisons](#)
[Reset](#)

VIRTUAL COMPLETE

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

*After deductible.

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

These plans 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.

[See plan comparisons](#)

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

[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*	\$0*	\$0*	\$0*
Office visits – primary care	10%*	20%*	20%*	30%*
Office visits – urgent care	10%*	20%*	20%*	30%*
Office visits – specialty care	10%*	20%*	20%*	30%*
Office visits – naturopathic care	10%*	20%*	20%*	30%*
Lab	10%*	20%*	20%*	30%*
X-ray/diagnostic tests	10%*	20%*	20%*	30%*
CT, MRI, and PET scans	10%*	20%*	20%*	30%*
Outpatient surgery	10%*	20%*	20%*	30%*
Inpatient hospital care	10%*	20%*	20%*	30%*
Emergency care	10%*	20%*	20%*	30%*
Routine eye exam	10%*	20%*	20%*	30%*

*After deductible.

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.

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

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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*	\$0*	0%*	\$0*
Office visits – primary care	20%*	30%*	10%*	20%*
Office visits – urgent care	20%*	30%*	10%*	20%*
Office visits – specialty care	20%*	30%*	10%*	20%*
Office visits – naturopathic care	20%*	30%*	10%*	20%*
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.

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.

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

[See plan comparisons](#)

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

[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*	\$0*	\$0*	\$0*
Office visits – primary care	30%*	20%*	30%*	20%*
Office visits – urgent care	30%*	20%*	30%*	20%*
Office visits – specialty care	30%*	20%*	30%*	20%*
Office visits – naturopathic care	30%*	20%*	30%*	20%*
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.

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.

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

[See plan comparisons](#)

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

[Reset](#)

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*	\$0*	\$0*
Office visits – primary care	30%*	20%*	30%*
Office visits – urgent care	30%*	20%*	30%*
Office visits – specialty care	30%*	20%*	30%*
Office visits – naturopathic care	30%*	20%*	30%*
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.

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.

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

[See plan comparisons](#)

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

[Reset](#)

HIGH DEDUCTIBLE HEALTH PLAN

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

*After deductible.

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

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

[See plan comparisons](#)

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

[Reset](#)

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

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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](#)

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

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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](#)

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

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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](#)

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

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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.

[See plan comparisons](#)

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

[Reset](#)

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

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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](#)

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

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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.

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	Cost share applicable to the service when provided in person.	\$0	Cost share applicable to the service when provided in person.
Office visits – primary care	20%*	30%	\$20	\$40
Office visits – urgent care	20%*	Not covered, except for services received outside the service area ^{1,2}	\$20	Not covered, except for services received outside the service area ^{1,2}
Office visits – specialty care	20%*	30%	\$20	\$40
Office visits – naturopathic care	20%*	30%	\$20	\$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)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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](#)

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	Cost share applicable to the service when provided in person.	\$0	Cost share applicable to the service when provided in person.
Office visits – primary care	\$25	\$45	\$25	\$45
Office visits – urgent care	\$45	Not covered, except for services received outside the service area ^{1,2}	\$45	Not covered, except for services received outside the service area ^{1,2}
Office visits – specialty care	\$35	\$55	\$35	\$55
Office visits – naturopathic care	\$25	\$45	\$25	\$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	

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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.

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	Cost share applicable to the service when provided in person.	\$0	Cost share applicable to the service when provided in person.
Office visits – primary care	\$20	\$40	\$25	\$45
Office visits – urgent care	\$20	Not covered, except for services received outside the service area ^{1,2}	\$45	Not covered, except for services received outside the service area ^{1,2}
Office visits – specialty care	\$20	\$40	\$35	\$55
Office visits – naturopathic care	\$20	\$40	\$25	\$45
Lab	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.

¹The limit of 10 covered Services does not apply.

²If 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.

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](#)

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

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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.

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	Cost share applicable to the service when provided in person.	\$0	Cost share applicable to the service when provided in person.
Office visits – primary care	\$30	\$50	30%*	40%
Office visits – urgent care	\$50	Not covered, except for services received outside the service area ^{1,2}	30%*	Not covered, except for services received outside the service area ^{1,2}
Office visits – specialty care	\$40	\$60	30%*	40%
Office visits – naturopathic care	\$30	\$50	30%*	40%
Lab	\$30	\$50	30%*	40%
X-ray/diagnostic tests	\$30	\$50	30%*	40%
CT, MRI, and PET scans	\$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.

¹The limit of 10 covered Services does not apply.

²If 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.

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.

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	Cost share applicable to the service when provided in person.	\$0	Cost share applicable to the service when provided in person.
Office visits – primary care	\$30	\$50	\$30	\$50
Office visits – urgent care	\$50	Not covered, except for services received outside the service area ^{1,2}	\$50	Not covered, except for services received outside the service area ^{1,2}
Office visits – specialty care	\$40	\$60	\$40	\$60
Office visits – naturopathic care	\$30	\$50	\$30	\$50
Lab	\$30	\$50	\$30	\$50
X-ray/diagnostic tests	\$30	\$50	\$30	\$50
CT, MRI, and PET scans	\$100	Not covered	\$100	Not covered
Outpatient surgery	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency care	20%*	Covered at the in-network cost share ¹	20%*	Covered at the in-network cost share ¹
Routine eye exam	\$30	\$50	\$30	\$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans		A pharmacy rider must be purchased with all KP Plus plans	

*After deductible.

¹The limit of 10 covered Services does not apply.

²If 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.

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.

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	Cost share applicable to the service when provided in person.	\$0	Cost share applicable to the service when provided in person.
Office visits – primary care	\$30	\$50	\$35	\$55
Office visits – urgent care	\$50	Not covered, except for services received outside the service area ^{1,2}	\$55	Not covered, except for services received outside the service area ^{1,2}
Office visits – specialty care	\$40	\$60	\$45	\$65
Office visits – naturopathic care	\$30	\$50	\$35	\$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.

¹The limit of 10 covered Services does not apply.

²If 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.

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.

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	Cost share applicable to the service when provided in person.
Office visits – primary care	\$35	\$55
Office visits – urgent care	\$55	Not covered, except for services received outside the service area ^{1,2}
Office visits – specialty care	\$45	\$65
Office visits – naturopathic care	\$35	\$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.

¹The limit of 10 covered Services does not apply.

²If 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.

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](#)

Dual Choice PPO

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

*After deductible.

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

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

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

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	30%*	\$0	30%*
Office visits – primary care	\$40 (\$20 enhanced benefit)	30%*	\$50 (\$30 enhanced benefit)	30%*
Office visits – urgent care	\$80 (\$40 enhanced benefit)	30%*	\$100 (\$50 enhanced benefit)	30%*
Office visits – specialty care	\$50 (\$30 enhanced benefit)	30%*	\$60 (\$40 enhanced benefit)	30%*
Office visits – naturopathic care	\$20	30%*	\$30	30%*
Lab	\$20	30%*	\$30	30%*
X-ray/diagnostic tests	\$20	30%*	\$30	30%*
CT, MRI, and PET scans	\$50	30%*	\$50	30%*
Outpatient surgery	\$50	30%*	\$100	30%*
Inpatient hospital care	\$200 per day, \$1,000 per admission	30%*	\$200 per day, \$1,000 per admission	30%*
Emergency care	\$200		\$200	
Routine eye exam	\$40 (\$20 enhanced benefit)	30%*	\$50 (\$30 enhanced benefit)	30%*

*After deductible.

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

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

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

[See plan comparisons](#)

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

[Reset](#)

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

*After deductible.

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

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

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

[See plan comparisons](#)

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

[Reset](#)

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

*After deductible.

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

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

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

[See plan comparisons](#)

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

[Reset](#)

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

*After deductible.

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

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

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

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

[See plan comparisons](#)
[Reset](#)

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	40%*	\$0	40%*
Office visits – primary care	\$40 (\$20 enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	40%*
Office visits – urgent care	\$80 (\$40 enhanced benefit)	40%*	\$80 (\$40 enhanced benefit)	40%*
Office visits – specialty care	\$50 (\$30 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	40%*
Office visits – naturopathic care	\$20	40%*	\$20	40%*
Lab	\$20	40%*	\$20	40%*
X-ray/diagnostic tests	\$20	40%*	\$20	40%*
CT, MRI, and PET scans	\$100	40%*	\$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	\$40 (\$20 enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	40%*

*After deductible.

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

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

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

[See plan comparisons](#)

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

[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	40%*	\$0	40%*
Office visits – primary care	30%*(20%* enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	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	20%*	40%*	\$20	40%*
Lab	20%*	40%*	20%*	40%*
X-ray/diagnostic tests	20%*	40%*	20%*	40%*
CT, MRI, and PET scans	20%*	40%*	20%*	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	\$200*		\$200*	
Routine eye exam	30%*(20%* enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	40%*

*After deductible.

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

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

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

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	40%*	\$0	40%*
Office visits – primary care	\$45 (\$25 enhanced benefit)	40%*	\$45 (\$25 enhanced benefit)	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	\$25	40%*	\$25	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.

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

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

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

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

[See plan comparisons](#)
[Reset](#)

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	50%*	\$0	40%*
Office visits – primary care	\$40 (\$20 enhanced benefit)	50%*	\$45 (\$25 enhanced benefit)	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	\$20	50%*	\$25	40%*
Lab	30%*	50%*	\$25	40%*
X-ray/diagnostic tests	30%*	50%*	\$25	40%*
CT, MRI, and PET scans	30%*	50%*	\$100	40%*
Outpatient surgery	30%*	50%*	20%*	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency care	\$200*		20%*	
Routine eye exam	\$40 (\$20 enhanced benefit)	50%*	\$45 (\$25 enhanced benefit)	40%*

*After deductible.

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

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

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

[See plan comparisons](#)

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

[Reset](#)

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

*After deductible.

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

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

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

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	40%*	\$0	50%*
Office visits – primary care	\$50 (\$30 enhanced benefit)	40%*	40%* (30%* enhanced benefit)	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	\$30	40%*	30%*	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.

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

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

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

[See plan comparisons](#)

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

[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	40%*	\$0	40%*
Office visits – primary care	\$50 (\$30 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	40%*
Office visits – urgent care	\$100 (\$50 enhanced benefit)	40%*	\$100 (\$50 enhanced benefit)	40%*
Office visits – specialty care	\$60 (\$40 enhanced benefit)	40%*	\$60 (\$40 enhanced benefit)	40%*
Office visits – naturopathic care	\$30	40%*	\$30	40%*
Lab	\$30	40%*	\$30	40%*
X-ray/diagnostic tests	\$30	40%*	\$30	40%*
CT, MRI, and PET scans	\$100	40%*	\$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	\$50 (\$30 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	40%*

*After deductible.

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

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

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

[See plan comparisons](#)

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

[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	40%*	\$0	40%*
Office visits – primary care	\$50 (\$30 enhanced benefit)	40%*	\$55 (\$35 enhanced benefit)	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	\$30	40%*	\$35	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.

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

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

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

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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	50%*
Office visits – primary care	\$55 (\$35 enhanced benefit)	50%*
Office visits – urgent care	\$100 (\$55 enhanced benefit)	50%*
Office visits – specialty care	\$65 (\$45 enhanced benefit)	50%*
Office visits – naturopathic care	\$35	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.

*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 contact your sales executive or account manager.

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals. PPO plans designated "VC" are designed to pair with our Virtual Complete plans. To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."

[See plan comparisons](#)
[Reset](#)

Dual Choice PPO Virtual Complete

Plan name	DUAL CHOICE PPO PLAN VC 2500/40/20%/6500	
Network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	\$2,500/\$5,000	\$5,000/\$15,000
Annual out-of-pocket maximum (IND/FAM)	\$6,500/\$13,000	\$13,500/\$27,000
Office visits – preventive and well-child care	\$0	40%*
Office visits – prenatal care	\$0	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – primary care	\$60 (\$40 enhanced benefit) for the first 3 visits; then \$60* (\$40* enhanced benefit) ¹	40%*
Office visits – urgent care	\$60* (\$40* enhanced benefit)	40%*
Office visits – specialty care	\$60* (\$40* enhanced benefit)	40%*
Office visits – naturopathic care	\$40 for the first 3 visits; then \$40* ¹	40%*
Lab	\$15	40%*
X-ray/diagnostic tests	20%*	40%*
CT, MRI, and PET scans	20%*	40%*
Outpatient surgery	20%*	40%*
Inpatient hospital care	20%*	40%*
Emergency care	20%*	
Routine eye exam	\$60* (\$40* enhanced benefit) ¹	40%*
Outpatient prescription drugs	Kaiser Permanente Pharmacies	
	\$15* generic; \$40* preferred brand-name; \$60* non-preferred brand-name; 20%* (up to a max of \$250) specialty	Not covered
	MedImpact Pharmacies	
	\$25* generic; \$60* preferred brand-name; \$90* non-preferred brand-name; 30%* specialty	Not covered

*After deductible.

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

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

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals. PPO plans designated "VC" are designed to pair with our Virtual Complete plans.

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

[See plan comparisons](#)
[Reset](#)

Dual Choice PPO Virtual Complete

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

*After deductible.

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

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

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals. PPO plans designated "VC" are designed to pair with our Virtual Complete plans.

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

[See plan comparisons](#)
[Reset](#)

Dual Choice PPO Virtual Complete

Plan name	DUAL CHOICE PPO PLAN VC 4000/50/30%/8150	
Network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	\$8,000/\$16,000
Annual out-of-pocket maximum (IND/FAM)	\$8,150/\$16,300	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	50%*
Office visits – prenatal care	\$0	50%*
Telehealth (phone/video)	\$0 ¹	50%*
Office visits – primary care	\$70 (\$50 enhanced benefit) for the first 3 visits; then \$70* (\$50* enhanced benefit) ¹	50%*
Office visits – urgent care	\$70* (\$50* enhanced benefit)	50%*
Office visits – specialty care	\$70* (\$50* enhanced benefit)	50%*
Office visits – naturopathic care	\$50 for the first 3 visits; then \$50* ¹	50%*
Lab	\$15	50%*
X-ray/diagnostic tests	30%*	50%*
CT, MRI, and PET scans	30%*	50%*
Outpatient surgery	30%*	50%*
Inpatient hospital care	30%*	50%*
Emergency care	30%*	
Routine eye exam	\$70* (\$50* enhanced benefit) ¹	50%*
Outpatient prescription drugs	Kaiser Permanente Pharmacies	
	\$15* generic; \$50* preferred brand-name; \$70* non-preferred brand-name; 30%* (up to a max of \$250) specialty	Not covered
	MedImpact Pharmacies	
	\$25* generic; \$70* preferred brand-name; \$100* non-preferred brand-name; 40%* specialty	Not covered

*After deductible.

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

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

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals. PPO plans designated "VC" are designed to pair with our Virtual Complete plans.

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

[See plan comparisons](#)
[Reset](#)

Dual Choice PPO Virtual Complete

Plan name	DUAL CHOICE PPO PLAN VC 5000/50/40%/8150	
Network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	\$5,000/\$10,000	\$10,000/\$20,000
Annual out-of-pocket maximum (IND/FAM)	\$8,150/\$16,300	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	50%*
Office visits – prenatal care	\$0	50%*
Telehealth (phone/video)	\$0 ¹	50%*
Office visits – primary care	\$70 (\$50 enhanced benefit) for the first 3 visits; then \$70* (\$50* enhanced benefit) ¹	50%*
Office visits – urgent care	\$70* (\$50* enhanced benefit)	50%*
Office visits – specialty care	\$70* (\$50* enhanced benefit)	50%*
Office visits – naturopathic care	\$50 for the first 3 visits; then \$50* ¹	50%*
Lab	\$15	50%*
X-ray/diagnostic tests	40%*	50%*
CT, MRI, and PET scans	40%*	50%*
Outpatient surgery	40%*	50%*
Inpatient hospital care	40%*	50%*
Emergency care	40%*	
Routine eye exam	\$70* (\$50* enhanced benefit) ¹	50%*
Outpatient prescription drugs	Kaiser Permanente Pharmacies	
	\$15* generic; \$50* preferred brand-name; \$70* non-preferred brand-name; 40%* (up to a max of \$250) specialty	Not covered
	MedImpact Pharmacies	
	\$25* generic; \$70* preferred brand-name; \$100* non-preferred brand-name; 50%* specialty	Not covered

*After deductible.

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

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

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

[See plan comparisons](#)

To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "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*	30%*	\$0*	40%*
Office visits – primary care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – naturopathic care	10%*	30%*	20%*	40%*
Lab	10%*	30%*	20%*	40%*
X-ray/diagnostic tests	10%*	30%*	20%*	40%*
CT, MRI, and PET scans	10%*	30%*	20%*	40%*
Outpatient surgery	10%*	30%*	20%*	40%*
Inpatient hospital care	10%*	30%*	20%*	40%*
Emergency care	10%*		20%*	
Routine eye exam	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*

*After deductible.

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

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

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

[See plan comparisons](#)

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

[Reset](#)

Dual Choice PPO

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

*After deductible.

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

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

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

[See plan comparisons](#)

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

[Reset](#)

Dual Choice PPO

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

*After deductible.

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

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

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

[See plan comparisons](#)

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

[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%*	30%*	\$0*	40%*
Office visits – primary care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*
Office visits – naturopathic care	10%*	30%*	20%*	40%*
Lab	10%*	30%*	20%*	40%*
X-ray/diagnostic tests	10%*	30%*	20%*	40%*
CT, MRI, and PET scans	10%*	30%*	20%*	40%*
Outpatient surgery	10%*	30%*	20%*	40%*
Inpatient hospital care	10%*	30%*	20%*	40%*
Emergency care	10%*		20%*	
Routine eye exam	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*

*After deductible.

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

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

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

[See plan comparisons](#)

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

[Reset](#)

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*	50%*	\$0*	40%*
Office visits – primary care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	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	30%*	50%*	20%*	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.

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

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

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

[See plan comparisons](#)

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

[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*	50%*	\$0*	40%*
Office visits – primary care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	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	30%*	50%*	20%*	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.

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

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

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

[See plan comparisons](#)

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

[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*	50%*	\$0*	40%*
Office visits – primary care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	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	30%*	50%*	20%*	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.

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

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

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

[See plan comparisons](#)

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

[Reset](#)

Dual Choice PPO

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

*After deductible.

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

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

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

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

[See plan comparisons](#)
[Reset](#)

OUT-OF-AREA PPO PLUS

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

*After deductible.

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC)*. To get a copy of the EOC, please 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 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	45%*	\$0	45%*
Office visits – primary care	\$20	45%*	\$30	45%*
Office visits – urgent care	\$20	45%*	\$50	45%*
Office visits – specialty care	\$20	45%*	\$40	45%*
Office visits – naturopathic care	\$20	45%*	\$30	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.

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 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	45%*	\$0	45%*
Office visits – primary care	\$25	45%*	\$30	45%*
Office visits – urgent care	\$45	45%*	\$50	45%*
Office visits – specialty care	\$35	45%*	\$40	45%*
Office visits – naturopathic care	\$25	45%*	\$30	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.

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

*After deductible.

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	40%*	\$0	40%*
Office visits – primary care	\$35	40%*	\$35	40%*
Office visits – urgent care	\$55	40%*	\$55	40%*
Office visits – specialty care	\$45	40%*	\$45	40%*
Office visits – naturopathic care	\$35	40%*	\$35	40%*
Lab	\$35	40%*	\$35	40%*
X-ray/diagnostic tests	\$35	40%*	\$35	40%*
CT, MRI, and PET scans	30%*	40%*	30%*	40%*
Outpatient surgery	30%*	40%*	30%*	40%*
Inpatient hospital care	30%*	40%*	30%*	40%*
Emergency care	20%*		20%*	
Routine eye exam	\$35	40%*	\$35	40%*

*After deductible.

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC)*. To get a copy of the EOC, please 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 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*	30%*	\$0*	30%*
Office visits – primary care	20%*	30%*	20%*	30%*
Office visits – urgent care	20%*	30%*	20%*	30%*
Office visits – specialty care	20%*	30%*	20%*	30%*
Office visits – naturopathic care	20%*	30%*	20%*	30%*
Lab	20%*	30%*	20%*	30%*
X-ray/diagnostic tests	20%*	30%*	20%*	30%*
CT, MRI, and PET scans	20%*	30%*	20%*	30%*
Outpatient surgery	20%*	30%*	20%*	30%*
Inpatient hospital care	20%*	30%*	20%*	30%*
Emergency care	20%*		10%*	
Routine eye exam	20%*	30%*	20%*	30%*

*After deductible.

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

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

[Start over](#)

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.

¹The limit of 10 covered Services does not apply.

²If 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.

³First 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.

[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

ALTERNATIVE CARE

Traditional and deductible (including KP Plus¹), and HSA-qualified, HDHP plans

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

Buy-up self-referred alternative care benefits

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

*Subject to deductible on HSA-qualified, plans.

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

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

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

Buy-up self-referred alternative care benefits

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

*Subject to deductible on HSA-qualified, plans.

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

Buy-up self-referred alternative care benefits

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

*Subject to deductible on HSA-qualified, plans.

¹Rider benefits only available in-network

Added Choice POS, Dual Choice PPO, and PPO Plus¹ members can get care from:

- In-network/PPO providers
 - The CHP Group
 - First Choice Health providers in OR, WA, AK, ID, MT, WY, ND, and SD
 - First Health Network providers in all other states
- Out-of-network/nonparticipating providers

VISION HARDWARE

Traditional, deductible (including KP Plus²), 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

Each calendar year, one pair of eyeglass lenses and a frame, or contact lenses.

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

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

Added Choice POS, Dual Choice PPO, and PPO Plus members may use this benefit with:

- Vision Essentials by Kaiser Permanente
- In-network/PPO optical providers
 - First Choice Health providers in OR, WA, AK, ID, MT, WY, ND, and SD
 - First Health Network providers in all other states
- Out-of-network/nonparticipating optical providers

¹PPO Plus members do not have access to The CHP Group.

²Rider benefits only available in-network for KP Plus plans.

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

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

SENIOR ADVANTAGE

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

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

