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.





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

A BETTER WAY TO TAKE CARE OF BUSINESS

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| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|--------------------|--------------|---------|----|---------------|----------------|-------------|-------|----------------|-------------|
| | | | | | | A BET | | O TAKE CARE | OF BUSINESS |
| 2024 Comp | lete Suit | te™ pla | ns | | | | | | |
| The list below inc | | | | s. Select a p | lan to navigat | e to the fu | ıll | Plans sele | ected: |
| list of benefits. | | | | | | | | Comp | are plans |
| | | | | | | | | Comp | |
| | | | | | | | | | |
| Traditi | ional Copay | 1 | | Ded | uctible | | Vi | rtual Complet | e |
| TRAD | PLAN A 10/10 | 000 | | DED PLAN A | 250/10/10%/200 | 0 | DED P | LAN VC 2500/40 | /20%/5500 |
| TRAD | PLAN B 20/1 | 500 | | DED PLAN A | 250/15/20%/250 | 0 | DED P | LAN VC 3000/40 | /30%/6000 |
| TRAD | PLAN C 20/2 | 000 | | DED PLAN B | 500/20/10%/300 | 0 | DED P | LAN VC 4000/50 | /30%/7000 |
| TRAD | PLAN D 30/2 | 500 | | DED PLAN B | 500/10%/10%/20 | 000 | DED P | LAN VC 5000/50 | /40%/8000 |
| TRAD | PLAN E 35/30 | 000 | | DED PLAN B | 500/10/20%/200 | 0 | | | |
| | | | | DED PLAN B | 500/20/20%/300 | 0 | | | |
| | | | | DED PLAN C | 750/20/20%/325 | 0 | | | |
| | | | | DED PLAN C | 750/20%/20%/30 | 000 | | | |
| | | | | DED PLAN D | 1000/20/20%/30 | 000 | | | |
| | | | | DED PLAN D | 1000/25/20%/40 | 00 | | | |
| | | | | DED PLAN E | 500/25/20%/55 | 00 | | | |
| | | | | DED PLAN E | 500/20/30%/40 | 00 | | | |
| | | | | DED PLAN F 2 | 2000/25/20%/50 | 00 | | | |
| | | | | DED PLAN G | 2500/25/20%/50 | 00 | | | |
| | | | | DED PLAN G | 2500/30/30%/50 | 000 | | | |
| | | | | DED PLAN H | 3000/30/20%/73 | 350 | | | |
| | | | | DED PLAN H | 3000/30%/30%/ | 6000 | | | |
| | | | | DED PLAN I 3 | 500/30/20%/735 | 50 | | | |
| | | | | DED PLAN J 4 | 000/30/20%/75 | 00 | | | |
| | | | | DED PLAN K | 5000/30/20%/73 | 50 | | | |
| | | | | DED PLAN L & | 000/35/20%/75 | 00 | | | |
| | | | | DED PLAN M | 7500/35/30%/85 | 500 | | | |

Reset

Clear all plans selected

| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|-------------------|---------------|-----------|----|---------------|------------------|-------------|-------------|-------------------|----------------|
| | | | | | | A BET | | O TAKE CARE | OF BUSINESS |
| 2024 Comp | lete Sui | te™ pla | ns | | | | | | |
| The list below in | | | | s. Select a p | lan to navigate | e to the fu | II | Plans sele | ected: |
| list of benefits. | | | | | | | | Comp | are plans |
| | | | | | | | | Comp | |
| | | | | | | | | | |
| High deductibl | le health pla | an (HDHP) | | KP | Plus | | D | ual Choice PP | 0 |
| HDHP PL | AN A 1600/10% | 6/2500 | | KP PLUS PLAN | A 10/1000 | | DUAL CHOIC | E PPO PLAN A 10/ | 1500 |
| HDHP PL | AN A 1600/209 | %/3500 | | KP PLUS PLAN | B 20/1500 | | DUAL CHOIC | E PPO PLAN B 20/ | 2000 |
| HDHP PL | AN B 2000/209 | %/4000 | | KP PLUS PLAN | C 20/2000 | | DUAL CHOIC | E PPO PLAN C 20/ | 2500 |
| HDHP PL | AN B 2000/30 | %/4000 | | KP PLUS PLAN | D 30/2500 | | DUAL CHOIC | E PPO PLAN D 30/ | 3000 |
| HDHP PL | AN C 2500/209 | %/5000 | | KP PLUS PLAN | E 35/3000 | | DUAL CHOIC | E PPO PLAN E 35/3 | 3500 |
| HDHP PL | AN C 2500/309 | %/5000 | | KP PLUS PLAN | A 250/10/10%/200 | 0 | DUAL CHOIC | E PPO PLAN A 250 | /10/10%/2500 |
| HDHP PL | AN E 3200/10% | 6/6000 | | KP PLUS PLAN | A 250/15/20%/250 | 0 | DUAL CHOIC | E PPO PLAN A 250 | /15/20%/3000 |
| HDHP PL | AN E 3200/20% | %/6000 | | KP PLUS PLAN | B 500/20/10%/300 | 0 | DUAL CHOIC | E PPO PLAN B 500 | /20/10%/3500 |
| HDHP PL | AN E 3200/30% | %/6000 | | KP PLUS PLAN | B 500/10%/10%/20 | 000 | DUAL CHOIC | E PPO PLAN B 500 | /10%/10%/3000 |
| HDHP PL | AN F 3500/20% | 6/7000 | | KP PLUS PLAN | B 500/10/20%/200 | 0 | DUAL CHOIC | E PPO PLAN B 500 | /10/20%/3000 |
| HDHP PL | AN F 3500/30% | %/7000 | | KP PLUS PLAN | B 500/20/20%/300 | 00 | DUAL CHOIC | E PPO PLAN B 500 | /20/20%/3500 |
| HDHP PL | AN G 4000/20 | %/7000 | | KP PLUS PLAN | C 750/20/20%/325 | 0 | DUAL CHOIC | E PPO PLAN C 750 | /20/20%/3500 |
| HDHP PL | AN G 4000/30 | %/7000 | | KP PLUS PLAN | C 750/20%/20%/30 | 000 | DUAL CHOIC | E PPO PLAN C 750 | /20%/20%/3500 |
| HDHP PL | AN H 5000/20 | %/7000 | | KP PLUS PLAN | D 1000/20/20%/30 | 000 | DUAL CHOIC | E PPO PLAN D 100 | 0/20/20%/4000 |
| HDHP PL | AN H 5000/30 | %/7000 | | KP PLUS PLAN | D 1000/25/20%/40 | 000 | DUAL CHOIC | E PPO PLAN D 100 | 0/25/20%/5000 |
| HDHP PL | AN H 5000/40 | %/7000 | | KP PLUS PLAN | E 1500/25/20%/55 | 00 | DUAL CHOIC | E PPO PLAN E 150 | 0/25/20%/6000 |
| HDHP PL | AN H 5000/50 | %/7000 | | KP PLUS PLAN | E 1500/20/30%/40 | 00 | DUAL CHOIC | E PPO PLAN E 150 | 0/20/30%/5000 |
| | | | | KP PLUS PLAN | F 2000/25/20%/50 | 00 | DUAL CHOIC | E PPO PLAN F 200 | 0/25/20%/6000 |
| | | | | KP PLUS PLAN | G 2500/25/20%/50 | 000 | DUAL CHOIC | E PPO PLAN G 250 | 0/25/20%/6000 |
| | | | | KP PLUS PLAN | G 2500/30/30%/50 | 000 | DUAL CHOIC | E PPO PLAN G 250 |)0/30/30%/6000 |
| | | | | KP PLUS PLAN | H 3000/30/20%/73 | 350 | DUAL CHOIC | E PPO PLAN H 300 |)0/30/20%/8150 |
| | | | | KP PLUS PLAN | H 3000/30%/30%/ | 6000 | DUAL CHOICI | E PPO PLAN H 3000 |)/30%/30%/7000 |
| | | | | KP PLUS PLAN | 3500/30/20%/73 | 50 | DUAL CHOIC | E PPO PLAN I 350 | 0/30/20%/8000 |
| | | | | KP PLUS PLAN | J 4000/30/20%/75 | 00 | DUAL CHOIC | E PPO PLAN J 400 | 0/30/20%/8150 |
| | | | | KP PLUS PLAN | K 5000/30/20%/73 | 350 | DUAL CHOIC | E PPO PLAN K 500 | 0/30/20%/8150 |
| | | | | KP PLUS PLAN | L 6000/35/20%/75 | 00 | DUAL CHOIC | E PPO PLAN L 600 | 0/35/20%/8000 |
| | | | | KP PLUS PLAN | M 7500/35/30%/8 | 500 | DUAL CHOIC | E PPO PLAN M 750 | 00/35/30%/8500 |

Reset

Clear all plans selected

| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | РРО | OOA | RIDERS | SR. ADV. |
|-------------------------------------|---------------|-------------|-----------|---------------|---------------|-------------|--------------|-----------------|-------------|
| | | | | | | A BET | TER WAY TO | O TAKE CARE | OF BUSINESS |
| 2024 Comp | lete Suit | te™ pla | ns | | | | | | |
| The list below in list of benefits. | ncludes all 2 | 024 plan o | offerings | s. Select a p | an to navigat | e to the fu | II | Plans sele | ected: |
| list of benefits. | | | | | | | | Comp | are plans |
| | | | | | | | | | |
| | Dual C | hoice PPO | | | | Out | t of Area Pl | PO Plus | |
| DUAL | CHOICE PPO P | LAN VC 2500 |)/40/20%/ | 6500 | | PPO PLUS PL | AN WDB 500. |)/20%/2500 | |
| | CHOICE PPO P | | | | | | AN WDC 750 | | |
| DUAL | CHOICE PPO P | LAN VC 4000 |)/50/30%/ | /8150 | | PPO PLUS PL | AN WDT 100. | 0/20%/3000 | |
| DUAL | CHOICE PPO P | LAN VC 5000 |)/50/40%/ | /8150 | | PPO PLUS PL | AN WDE 100. | 0/30%/4750 | |
| DUAL | CHOICE PPO H | DHP PLAN A | 1600/10% | %/2500 | | PPO PLUS PL | AN WDU 150 | 0/20%/5500 | |
| DUAL | CHOICE PPO H | DHP PLAN A | 1600/209 | %/3500 | | PPO PLUS PL | AN WDP 150. | 0/30%/6000 | |
| DUAL | CHOICE PPO H | DHP PLAN B | 2000/200 | %/4000 | | PPO PLUS PL | AN WDN 200. | 00/30%/6000 | |
| DUAL | CHOICE PPO H | DHP PLAN B | 2000/309 | %/4000 | | PPO PLUS PL | AN WDX 300. | 0/30%/6850 | |
| DUAL | CHOICE PPO H | DHP PLAN C | 2500/209 | %/5000 | | PPO PLUS PL | AN WDR 400. | 0/30%/7350 | |
| DUAL | CHOICE PPO H | DHP PLAN C | 2500/309 | %/5000 | | PPO PLUS PL | AN WDS 500. | 0/30%/7350 | |
| DUAL | CHOICE PPO H | DHP PLAN E | 3200/10% | %/6000 | | PPO PLUS HI | OHP AA PLAN | I WFI 1600/20%/ | 3500 |
| DUAL | CHOICE PPO H | DHP PLAN E | 3200/20% | %/6000 | | PPO PLUS HI | OHP AA PLAN | WAS 2800/20% | /4000 |
| DUAL | CHOICE PPO H | DHP PLAN E | 3200/30% | %/6000 | | | | | |
| DUAL | CHOICE PPO H | DHP PLAN F | 3500/20% | %/7000 | | | | | |
| DUAL | CHOICE PPO H | DHP PLAN F | 3500/20% | %/7000 | | | | | |

Reset Clear all plans selected

DUAL CHOICE PPO HDHP PLAN F 3500/30%/7000 DUAL CHOICE PPO HDHP PLAN G 4000/20%/7000 DUAL CHOICE PPO HDHP PLAN G 4000/30%/7000 DUAL CHOICE PPO HDHP PLAN H 5000/20%/7000 DUAL CHOICE PPO HDHP PLAN H 5000/40%/7000

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



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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 |
| | | TRAD PLAN A 10/1000 | * | t | | | |
| MT SU14 | ANS | TRAD PLAN B 20/1500 | | * | t | | |
| KAISER PERMANENTE PLUS TM | TRADITIONAL PLANS | TRAD PLAN C 20/2000 | | | * | t | t |
| KAISER | TRA | TRAD PLAN D 30/2500 | | | | * | t |
| | | TRAD PLAN E 35/3000 | | | | | * |

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

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

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



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

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

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

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

| | | | | | D | UAL C | CHOIC | e ppo | PLAN | S | | |
|--------------------------------------|------------------|-----------------------------|-------------------------------|-------------------------------|-------------------------------|--------------------------------|-------------------------------|----------------------------|----------------------------|--------------------------------|--------------------------------|--------------------------------|
| | | | PPO PLAN A 250/10/10%/2500 | PPO PLAN A 250/15/20%/3000 | PPO PLAN B 500/20/10%/3500 | PPO PLAN B 500/10%/10%/3000 | PPO PLAN B 500/10/20%/3000 | PPO PLAN B 500/20//3500 | PPO PLAN C 750/20%/3500 | PPO PLAN C 750/20%/20%/3500 | PPO PLAN D 1000/20/20%/4000 | PPO PLAN D 1000/25/20%/5000 |
| | | DED PLAN A 250/10/10%/2000 | * | † | † | | | | | | | |
| | | DED PLAN A 250/15/20%/2500 | | * | † | | | † | | | | |
| LUS™ | 10 | DED PLAN B 500/20/10%/3000 | | | * | t | | t | † | | | |
| KAISER PERMANENTE PLUS TM | DEDUCTIBLE PLANS | DED PLAN B 500/10%/10%/2000 | | | | * | | | | † | | |
| R PERMA | DEDUCTIE | DED PLAN B 500/10/20%/2000 | | | | | * | † | † | | | |
| KAISE | | DED PLAN B 500/20/20%/3000 | | | | | | * | † | | | |
| | | DED PLAN C 750/20/20%/3250 | | | | | | | * | † | | + |
| | | DED PLAN C 750/20%/20%/3000 | | | | | | | | * | | + |

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

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.





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

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

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

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

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

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

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

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



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

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

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

† 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 | | | | |
| | | DED PLAN H 3000/30/20%/7350 | * | | † | t | | | | | | | |
| | | DED PLAN H 3000/30%/30%/6000 | | * | t | | | | | | | | |
| IE PLUS TM | -ANS | DED PLAN I 3500/30/20%/7350 | | | * | t | | | | | | | |
| KAISER PERMANENTE PLUS TM | DEDUCTIBLE PLANS | DED PLAN J 4000/30/20%/7500 | | | | * | t | † | | | | | |
| KAISER P | DEDI | DED PLAN K 5000/30/20%/7350 | | | | | * | + | t | | | | |
| | | DED PLAN L 6000/35/20%/7500 | | | | | | * | t | | | | |
| | | 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.



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2024 COMPLETE SUITE[™] PAIRING GUIDE High deductible plans

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

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

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

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

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

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



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2024 COMPLETE SUITE[™] PAIRING GUIDE High deductible plans

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

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

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

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

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

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



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2024 COMPLETE SUITE[™] PAIRING GUIDE High deductible plans

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

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

T 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 |
| | HDHP PLAN G 4000/20%/7000 | * | t | t | t | |
| NS | HDHP PLAN G 4000/30%/7000 | | * | | t | |
| HIGH DEDUCTIBLE HEALTH PLANS | HDHP PLAN H 5000/20%/7000 | | | * | t | t |
| GH DEDUCTIBI | HDHP PLAN H 5000/30%/7000 | | | | * | t |
| Ξ | 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.



VC

PPO

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.

t 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 | | | | | |
| | DED PLAN VC 2500/40/20%/5500 | × | t | | | | | | | |
| PLETE PLANS | DED PLAN VC 3000/40/30%/6000 | | * | t | | | | | | |
| VIRTUAL COMPLETE PLANS | DED PLAN VC 4000/50/30%/7000 | | | * | t | | | | | |
| | 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.





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

| 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.



| OVERVIEW TRAD | DED | VC H | DHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------|----------|--------------------------|-----|--------------------------|--------|------------------------|
| Below are highlights of the you the flexibility to choos business goals. To compare the benefits o plan and then select "See | e a plan th f up to any | at helps me | et emplo | oyee needs a | nd | ach | | comparisons Reset |
| | | | DEDU | CTIBLE | | | | |
| Plan Name | | D PLAN A 0/10%/2000 | | ED PLAN A 15/20%/2500 | | ED PLAN B 20/10%/3000 | | D PLAN B %/10%/2000 |
| Annual medical deductible (IND/FAM) (per calendar year) | \$2 | 250/\$750 | 9 | \$250/\$750 | \$! | 500/\$1,500 | \$50 | 0/\$1,500 |
| Annual out-of-pocket maximum (IND/FAM) | \$2,0 | 00/\$6,000 | \$2 | ,500/\$7,500 | \$3 | ,000/\$6,000 | \$2,0 | 00/\$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.



| OVERVIEW TRAD | DED VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------|-----------------------------|------|--------------------------|--------|------------------------|
| Below are highlights of the you the flexibility to choose business goals. To compare the benefits of plan and then select "See p | a plan that helps up to any 3 plans | , check the | ployee needs a | and | ch | | comparisons Reset |
| | | DEDI | JCTIBLE | | | | |
| Plan Name | DED PLAN B 500/10/20%/200 | 00 50 | DED PLAN B 0/20/20%/3000 | | ED PLAN C 20/20%/3250 | | 0 PLAN C %/20%/3000 |
| Annual medical deductible (IND/FAM) (per calendar year) | \$500/\$1,500 | | \$500/\$1,500 | \$7 | 50/\$2,250 | \$75 | 0/\$2,250 |
| Annual out-of-pocket maximum (IND/FAM) | \$2,000/\$6,000 | | \$3,000/\$9,000 | \$3, | 250/\$9,750 | \$3,0 | 00/\$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.



| Below are highlights of the benefits for each plan. A variety of options gives rou the flexibility to choose a plan that helps meet employee needs and business goals. To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons." | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--|--|--|--|--|--|--|--|
| DEDUCTIBLE | | | | | | | | | | | | |
| Plan Name | DED 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 | | | | | | | | |

VC

HDHP

KP PLUS

PPO

OOA

RIDERS

SR. ADV.

DED

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

*After deductible.

OVERVIEW

TRAD



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|-------------------------------------------------------------------------------------------------|----------------------------|------------------------|----------------------------|----------|-----------------------------|-------|--------------------------|--------|-------------------------|
| | | | | | | | | | |
| Below are highli you the flexibilit business goals. To compare the plan and then se | y to choose benefits of | a plan th up to any | at helps m v 3 plans, c | ieet emp | oloyee needs a | nd | ch | | comparisons Reset |
| | | | | DEDL | JCTIBLE | | | | |
| Plan Na | ime | | D PLAN F 25/20%/5000 |) 250 | DED PLAN G 0/25/20%/5000 | | ED PLAN G 30/30%/5000 | | D PLAN H 80/20%/7350 |
| Annual medical de (IND/FAM) (per cal | | \$2,0 | 00/\$6,000 | 9 | 52,500/\$7,500 | \$2, | 500/\$5,000 | \$3,0 | 00/\$9,000 |
| Annual out-of-poc maximum (IND/FA | | \$5,00 | 00/\$10,000 | \$ | 5,000/\$10,000 | \$5,0 | 000/\$10,000 | \$7,3 | 50/\$14,700 |
| Office visits - prev well-child care | entive and | | \$0 | | \$0 | | \$0 | | \$0 |
| Office visits - pren | atal care | | \$0 | | \$0 | | \$0 | | \$0 |
| Telehealth (phone | /video) | | \$0 | | \$0 | | \$0 | | \$0 |
| Office visits - prim | ary care | | \$25 | | \$25 | | \$30 | | \$30 |
| Office visits - urge | ent care | | \$45 | | \$45 | | \$30 | | \$50 |
| Office visits - spec | ialty care | | \$35 | | \$35 | | \$30 | | \$40 |
| Office visits - natu | ropathic care | | \$25 | | \$25 | | \$30 | | \$30 |
| Lab | | | \$25 | | \$25 | | 30%* | | \$30 |
| X-ray/diagnostic te | ests | | \$25 | | \$25 | | 30%* | | \$30 |
| CT, MRI, and PET s | cans | | \$100 | | \$100 | | 30%* | | \$100 |
| Outpatient surger | у | | 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.



| OVERVIEW TRAD | DED VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------|------------------------------|-------|---------------------------|--------|------------------------|
| Below are highlights of the you the flexibility to choose business goals. To compare the benefits of plan and then select "See p | a plan that helps i up to any 3 plans, | meet emp | oloyee needs a | nd | ich | | comparisons Reset |
| | | DEDL | JCTIBLE | | | | |
| Plan Name | DED PLAN H 3000/30%/30%/60 | 00 350 | DED PLAN I 00/30/20%/7350 | | ED PLAN J /30/20%/7500 | | 0 PLAN K 0/20%/7350 |
| Annual medical deductible (IND/FAM) (per calendar year) | \$3,000/\$6,000 | \$ | 3,500/\$10,500 | \$4,0 | 000/\$10,000 | \$5,00 | 0/\$10,000 |
| Annual out-of-pocket maximum (IND/FAM) | \$6,000/\$12,000 | \$ | 7,350/\$14,700 | \$7,5 | 500/\$15,000 | \$7,35 | 50/\$14,700 |
| Office visits – preventive and well-child care | \$0 | | \$0 | | \$0 | | \$0 |
| Office visits - prenatal care | \$0 | | \$0 | | \$0 | | \$0 |
| Telehealth (phone/video) | \$0 | | \$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.



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | |
|-------------------------------------------------------------------------------------------------|----------------------------|--------------------------|------------------------|----------------------------|-------------|-------|------------|------------------|---------------------|--|--|--|
| | | | | | | A BET | TER WAY TO | O TAKE CARE | OF BUSINESS | | | |
| Below are highli you the flexibilit business goals. To compare the plan and then se | y to choose benefits of | e a plan th up to any | nat helps v 3 plans | s meet emp s, check the | loyee needs | and | ich | | comparisons eset | | | |
| | | | | DEDU | JCTIBLE | | | | | | | |
| Plan Na | ame | | DED PLAN | N L 6000/35/2 | 0%/7500 | | DED PLAN N | л 7500/35/30% | /8500 | | | |
| Annual medical de (IND/FAM) (per cal | | | \$ | 6,000/\$12,00 | 0 | | \$7, | 500/\$14,500 | | | | |
| Annual out-of-poc maximum (IND/FA | | | \$ | 7,500/\$15,00 | 0 | | \$8, | \$8,500/\$17,000 | | | | |
| Office visits - prev well-child care | entive and | | | \$0 | | | | \$0 | | | | |
| Office visits - pren | atal care | | | \$0 | | | | \$0 | | | | |
| Telehealth (phone | /video) | | | \$0 | | | | \$0 | | | | |
| Office visits - prim | ary care | | | \$35 | | | | \$35 | | | | |
| Office visits – urge | ent care | | | \$55 | | | | \$55 | | | | |
| Office visits – spec | ialty care | | | \$45 | | | | \$45 | | | | |
| Office visits – natu | ropathic care | | | \$35 | | | | \$35 | | | | |
| Lab | | | | \$35 | | | | \$35 | | | | |
| X-ray/diagnostic te | ests | | | \$35 | | | | \$35 | | | | |
| CT, MRI, and PET s | cans | | | \$150 | | | | \$150 | | | | |
| Outpatient surger | у | | | 20%* | | | | 30%* | | | | |
| Inpatient hospital | care | | | 20%* | | | | 30%* | | | | |
| Emergency care | | | | 20%* | | | 30%* | | | | | |
| Routine eye exam | | | | \$35 | | | | \$35 | | | | |

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

*After deductible.



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|----------------------------------|------|-----|----|------|----------|-----|----------|----------|-------------|
| | | | | | | | | | |
| Below are high | 0 | | | | y | 0 , | | See plan | comparisons |
| flexibility to cho | 1 | 1 | | 1 5 | | 0 | ls. Dual | | |
| Choice PPO pla To compare the | 1 | | | | | | ach plan | R | leset |
| and then select | | | | ., | | | | | |

| | VIRT | UAL 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 |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|----------------------------------------------------------|----------------|-----------|------------------------|-----------|----------------------------|------------|-------------------------|----------|------------------------|
| | | | | | | | | | |
| Below are highl you the flexibilit business goals. | 0 | | | | J | 0 | | See plan | comparisons |
| To compare the | benefits of u | up to any | 3 plans, | check the | checkboxes i | next to ea | ch | F | Reset |
| plan and then s | elect "See pl | an comp | arisons." | | | | | | |
| | | HI | GH DE | DUCTIE | BLE HEALT | H PLA | N | | |
| Plan Na | ame | | IP PLAN A /10%/2500 | | IDHP PLAN A 00/20%/3500 | | HP PLAN B 0/20%/4000 | | IP PLAN B /30%/4000 |
| Accumulation typ | е | Ag | gregate | | Aggregate | Δ | ggregate | Ag | gregate |
| Annual medical d (IND/FAM) (per ca | | \$1,60 | 00/\$3,200 | \$ | 1,600/\$3,200 | \$2, | 000/\$4,000 | \$2,0 | 00/\$4,000 |
| Annual out-of-poo maximum (IND/F/ | | \$2,50 | 00/\$5,000 | \$ | 3,500/\$7,000 | \$4, | 000/\$8,000 | \$4,0 | 00/\$8,000 |
| Office visits – prev well-child care | ventive and | | \$0 | | \$0 | | \$0 | | \$0 |
| Office visits – prei | natal care | | \$0 | | \$0 | | \$0 | | \$0 |
| Telehealth (phone | e/video) | | \$0* | | \$0* | | \$0* | | \$0* |
| Office visits – prin | nary care | | 10%* | | 20%* | | 20%* | | 30%* |
| Office visits – urge | ent care | | 10%* | | 20%* | | 20%* | | 30%* |
| Office visits – spe | cialty care | | 10%* | | 20%* | | 20%* | | 30%* |
| Office visits – natu | uropathic care | | 10%* | | 20%* | | 20%* | | 30%* |
| Lab | | | 10%* | | 20%* | | 20%* | | 30%* |
| X-ray/diagnostic t | ests | | 10%* | | 20%* | | 20%* | | 30%* |
| CT, MRI, and PET s | cans | | 10%* | | 20%* | | 20%* | | 30%* |
| Outpatient surger | у | | 10%* | | 20%* | | 20%* | | 30%* |
| Inpatient hospita | care | | 10%* | | 20%* | | 20%* | | 30%* |
| Emergency care | | | 10%* | | 20%* | | 20%* | | 30%* |
| Routine eye exam | 1 | | 10%* | | 20%* | | 20%* | | 30%* |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|-----------------------------------------|---------------|-----------|------------------------|----------|----------------------------|------------|-------------------------|----------|------------------------|
| | | | | | | | | | |
| Below are highli you the flexibility | - | | | | • · | - | | See plan | comparisons |
| business goals. To compare the | benefits of ı | in to any | 3 plans o | heck the | checkboxes r | next to ea | ch | F | Reset |
| plan and then se | | | • | | | | | | |
| | | HI | GH DE | DUCTIE | BLE HEALT | H PLAI | N | | |
| | | | | | | | <u> </u> | | |
| Plan Na | me | | IP PLAN C /20%/5000 | | IDHP PLAN C 00/30%/5000 | | HP PLAN E)/10%/6000 | | IP PLAN E /20%/6000 |
| Accumulation type | ; | Ag | Igregate | | Aggregate | E | mbedded | En | nbedded |
| Annual medical de (IND/FAM) (per cal | | \$2,5 | 00/\$5,000 | \$ | 2,500/\$5,000 | \$3, | 200/\$6,400 | \$3,2 | 00/\$6,000 |
| Annual out-of-poc maximum (IND/FA | | \$5,0 | 00/\$7,500 | \$ | 5,000/\$7,500 | \$6, | 000/\$9,000 | \$6,00 | 00/\$12,000 |
| Office visits – prev well-child care | entive and | | \$0 | | \$0 | | \$0 | | \$0 |
| Office visits – pren | atal care | | \$0 | | \$0 | | \$0 | | \$0 |
| Telehealth (phone | /video) | | \$0* | | \$0* | | 0%* | | \$0* |
| Office visits – prim | ary care | | 20%* | | 30%* | | 10%* | | 20%* |
| Office visits – urge | ent care | | 20%* | | 30%* | | 10%* | | 20%* |
| Office visits – spec | ialty care | | 20%* | | 30%* | | 10%* | | 20%* |
| Office visits – natu | ropathic care | | 20%* | | 30%* | | 10%* | | 20%* |
| Lab | | | 20%* | | 30%* | | 10%* | | 20%* |
| X-ray/diagnostic te | ests | | 20%* | | 30%* | | 10%* | | 20%* |
| CT, MRI, and PET se | cans | | 20%* | | 30%* | | 10%* | | 20%* |
| Outpatient surger | у | | 20%* | | 30%* | | 10%* | | 20%* |
| Inpatient hospital | care | | 20%* | | 30%* | | 10%* | | 20%* |

Emergency care

Routine eye exam

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

30%*

30%*

10%*

10%*

20%*

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 visit account.kp.org or contact your Kaiser Permanente representative.



20%*

20%*

| OVERVIEW TRAD | DED VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | |
|-----------------------------------------------------------------------------------|------------------------|---------------|-----------------------------|------------|-------------------------|----------|----------------------|--|
| | | _ | | | | | | |
| Below are highlights of the k you the flexibility to choose business goals. | | | 5 | 0 | | See plan | comparisons | |
| To compare the benefits of u | up to any 3 pla | ns, check the | checkboxes n | ext to eac | ch | Reset | | |
| plan and then select "See pl | an comparisor | าร." | | | | | | |
| | HIGH | DEDUCTII | BLE HEALT | H PLAN | | | | |
| Plan Name | HDHP PLA 3200/30%/6 | | HDHP PLAN F 500/20%/7000 | | HP PLAN F)/30%/7000 | | P PLAN G 20%/7000 | |
| Accumulation type | Embedde | d | Embedded | En | nbedded | Em | bedded | |
| Annual medical deductible (IND/FAM) (per calendar year) | \$3,200/\$6,0 | 000 \$ | 3,500/\$7,000 | \$3,5 | 500/\$7,000 | \$4,00 | 00/\$8,000 | |
| Annual out-of-pocket maximum (IND/FAM) | \$6,000/\$12, | 000 \$ | 7,000/\$14,000 | \$7,00 | 00/\$14,000 | \$7,00 | 0/\$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 | and PET scans 30%* | | 20%* | | 30%* | 20%* | | |
| Outpatient surgery | tient 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%* | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|------------|---------------------|-------------|---------------|--------------|------------|------------|-------------|--|--|--|
| Below are highli | ights of the l | penefits f | for each | plan. A var | iety of optio | ns gives | | See plan | comparisons | | | |
| you the flexibilit | y to choose | a plan th | at helps | meet emp | loyee needs | and | | | | | | |
| 1 | o compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons." | | | | | | | | | | | |
| | | Н | IGH D | EDUCTI | BLE HEAL | TH PLA | N | | | | | |
| Plan Na | ame |) | HDHP PI 5000/30% | | | | | | | | | |
| Accumulation type | е | | Embedo | led | E | mbedded | | Embedded | | | | |
| Annual medical d (IND/FAM) (per ca | | | \$4,000/\$8 | 3,000 | \$5,0 | 000/\$10,000 | \$5,000/\$ | 10,000 | | | | |
| Annual out-of-poc maximum (IND/FA | | | \$7,000/\$1 | 4,000 | \$7,0 | 000/\$14,000 | | \$7,000/\$ | 14,000 | | | |
| Office visits – prev well-child care | ventive and | | \$0 | | | \$0 | \$0 | | | | | |
| Office visits – prer | natal care | | \$0 | | | \$0 | | \$0 | | | | |
| Telehealth (phone | ehealth (phone/video) \$0* \$0* | | | | | | | | ¢. | | | |
| Office visits – prin | Office visits – primary care 30%* | | | | | | | 30% | * | | | |
| Office visits – urge | ent care | | 30%' | ۲ | | 20%* | | | * | | | |
| Office visits – spec | cialty care | | 30%' | ç | | 20%* | 30%* | | | | | |
| Office visits – naturopathic care 30%* 20% | | | | | | | | 30% | * | | | |

Emergency care

Routine eye exam

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

Outpatient surgery

Lab

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

20%*

20%*

20%*

20%*

20%*

20%*

20%*

30%*

30%*

30%*

30%*

30%*

30%*

30%*

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.



30%*

30%*

30%*

30%*

30%* 30%*

30%*

| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------|----------------|---------|------------------|------|--------------|----------|--|--|--|--|
| | | | | | | | | | | | | | |
| you the flexibility business goals. | 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." | | | | | | | | | | | | |
| plan and then se | elect "See pl | an compa | arisons | | | | | | | | | | |
| HIGH DEDUCTIBLE HEALTH PLAN | | | | | | | | | | | | | |
| Plan Name HDHP PLAN H 5000/40%/7000 5000/50%/7000 | | | | | | | | | | | | | |
| Accumulation type | ; | | | Embedded | | | l | Embedded | | | | | |
| Annual medical de (IND/FAM) (per cal | | | \$ | 5,000/\$10,000 | 0 | | \$5, | 000/\$10,000 | | | | | |
| Annual out-of-poc maximum (IND/FA | | | \$ | 7,000/\$14,000 |) | \$7,000/\$14,000 | | | | | | | |
| Office visits – prev well-child care | entive and | | | \$0 | | | | \$0 | | | | | |
| Office visits – pren | atal care | | | \$0 | | | | \$0 | | | | | |
| Telehealth (phone | /video) | | | \$0* | | | | \$0* | | | | | |
| Office visits – prim | ary care | | | 40%* | | | | 50%* | | | | | |
| Office visits – urge | ent care | | | 40%* | | | | 50%* | | | | | |
| Office visits – spec | ialty care | | | 40%* | | | | 50%* | | | | | |
| Office visits – natu | ropathic care | | | 40%* | | | | 50%* | | | | | |
| Lab | | | | 40%* | | | | 50%* | | | | | |
| X-ray/diagnostic te | ests | | | 40%* | | 50%* | | | | | | | |
| CT, MRI, and PET se | ans | | | 40%* | | | | 50%* | | | | | |
| Outpatient surger | y | | | 40%* | | | | 50%* | | | | | |
| Inpatient hospital | care | | | 40%* | | | | 50%* | | | | | |
| Emergency care | | | | 40%* | | 50%* | | | | | | | |
| Routine eye exam | | | 40%* 50%* | | | | | | | | | | |

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



KP PLUS PLANS

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

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

| KP Plus Benefit Design Summary | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|
| Limited to 10 medical services and 5 pharmacy fills per 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 | | | | | | | | |

| OVERVIEW TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | | |
|-----------------------------------------------------------------------------|-------|------------------------------|-------------|---------------------------------------------------------------------|-----------|--------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------|--|--|--|--|--|
| | | | | _ | | | | | | | | | |
| Below are highlights of t you the flexibility to choo business goals. | | | | | - | | | comparisons | | | | | |
| To compare the benefits plan and then select "Se | | 5 1 | heck the | checkboxes n | ext to ea | ich | | Reset | | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN A 10/1000 KP PLUS PLAN B 20/1500 | | | | | | | | | | | | | |
| Network | In | -network | (limi | ut-of-network ted to 10 covered per year, combined) | | n-network | Out-of-netwo | | | | | | |
| Annual medical deductible (IND/FAM) (per calendar yea | r) | N/A | | N/A | | N/A | | N/A | | | | | |
| Annual out-of-pocket maximum (IND/FAM) | \$1,0 | 000/\$2,000 | | N/A | \$1, | 500/\$3,000 | | N/A | | | | | |
| Office visits – preventive and well-child care | I | \$0 | | \$0 | | \$0 | | \$0 | | | | | |
| Office visits – prenatal care | | \$0 | | \$0 | | \$0 | | | | | | | |
| Telehealth (phone/video) | | \$0 | | are applicable to the e when provided in person. | | \$0 | service w | applicable to the hen provided in person. | | | | | |
| Office visits – primary care | | \$10 | | \$30 | | \$20 | \$40 | | | | | | |
| Office visits – urgent care | | \$30 | services | overed, except for received outside the service area ^{1,2} | e \$40 | | services re | ered, except for ceived outside the vice area ^{1,2} | | | | | |
| Office visits – specialty care | | \$20 | | \$40 | | \$30 | | \$50 | | | | | |
| Office visits – naturopathic c | are | \$10 | | \$30 | | \$20 | | \$40 | | | | | |
| Lab | | \$10 | | \$30 | | \$20 | | \$40 | | | | | |
| X-ray/diagnostic tests | | \$10 | | \$30 | | \$20 | | \$40 | | | | | |
| CT, MRI, and PET scans | | \$50 | | Not covered | | \$50 | No | ot covered | | | | | |
| Outpatient surgery | | \$50 | | Not covered | | \$50 | No | ot covered | | | | | |
| Inpatient hospital care | | r day, \$500 per dmission | | Not covered | | er day, \$500 per admission | | ot covered | | | | | |
| Emergency care | | \$100 | Covere | d at the in-network cost share ¹ | | \$100 | | at the in-network ost share ¹ | | | | | |
| Routine eye exam | | \$10 | | \$30 | | \$20 | | \$40 | | | | | |
| Outpatient prescription drug | | -network | | network (limited to ription fills per year) | | n-network | Out-of-network (limited to 5 prescription fills per year) | | | | | | |
| | | cy rider must be | purchased v | vith all KP Plus plans | A pharma | acy rider must be | purchased with | n all KP Plus plans | | | | | |

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.



| OVERVIEW | TRAD | DED | VC F | IDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | |
|----------------------------------------------------------------|-------------|-----------|---------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|-----------|----------------------------------|----------------|--------------------------------------------------------------------|--|--|--|--|
| | | | | | _ | | | | | | | | |
| Below are highligh you the flexibility t business goals. | | | | | 5 | 0 | | See plan | comparisons | | | | |
| To compare the be plan and then sele | | | • | eck the | checkboxes n | ext to ea | ich | | Reset | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan nameKP PLUS PLAN C 20/2000KP PLUS PLAN D 30/2500 | | | | | | | | | | | | | |
| Network | | In- | network | (limi | out-of-network ted to 10 covered per year, combined) | | n-network | (limited | of-network to 10 covered r year, combined) | | | | |
| Annual medical dedu (IND/FAM) (per calen | | | N/A | | N/A | | N/A | | N/A | | | | |
| Annual out-of-pocket maximum (IND/FAM | | \$2,00 | 00/\$4,000 | | N/A | \$2, | 500/\$5,000 | | N/A | | | | |
| Office visits – preven well-child care | tive and | | \$0 | | \$0 | | \$0 | | \$0 | | | | |
| Office visits – prenat | al care | | \$0 \$0 \$0 | | | | | | \$0 | | | | |
| Telehealth (phone/vi | deo) | | \$0 | | are applicable to the e when provided in person. | | \$0 | service w | applicable to the hen provided in person. | | | | |
| Office visits – primar | y care | | \$20 | | \$40 | | \$30 | \$50 | | | | | |
| Office visits – urgent | care | | \$40 | services | overed, except for received outside the service area ^{1,2} | • | \$50 | services ree | ered, except for ceived outside the vice area ^{1,2} | | | | |
| Office visits – special | ty care | | \$30 | | \$50 | | \$40 | | \$60 | | | | |
| Office visits – naturo | pathic care | | \$20 | | \$40 | | \$30 | | \$50 | | | | |
| Lab | | | \$20 | | \$40 | | \$30 | | \$50 | | | | |
| X-ray/diagnostic test | s | | \$20 | | \$40 | | \$30 | | \$50 | | | | |
| CT, MRI, and PET scar | ıs | | \$50 | | Not covered | | \$50 | No | t covered | | | | |
| Outpatient surgery | | | \$50 | | Not covered | | \$100 | No | t covered | | | | |
| Inpatient hospital ca | re | | day, \$1,000 per mission | | Not covered | | er day, \$1,000 per admission | | t covered | | | | |
| Emergency care | | | \$200 Covered at the in-network cost share ¹ | | | | \$200 | | t the in-network st share ¹ | | | | |
| Routine eye exam | | | \$20 | | \$40 | | \$30 | \$50 | | | | | |
| Outpatient prescript | ion drugs | In- | network | Out-of-network (limited to 5 prescription fills per year) | | | n-network | | twork (limited to tion fills per year) | | | | |
| *After deductible | | A pharmac | y rider must be p | urchased v | vith all KP Plus plans | A pharma | acy rider must be p | ourchased with | all KP Plus plans | | | | |

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.



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | |
|---------------------------------------------------------------------|--------------|-----------|--------------|----------------|---------------------------------------------------------------------|-----------|--------------------------------------------------------------------------|------------------|--------------------------------------------------------------------|--|--|--|--|
| | | | | | | | | | | | | | |
| Below are highlig you the flexibility business goals. | | | | | | - | | | comparisons | | | | |
| To compare the k plan and then sel | | | | | checkboxes r | ext to ea | ich | | Reset | | | | |
| | | | | KP | Plus | | | | | | | | |
| Plan name KP PLUS PLAN E 35/3000 KP PLUS PLAN A 250/10/10%/2000 | | | | | | | | | | | | | |
| Network | | In- | network | (limi | Out-of-network ted to 10 covered per year, combined | | In-network Out-of-network (limited to 10 cover services per year, com | | | | | | |
| Annual medical dec (IND/FAM) (per cale | | | N/A | | N/A | \$ | 250/\$750 | | N/A | | | | |
| Annual out-of-pock maximum (IND/FAN | | \$3,0 | 00/\$6,000 | | N/A | \$2, | 000/\$6,000 | | N/A | | | | |
| Office visits – preve well-child care | ntive and | | \$0 | | \$0 | | \$0 | | \$0 | | | | |
| Office visits – prena | ital care | | \$0 | | \$0 | | \$0 | | \$0 | | | | |
| Telehealth (phone/ | video) | | \$0 | | are applicable to the e when provided in person. | | \$0 | service w | applicable to the hen provided in person. | | | | |
| Office visits – prima | ary care | | \$35 | | \$55 | | \$10 | | \$30 | | | | |
| Office visits – urger | nt care | | \$60 | services | overed, except for received outside the service area ^{1,2} | e | \$10 | services re | ered, except for ceived outside the vice area ^{1,2} | | | | |
| Office visits – specia | alty care | | \$45 | | \$65 | | \$10 | | \$30 | | | | |
| Office visits – natur | opathic care | | \$35 | | \$55 | | \$10 | | \$30 | | | | |
| Lab | | | \$35 | | \$55 | | 10%* | | 20% | | | | |
| X-ray/diagnostic tes | its | | \$35 | | \$55 | | 10%* | | 20% | | | | |
| CT, MRI, and PET sca | ans | | \$50 | | Not covered | | 10%* | No | it covered | | | | |
| Outpatient surgery | | | \$150 | | Not covered | | 10%* | No | it covered | | | | |
| Inpatient hospital o | are | \$800 p | er admissior | 1 | Not covered | | 10%* | Not covere | | | | | |
| Emergency care | | | \$200 | Covere | ed at the in-network cost share ¹ | | \$200* | | at the in-network ost share ¹ | | | | |
| Routine eye exam | | | \$35 | | \$55 | | \$10 | | \$30 | | | | |
| Outpatient prescrip | tion drugs | In- | network | | network (limited to ription fills per year) | I | n-network | | Out-of-network (limited to 5 prescription fills per year) | | | | |
| *After deductible | | A pharmac | y rider must | be purchased v | vith all KP Plus plans | A pharma | acy rider must b | e purchased with | n all KP Plus plans | | | | |

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.



| OVERVIEW T | RAD | DED | VC | HDHP | KP PLUS | KP PLUS PPO OOA | | RIDERS | SR. ADV. | | | | |
|-----------------------------------------------------------------------------------------|-----------------------|------------|-------------------------------------------------------------------|---------------|--------------------------------------------------------------------|-----------------|---------------------------------------------------------------------|------------------|--------------------------------------------------------------------|--|--|--|--|
| Below are highlight you the flexibility to business goals. To compare the ber | choose | a plan th | at helps i | meet emp | loyee needs a | nd | | | comparisons Reset | | | | |
| plan and then selec | | | - | Check the | CHECKDOXEST | iext to ea | | | | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN A 250/15/20%/2500 KP PLUS PLAN B 500/20/10%/3000 | | | | | | | | | | | | | |
| Network | | In-i | network | (limi | ut-of-network ted to 10 covered per year, combined | | Out-of-netw In-network (limited to 10 co services per year, c | | | | | | |
| Annual medical deduc (IND/FAM) (per calenda | | \$25 | 50/\$750 | | N/A | \$! | 500/\$1,500 | | N/A | | | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$2,50 | 0/\$7,500 | | N/A | \$3, | ,000/\$6,000 | | N/A | | | | |
| Office visits – preventiv well-child care | ve and | | \$0 | \$0 | | | | | | | | | |
| Office visits – prenatal | care | | \$0 | \$0 | \$0 | | | | | | | | |
| Telehealth (phone/vide | eo) | | \$0 | | are applicable to the when provided in person. | ! | \$0 | service w | applicable to the hen provided in person. | | | | |
| Office visits – primary | care | | \$15 | | \$35 | | \$20 | | \$40 | | | | |
| Office visits – urgent ca | are | | \$35 | services | overed, except for received outside the ervice area ^{1,2} | e | \$40 | services rec | ered, except for ceived outside the vice area ^{1,2} | | | | |
| Office visits – specialty | care | | \$25 | | \$45 | | \$30 | | \$50 | | | | |
| Office visits – naturopa | athic care | | \$15 | | \$35 | | \$20 | | \$40 | | | | |
| Lab | | | \$15 | | \$35 | | \$20 | | \$40 | | | | |
| X-ray/diagnostic tests | | | \$15 | | \$35 | | \$20 | | \$40 | | | | |
| CT, MRI, and PET scans | | | \$100 | | Not covered | | \$100 | No | t covered | | | | |
| Outpatient surgery | | | 20%* | | Not covered | | 10%* | No | t covered | | | | |
| Inpatient hospital care | | | 20%* | Not covered | | 10%* | No | t covered | | | | | |
| Emergency care | | 2 | 20%* | Covere | d at the in-network cost share ¹ | | 10%* | | at the in-network ost share ¹ | | | | |
| Routine eye exam | | | \$15 | | \$35 | | \$20 | | \$40 | | | | |
| Outpatient prescription | n drugs | In-i | network Out-of-network (limited to 5 prescription fills per year) | | | I | n-network | | twork (limited to tion fills per year) | | | | |
| | J ² | A pharmacy | rider must k | e purchased w | rith all KP Plus plans | A pharma | acy rider must b | e purchased with | all KP Plus plans | | | | |

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.



| OVERVIEW TRA | D | DED | VC | HDHP KP PLUS PPO OOA | | OOA | RIDERS | SR. ADV. | | | | | | |
|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------|--------------|----------------------|---------------------------------------------------------------------|---------|-----------------------------------------------------------|------------------|--------------------------------------------------------------------|--|--|--|--|--|
| you the flexibility to ch business goals. | To compare the benefits of up to any 3 plans, check the checkboxes next to each Reset | | | | | | | | | | | | | |
| | plan and then select "See plan comparisons." | | | | | | | | | | | | | |
| KP Plus | | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN B 500/10%/10%/2000 KP PLUS PLAN B 500/10/20%/2000 | | | | | | | | | | | | | | |
| Network | | In- | network | (limi | ut-of-network ted to 10 covered per year, combined | | Out-of-network (limited to 10 co services per year, co | | | | | | | |
| Annual medical deductib (IND/FAM) (per calendar y | | \$50 | 0/\$1,500 | | N/A | \$ | 500/\$1,500 | | N/A | | | | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$2,00 | 00/\$6,000 | | N/A | \$2 | ,000/\$6,000 | | N/A | | | | | |
| Office visits – preventive a well-child care | and | | \$0 | | \$0 | | \$0 | | \$0 | | | | | |
| Office visits – prenatal car | re | \$0 \$0 \$0 | | | | | | | \$0 | | | | | |
| Telehealth (phone/video) | | | \$0 | | are applicable to the e when provided in person. | | \$0 | service w | applicable to the hen provided in person. | | | | | |
| Office visits – primary car | е | | 10%* | | 20% | | \$10 | \$30 | | | | | | |
| Office visits – urgent care | | | 10%* | services | overed, except for received outside the service area ^{1,2} | e | \$10 | services rec | ered, except for ceived outside the vice area ^{1,2} | | | | | |
| Office visits – specialty ca | re | | 10%* | | 20% | | \$10 | | \$30 | | | | | |
| Office visits – naturopath | ic care | | 10%* | | 20% | | \$10 | | \$30 | | | | | |
| Lab | | | 10%* | | 20% | | 20%* | | 30% | | | | | |
| X-ray/diagnostic tests | | | 10%* | | 20% | | 20%* | | 30% | | | | | |
| CT, MRI, and PET scans | | | 10%* | | Not covered | | 20%* | No | t covered | | | | | |
| Outpatient surgery | | | 10%* | | Not covered | | 20%* | No | t covered | | | | | |
| Inpatient hospital care 10%* Not covered 20%* | | | | | | | No | t covered | | | | | | |
| Emergency care | | | \$200* | Covere | ed at the in-network cost share ¹ | | \$200* | | t the in-network st share ¹ | | | | | |
| Routine eye exam | | | 10%* | | 20% | | \$10 | | \$30 | | | | | |
| Outpatient prescription d | rugs | In- | network | | network (limited to ription fills per year) | | n-network | | twork (limited to tion fills per year) | | | | | |
| | · | A pharmac | y rider must | be purchased v | vith all KP Plus plans | A pharm | acy rider must b | e purchased with | all KP Plus plans | | | | | |

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| OVERVIEW TRA | ٩D | DED | VC | HDHP | KP PLUS | PPO OOA | | RIDERS | SR. ADV. | | | | |
|-----------------------------------------------------------------------------------------|---------|------------|----------------------------------------------------------------------|----------------|--------------------------------------------------------------------|------------|-----------------------------------------------------------|------------------|--------------------------------------------------------------------|--|--|--|--|
| Below are highlights of you the flexibility to ch business goals. | hoose | a plan th | at helps | meet emp | loyee needs a | nd | sch | | comparisons Reset | | | | |
| To compare the bener plan and then select " | | - | - | | CHECKDOXEST | iext to ea | | | | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN B 500/20/20%/3000 KP PLUS PLAN C 750/20/20%/3250 | | | | | | | | | | | | | |
| Network | | In- | network | (limi | out-of-network ted to 10 covered per year, combined | | Out-of-network (limited to 10 co services per year, co | | | | | | |
| Annual medical deductib (IND/FAM) (per calendar | | \$50 | 0/\$1,500 | | N/A | \$ | 750/\$2,250 | | N/A | | | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$3,00 | 00/\$9,000 | | N/A | \$3 | ,250/\$9,750 | | N/A | | | | |
| Office visits – preventive well-child care | and | | \$0 | | \$0 | | | | | | | | |
| Office visits – prenatal ca | re | | \$0 | \$0 | | | | | | | | | |
| Telehealth (phone/video) |) | | \$0 | | are applicable to the e when provided in person. | | \$0 | service w | applicable to the hen provided in person. | | | | |
| Office visits – primary car | re | | \$20 | | \$40 | | \$20 | | \$40 | | | | |
| Office visits – urgent care |) | | \$40 | services | overed, except for received outside th service area ^{1,2} | e | \$40 | services rec | ered, except for ceived outside the vice area ^{1,2} | | | | |
| Office visits – specialty ca | are | | \$30 | | \$50 | | \$30 | | \$50 | | | | |
| Office visits – naturopath | ic care | | \$20 | | \$40 | | \$20 | | \$40 | | | | |
| Lab | | | \$20 | | \$40 | | \$20 | | \$40 | | | | |
| X-ray/diagnostic tests | | | \$20 | | \$40 | | \$20 | | \$40 | | | | |
| CT, MRI, and PET scans | | | \$100 | | Not covered | | \$100 | No | t covered | | | | |
| Outpatient surgery | | | 20%* | | Not covered | | 20%* | No | t covered | | | | |
| Inpatient hospital care20%*Not covered20%* | | | | | | | 20%* | Not covered | | | | | |
| Emergency care | | | 20%* | Covere | ed at the in-network cost share ¹ | | 20%* | | at the in-network ost share ¹ | | | | |
| Routine eye exam | | | \$20 | | \$40 | | \$20 | | \$40 | | | | |
| Outpatient prescription of | Iruas | In- | In-network Out-of-network (limited to 5 prescription fills per year) | | | | n-network | | twork (limited to tion fills per year) | | | | |
| | 5 | A pharmacy | / rider must | be purchased v | vith all KP Plus plans | A pharma | acy rider must b | e purchased with | all KP Plus plans | | | | |

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| OVERVIEW TI | RAD | DED | VC | HDHP | KP PLUS | US PPO OOA | | RIDERS | SR. ADV. | | | | |
|-----------------------------------------------------------------------------------------|-----------|------------|------------|------------------------------------------------|-------------------------------------------------------------------------|------------|-----------------------------------------------------------|------------------|--------------------------------------------------------------------|--|--|--|--|
| Below are highlights you the flexibility to business goals. To compare the ben | choose | a plan th | at helps | meet emp | loyee needs a | nd | ach | | comparisons Reset | | | | |
| plan and then select | | | • | | | | | | | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN C 750/20%/20%/3000 KP PLUS PLAN D 1000/20/20%/3000 | | | | | | | | | | | | | |
| Network | | In-i | network | (limi | ut-of-network ted to 10 covered per year, combined | | Out-of-network (limited to 10 co services per year, co | | | | | | |
| Annual medical deduct (IND/FAM) (per calenda | | \$750 | 0/\$2,250 | | N/A | \$1, | ,000/\$3,000 | | N/A | | | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$3,00 | 0/\$9,000 | | N/A | \$3 | ,000/\$9,000 | | N/A | | | | |
| Office visits – preventiv well-child care | /e and | | \$0 | \$0 | | | | | | | | | |
| Office visits – prenatal | care | | \$0 | \$0 | \$0 | | | | | | | | |
| Telehealth (phone/vide | 90) | | \$0 | | are applicable to the when provided in person. | 2 | \$0 | service w | applicable to the hen provided in person. | | | | |
| Office visits – primary of | are | 2 | 20%* | | 30% | | \$20 | \$40 | | | | | |
| Office visits – urgent ca | ire | 2 | 20%* | services | overed, except for received outside th ervice area ^{1,2} | e | \$20 | services rec | ered, except for ceived outside the vice area ^{1,2} | | | | |
| Office visits – specialty | care | | 20%* | | 30% | | \$20 | | \$40 | | | | |
| Office visits – naturopa | thic care | | 20%* | | 30% | | \$20 | | \$40 | | | | |
| Lab | | 2 | 20%* | | 30% | | 20%* | | 30% | | | | |
| X-ray/diagnostic tests | | 2 | 20%* | | 30% | | 20%* | | 30% | | | | |
| CT, MRI, and PET scans | | 2 | 20%* | | Not covered | | 20%* | No | t covered | | | | |
| Outpatient surgery | | 2 | 20%* | | Not covered | | 20%* | No | t covered | | | | |
| Inpatient hospital care 20%* Not covered 20%* | | | | | | | No | t covered | | | | | |
| Emergency care | | \$ | 200* | Covere | d at the in-network cost share ¹ | | \$200* | | t the in-network st share ¹ | | | | |
| Routine eye exam | | | 20%* | | 30% | | \$20 | | \$40 | | | | |
| Outpatient prescriptior | In-i | network | | network (limited to ription fills per year) | | n-network | Out-of-network (limited to 5 prescription fills per year | | | | | | |
| | 5- | A pharmacy | rider must | be purchased w | vith all KP Plus plans | A pharma | acy rider must b | e purchased with | all KP Plus plans | | | | |

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| OVERVIEW T | RAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | | |
|-------------------------------------------------------------------------------------------|------------|----------------------------------------------------------------------|----------------|---------------|--------------------------------------------------------------------|----------|-------------------|------------------|--------------------------------------------------------------------|--|--|--|--|--|
| Below are highlight you the flexibility to business goals. To compare the ber | choose | a plan th | at helps r | neet emp | loyee needs a | nd | ach | | comparisons Reset | | | | | |
| plan and then selec | t "See pl | an comp | arisons." | | | | | | | | | | | |
| KP Plus | | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN D 1000/25/20%/4000 KP PLUS PLAN E 1500/25/20%/5500 | | | | | | | | | | | | | | |
| Network | | In- | network | (limi | ut-of-network ted to 10 covered per year, combined | | n-network | (limited | of-network to 10 covered r year, combined) | | | | | |
| Annual medical deduc (IND/FAM) (per calenda | | \$1,00 | 00/\$3,000 | | N/A | \$1, | 500/\$4,500 | | N/A | | | | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$4,00 | 0/\$12,000 | | N/A | \$5, | 500/\$11,000 | | N/A | | | | | |
| Office visits – preventiv well-child care | ve and | | \$0 | | \$0 | | \$0 | | \$0 | | | | | |
| Office visits – prenatal | care | | \$0 | | \$0 | | \$0 | \$0 | | | | | | |
| Telehealth (phone/vide | eo) | | \$0 | | are applicable to the when provided in person. | ! | \$0 | service w | applicable to the hen provided in person. | | | | | |
| Office visits – primary | care | | \$25 | | \$45 | | \$25 | | \$45 | | | | | |
| Office visits – urgent ca | are | | \$45 | services | overed, except for received outside the ervice area ^{1,2} | e | \$45 | services rec | ered, except for reived outside the vice area ^{1,2} | | | | | |
| Office visits – specialty | care | | \$35 | | \$55 | | \$35 | | \$55 | | | | | |
| Office visits – naturopa | athic 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 | No | t covered | | | | | |
| Outpatient surgery | | | 20%* | | Not covered | | 20%* | No | t covered | | | | | |
| Inpatient hospital care | 9 | | 20%* | | Not covered | | 20%* | No | t covered | | | | | |
| Emergency care | | | 20%* | Covere | d at the in-network cost share ¹ | | 20%* | | t the in-network st share ¹ | | | | | |
| Routine eye exam | | | \$25 | | \$45 | | \$25 | | \$45 | | | | | |
| Outpatient prescription | n drugs | In-network Out-of-network (limited to 5 prescription fills per year) | | | | I | n-network | | Out-of-network (limited to 5 prescription fills per year) | | | | | |
| | | A pharmacy | y rider must b | e purchased w | rith all KP Plus plans | A pharma | acy rider must be | e purchased with | all KP Plus plans | | | | | |

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| OVERVIEW TRA | ٩D | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------|--------------|----------------|--------------------------------------------------------------------|-----------------------------------------------------------|------------------|------------------|--------------------------------------------------------------|--|--|--|--|
| Below are highlights of you the flexibility to ch business goals. To compare the bene | hoose | a plan th | at helps | meet emp | loyee needs a | nd | ach | | comparisons Reset | | | | |
| plan and then select " | See p | lan comp | arisons." | | | | | | | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN E 1500/20/30%/4000 KP PLUS PLAN F 2000/25/20%/500 | | | | | | | | | | | | | |
| Network | | In- | network | (limi | out-of-network ted to 10 covered per year, combined | | n-network | (limited | of-network to 10 covered r year, combined) | | | | |
| Annual medical deductib (IND/FAM) (per calendar | | \$1,50 | 0/\$4,500 | | N/A | \$2 | ,000/\$6,000 | | N/A | | | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$4,00 | 0/\$12,000 | | N/A | \$5, | 000/\$10,000 | | N/A | | | | |
| Office visits – preventive well-child care | and | | \$0 | | \$0 | | \$0 | | \$0 | | | | |
| Office visits – prenatal ca | re | | \$0 | | \$0 | | \$0 | | \$0 | | | | |
| Telehealth (phone/video) |) | | \$0 | | are applicable to the e when provided in person. | | \$0 | service w | applicable to the hen provided in person. | | | | |
| Office visits – primary car | re | | \$20 | | \$40 | | \$25 | | \$45 | | | | |
| Office visits – urgent care | ; | | \$20 | services | overed, except for received outside th service area ^{1,2} | e | \$45 | services rec | ered, except for ceived outside the vice area ^{1,2} | | | | |
| Office visits – specialty ca | are | | \$20 | | \$40 | | \$35 | | \$55 | | | | |
| Office visits – naturopath | ic 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 | No | t covered | | | | |
| Outpatient surgery | | | 30%* | | Not covered | | 20%* | No | t covered | | | | |
| Inpatient hospital care | | | 30%* | | Not covered | | 20%* | No | t covered | | | | |
| Emergency care | | \$ | 5200* | Covere | ed at the in-network cost share ¹ | | 20%* | | at the in-network ost share ¹ | | | | |
| Routine eye exam | | | \$20 | | \$40 | | \$25 | | \$45 | | | | |
| Outpatient prescription of | tion drugs In-network Out-of-network (limited to 5 prescription fills per year) In-network | | | | n-network | Out-of-network (limited to 5 prescription fills per year) | | | | | | | |
| | 5 | A pharmacy | / rider must | be purchased v | vith all KP Plus plans | A pharma | acy rider must b | e purchased with | all KP Plus plans | | | | |

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| OVERVIEW TRA | D | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | |
|------------------------------------------------------------------------------------------------|------------|------------|--------------|----------------|------------------------------------------------------------------------|---------|------------------|--------------------------------------------------------------|--------------------------------------------------------------------|--|--|--|--|
| Below are highlights c you the flexibility to ch business goals. To compare the benef | noose | a plan th | at helps | meet emp | loyee needs a | nd | ach | | comparisons Reset | | | | |
| plan and then select "S | | - | - | | | | | | | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN G 2500/25/20%/5000 KP PLUS PLAN G 2500/30/30%/500 | | | | | | | | | | | | | |
| Network | | In- | network | (limi | out-of-network ted to 10 covered per year, combined | | n-network | (limited | of-network to 10 covered r year, combined) | | | | |
| Annual medical deductib (IND/FAM) (per calendar y | - | \$2,50 | 00/\$7,500 | | N/A | \$2 | ,500/\$5,000 | | N/A | | | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$5,00 | 0/\$10,000 | | N/A | \$5, | 000/\$10,000 | | N/A | | | | |
| Office visits – preventive a well-child care | and | | \$0 | | \$0 | | \$0 | | \$0 | | | | |
| Office visits – prenatal car | re | | \$0 | | \$0 | | \$0 | | \$0 | | | | |
| Telehealth (phone/video) | | | \$0 | | are applicable to the e when provided in person. | | \$0 | service w | applicable to the hen provided in person. | | | | |
| Office visits – primary car | е | | \$25 | | \$45 | | \$30 | | \$50 | | | | |
| Office visits – urgent care | | | \$45 | services | overed, except for received outside th service area ^{1,2} | e | \$30 | services rec | ered, except for ceived outside the vice area ^{1,2} | | | | |
| Office visits – specialty ca | re | | \$35 | | \$55 | | \$30 | | \$50 | | | | |
| Office visits – naturopath | ic care | | \$25 | | \$45 | | \$30 | | \$50 | | | | |
| Lab | | | \$25 | | \$45 | | 30%* | | 40% | | | | |
| X-ray/diagnostic tests | | | \$25 | | \$45 | | 30%* | | 40% | | | | |
| CT, MRI, and PET scans | | | \$100 | | Not covered | | 30%* | No | t covered | | | | |
| Outpatient surgery | | | 20%* | | Not covered | | 30%* | No | t covered | | | | |
| Inpatient hospital care | | 2 | 20%* | | Not covered | | 30%* | No | t covered | | | | |
| Emergency care | | | 20%* | Covere | ed at the in-network cost share ¹ | | \$200* | | at the in-network ost share ¹ | | | | |
| Routine eye exam | | | \$25 | | \$45 | | \$30 | | \$50 | | | | |
| Outpatient prescription d | In-network | | | | Out-of-network (limited to 5 prescription fills per year) In-networ | | | rk Out-of-network (limited to 5 prescription fills per year) | | | | | |
| | 5 | A pharmacy | / rider must | be purchased v | vith all KP Plus plans | A pharm | acy rider must b | e purchased with | all KP Plus plans | | | | |

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| OVERVIEW TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | | | |
|--------------------------------------------------------------------------------|--------|----------------|---------------|--------------------------------------------------------------------------|-----------|-----------------|------------------|--------------------------------------------------------------------|--|--|--|--|--|--|
| | | | | - | | | | | | | | | | |
| Below are highlights of the you the flexibility to choos business goals. | | | | y | 0 | | See plan | comparisons | | | | | | |
| To compare the benefits c plan and then select "See | | • | check the | checkboxes n | ext to ea | ch | | Reset | | | | | | |
| KP Plus | | | | | | | | | | | | | | |
| Plan name | | | | | | | | | | | | | | |
| Network | In-1 | network | (limit | ut-of-network ed to 10 covered per year, combined) | | n-network | (limited | of-network I to 10 covered er year, combined) | | | | | | |
| Annual medical deductible (IND/FAM) (per calendar year) | \$3,00 | 00/\$9,000 | | N/A | \$3, | 000/\$6,000 | | N/A | | | | | | |
| Annual out-of-pocket maximum (IND/FAM) | \$7,35 | 0/\$14,700 | | N/A | \$6,0 | 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 | | re applicable to the when provided in person. | | \$0 | service w | applicable to the hen provided in person. | | | | | | |
| Office visits – primary care | | \$30 | | \$50 | | 30%* | | 40% | | | | | | |
| Office visits – urgent care | | \$50 | services | overed, except for received outside the ervice area ^{1,2} | | 30%* | services re | ered, except for ceived outside the vice area ^{1,2} | | | | | | |
| Office visits – specialty care | | \$40 | | \$60 | | 30%* | | 40% | | | | | | |
| Office visits – naturopathic car | e | \$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%* | No | ot covered | | | | | | |
| Outpatient surgery | | 20%* | | Not covered | | 30%* | No | ot covered | | | | | | |
| Inpatient hospital care | | 20%* | | Not covered | | 30%* | No | ot covered | | | | | | |
| Emergency care | | 20%* | Covere | d at the in-network cost share ¹ | | \$200* | | at the in-network ost share ¹ | | | | | | |
| Routine eye exam | | \$30 | | \$50 | | 30%* | | 40% | | | | | | |
| Outpatient prescription drugs | | network | | network (limited to iption fills per year) | Ir | n-network | | twork (limited to tion fills per year) | | | | | | |
| , , , , , , , , , , , , , , , , , , , | | / rider must b | e purchased w | ith all KP Plus plans | A pharma | cy rider must b | e purchased with | all KP Plus plans | | | | | | |

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| OVERVIEW TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | | |
|--------------------------------------------------------------------------|-------|----------------|----------------|--------------------------------------------------------------------|-----------|------------------|------------------|--------------------------------------------------------------|--|--|--|--|--|
| Below are highlights of you the flexibility to cho business goals. | | | | y | • | | See plan | comparisons | | | | | |
| To compare the benefits plan and then select "Se | | , , | check the | checkboxes n | ext to ea | ich | | Reset | | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN I 3500/30/20%/7350 KP PLUS PLAN J 4000/3 | | | | | | | | | | | | | |
| Network | In | -network | (limi | ut-of-network ted to 10 covered per year, combined | | n-network | (limited | of-network to 10 covered r year, combined) | | | | | |
| Annual medical deductible (IND/FAM) (per calendar yea | \$3,5 | 00/\$10,500 | | N/A | \$4, | 000/\$10,000 | | N/A | | | | | |
| Annual out-of-pocket maximum (IND/FAM) | \$7,3 | 50/\$14,700 | | N/A | \$7, | 500/\$15,000 | | N/A | | | | | |
| Office visits – preventive an well-child care | d | \$0 | | \$0 | | \$0 | | \$0 | | | | | |
| Office visits – prenatal care | | \$0 | | \$0 | | \$0 | | \$0 | | | | | |
| Telehealth (phone/video) | | \$0 | | are applicable to the when provided in person. | | \$0 | service w | applicable to the hen provided in person. | | | | | |
| Office visits – primary care | | \$30 | | \$50 | | \$30 | | \$50 | | | | | |
| Office visits – urgent care | | \$50 | services | overed, except for received outside the ervice area ^{1,2} | e | \$50 | services red | ered, except for ceived outside the vice area ^{1,2} | | | | | |
| Office visits – specialty care | | \$40 | | \$60 | | \$40 | | \$60 | | | | | |
| Office visits – naturopathic | are | \$30 | | \$50 | | \$30 | | \$50 | | | | | |
| Lab | | \$30 | | \$50 | | \$30 | | \$50 | | | | | |
| X-ray/diagnostic tests | | \$30 | | \$50 | | \$30 | | \$50 | | | | | |
| CT, MRI, and PET scans | | \$100 | | Not covered | | \$100 | No | t covered | | | | | |
| Outpatient surgery | | 20%* | | Not covered | | 20%* | No | t covered | | | | | |
| Inpatient hospital care | | 20%* | | Not covered | | 20%* | No | t covered | | | | | |
| Emergency care | | 20%* | Covere | d at the in-network cost share ¹ | | 20%* | | at the in-network ost share ¹ | | | | | |
| Routine eye exam | | \$30 | | \$50 | | \$30 | | \$50 | | | | | |
| Outpatient prescription dru | | -network | | network (limited to ription fills per year) | I | | | twork (limited to tion fills per year) | | | | | |
| , , , | | y rider must k | be purchased w | vith all KP Plus plans | A pharma | acy rider must b | e purchased with | all KP Plus plans | | | | | |

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.



| OVERVIEW TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | | |
|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------|----------------|---------------------------------------------------------------------|------------|------------------|------------------|--------------------------------------------------------------------|--|--|--|--|--|
| Below are highlights of you the flexibility to cho business goals. | ose a plan tł | nat helps | meet emp | loyee needs a | nd | | | comparisons Reset | | | | | |
| To compare the benefit: plan and then select "Se | | | спеск тпе | checkboxes n | lext to ea | icn | | | | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN K 5000/30/20%/7350 KP PLUS PLAN L 6000/35/20%/750 | | | | | | | | | | | | | |
| Network | | -network | (limi | ut-of-network ted to 10 covered per year, combined | | n-network | (limited | of-network to 10 covered r year, combined) | | | | | |
| Annual medical deductible (IND/FAM) (per calendar yea | \$5.0 | 00/\$10,000 | | N/A | \$6,0 | 000/\$12,000 | | N/A | | | | | |
| Annual out-of-pocket maximum (IND/FAM) | \$7,3 | 50/\$14,700 | | N/A | \$7,5 | 500/\$15,000 | | N/A | | | | | |
| Office visits – preventive an well-child care | ıd | \$0 | | \$0 | | \$0 | | \$0 | | | | | |
| Office visits – prenatal care | | \$0 | | \$0 | | \$0 | | \$0 | | | | | |
| Telehealth (phone/video) | | \$0 | | are applicable to the when provided in person. | ! | \$0 | service w | applicable to the hen provided in person. | | | | | |
| Office visits – primary care | | \$30 | | \$50 | | \$35 | | \$55 | | | | | |
| Office visits – urgent care | | \$50 | services | overed, except for received outside the service area ^{1,2} | e | \$55 | services rec | ered, except for ceived outside the vice 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 | No | t covered | | | | | |
| Outpatient surgery | | 20%* | | Not covered | | 20%* | No | t covered | | | | | |
| Inpatient hospital care | | 20%* | | Not covered | | 20%* | No | t covered | | | | | |
| Emergency care | | 20%* | Covere | d at the in-network cost share ¹ | | 20%* | | t the in-network st share ¹ | | | | | |
| Routine eye exam | | \$30 | | \$50 | | \$35 | | \$55 | | | | | |
| Outpatient prescription dru | ugs In-network Out-of-network (limited to 5 prescription fills per year) In-network | | | Out-of-network (limited to 5 prescription fills per year | | | | | | | | | |
| , , , , , , , , , , , , , , , , , , , , | | cy rider must l | be purchased w | vith all KP Plus plans | A pharma | acy rider must b | e purchased with | all KP Plus plans | | | | | |

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.



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | РРО | OOA | RIDERS | SR. ADV. | | | | |
|-------------------------------------------------------------|---------------|-----|----|----------------|--------------------|---------------------------------------------------|----------------------------------------------------------|---------------------------------------------------|----------------|--|--|--|--|
| | | | | | | | | | | | | | |
| Below are highlig you the flexibility business goals. | | | | • | | - | | | comparisons | | | | |
| To compare the l plan and then se | | | • | | checkboxes | next to ea | ach | K | leset | | | | |
| KP Plus | | | | | | | | | | | | | |
| Plan name KP PLUS PLAN M 7500/35/30%/8500 | | | | | | | | | | | | | |
| Network | | | | In-network | | (limit | | ut-of-network ed services per yea | ır, combined) | | | | |
| Annual medical de (IND/FAM) (per cale | | | \$ | 7,500/\$14,500 | | | | N/A | | | | | |
| Annual out-of-pock maximum (IND/FA | | | \$ | 8,500/\$17,000 | | | | N/A | | | | | |
| Office visits – preve well-child care | entive and | | | \$0 | | | | \$0 | | | | | |
| Office visits – prena | atal care | | | \$0 | | | | \$0 | | | | | |
| Telehealth (phone/ | | | | \$0 | | Cost sl | nare applicable | to the service who person. | en provided in | | | | |
| Office visits – prim | ary care | | | \$35 | | NL - | 1 | \$55 | 1 | | | | |
| Office visits – urge | | | | \$55 | | Not co | | or services receive ervice area ^{1,2} | ed outside the | | | | |
| Office visits – speci | | | | \$45 | | | | \$65 | | | | | |
| Office visits – natur | ropathic care | | | \$35 | | | | \$55 | | | | | |
| Lab | | | | \$35 | | | | \$55 | | | | | |
| X-ray/diagnostic te | sts | | | \$35 | | | | \$55 | | | | | |
| CT, MRI, and PET sc | ans | | | \$150 | | | I | Not covered | | | | | |
| Outpatient surgery | 1 | | | 30%* | | | 1 | 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 prescrip | ation drugs | | | In-network | | Out-of- | ut-of-network (limited to 5 prescription fills per year) | | | | | | |
| outpatient prestri | | | | A pharr | nacy rider must be | purchased wi | th all KP Plus p | lans | | | | | |

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.



| OVERVIEW TR | RAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | | |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------|---------|---------------|--------|--------------------------------------------|--------|-------------|--|--|--|--|--|
| you the flexibility to o business goals. To compare the bend | o compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons." | | | | | | | | | | | | | |
| | | | ĺ | Dual Cl | noice PPO | | | | | | | | | |
| Plan name | | | | | | | | | | | | | | |
| Network | | ln-n | etwork | Οι | ıt-of-network | l | n-network | Out- | of-network | | | | | |
| Annual medical deducti (IND/FAM) (per calendar | | \$ | 0/\$0 | \$1 | ,500/\$3,000 | | \$0/\$0 | \$2,0 | 00/\$4,000 | | | | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$1,50 | 0/\$3,000 | \$4 | ,500/\$9,000 | \$2, | 000/\$4,000 | \$6,00 | 00/\$12,000 | | | | | |
| Office visits – preventive well-child care | e and | | \$0 | | 30%* | | \$0 | | 30%* | | | | | |
| Office visits – prenatal c | are | | \$0 | | 30%* | | \$0 | | 30%* | | | | | |
| Telehealth (phone/video | 0) | | \$0 | | 30%* | | \$0 | | 30%* | | | | | |
| Office visits – primary ca | are | | D enhanced mefit) | | 30%* | \$40 (| \$20 enhanced benefit) | | 30%* | | | | | |
| Office visits – urgent ca | re | | 0 enhanced nefit) | | 30%* | \$80 (| \$40 enhanced benefit) | | 30%* | | | | | |
| Office visits – specialty of | care | | 0 enhanced nefit) | | 30%* | \$50 (| \$30 enhanced benefit) | | 30%* | | | | | |
| Office visits – naturopat care | hic | | \$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 | | · | day, \$500 pe nission | er | 30%* | | \$100 per day, \$500 per admission 30%* | | | | | | | |
| Emergency care | | | | \$100 | | | | \$100 | | | | | | |
| Routine eye exam | | | D enhanced mefit) | | 30%* | \$40 (| \$20 enhanced benefit) | | 30%* | | | | | |

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



| OVERVIEW TR | RAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|--------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|-------------------------|-------------|---------------|--------|---------------------------------|--------------|----------------------|
| Below are highlights you the flexibility to o business goals. To compare the bene plan and then select | choose efits o [.] | e a plan th f up to any | iat helps / 3 plans, | , check the | loyee needs a | and | ach | | comparisons Reset |
| | 5001 | | | | noice PPO | | | | |
| Plan name | | D | | CE PPO PLAN | | | | E PPO PLAN D | 30/3000 |
| Network | | | etwork | | it-of-network | | n-network | | of-network |
| Annual medical deducti (IND/FAM) (per calendar | | | 0/\$0 | | ,000/\$4,000 | | \$0/\$0 | | 00/\$4,000 |
| Annual out-of-pocket maximum (IND/FAM) | | \$2,50 | 0/\$5,000 | \$6 | 000/\$12,000 | \$3, | 000/\$6,000 | \$6,00 | 0/\$12,000 |
| Office visits – preventive well-child care | e and | | \$0 | | 30%* | | \$0 | | 30%* |
| Office visits – prenatal c | are | | \$0 | | 30%* | | \$0 | | 30%* |
| Telehealth (phone/vide | 0) | | \$0 | | 30%* | | \$0 | | 30%* |
| Office visits – primary ca | are | - | 0 enhanced nefit) | | 30%* | \$50 (| \$30 enhanced benefit) | | 30%* |
| Office visits – urgent ca | re | | 0 enhanced nefit) | | 30%* | \$100 | (\$50 enhanced benefit) | | 30%* |
| Office visits – specialty of | care | | 0 enhanced nefit) | | 30%* | \$60 (| \$40 enhanced benefit) | | 30%* |
| Office visits – naturopat care | hic | | \$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 | | | day, \$1,00 dmission | 0 | 30%* | | per day, \$1,000 r admission | 30%* | |
| Emergency care | | | | \$200 | | | | \$200 | |
| Routine eye exam | | - | 0 enhanced nefit) | | 30%* | \$50 (| \$30 enhanced benefit) | | 30%* |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | | |
|------------------------------------------------------------|--------------------------------------------------------------------------------------|----------|-----------------------|---------|---------------|-------|--------------------------|--------|-------------|--|--|--|--|--|
| you the flexibility business goals. To compare the b | o compare the benefits of up to any 3 plans, check the checkboxes next to each Reset | | | | | | | | | | | | | |
| | | | | Dual Cl | noice PPO | | | | | | | | | |
| Plan nam | Plan name DUAL CHOICE PPO PLAN E 35/3500 DUAL CHOICE PPO PLAN A 250/10/10%/25 | | | | | | | | | | | | | |
| Network | | In-n | ietwork | Οι | ıt-of-network | Ir | n-network | Out- | of-network | | | | | |
| Annual medical dec (IND/FAM) (per cale | | \$ | 0/\$0 | \$2 | ,000/\$4,000 | \$2 | 250/\$750 | \$2,0 | 00/\$6,000 | | | | | |
| Annual out-of-pocke maximum (IND/FAN | | \$3,50 | 0/\$7,000 | \$6, | 000/\$12,000 | \$2,5 | 500/\$7,500 | \$6,00 | 00/\$12,000 | | | | | |
| Office visits – preve well-child care | ntive and | | \$0 | | 30%* | | \$0 | | 30%* | | | | | |
| Office visits – prena | tal care | | \$0 | | 30%* | | \$0 | | 30%* | | | | | |
| Telehealth (phone/v | /ideo) | | \$0 | | 30%* | | \$0 | | 30%* | | | | | |
| Office visits – prima | iry care | | 5 enhanced enefit) | | 30%* | | 510 enhanced benefit) | | 30%* | | | | | |
| Office visits – urgen | it care | - | 0 enhanceo enefit) | b | 30%* | | 510 enhanced benefit) | | 30%* | | | | | |
| Office visits – specia | alty care | | 5 enhanced enefit) | | 30%* | | 510 enhanced benefit) | | 30%* | | | | | |
| Office visits – nature care | opathic | | \$35 | | 30%* | | \$10 | | 30%* | | | | | |
| Lab | | | \$35 | | 30%* | | 10%* | | 30%* | | | | | |
| X-ray/diagnostic tes | its | | \$35 | | 30%* | | 10%* | | 30%* | | | | | |
| CT, MRI, and PET sca | ins | | \$50 | | 30%* | | 10%* | | 30%* | | | | | |
| Outpatient surgery | | \$ | 5150 | | 30%* | | 10%* | | 30%* | | | | | |
| Inpatient hospital c | are | \$800 pe | er admissior | ו | 30%* | | 10%* | | 30%* | | | | | |
| Emergency care | | | | \$200 | | | | \$200* | | | | | | |
| Routine eye exam | | | 5 enhanced enefit) | | 30%* | | 10 enhanced benefit) | | 30%* | | | | | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | | |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------|-----------------------|---------|---------------|-------|------------------------------|--------|-------------|--|--|--|--|--|
| you the flexibility business goals. To compare the b | To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons." | | | | | | | | | | | | | |
| | | | | Dual Cl | noice PPO | | | | | | | | | |
| Plan nam | Plan name DUAL CHOICE PPO PLAN A 250/15/20%/3000 DUAL CHOICE PPO PLAN B 500/20/10%/350 | | | | | | | | | | | | | |
| Network | | ln-n | ietwork | 01 | ut-of-network | Ir | n-network | Out- | of-network | | | | | |
| Annual medical ded (IND/FAM) (per cale | | \$25 | 0/\$750 | \$2 | 2,000/\$6,000 | \$5 | 00/\$1,500 | \$2,5 | 00/\$7,500 | | | | | |
| Annual out-of-pocke maximum (IND/FAN | | \$3,00 | 0/\$9,000 | \$6 | ,000/\$12,000 | \$3,5 | 500/\$10,500 | \$7,50 | 00/\$15,000 | | | | | |
| Office visits – preve well-child care | ntive and | | \$0 | | 30%* | | \$0 | | 30%* | | | | | |
| Office visits – prena | tal care | | \$0 | | 30%* | | \$0 | | 30%* | | | | | |
| Telehealth (phone/v | video) | | \$0 | | 30%* | | \$0 | | 30%* | | | | | |
| Office visits – prima | ry care | | 5 enhanced enefit) | | 30%* | | \$20 enhanced benefit) | | 30%* | | | | | |
| Office visits – urgen | t care | | 5 enhanced enefit) | | 30%* | | \$80 (\$40 enhanced benefit) | | 30%* | | | | | |
| Office visits – specia | alty care | | 5 enhanced enefit) | | 30%* | | \$30 enhanced benefit) | | 30%* | | | | | |
| Office visits – nature care | opathic | | \$15 | | 30%* | | \$20 | | 30%* | | | | | |
| Lab | | | \$15 | | 30%* | | \$20 | | 30%* | | | | | |
| X-ray/diagnostic tes | ts | | \$15 | | 30%* | | \$20 | | 30%* | | | | | |
| CT, MRI, and PET sca | ins | \$ | 5100 | | 30%* | | \$100 | | 30%* | | | | | |
| Outpatient surgery | | 2 | 20%* | | 30%* | | 10%* | | 30%* | | | | | |
| Inpatient hospital ca | are | 2 | 0%* | | 30%* | | 10%* | | 30%* | | | | | |
| Emergency care | | | | 20%* | | | | 10%* | | | | | | |
| Routine eye exam | | | 5 enhanced enefit) | | 30%* | | \$20 enhanced benefit) | | 30%* | | | | | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | | |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------|-----------------------|--------|---------------|-------|--------------------------|--------|-------------|--|--|--|--|--|
| you the flexibility t business goals. To compare the be | To compare the benefits of up to any 3 plans, check the checkboxes next to each blan and then select "See plan comparisons." | | | | | | | | | | | | | |
| | Dual Choice PPO | | | | | | | | | | | | | |
| Plan name | Plan name DUAL CHOICE PPO PLAN B 500/10%/10%/3000 DUAL CHOICE PPO PLAN B 500/10/20%/30 | | | | | | | | | | | | | |
| Network | | ln-n | ietwork | 01 | ut-of-network | Ir | ı-network | Out- | of-network | | | | | |
| Annual medical ded (IND/FAM) (per calen | | \$500 |)/\$1,500 | \$2 | 2,500/\$7,500 | \$5 | 00/\$1,500 | \$2,5 | 00/\$7,500 | | | | | |
| Annual out-of-pocket maximum (IND/FAM | | \$3,00 | 0/\$9,000 | \$7 | 500/\$15,000 | \$3,0 | 000/\$9,000 | \$7,50 | 00/\$15,000 | | | | | |
| Office visits – preven well-child care | itive and | | \$0 | | 30%* | | \$0 | | 40%* | | | | | |
| Office visits – prenat | al care | | \$0 | | 30%* | | \$0 | | 40%* | | | | | |
| Telehealth (phone/vi | deo) | | \$0 | | 30%* | | \$0 | | 40%* | | | | | |
| Office visits – primar | y care | | %* enhance enefit) | d | 30%* | | 510 enhanced benefit) | | 40%* | | | | | |
| Office visits – urgent | care | | %* enhance enefit) | d | 30%* | | 510 enhanced benefit) | | 40%* | | | | | |
| Office visits – special | ty care | | %* enhance enefit) | d | 30%* | | 510 enhanced benefit) | | 40%* | | | | | |
| Office visits – naturo care | pathic | 1 | 0%* | | 30%* | | \$10 | | 40%* | | | | | |
| Lab | | 1 | 0%* | | 30%* | | 20%* | | 40%* | | | | | |
| X-ray/diagnostic test | S | 1 | 0%* | | 30%* | | 20%* | | 40%* | | | | | |
| CT, MRI, and PET scar | ıs | 1 | 0%* | | 30%* | | 20%* | | 40%* | | | | | |
| Outpatient surgery | | 1 | 0%* | | 30%* | | 20%* | | 40%* | | | | | |
| Inpatient hospital ca | re | 1 | 0%* | | 30%* | | 20%* | | 40%* | | | | | |
| Emergency care | | | | \$200* | | | | \$200* | | | | | | |
| Routine eye exam | | | %* enhance enefit) | d | 30%* | | 510 enhanced benefit) | | 40%* | | | | | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | |
|------------------------------------------------------------------------------------------------|----------------------------|----------------------------|-------------------------|-----------------------|---------------|-------|---------------------------------|-------------------------------|--------------|--|------|--|
| Below are highl you the flexibilit business goals. To compare the plan and then se | ty to choose benefits o | e a plan th f up to any | nat helps y 3 plans, | meet emp check the | loyee needs a | and | ach | See plan compariso h Reset | | | | |
| | | | | Dual Cl | noice PPO | | | | | | | |
| Plan na | me | DUAL | CHOICE PP | O PLAN B 50 | 0/20/20%/3500 | DUA | AL CHOICE PP | O PLAN C 750 | /20/20%/3500 | | | |
| Network | | ln-n | etwork | Οι | ıt-of-network | Ir | n-network | Out- | of-network | | | |
| Annual medical d (IND/FAM) (per ca | | \$500 |)/\$1,500 | \$2 | ,500/\$7,500 | \$7 | 50/\$2,250 | \$3,0 | 00/\$9,000 | | | |
| Annual out-of-poo maximum (IND/F/ | | \$3,500 | 0/\$10,500 | \$7, | 500/\$15,000 | \$3,5 | 00/\$10,500 | \$7,50 | 00/\$22,500 | | | |
| Office visits – prev well-child care | ventive and | | \$0 | | 40%* | | \$0 | | 40%* | | | |
| Office visits – prei | natal care | | \$0 | | 40%* | | \$0 | 40%* | | | | |
| Telehealth (phone | e/video) | | \$0 | | 40%* | | \$0 | | 40%* | | | |
| Office visits – prin | nary care | | 0 enhanced enefit) | | 40%* | | \$40 (\$20 enhanced benefit) | | 40%* | | | |
| Office visits – urgo | ent care | | 0 enhanced enefit) | | 40%* | | \$80 (\$40 enhanced benefit) | | | | 40%* | |
| Office visits – spe | cialty care | | 0 enhanced enefit) | | 40%* | | 530 enhanced benefit) | | 40%* | | | |
| Office visits – natu care | uropathic | | \$20 | | 40%* | | \$20 | | 40%* | | | |
| Lab | | | \$20 | | 40%* | | \$20 | | 40%* | | | |
| X-ray/diagnostic t | ests | | \$20 | | 40%* | | \$20 | | 40%* | | | |
| CT, MRI, and PET s | scans | \$ | 5100 | | 40%* | | \$100 | | 40%* | | | |
| Outpatient surger | ry | 2 | 0%* | | 40%* | | 20%* | | 40%* | | | |
| Inpatient hospita | l care | 2 | 0%* | | 40%* | | 20%* 4 | | | | | |
| Emergency care | | | | 20%* | | 20%* | | | | | | |
| Routine eye exam | 1 | | 0 enhanced enefit) | | 40%* | | \$20 enhanced benefit) | | 40%* | | | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | PPO OOA | | SR. ADV. | |
|-------------------------------------------------------------------------------------------------|----------------------------|------------------------|----------------------------|------------|----------------|--------|------------------------------|-------------|----------------------|--|
| Below are highli you the flexibilit business goals. To compare the plan and then se | y to choose benefits of | a plan th up to any | at helps m / 3 plans, c | eet emp | loyee needs a | nd | ich | | comparisons Reset | |
| | | | D | ual Ch | noice PPO | | | | | |
| Plan na | me | DUAL | CHOICE PPO I | PLAN C 750 | 0/20%/20%/3500 | DUA | L CHOICE PPO | PLAN D 1000 | /20/20%/4000 | |
| Network | | In-r | network | 0ι | ıt-of-network | Ir | n-network | Out- | of-network | |
| Annual medical de (IND/FAM) (per cal | | \$750 | 0/\$2,250 | \$3 | ,000/\$9,000 | \$1,0 | 000/\$3,000 | \$3,0 | 00/\$9,000 | |
| Annual out-of-poc maximum (IND/FA | | \$3,50 | 0/\$10,500 | \$7, | 500/\$22,500 | \$4,0 | 000/\$12,000 | \$9,00 | 00/\$27,000 | |
| Office visits – prev well-child care | entive and | | \$0 | | 40%* | | \$0 | | 40%* | |
| Office visits – prer | natal care | | \$0 | | 40%* | | \$0 | 40%* | | |
| Telehealth (phone | /video) | | \$0 | | 40%* | | \$0 | 40%* | | |
| Office visits – prin | nary care | | %* enhanced enefit) | | 40%* | | \$40 (\$20 enhanced benefit) | | 40%* | |
| Office visits – urge | ent care | | %* enhanced enefit) | | 40%* | | \$20 enhanced benefit) | | 40%* | |
| Office visits – spec | ialty care | | %* enhanced enefit) | | 40%* | | \$20 enhanced benefit) | | 40%* | |
| Office visits – natu | ıropathic care | | 20%* | | 40%* | | \$20 | | 40%* | |
| Lab | | 2 | 20%* | | 40%* | | 20%* | | 40%* | |
| X-ray/diagnostic te | ests | | 20%* | | 40%* | | 20%* | | 40%* | |
| CT, MRI, and PET s | cans | | 20%* | | 40%* | | 20%* | | 40%* | |
| Outpatient surger | у | | 20%* | | 40%* | | 20%* | | 40%* | |
| Inpatient hospital | care | 2 | 20%* | | 40%* | | 20%* 40%* | | | |
| Emergency care | | | \$ | 200* | | \$200* | | | | |
| Routine eye exam | | | %* enhanced enefit) | | 40%* | | \$20 enhanced benefit) | | 40%* | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | PPO OOA | | SR. ADV. | | | | | | |
|-------------------------------------------------------------------------------------------------|--------------------------|------------------------------------|-------------------------|-------------|----------------|-------|---------------------------------|---------------|----------------------|--|------|--|------|--|------|
| Below are highli you the flexibilit business goals. To compare the plan and then se | y to choos benefits o | e a plan th f up to an <u>y</u> | nat helps y 3 plans, | , check the | loyee needs a | and | ich | | comparisons Reset | | | | | | |
| | | | | Dual Cl | noice PPO | | | | | | | | | | |
| Plan naı | ne | DUAL | CHOICE PP | O PLAN D 10 | 00/25/20%/5000 | DUA | L CHOICE PP(|) PLAN E 1500 | 0/25/20%/6000 | | | | | | |
| Network | | In-n | network | 0ι | ut-of-network | Ir | n-network | Out | of-network | | | | | | |
| Annual medical de (IND/FAM) (per cal | | \$1,00 | 0/\$3,000 | \$3 | 8,000/\$9,000 | \$1,5 | 500/\$4,500 | \$3,5 | 00/\$10,500 | | | | | | |
| Annual out-of-poc maximum (IND/FA | | \$5,000 | 0/\$15,000 | \$9, | 000/\$27,000 | \$6,0 | 00/\$12,000 | \$10,5 | 00/\$21,000 | | | | | | |
| Office visits – prev well-child care | ventive and | | \$0 | | 40%* | | \$0 | \$0 40%* | | | | | | | |
| Office visits – prer | natal care | | \$0 | | 40%* | | \$0 | | 40%* | | | | | | |
| Telehealth (phone | /video) | | \$0 | | 40%* | | \$0 | | 40%* | | | | | | |
| Office visits – prin | nary care | | 5 enhanced enefit) | | 40%* | | \$45 (\$25 enhanced benefit) | | 40%* | | | | | | |
| Office visits – urge | ent care | | 5 enhanced enefit) | | 40%* | | \$90 (\$45 enhanced benefit) | | • | | 40%* | | | | |
| Office visits – spec | cialty care | | 5 enhanced enefit) | | 40%* | | 535 enhanced benefit) | | 40%* | | | | | | |
| Office visits – natu care | ıropathic | | \$25 | 25 40%* | | | \$25 | | \$25 | | \$25 | | \$25 | | 40%* |
| Lab | | | \$25 | | 40%* | | \$25 | | 40%* | | | | | | |
| X-ray/diagnostic te | ests | | \$25 | | 40%* | | \$25 | | 40%* | | | | | | |
| CT, MRI, and PET s | cans | \$ | 5100 | | 40%* | | \$100 | | 40%* | | | | | | |
| Outpatient surger | у | 2 | 20%* | | 40%* | | 20%* | | 40%* | | | | | | |
| Inpatient hospital | care | 2 | 20%* | | 40%* | | 20%* | 20%* 40% | | | | | | | |
| Emergency care | | | | 20%* | | 20%* | | | | | | | | | |
| Routine eye exam | | | 5 enhanced enefit) | | 40%* | | 525 enhanced benefit) | 409 | | | | | | | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO OOA | | RIDERS | SR. ADV. |
|-------------------------------------------------------------------------------------------------|-------------|----------------------------|-------------------------|-----------------------|----------------|---------|---------------------------------|---------------|----------------------|
| Below are highli you the flexibilit business goals. To compare the plan and then se | benefits o | e a plan th f up to any | nat helps / 3 plans, | meet emp check the | loyee needs a | and | ich | | comparisons Reset |
| | | | | Dual Cl | noice PPO | | | | |
| Plan nai | me | DUAL (| CHOICE PP(| D PLAN E 150 | 00/20/30%/5000 | DUA | L CHOICE PPO |) PLAN F 2000 | 0/25/20%/6000 |
| Network | | In-n | etwork | Οι | ıt-of-network | Ir | n-network | Out- | of-network |
| Annual medical d (IND/FAM) (per ca | | \$1,50 | 0/\$4,500 | \$3, | 500/\$10,500 | \$2,0 | 000/\$6,000 | \$4,0 | 00/\$12,000 |
| Annual out-of-poc maximum (IND/F/ | | \$5,000 |)/\$12,000 | \$10 | ,500/\$21,000 | \$6,0 | 00/\$12,000 | \$12,0 | 00/\$24,000 |
| Office visits – prev well-child care | ventive and | | \$0 | | 50%* | | \$0 | | 40%* |
| Office visits – prer | natal care | | \$0 | | 50%* | | \$0 | | 40%* |
| Telehealth (phone | e/video) | | \$0 | | 50%* | | \$0 | | 40%* |
| Office visits – prin | nary care | | 0 enhanced enefit) | | 50%* | | \$45 (\$25 enhanced benefit) | | 40%* |
| Office visits – urge | ent care | | 0 enhanced enefit) | | 50%* | | \$90 (\$45 enhanced benefit) | | 40%* |
| Office visits – spec | cialty care | | 0 enhanced enefit) | | 50%* | | 535 enhanced benefit) | | 40%* |
| Office visits – natu care | uropathic | | \$20 | | 50%* | | \$25 | | 40%* |
| Lab | | 3 | 0%* | | 50%* | | \$25 | | 40%* |
| X-ray/diagnostic to | ests | 3 | 0%* | | 50%* | | \$25 | | 40%* |
| CT, MRI, and PET s | cans | 3 | 0%* | | 50%* | | \$100 | | 40%* |
| Outpatient surger | у | 3 | 0%* | | 50%* | | 20%* | | 40%* |
| Inpatient hospital | care | 3 | 0%* | | 50%* | 20%* | | | 40%* |
| Emergency care | | | | \$200* | | 20%* | | | |
| Routine eye exam | 1 | | 0 enhanced enefit) | | 50%* | | 525 enhanced benefit) | 409 | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | |
|----------------------------------------------------------------------------|-------------|-------------|-----------------------|-------------|----------------|--------|------------------------------|-------------|----------------------|--|
| Below are highl you the flexibilit business goals. To compare the | to choos | e a plan th | nat helps | meet emp | loyee needs a | and | ich | | comparisons Reset | |
| plan and then se | | | parisons." | | | | | | | |
| | | · | | Dual Ch | noice PPO | | | | | |
| Plan na | me | DUAL | CHOICE PP(|) PLAN G 25 | 00/25/20%/6000 | DUA | L CHOICE PPC | PLAN G 2500 | /30/30%/6000 | |
| Network | | In-n | ietwork | Οι | ıt-of-network | In | ı-network | Out- | of-network | |
| Annual medical d (IND/FAM) (per ca | | \$2,50 | 0/\$7,500 | \$4, | 500/\$13,500 | \$2,5 | 500/\$5,000 | \$4,50 | 00/\$13,500 | |
| Annual out-of-poc maximum (IND/F/ | | \$6,000 | 0/\$12,000 | \$13 | ,500/\$27,000 | \$6,0 | 00/\$12,000 | \$13,5 | 00/\$27,000 | |
| Office visits – prev well-child care | ventive and | | \$0 | | 40%* | | \$0 | | 50%* | |
| Office visits – prer | natal care | | \$0 | | 40%* | | \$0 | 50%* | | |
| Telehealth (phone | e/video) | | \$0 | | 40%* | | \$0 | | 50%* | |
| Office visits – prin | nary care | - | 5 enhanced enefit) | | 40%* | | \$50 (\$30 enhanced benefit) | | 50%* | |
| Office visits – urge | ent care | | 5 enhanced enefit) | | 40%* | | \$50 (\$30 enhanced benefit) | | 50%* | |
| Office visits – spec | cialty care | | 5 enhanced enefit) | | 40%* | | 530 enhanced benefit) | | 50%* | |
| Office visits – natu care | uropathic | | \$25 | | 40%* | | \$30 | | 50%* | |
| Lab | | | \$25 | | 40%* | | 30%* | | 50%* | |
| X-ray/diagnostic to | ests | | \$25 | | 40%* | | 30%* | | 50%* | |
| CT, MRI, and PET s | cans | 4 | 5100 | | 40%* | | 30%* | | 50%* | |
| Outpatient surger | ry | 2 | 0%* | | 40%* | | 30%* | | 50%* | |
| Inpatient hospital | care | 2 | 20%* | | 40%* | | 30%* | 50%* | | |
| Emergency care | | | | 20%* | | \$200* | | | | |
| Routine eye exam | 1 | | 5 enhanced enefit) | | 40%* | | 530 enhanced benefit) | | 50%* | |

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



| OVERVIEW TRAD | DED | VC | HDHP | KP PLUS | PPO | PPO OOA | | SR. ADV. |
|-----------------------------------------------------------------------------|-------------------------------|------------------------|------------|--------------------------|------------|------------------------------|--------|---------------|
| | | | | | | | | |
| Below are highlights of t you the flexibility to choo business goals. | ose a plan th | nat helps m | neet emp | loyee needs a | nd | | | i comparisons |
| To compare the benefits plan and then select "Se | | | heck the | checkboxes r | iext to ea | ich | | Reset |
| | | D |)ual Ch | oice PPO | | | | |
| Plan name | DUAL CH | IOICE PPO PI | LAN H 3000 | 0/30/20%/8150 | DUAL C | 80%/30%/7000 | | |
| Network | In-network Out-of-network In- | | | | | | Out | -of-network |
| Annual medical deductible (IND/FAM) (per calendar yea | r) \$3,00 | 00/\$9,000 | \$5, | 000/\$15,000 | \$3, | 000/\$6,000 | \$5,0 | 00/\$15,000 |
| Annual out-of-pocket maximum (IND/FAM) | \$8,15 | 0/\$16,300 | \$15 | ,000/\$30,000 | \$7,0 | 00/\$14,000 | \$15,0 | 000/\$30,000 |
| Office visits – preventive and well-child care | Ł | \$0 | | 40%* | | \$0 | | 50%* |
| Office visits – prenatal care | | \$0 | | 40%* | | \$0 | 50%* | |
| Telehealth (phone/video) | | \$0 | | 40%* | | \$0 | | 50%* |
| Office visits – primary care | | 0 enhanced enefit) | | 40%* | | 30%* enhance benefit) | d | 50%* |
| Office visits – urgent care | | 50 enhanced enefit) | | 40%* | | 40%* (30%* enhanced benefit) | | 50%* |
| Office visits – specialty care | | 0 enhanced enefit) | | 40%* | | 30%* enhance benefit) | d | 50%* |
| Office visits – naturopathic c | are | \$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 | 2 | 20%* | 40%* 30%* | | | | | 50%* |
| Inpatient hospital care | | 20%* | | 40%* | | 30%* | | 50%* |
| Emergency care | | | 20%* | | | | \$200* | |
| Routine eye exam | | 40%* | | 30%* enhance benefit) | d | 50%* | | |

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



| OVERVIEW TRAD | DED | VC | HDHP KP PLUS PPO OOA | | RIDERS | SR. ADV. | | |
|-----------------------------------------------------------------------------|-----------|------------------------|----------------------|---------------|------------|---------------------------------|--------------|--------------|
| | | | | | | | | |
| Below are highlights of t you the flexibility to choo business goals. | | • | | | - | | | comparisons |
| To compare the benefits plan and then select "Se | | | check the | checkboxes r | next to ea | ich | | Reset |
| | | C | Dual Ch | oice PPO | | | | |
| Plan name | DUAL C | HOICE PPO P | LAN I 3500 | /30/20%/8000 | DUAL | CHOICE PPO F | PLAN J 4000/ | 30/20%/8150 |
| Network | In- | network | Οι | ıt-of-network | Ir | n-network | Out | -of-network |
| Annual medical deductible (IND/FAM) (per calendar yea | r) \$3,50 | 0/\$10,500 | \$5, | 500/\$16,500 | \$4,0 | 000/\$10,000 | \$6,0 | 00/\$18,000 |
| Annual out-of-pocket maximum (IND/FAM) | \$8,00 | 0/\$16,000 | \$15 | ,000/\$30,000 | \$8,1 | 50/\$16,300 | \$15,0 | 000/\$30,000 |
| Office visits – preventive and well-child care | 1 | \$0 | | 40%* | | \$0 | 40%* | |
| Office visits – prenatal care | | \$0 | | 40%* | | \$0 | 40%* | |
| Telehealth (phone/video) | | \$0 | | 40%* | | \$0 | | 40%* |
| Office visits – primary care | | 30 enhanced enefit) | | 40%* | | 530 enhanced benefit) | | 40%* |
| Office visits – urgent care | | 50 enhanced enefit) | | 40%* | | \$100 (\$50 enhanced benefit) | | 40%* |
| Office visits – specialty care | | 10 enhanced enefit) | | 40%* | | 40 enhanced benefit) | | 40%* |
| Office visits – naturopathic c | are | \$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 | | 30 enhanced enefit) | | 40%* | | \$50 (\$30 enhanced benefit) | | 40%* |

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



| OVERVIEW 1 | FRAD | DED | VC | HDHP | KP PLUS | PPO OOA | | RIDERS | SR. ADV. | | | | |
|---------------------------------------------------------------------------------------|----------------------|-------------|----------------------|-------------|--------------------------|---------|----------------------------------|--------------|----------------------|--|--|--|------|
| Below are highlight you the flexibility to business goals. To compare the be | o choose | e a plan th | at helps r | neet emp | loyee needs a | and | ich | | comparisons Reset | | | | |
| plan and then selec | | | arisons." | | | | | | | | | | |
| | | | | Dual Ch | ioice PPO | | | | | | | | |
| Plan name | | DUAL CH | OICE PPO P | PLAN K 5000 | /30/20%/8150 | DUAL | CHOICE PPO P | LAN L 6000/3 | 35/20%/8000 | | | | |
| Network | | ln-n | etwork | Ou | t-of-network | lr | n-network | Out- | of-network | | | | |
| Annual medical dedu (IND/FAM) (per calend | | \$5,000 |)/\$10,000 | \$6, | 500/\$19,500 | \$6,0 | 00/\$12,000 | \$7,50 | 00/\$18,000 | | | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$8,150 |)/\$16,300 | \$15, | 000/\$30,000 | \$8,0 | 00/\$16,000 | \$15,0 | 00/\$30,000 | | | | |
| Office visits – prevent well-child care | ive and | | \$0 | | 40%* | | \$0 | | 40%* | | | | |
| Office visits – prenata | l care | | \$0 | | 40%* | | \$0 | 40%* | | | | | |
| Telehealth (phone/vid | leo) | | \$0 | | 40%* | | \$0 | | 40%* | | | | |
| Office visits – primary | care | | 0 enhanced mefit) | | 40%* | | \$55 (\$35 enhanced benefit) | | 40%* | | | | |
| Office visits – urgent o | care | | 0 enhanced nefit) | | 40%* | | \$100 (\$55 enhanced benefit) | | | | | | 40%* |
| Office visits – specialt | y care | | 0 enhanced mefit) | | 40%* | | 545 enhanced benefit) | | 40%* | | | | |
| Office visits – naturop care | athic | Q | \$30 | | 40%* | | \$35 | | 40%* | | | | |
| Lab | | ç | \$30 | | 40%* | | \$35 | | 40%* | | | | |
| X-ray/diagnostic tests | | Q | \$30 | | 40%* | | \$35 | | 40%* | | | | |
| CT, MRI, and PET scans | S | \$ | 100 | | 40%* | | \$150 | | 40%* | | | | |
| Outpatient surgery | | 2 | 0%* | | 40%* | | 20%* | | 40%* | | | | |
| Inpatient hospital care 20%* 40%* 20%* | | | | | 20%* | | 40%* | | | | | | |
| Emergency care | | | | 20%* | | | | 20%* | | | | | |
| Routine eye exam | 0 enhanced mefit) | | 40%* | | 535 enhanced benefit) | | 40%* | | | | | | |

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



| OVERVIEW - | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | | |
|--------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------|------------|---------------|---------------|------|-------|--------------|---------------------|--|--|--|--|
| Below are highligh you the flexibility to business goals. To compare the be | o choose | e a plan th | at helps | s meet emp | loyee needs a | and | ich | | comparisons eset | | | | |
| plan and then sele | | | | | | | | | | | | | |
| | Dual Choice PPO | | | | | | | | | | | | |
| Plan name | Plan name DUAL CHOICE PPO PLAN M 7500/35/30%/8500 | | | | | | | | | | | | |
| Network | | In-network Out-of-network | | | | | | | | | | | |
| Annual medical dedu (IND/FAM) (per calend | | | \$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 – prevent well-child care | tive and | | | \$0 | | | | 50%* | | | | | |
| Office visits – prenata | al care | | | \$0 | | | | 50%* | | | | | |
| Telehealth (phone/vio | deo) | | | \$0 | | | | 50%* | | | | | |
| Office visits – primary | y care | | \$55 (\$35 | 5 enhanced be | nefit) | | | 50%* | | | | | |
| Office visits – urgent | care | | \$100 (\$5 | 5 enhanced be | enefit) | | | 50%* | | | | | |
| Office visits – specialt | ty care | | \$65 (\$45 | 5 enhanced be | nefit) | | | 50%* | | | | | |
| Office visits – naturop care | oathic | | | \$35 | | | | 50%* | | | | | |
| Lab | | | | \$35 | | | | 50%* | | | | | |
| X-ray/diagnostic tests | ; | | | \$35 | | | | 50%* | | | | | |
| CT, MRI, and PET scan | S | | | \$150 | | 50%* | | | | | | | |
| Outpatient surgery | | | | 30%* | | 50%* | | | | | | | |
| Inpatient hospital car | re | | | 30%* | | 50%* | | | | | | | |
| Emergency care | | | | | 3 | 0%* | | | | | | | |
| Routine eye exam | | | \$55 (\$35 | 5 enhanced be | nefit) | | | 50%* | | | | | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------|------------|----------|----------------------------------------------------------------------------------------------------------|---------------|------------|------------------|----------|--|
| Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals. PPO plans designated "VC" are designed to pair with our Virtual Complete plans. To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons." | | | | | | | | | | |
| | | Du | ial Cho | oice PPC |) Virtual C | omple | te | | | |
| | Plan na | me | | | DUAL C | HOICE PPO | PLAN VC 25 | 600/40/20%/650 | 00 | |
| Network | | | | | In-network | | | Out-of-netwo | ork | |
| Annual medical d | eductible (IND |)/FAM) (per o | calendar y | ear) | \$2,500/\$5,000 | | | \$5,000/\$15,000 | | |
| Annual out-of-poo | ket maximu | m (IND/FAM |) | | \$6,500/\$13,000 | | | \$13,500/\$27, | 000 | |
| Office visits – prev | ventive and w | ell-child car | e | | \$0 | | | | | |
| Office visits – prei | natal care | | | | \$0 | | | | | |
| Telehealth (phone | e/video) | | | \$0 | \$0 for the first 3 visits; then \$0 ¹ | | | 40%* | | |
| Office visits – prin | nary care | | | | \$60 (\$40 enhanced benefit) for the first 3 visits; then \$60* (\$40* enhanced benefit) ¹ | | | 40%* | | |
| Office visits – urg | ent care | | | \$ | 60* (\$40* enhance | d benefit) | | 40%* | | |
| Office visits – spe | cialty care | | | \$ | 50* (\$40* enhance | d benefit) | | 40%* | | |
| Office visits – nati | uropathic care | • | | \$40 | for the first 3 visits | ; then \$40*1 | | 40%* | | |
| Lab | | | | | \$15 | | | 40%* | | |
| X-ray/diagnostic t | | 20%* | | | 40%* | | | | | |
| CT, MRI, and PET s | | 20%* | | | 40%* | | | | | |
| Outpatient surgery | | | | | 20%* | | | 40%* | | |
| Innationt hosnita | L cara | | | | 20%* | | | //0%* | | |

| outpatient surgery | 2070 | 4070 | | | | |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------|--|--|--|--|
| 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 | | | | |

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------|----------|-------------------------------------------|---------------|------------|-------------------|----------|--|--|--|
| flexibility to chooplans designate To compare the | Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals. PPO blans 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 blan and then select "See plan comparisons." | | | | | | | | | | | |
| | | Du | ial Ch | oice PPC |) Virtual C | omple | te | | | | | |
| | Plan nai | me | | | DUAL C | HOICE PPO | PLAN VC 30 | 00/40/30%/70 | 00 | | | |
| Network | | | | | In-network | | | | ork | | | |
| Annual medical de | eductible (IND | /FAM) (per c | alendar y | ear) | \$3,000/\$6,000 | | | \$6,000/\$18,000 | | | | |
| Annual out-of-poc | ket maximur | n (IND/FAM) |) | | \$7,000/\$14,000 | | | \$15,000/\$30,000 | | | | |
| Office visits – prev | entive and w | ell-child car | е | | \$0 | | | 50%* | | | | |
| Office visits – pren | atal care | | | | \$0 | | | 50%* | | | | |
| Telehealth (phone | /video) | | | | \$0 ¹ | | | 50%* | | | | |
| Office visits – prim | nary care | | | | 40 enhanced benef nen \$60* (\$40* enł | - | | 50%* | | | | |
| Office visits – urge | ent care | | | \$ | 60* (\$40* enhance | d benefit) | | 50%* | | | | |
| Office visits – spec | Office visits – specialty care | | | | 60* (\$40* enhance | d benefit) | | 50%* | | | | |
| Office visits – naturopathic care | | | | \$40 | for the first 3 visits | ; then \$40*1 | | 50%* | | | | |
| Lab | Lab | | | | \$15 | | | 50%* | | | | |
| X-ray/diagnostic te | ests | | | | 30%* | | | 50%* | | | | |

| Outpatient surgery |
|-------------------------|
| Inpatient hospital care |
| Emergency care |
| Routine eye exam |
| |

CT, MRI, and PET scans

| Emergency care | 30%* | | | | |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------|----------------|--|--|--|
| Routine eye exam | \$60* (\$40* enhanced benefit) ¹ | 50%* | | | |
| Outpatient prescription drugs | Kaiser Permane | nte Pharmacies | | | |
| | \$15* generic; \$40* preferred brand-name; \$60* non-preferred brand-name; 30%* (up to a max of \$250) specialty | Not covered | | | |
| | MedImpact | Pharmacies | | | |
| | \$25* generic; \$60* preferred brand- name; \$90* non-preferred brand-name; 40%* specialty | Not covered | | | |

30%*

30%*

30%*

*After deductible.

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

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50%*

50%*

50%*

| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | |
|-----------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------|-----------------------------------------|------------------------|--------------------------------------------|-------------------------------|------------|-------------------|----------|--|
| Below are highl flexibility to cho plans designate To compare the plan and then s | ose a plan ed "VC" are benefits of | that helps designed [:] up to any | meet emp to pair wit / 3 plans, c | oloyee ne h our Vir | eeds and busi tual Complete | See plan comparisons Reset | | | | |
| | | Du | al Choi | ce PPC |) Virtual C | omple | te | | | |
| | Plan na | me | | | DUAL C | HOICE PPO | PLAN VC 40 | 00/50/30%/81 | 50 | |
| Network | Network | | | | In-network | | | Out-of-network | | |
| Annual medical d | eductible (IND |)/FAM) (per d | alendar year |) | \$4,000/\$8,00 | 00 | | \$8,000/\$16,000 | | |
| Annual out-of-poo | ket maximu | m (IND/FAM) |) | | \$8,150/\$16,300 | | | \$15,000/\$30,000 | | |
| Office visits – prev | ventive and w | ell-child car | е | | \$0 | | | 50%* | | |
| Office visits – prei | natal care | | | | \$0 | | | 50%* | | |
| Telehealth (phone | e/video) | | | | \$0 ¹ | | | 50%* | | |
| Office visits – prin | nary care | | | | 50 enhanced benefi nen \$70* (\$50* enł | , | | 50%* | | |
| Office visits – urg | ent care | | | \$ | 70* (\$50* enhance | d benefit) | | 50%* | | |
| Office visits – spe | cialty care | | | \$ | 70* (\$50* enhance | d benefit) | | 50%* | | |
| Office visits – nati | uropathic care |) | | \$50 | for the first 3 visits; | ; then \$50*1 | | 50%* | | |
| Lab | | | | | \$15 | | | 50%* | | |
| X-ray/diagnostic t | ests | | | | 30%* | | | 50%* | | |
| CT, MRI, and PET s | cans | | | | 30%* | | | 50%* | | |
| | | | | | | | | | | |

\$25* generic; \$70* preferred brandname; \$100* non-preferred brand-name;

40%* specialty

| | MedImpact | Pharmacies |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------|
| | \$15* generic; \$50* preferred brand-name; \$70* non-preferred brand-name; 30%* (up to a max of \$250) specialty | Not co |
| Outpatient prescription drugs | Kaiser Permane | ente Pharmacies |
| Routine eye exam | \$70* (\$50* enhanced benefit) ¹ | 509 |
| Emergency care | 30 | %* |
| Inpatient hospital care | 30%* | 509 |
| | | |

Not covered

50%*

50%*

50%*

Not covered

*After deductible.

Outpatient surgery

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



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | | |
|--------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------|------------------------------------|-----------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------|------------|-------------------|----------|--|--|--|
| Below are highli flexibility to choo plans designate To compare the plan and then se | ose a plan d "VC" are benefits of | that helps designed up to any | meet en to pair w ⁄ 3 plans, | nployee ne vith our Vir check the | eeds and busi tual Complete | See plan comparisons Reset | | | | | | |
| Dual Choice PPO Virtual Complete | | | | | | | | | | | | |
| | Plan nai | ne | | | DUAL C | HOICE PPO | PLAN VC 50 | 00/50/40%/81 | 50 | | | |
| Network | | | | | In-network | | | Out-of-network | | | | |
| Annual medical de | eductible (IND | /FAM) (per o | alendar ye: | ar) | \$5,000/\$10,000 | | | | 000 | | | |
| Annual out-of-poc | ket maximur | n (IND/FAM) |) | | \$8,150/\$16,3 | 00 | | \$15,000/\$30,000 | | | | |
| Office visits – prev | entive and w | ell-child car | е | | \$0 | | | 50%* | | | | |
| Office visits – pren | atal care | | | | \$0 | | | 50%* | | | | |
| Telehealth (phone | /video) | | | | \$0 ¹ | | | 50%* | | | | |
| Office visits – prim | nary care | | | | \$70 (\$50 enhanced benefit) for the first 3 visits; then \$70* (\$50* enhanced benefit) ¹ | | | 50%* | | | | |
| Office visits – urge | ent care | | | \$ | 70* (\$50* enhance | d benefit) | | 50%* | | | | |
| Office visits – spec | ialty care | | | \$ | 70* (\$50* enhance | d benefit) | | 50%* | | | | |
| Office visits – natu | ropathic care | | | \$50 | for the first 3 visits; | ; then \$50*1 | | 50%* | | | | |
| Lab | | | | | \$15 | | | 50%* | | | | |
| X-ray/diagnostic te | ests | | | | 40%* | | | 50%* | | | | |

| Outpatient surgery | |
|-------------------------------|--|
| Inpatient hospital care | |
| Emergency care | |
| Routine eye exam | |
| Outpatient prescription drugs | |
| | |

CT, MRI, and PET scans

| Emergency care | 40 | %* |
|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| Routine eye exam | \$70* (\$50* enhanced benefit) ¹ | 50%* |
| Outpatient prescription drugs | Kaiser Permane | nte 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 |

40%*

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.

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50%*

50%*

50%*

| OVERVIEW TRA | D | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | | |
|---------------------------------------------------------------------------------------------------------------------------|---------|------------------------|----------------------------|------------|----------------|--------|---------------------------|-------------|------------------------|--|--|
| Below are highlights of you the flexibility to ch business goals. To compare the benef plan and then select " | ioose | a plan th up to any | at helps n v 3 plans, o | neet emp | loyee needs a | nd | ich | | i comparisons Reset | | |
| Dual Choice PPO | | | | | | | | | | | |
| Plan name | | DUAL CH | OICE PPO HI | OHP PLAN A | 1600/10%/2500 | DUAL C | HOICE PPO HD | HP PLAN A 1 | 600/20%/3500 | | |
| Network | | In- | network | 0 | ut-of-network | l | n-network | Out | -of-network | | |
| Accumulation type | | | A | ggregate | | | Ag | ggregate | | | |
| Annual medical deductib (IND/FAM) (per calendar y | - | \$1,60 | 00/\$3,200 | \$: | 3,500/\$9,750 | \$1, | 600/\$3,200 | \$3, | 500/\$9,750 | | |
| Annual out-of-pocket maximum (IND/FAM) | | \$2,50 | 00/\$5,000 | \$10 |),500/\$21,000 | \$3, | \$3,500/\$7,000 | | 500/\$23,000 | | |
| Office visits – preventive well-child care | and | | \$0 | | 30%* | | \$0 | | 40%* | | |
| Office visits – prenatal ca | re | | \$0 | | 30%* | | \$0 | | 40%* | | |
| Telehealth (phone/video) | | | \$0* | | 30%* | | \$0* | | 40%* | | |
| Office visits – primary car | e | |)%* enhance enefit) | d | 30%* | 30%* (| 20%* enhanced benefit) | k | 40%* | | |
| Office visits – urgent care | | |)%* enhance enefit) | d | 30%* | 30%* (| 20%* enhanced benefit) | k | 40%* | | |
| Office visits – specialty ca | re | |)%* enhance enefit) | d | 30%* | 30%* (| 20%* enhanced benefit) | k | 40%* | | |
| Office visits – naturopath | ic 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 | | |)%* enhance enefit) | d | 30%* | 30%* (| 20%* enhanced benefit) | k | 40%* | | |

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

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| OVERVIEW TRAI | D DED | VC Н | DHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | |
|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------|------------|--------------|---------|--------------------------|--------------|------------------------|--|
| Below are highlights of you the flexibility to cho business goals. To compare the benefit plan and then select "S | pose a plan th ts of up to an | nat helps me y 3 plans, che | et emplo | oyee needs a | nd | ıch | See pla | n comparisons Reset | |
| | | Du | ial Cho | oice PPO | | | | | |
| Plan name | DUAL CH | OICE PPO HDHI | P PLAN B 2 | 000/20%/4000 | DUAL CI | HOICE PPO HE | OHP PLAN B : | 2000/30%/4000 | |
| Network | In | -network | Out | -of-network | h | n-network | Ou | t-of-network | |
| Accumulation type | | Aggi | regate | | | A | ggregate | | |
| Annual medical deductible (IND/FAM) (per calendar ye | \$2.0 | 00/\$4,000 | \$4,0 | 00/\$12,000 | \$2, | 000/\$4,000 | \$4, | 000/\$12,000 | |
| Annual out-of-pocket maximum (IND/FAM) | \$4,0 | 00/\$8,000 | \$12,0 | 000/\$24,000 | \$4, | 000/\$8,000 | \$12, | 000/\$24,000 | |
| Office visits – preventive a well-child care | nd | \$0 | | 40%* | | \$0 | | 50%* | |
| Office visits – prenatal care | • | \$0 | | 40%* | | \$0 | | 50%* | |
| Telehealth (phone/video) | | \$0* | | 40%* | | \$0* | | 50%* | |
| Office visits – primary care | | 0%* enhanced penefit) | | 40%* | 40%* (| 30%* enhance benefit) | d | 50%* | |
| Office visits – urgent care | | 0%* enhanced benefit) | | 40%* | | 30%* enhance benefit) | d | 50%* | |
| Office visits – specialty care | י ב | 0%* enhanced benefit) | | 40%* | 40%* (| 30%* enhance benefit) | d | 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 | | 0%* enhanced benefit) | | 40%* | 40%* (| 30%* enhance benefit) | d | 50%* | |

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



| OVERVIEW TRA | AD | DED | VC H | IDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|-------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------|-----------------------------------------|-----------|---------------|---------|--------------------------|--------------|------------------------|
| Below are highlights of you the flexibility to c business goals. To compare the bene plan and then select ' | hoose efits of | a plan th up to any | at helps me [,] 3 plans, ch | et empl | oyee needs a | nd | ch | | n comparisons Reset |
| | | | Di | ual Ch | oice PPO | | | | |
| Plan name | | DUAL CHO | DICE PPO HDH | IP PLAN C | 2500/20%/5000 | DUAL CI | HOICE PPO HD | OHP PLAN C 2 | 500/30%/5000 |
| Network | | In-i | network | Οι | ıt-of-network | Ir | n-network | Out | -of-network |
| Accumulation type | | | Agg | iregate | | | A | ggregate | |
| Annual medical deductik (IND/FAM) (per calendar | | \$2,50 | 00/\$5,000 | \$5, | 000/\$15,000 | \$2, | 500/\$5,000 | \$5,0 | 00/\$15,000 |
| Annual out-of-pocket maximum (IND/FAM) | | \$5,00 | 00/\$7,500 | \$15 | ,000/\$30,000 | \$5, | 000/\$7,500 | \$15,0 | 000/\$30,000 |
| Office visits – preventive well-child care | and | | \$0 | | 40%* | | \$0 | | 50%* |
| Office visits – prenatal ca | are | | \$0 | | 40%* | | \$0 | | 50%* |
| Telehealth (phone/video |) | | \$0* | | 40%* | | \$0* | | 50%* |
| Office visits – primary ca | re | |)%* enhanced enefit) | | 40%* | | 30%* enhance benefit) | d | 50%* |
| Office visits – urgent care | e | • |)%* enhanced enefit) | | 40%* | | 30%* enhance benefit) | d | 50%* |
| Office visits – specialty ca | are | |)%* enhanced enefit) | | 40%* | | 30%* enhance benefit) | d | 50%* |
| Office visits – naturopath | nic 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 | | | 2 | 0%* | | | | 30%* | |
| Routine eye exam | | |)%* enhanced enefit) | | 40%* | | 30%* enhance benefit) | d | 50%* |

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| OVERVIEW T | RAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|------------------------------------------------------------------|------------|-----------|-------------------------|-----------|----------------|-----------|--------------------------|------------|------------------------|
| Below are highlight you the flexibility to business goals. | choose | a plan th | at helps m | ieet emp | loyee needs a | nd | | See pla | n comparisons Reset |
| To compare the ber plan and then selec | | | | neck the | checkboxes n | ext to ea | ich | | |
| | | | D | ual Ch | oice PPO | | | | |
| Plan name | | DUAL CH | OICE PPO HD | HP PLAN E | 3200/10%/6000 | DUAL C | HOICE PPO HI | OHP PLAN E | 3200/20%/6000 |
| Network | | In- | network | 0 | ut-of-network | | n-network | Ou | t-of-network |
| Accumulation type | | | En | nbedded | | | E | mbedded | |
| Annual medical deduc (IND/FAM) (per calend | | \$3,20 | 00/\$6,400 | \$5 | ,000/\$15,000 | \$3, | 200/\$6,000 | \$5, | 000/\$15,000 |
| Annual out-of-pocket maximum (IND/FAM) | | \$6,0 | 00/\$9,000 | \$15 | 5,000/\$30,000 | \$6,0 | 000/\$12,000 | \$15, | 000/\$30,000 |
| Office visits – preventi well-child care | ve and | | \$0 | | 30%* | | \$0 | | 40%* |
| Office visits – prenatal | care | | \$0 | | 30%* | | \$0 | | 40%* |
| Telehealth (phone/vid | eo) | | 0%* | | 30%* | | \$0* | | 40%* |
| Office visits – primary | care | , |)%* enhancec enefit) | 1 | 30%* | 30%* (| 20%* enhance benefit) | d | 40%* |
| Office visits – urgent c | are | |)%* enhancec enefit) | ł | 30%* | | 20%* enhance benefit) | d | 40%* |
| Office visits – specialty | / care | • |)%* enhancec enefit) | 1 | 30%* | 30%* (| 20%* enhance benefit) | d | 40%* |
| Office visits – naturopa | athic 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 | | |)%* enhanced enefit) | | 30%* | 30%* (| 20%* enhance benefit) | d | 40%* |

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

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| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | |
|--------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------|----------------|--------|--------------------------|---------|-------------------------------|--|
| you the flexibility business goals. | to choose | benefits for each plan. A variety of options gives a plan that helps meet employee needs and up to any 3 plans, check the checkboxes next to each | | | | | | | See plan comparisons Reset | |
| plan and then sele | | | | | | | | | | |
| | | | D | ual Ch | oice PPO | | | | | |
| Plan nam | Plan name DUAL CHOICE PPO HDHP PLAN E 3200/30%/6000 DUAL CHOICE PPO | | | | | | | | 3500/20%/7000 | |
| Network | | In- | network | 0 | ut-of-network | | n-network | Ou | t-of-network | |
| Accumulation type | | | Em | nbedded | | | E | mbedded | | |
| Annual medical ded (IND/FAM) (per caler | | \$3,20 | 00/\$6,000 | \$5 | ,000/\$15,000 | \$3, | 500/\$7,000 | \$5, | 500/\$16,500 | |
| Annual out-of-pocke maximum (IND/FAM | | \$6,00 | 0/\$12,000 | \$15 | 5,000/\$30,000 | \$7,0 | 000/\$14,000 | \$15, | 000/\$30,000 | |
| Office visits – prever well-child care | ntive and | | \$0 | | 50%* | | \$0 | | 40%* | |
| Office visits – prenat | tal care | | \$0 | | 50%* | | \$0 | | 40%* | |
| Telehealth (phone/v | ideo) | | \$0* | | 50%* | | \$0* | | 40%* | |
| Office visits – prima | ry care | , |)%* enhancec enefit) | I | 50%* | 30%* (| 20%* enhance benefit) | d | 40%* | |
| Office visits – urgen | t care | |)%* enhancec enefit) | I | 50%* | | 20%* enhance benefit) | d | 40%* | |
| Office visits – specia | lty care | |)%* enhancec enefit) | I | 50%* | 30%* (| 20%* enhance benefit) | d | 40%* | |
| Office visits – naturo | pathic care | | 30%* | | 50%* | | 20%* | | 40%* | |
| Lab | | | 30%* | | 50%* | | 20%* | | 40%* | |
| X-ray/diagnostic test | ts | | 30%* | | 50%* | | 20%* | | 40%* | |
| CT, MRI, and PET sca | ns | | 30%* | | 50%* | | 20%* | | 40%* | |
| Outpatient surgery | | | 30%* | | 50%* | | 20%* | | 40%* | |
| Inpatient hospital ca | are | | 30%* | | 50%* | | 20%* | | 40%* | |
| Emergency care | | | | 30%* | | | | 20%* | | |
| Routine eye exam | | • |)%* enhancec enefit) | | 50%* | 30%* (| 20%* enhance benefit) | d | 40%* | |

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

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| OVERVIEW T | RAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|---------------------------------------------------------------------------------------|------------|-----------|------------------------|----------|----------------|--------|--------------------------|--------------|------------------------|
| Below are highlight you the flexibility to business goals. To compare the be | o choose | a plan th | at helps m | ieet emp | loyee needs ar | nd | ich | See pla | n comparisons Reset |
| plan and then selec | ct "See pl | an comp | | ual Ch | oice PPO | | | | |
| Plan name | | DUAL CH | | | 3500/30%/7000 | DUAL C | HOICE PPO HI | OHP PLAN G 4 | 000/20%/7000 |
| Network | | In- | network | 0 | ut-of-network | l | n-network | Ou | t-of-network |
| Accumulation type | | | En | nbedded | | | E | mbedded | |
| Annual medical deduc (IND/FAM) (per calend | | \$3,50 | 00/\$7,000 | \$5 | ,500/\$16,500 | \$4, | 000/\$8,000 | \$6,0 | 000/\$12,000 |
| Annual out-of-pocket maximum (IND/FAM) | | \$7,00 | 0/\$14,000 | \$15 | 5,000/\$30,000 | \$7,0 | 000/\$14,000 | \$15, | 000/\$30,000 |
| Office visits – preventi well-child care | ive and | | \$0 | | 50%* | | \$0 | | 40%* |
| Office visits – prenata | l care | | \$0 | | 50%* | | \$0 | | 40%* |
| Telehealth (phone/vid | eo) | | \$0* | | 50%* | | \$0* | | 40%* |
| Office visits – primary | care | , |)%* enhance enefit) | k | 50%* | 30%* (| 20%* enhance benefit) | d | 40%* |
| Office visits – urgent c | are | |)%* enhance enefit) | k | 50%* | | 20%* enhance benefit) | ď | 40%* |
| Office visits – specialty | y care | |)%* enhance enefit) | k | 50%* | 30%* (| 20%* enhance benefit) | ď | 40%* |
| Office visits – naturop | athic 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 | 9 | | 30%* | | 50%* | | 20%* | | 40%* |
| Emergency care | | | | 30%* | | 20%* | | | |
| Routine eye exam | | • |)%* enhance enefit) | ł | 50%* | 30%* (| 20%* enhance benefit) | d | 40%* |

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

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



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| OVERVIEW TR | AD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|------------------------------------------------------------------|----------|----------|------------------------|-----------|---------------|-----------|--------------------------|------------|---------------|
| Below are highlights you the flexibility to c | | | | | | - | | See pla | n comparisons |
| business goals. To compare the bene plan and then select ' | | 1 | | heck the | checkboxes n | ext to ea | ach | | Reset |
| | | | C | Jual Ch | oice PPO | | | | |
| Plan name | | DUAL CHO | DICE PPO HD | HP PLAN G | 4000/30%/7000 | DUAL C | HOICE PPO HI | OHP PLAN H | 5000/20%/7000 |
| Network | | ln-r | network | Οι | ıt-of-network | | n-network | Ou | t-of-network |
| Accumulation type | | | Em | bedded | | | E | mbedded | |
| Annual medical deductil (IND/FAM) (per calendar | | \$4,00 | 0/\$8,000 | \$6, | 000/\$12,000 | \$5,0 | 000/\$10,000 | \$7, | 000/\$14,000 |
| Annual out-of-pocket maximum (IND/FAM) | | \$7,000 | 0/\$14,000 | \$15 | ,000/\$30,000 | \$7,0 | 000/\$14,000 | \$17, | 000/\$34,000 |
| Office visits – preventive well-child care | e and | | \$0 | | 50%* | | \$0 | | 40%* |
| Office visits – prenatal ca | are | | \$0 | | 50%* | | \$0 | | 40%* |
| Telehealth (phone/video |) | | \$0* | | 50%* | | \$0* | | 40%* |
| Office visits – primary ca | re | , | %* enhanced enefit) | | 50%* | 30%* (| 20%* enhance benefit) | d | 40%* |
| Office visits – urgent care | e | | %* enhanced enefit) | | 50%* | | 20%* enhance benefit) | d | 40%* |
| Office visits – specialty c | are | • | %* enhanced enefit) | | 50%* | 30%* (| 20%* enhance benefit) | d | 40%* |
| Office visits – naturopath | hic care | 3 | 30%* | | 50%* | | 20%* | | 40%* |
| Lab | | 3 | 30%* | | 50%* | | 20%* | | 40%* |
| X-ray/diagnostic tests | | 3 | 30%* | | 50%* | | 20%* | | 40%* |
| CT, MRI, and PET scans | | 3 | 30%* | | 50%* | | 20%* | | 40%* |
| Outpatient surgery | | 3 | 30%* | | 50%* | | 20%* | | 40%* |
| Inpatient hospital care | | 3 | 30%* | | 50%* | | 20%* | | 40%* |
| Emergency care | | | | 30%* | | 20%* | | | |
| Routine eye exam | | • | %* enhanced enefit) | | 50%* | 30%* (| 20%* enhance benefit) | d | 40%* |

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



| OVERVIEW TI | RAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|-------------------------------------------------|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------|---------------|---------|--------------------------|--------------|--------------|
| you the flexibility to business goals. | choose efits of | penefits for each plan. A variety of options gives a plan that helps meet employee needs and up to any 3 plans, check the checkboxes next to each an comparisons." | | | | | | | |
| | | | D | ual Ch | oice PPO | | | | |
| Plan name | | DUAL CH | DICE PPO HD | HP PLAN H | 5000/30%/7000 | DUAL CI | HOICE PPO HD | OHP PLAN H 5 | 000/40%/7000 |
| Network | | In- | network | 01 | ut-of-network | lı | n-network | Out | -of-network |
| Accumulation type | | | En | nbedded | | | Er | nbedded | |
| Annual medical deduct (IND/FAM) (per calenda | | \$5,00 | 0/\$10,000 | \$7, | 000/\$14,000 | \$5,0 | 000/\$10,000 | \$7,0 | 00/\$14,000 |
| Annual out-of-pocket maximum (IND/FAM) | | \$7,00 | 0/\$14,000 | \$17 | ,000/\$34,000 | \$7,0 | 000/\$14,000 | \$17,0 | 000/\$34,000 |
| Office visits – preventiv well-child care | ve and | | \$0 | | 50%* | | \$0 | | 50%* |
| Office visits – prenatal | care | | \$0 | | 50%* | | \$0 | | 50%* |
| Telehealth (phone/vide | :0) | | \$0* | | 50%* | | \$0* | | 50%* |
| Office visits – primary o | are | |)%* enhancec enefit) | 1 | 50%* | , | 40%* enhance benefit) | d | 50%* |
| Office visits – urgent ca | ire | |)%* enhancec enefit) | | 50%* | | 40%* enhance benefit) | d | 50%* |
| Office visits – specialty | care | |)%* enhancec enefit) | | 50%* | | 40%* enhance benefit) | d | 50%* |
| Office visits – naturopa | thic 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 | | |)%* enhancec enefit) | 1 | 50%* | | 40%* enhance benefit) | d | 50%* |

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



| OVERVIEW | TRAD | DED | VC F | IDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|-----------------------------------------------------------|-------------|--------|-------------|----------|-----------------------------|-----------|------------------|------------|----------------------------|
| Below are highli you the flexibilit business goals. | 0 | | | | , I | • | | See pla | n comparisons |
| To compare the plan and then se | | 1 | | neck the | checkboxes n | ext to ea | ach | | Reset |
| | | | OUT-(| OF-AR | EA PPO PL | US | | | |
| Plan na | me | PI | PO PLUS PLA | N WDB 50 | 0/20%/2500 | | PPO PLUS PL | AN WDC 750 |)/20%/3750 |
| Network | | PPO | providers | No | nparticipating providers | PP | O providers | | participating providers |
| Annual medical do (IND/FAM) (per cal | | \$500 |)/\$1,500 | \$ | 5750/\$2,250 | \$7 | \$750/\$2,250 | | 125/\$3,375 |
| Annual out-of-poc maximum (IND/FA | | \$2,50 | 0/\$7,500 | \$3 | ,500/\$10,500 | \$3, | \$3,750/\$11,250 | | 250/\$16,875 |
| Office visits – prev well-child care | entive and | | \$0 | | 35%* | | \$0 | | 35%* |
| Office visits – prer | natal care | | \$0 | | 35%* | | \$0 | | 35%* |
| Telehealth (phone | /video) | | \$0 | | 35%* | | \$0 | | 35%* |
| Office visits – prim | nary care | | \$30 | | 35%* | | \$30 | | 35%* |
| Office visits – urge | ent care | | \$50 | | 35%* | | \$50 | | 35%* |
| Office visits – spec | cialty care | | \$40 | | 35%* | | \$40 | | 35%* |

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| *After | deductible. | |
|--------|-------------|--|

Emergency care

Routine eye exam

Lab

Office visits – naturopathic care

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

Outpatient surgery

These plans 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.

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| Network | PPO providers | Nonparticipating providers | PPO providers | Nonparticipating providers |
|------------------------------------------------------------|-----------------|--------------------------------------|-------------------------------|----------------------------|
| Annual medical deductible (IND/FAM) (per calendar year) | \$1,000/\$3,000 | \$1,000/\$3,000 \$1,500/\$4,500 \$1, | | \$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, | |
| 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%* |
| | | | | |

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*After deductible.

Emergency care

Routine eye exam

Inpatient hospital care

business goals.

Plan name

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.

\$200*



OUT-OF-AREA PPO PLUS

PPO PLUS PLAN WDT 1000/20%/3000

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

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

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

plan and then select "See plan comparisons."

SR. ADV.

See plan comparisons

Reset

PPO PLUS PLAN WDE 1000/30%/4750



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| OVERVIEW | TRAD | DED | VC H | IDHP | KP PLUS | PPO | OOA | RIDER | S SR. ADV. | |
|-------------------------------------------------------------------------------------------------|-------------|-------------------------------|--------------|---------|-----------------------------|-------|---------------|----------------------|------------------------------|--|
| Below are highli you the flexibilit business goals. To compare the plan and then se | See p | See plan comparisons Reset | | | | | | | | |
| | | | OUT-C |)F-AR | EA PPO PL | US | | | | |
| Plan na | me | PF | PO PLUS PLAN | WDU 150 | 00/20%/5500 | | PPO PLUS PL | AN WDP 1500/30%/6000 | | |
| Network | | PPO | providers | No | nparticipating providers | PP | PPO providers | | onparticipating providers | |
| Annual medical d (IND/FAM) (per ca | | \$1,50 | 00/\$4,500 | \$2 | 2,250/\$6,750 | \$1, | 500/\$4,500 | | 52,250/\$6,750 | |
| Annual out-of-poc maximum (IND/F/ | | \$5,50 | 0/\$11,000 | \$7, | ,500/\$15,000 | \$6,0 | 000/\$12,000 | 0 \$7,500/\$15,000 | | |
| Office visits – prev well-child care | ventive and | | \$0 | | 45%* | | \$0 | | 45%* | |
| Office visits – prer | natal care | | \$0 | | 45%* | | \$0 | | 45%* | |

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*After deductible.

Lab

Telehealth (phone/video)

Office visits – primary care

Office visits – urgent care

Office visits - specialty care

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

Outpatient surgery

Emergency care

Routine eye exam

Office visits – naturopathic care

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20%*


| OVERVIEW | TRAD | DED | VC H | IDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. | |
|-------------------------------------------------------------------------------------------------|-----------------------------------------------|--------|--------------|---------|-----------------------------|------|---------------|-------------------|----------------------------|--|
| Below are highli you the flexibilit business goals. To compare the plan and then se | See plan comparisons Reset | | | | | | | | | |
| | | | OUT-(| OF-AR | EA PPO PL | US | | | | |
| Plan na | me | PF | PO PLUS PLAN | WDN 200 | 00/30%/6000 | | PPO PLUS PLAN | WDX 3000/30%/6850 | | |
| Network | | PPO | providers | No | nparticipating providers | PP | O providers | | oarticipating providers | |
| Annual medical do (IND/FAM) (per cal | | \$2,00 | 00/\$6,000 | \$3 | 3,000/\$9,000 | \$3, | 000/\$9,000 | \$4,5 | 00/\$13,500 | |
| Annual out-of-poc maximum (IND/FA | \$6 000/\$12 000 \\$7 \$00/\$15 000 \\$6 850/ | | 350/\$13,700 | \$8,4 | 00/\$16,800 | | | | | |
| Office visits – prev well-child care | entive and | | \$0 | | 40%* | | \$0 | | 40%* | |
| Office visits – pren | atal care | | \$0 | | 40%* | | \$0 | | 40%* | |

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Telehealth (phone/video)

Office visits – primary care

Office visits – urgent care

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

Outpatient surgery

Emergency care

*After deductible.

Routine eye exam

Lab

Office visits – specialty care

Office visits – naturopathic care

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\$200*



| OVERVIEW T | RAD | DED | VC H | DHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|-----------------------------------------------------------------------------------------------------------------|--------|-------------------------------|-------------|---------|-----------------------------|-------|--------------|-----------|-----------------------------|
| Below are highlights you the flexibility to business goals. To compare the ben plan and then select | See pl | See plan comparisons Reset | | | | | | | |
| | | | OUT-C |)F-AR | EA PPO PL | US | | | |
| Plan name | | PP | O PLUS PLAN | WDR 40(| 00/30%/7350 | | PPO PLUS PL | AN WDS 50 | 00/30%/7350 |
| Network | | PPO | providers | No | nparticipating providers | PP | O providers | No | nparticipating providers |
| Annual medical deduct (IND/FAM) (per calenda | | \$4,00 | 00/\$8,000 | \$6 | ,000/\$12,000 | \$5,0 | 000/\$10,000 | \$6 | ,500/\$13,000 |
| Annual out-of-pocket maximum (IND/FAM) | | \$7,35 | 0/\$14,700 | \$9, | ,000/\$18,000 | \$7,3 | 350/\$14,700 | \$9 | ,000/\$18,000 |
| Office visits – preventiv well-child care | ve and | | \$0 | | 40%* | | \$0 | | 40%* |
| Office visits – prenatal | care | | \$0 | | 40%* | | \$0 | | 40%* |
| Telehealth (phone/vide | 20) | | \$0 | | 40%* | | \$0 | | 40%* |

| maximum (IND/FAM) | \$7,330/\$1 4 ,700 | \$7,0007\$10,000 | ψ1,550/ψ14,700 | ψ7,000/ψ10,000 |
|------------------------------------------------|-------------------------------|------------------|----------------|----------------|
| 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.

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| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
|------------------------------------------|---------------|---------|-----------|-----------|------------------------------|------------|-------------|-------------|--------------------------|
| | | | | | | | | | |
| Below are highlig you the flexibility | - | | | | | - | | See plan | comparisons |
| business goals. | | | | neeremp | | ind | | | |
| To compare the l plan and then se | | | - | check the | checkboxes r | next to ea | ich | | Reset |
| plan and then se | lect See pi | an comp | | | | | | | |
| | | | OUT | -OF-AR | EA PPO PI | US | | | |
| Plan nar | ne | PPO PLU | S HDHP AA | PLAN WFI | 1600/20%/3500 | PPO PL | US HDHP AA | PLAN WAS 28 | 00/20%/4000 |
| Network | | PPO | providers | No | onparticipating providers | PP | O providers | | articipating roviders |
| Accumulation type | | | A | ggregate | | | l | Aggregate | |
| Annual medical de (IND/FAM) (per cale | | \$1,60 | 0/\$3,200 | \$ | 3,500/\$7,000 | \$2, | 800/\$5,600 | \$3,5 | 00/\$7,000 |
| Annual out-of-pock maximum (IND/FA | | \$3,50 | 0/\$7,000 | \$6 | ,000/\$12,000 | \$4, | 000/\$8,000 | \$7,00 | 00/\$14,000 |
| Office visits – preve well-child care | entive and | | \$0 | | 30%* | | \$0 | | 30%* |
| Office visits – prena | atal care | | \$0 | | 30%* | | \$0 | | 30%* |
| Telehealth (phone/ | video) | | \$0* | | 30%* | | \$0* | | 30%* |
| Office visits – prima | ary care | 2 | 20%* | | 30%* | | 20%* | | 30%* |
| Office visits – urger | nt care | 2 | 20%* | | 30%* | | 20%* | | 30%* |
| Office visits – speci | alty care | 2 | 20%* | | 30%* | | 20%* | | 30%* |
| Office visits – natur | ropathic care | 2 | 20%* | | 30%* | | 20%* | | 30%* |
| Lab | | 2 | 20%* | | 30%* | | 20%* | | 30%* |
| X-ray/diagnostic te | sts | 2 | 20%* | | 30%* | | 20%* | | 30%* |
| CT, MRI, and PET sc | ans | 2 | 20%* | | 30%* | | 20%* | | 30%* |
| Outpatient surgery | , | 2 | 20%* | | 30%* | | 20%* | | 30%* |
| Inpatient hospital | care | 2 | 20%* | | 30%* | | 20%* | | 30%* |
| Emergency care | | | | 20%* | | | | 10%* | |
| Routine eye exam | | 2 | 20%* | | 30%* | | 20%* | | 30%* |

*After deductible.

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

Compare plans - traditional, deductible, HDHP

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

*After deductible.

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





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

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

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

*After deductible.

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



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SUPPLEMENTAL BENEFIT OPTIONS OUTPATIENT PRESCRIPTION DRUGS

VC

Traditional, deductible, and HSA-qualified, HDHP plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

HSA-QUALIFIED, HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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

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



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| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
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Kaiser Permanente Plus Plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

| | Kaiser Perman | ente Pharmacie | 95 | Out-of-Network Pharmacies (Limited to 5 prescription fills per year) | | | | |
|---------|--------------------|----------------------------|-----------|-------------------------------------------------------------------------|--------------------|----------------------------|-----------|--|
| Generic | Preferred Brand | Non- Preferred Brand | Specialty | Generic | Preferred Brand | Non- Preferred Brand | Specialty | |
| \$10 | \$20 | \$40 | \$100 | \$30 | \$40 | \$60 | \$120 | |
| \$10 | \$20 | \$40 | \$150 | \$30 | \$40 | \$60 | \$170 | |
| \$10 | \$30 | \$60 | 50% | \$30 | \$50 | \$80 | 50% | |
| \$15 | \$30 | \$50 | \$100 | \$35 | \$50 | \$70 | \$120 | |
| \$15 | \$30 | \$50 | \$150 | \$35 | \$50 | \$70 | \$170 | |
| \$15 | \$30 | \$50 | \$200 | \$35 | \$50 | \$70 | \$220 | |
| \$15 | \$60 | \$80 | 50% | \$35 | \$80 | \$100 | 50% | |
| \$20 | \$40 | \$60 | \$150 | \$40 | \$60 | \$80 | \$170 | |
| \$20 | \$40 | \$60 | \$200 | \$40 | \$60 | \$80 | \$220 | |

Note: Mail order only available through Kaiser Permanente Pharmacies.



| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
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Dual Choice PPO and HSA-qualified, Dual Choice PPO plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

| | Kaiser Perman | ente Pharmacie | S | MedImpact Pharmacies | | | | | |
|---------|----------------------------|----------------|--------------------------------------|----------------------|--------------------|----------------------------|-----------|--|--|
| Generic | Preferred Generic Brand | | Non- Preferred Brand Specialty | | Preferred Brand | Non- Preferred Brand | Specialty | | |
| \$10 | \$20 | \$40 | \$100 | \$20 | \$40 | \$70 | 25% | | |
| \$10 | \$20 | \$40 | \$150 | \$20 | \$40 | \$70 | 30% | | |
| \$10 | \$30 | \$60 | 50% | \$20 | \$50 | \$90 | 50% | | |
| \$15 | \$30 | \$50 | \$100 | \$25 | \$50 | \$80 | 25% | | |
| \$15 | \$30 | \$50 | \$150 | \$25 | \$50 | \$80 | 30% | | |
| \$15 | \$30 | \$50 | \$200 | \$25 | \$50 | \$80 | 35% | | |
| \$15 | \$60 | \$80 | 50% | \$25 | \$80 | \$110 | 50% | | |
| \$20 | \$40 | \$60 | \$150 | \$30 | \$60 | \$90 | 30% | | |
| \$20 | \$40 | \$60 | \$200 | \$30 | \$60 | \$90 | 35% | | |



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

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

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

| | Kaiser Perman | ente Pharmacie | S | MedImpact Pharmacies | | | | | |
|---------|--------------------|----------------------------|-----------|----------------------|--------------------|----------------------------|-----------|--|--|
| Generic | Preferred Brand | Non- Preferred Brand | Specialty | Generic | Preferred Brand | Non- Preferred Brand | Specialty | | |
| \$10 | \$20 | \$40 | \$100 | \$20 | \$40 | \$70 | 25% | | |
| \$10 | \$20 | \$40 | \$150 | \$20 | \$40 | \$70 | 30% | | |
| \$10 | \$30 | \$60 | 50% | \$20 | \$50 | \$90 | 50% | | |
| \$15 | \$30 | \$50 | \$100 | \$25 | \$50 | \$80 | 25% | | |
| \$15 | \$30 | \$50 | \$150 | \$25 | \$50 | \$80 | 30% | | |
| \$15 | \$30 | \$50 | \$200 | \$25 | \$50 | \$80 | 35% | | |
| \$15 | \$60 | \$80 | 50% | \$25 | \$80 | \$110 | 50% | | |
| \$20 | \$40 | \$60 | \$150 | \$30 | \$60 | \$90 | 30% | | |
| \$20 | \$40 | \$60 | \$200 | \$30 | \$60 | \$90 | 35% | | |
| 10% | 10% | 10% | 10% | 20% | 20% | 20% | 20% | | |
| 20% | 20% | 20% | 20% | 30% | 30% | 30% | 30% | | |
| 30% | 30% | 30% | 30% | 40% | 40% | 40% | 40% | | |
| 40% | 40% | 40% | 40% | 50% | 50% | 50% | 50% | | |

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

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

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| OVERVIEW | TRAD | DED | VC | HDHP | KP PLUS | PPO | OOA | RIDERS | SR. ADV. |
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Out-of-Area PPO Plus and HSA-qualified, Out-of-Area PPO Plus plans

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

DEDUCTIBLE COST SHARE OPTIONS

| | 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 | \$20 \$40 | | \$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% 40% | | | | | | | | | |
| 50% | 50% | 50% | 50% | No | | | | | | | | |



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

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



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

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

- In-network/PPO providers
 - The CHP Group
 - o 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
 - o 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.





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

| 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%.



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

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

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.



