2022 PLANS AND PRODUCTS | OREGON



Complete Suite[™] plan comparison chart

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

kp.org/dualchoice/nw/producers





Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
					A BETTER WAY	TO TAKE CAR	E OF BUSINESS

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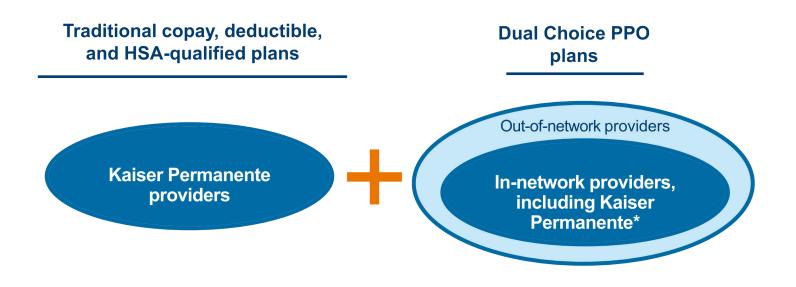
◀ 2 ►

PPO

OOA

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 Senior Advantage plans are also available for group coverage.

Note: Deductible and traditional copay plans are designed with embedded accumulations. High deductible health plans using aggregate accumulation have been specifically noted. All other high deductible health plans are designed with embedded accumulations.

^{*}In-network providers for Dual Choice PPO plans include First Choice Health and First Health Network providers.



Overview	IKAD	DED	VC I		0 004	JR. ADV.
you the flexibility business goals. To compare the	y to choose benefits of u	penefits for each p a plan that helps up to any 3 plans, an comparisons."	meet employee r check the check	needs and		plan comparisons Reset
			TRADITION	AL		
Plan Na	ime	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 de (IND/FAM) (per cal		\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0
Annual out-of-poc maximum (IND/FA		\$1,000/\$2,000	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000
Office visits – prev well-child care	entive and	\$0	\$0	\$0	\$0	\$0
Office visits - pren	atal care	\$0	\$0	\$0	\$0	\$0
Telehealth (phone	/video)	\$0	\$0	\$0	\$0	\$0
Office visits - prim	ary care	\$10	\$20	\$20	\$30	\$35
Office visits - urge	nt care	\$30	\$40	\$40	\$50	\$60
Office visits - spec	ialty care	\$20	\$30	\$30	\$40	\$45
Office visits - natu	ropathic care	\$10	\$20	\$20	\$30	\$35
Lab		\$10	\$20	\$20	\$30	\$35
X-ray/diagnostic te	ests	\$10	\$20	\$20	\$30	\$35
CT, MRI, and PET se	cans	\$50	\$50	\$50	\$50	\$50
Outpatient surger	у	\$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

VC

PPO

HDHP

OOA

SR. ADV.

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

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



Overview

TRAD

DED

Overview	TRAD	DED	VC	VC HDHP		OOA	SR. ADV.
		_					
-	nlights of the b lity to choose a s.		•		-	See pla	n comparisons
0	e benefits of u	p to any 3 pla	ns, check the	checkboxes n	ext to each		Reset
plan and then	select "See pla	in comparisor	IS."				
			DEDL	JCTIBLE			
Plan	Name	DED PLAN 250/10/10%/2		DED PLAN A 0/15/20%/2500	DED PLAN B 500/20/10%/3000		ED PLAN B 0%/10%/2000
Annual medical (IND/FAM) (per o		\$250/\$75	0	\$250/\$750	\$500/\$1,500	\$!	500/\$1,500
Annual out-of-p maximum (IND/		\$2,000/\$6,0)00 \$	2,500/\$7,500	\$3,000/\$6,000	\$2,	000/\$6,000
Office visits – pr well-child care	eventive and	\$0		\$0	\$0		\$0
Office visits - pr	enatal care	\$0		\$0	\$0		\$0
Telehealth (pho	ne/video)	\$0		\$0	\$0		\$0
Office visits – pr	imary care	\$10		\$15	\$20		10%*
Office visits – ur	gent care	\$10		\$35	\$40		10%*
Office visits – sp	ecialty care	\$10		\$25	\$30		10%*
Office visits – na	turopathic care	\$10		\$15	\$20		10%*
Lab		10%*		\$15	\$20		10%*
X-ray/diagnostic	: tests	10%*		\$15	\$20		10%*
CT, MRI, and PE	l scans	10%*		\$100	\$100		10%*
Outpatient surg	ery	\$10*		20%*	10%*		10%*
Inpatient hospit	tal care	10%*		20%*	10%*		10%*
Emergency care		\$200*		20%*	10%*		\$200*
Routine eye exa	m	\$10		\$15	\$20		10%*

*After deductible.



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
-	lity to choose a		•	riety of options ployee needs ar	•	See pla	n comparisons
0		p to any 3 pla	ans, check th	e checkboxes n	ext to each		Reset
plan and then	select "See pla	in compariso	ns."				
			DED	UCTIBLE			
Plan	Name	DED PLAI 500/10/20%		DED PLAN B 00/20/20%/3000	DED PLAN C 750/20/20%/3000		ED PLAN C 20/20%/3250
Annual medical (IND/FAM) (per o		\$500/\$1,5	500	\$500/\$1,500	\$750/\$2,250	\$	750/\$2,250
Annual out-of-p maximum (IND/		\$2,000/\$6,	000	\$3,000/\$9,000	\$3,000/\$9,000	\$3	,250/\$9,750
Office visits – pr well-child care	eventive and	\$0		\$0	\$0		\$0
Office visits – pr	enatal care	\$0		\$0	\$0		\$0
Telehealth (pho	ne/video)	\$0		\$0	\$0		\$0
Office visits - pr	imary care	\$10		\$20	\$20		\$20
Office visits – ur	gent care	\$10		\$40	\$20		\$40
Office visits – sp	ecialty care	\$10		\$30	\$20		\$30
Office visits – na	turopathic care	\$10		\$20	\$20		\$20
Lab		20%*		\$20	20%*		\$20
X-ray/diagnostic	: tests	20%*		\$20	20%*		\$20
CT, MRI, and PE	F scans	20%*		\$100	20%*		\$100
Outpatient surg	ery	\$10*		20%*	\$20*		20%*
Inpatient hospit	tal care	20%*		20%*	20%*		20%*
Emergency care		\$200*		20%*	\$200*		20%*
Routine eye exa	im	\$10		\$20	\$20		\$20

*After deductible.



Overview	TRAD	DED	ED VC		РРО	OOA	SR. ADV.
-	lity to choose a	enefits for each p a plan that helps r			•	See pla	n comparisons
To compare th	e benefits of u	p to any 3 plans,	check the	checkboxes ne	ext to each		Reset
plan and then	select "See pla	an comparisons."					
			DEDU	CTIBLE			
Plan	Name	DED PLAN C 750/20%/20%/300		DED PLAN D 0/20/20%/3000	DED PLAN D 1000/25/20%/4000		ED PLAN E /25/20%/5500
Annual medical (IND/FAM) (per o		\$750/\$2,250	\$	1,000/\$3,000	\$1,000/\$3,000	\$1,	500/\$4,500
Annual out-of-p maximum (IND/		\$3,000/\$9,000	\$	3,000/\$9,000	\$4,000/\$12,000	\$5,	500/\$11,000
Office visits – pr well-child care	eventive and	\$0		\$0	\$0		\$0
Office visits - pr	enatal care	\$0		\$0	\$0		\$0
Telehealth (pho	ne/video)	\$0		\$0	\$0		\$0
Office visits - pr	imary care	20%*		\$20	\$25		\$25
Office visits - ur	gent care	20%*		\$20	\$45		\$45
Office visits – sp	ecialty care	20%*		\$20	\$35		\$35
Office visits – na	turopathic care	20%*		\$20	\$25		\$25
Lab		20%*		20%*	\$25		\$25
X-ray/diagnostic	: tests	20%*		20%*	\$25		\$25
CT, MRI, and PE	l scans	20%*		20%*	\$100		\$100
Outpatient surg	ery	20%*		\$20*	20%*		20%*
Inpatient hospi	tal care	20%*		20%*	20%*		20%*
Emergency care		\$200*		\$200*	20%*		20%*
Routine eye exa	m	20%*		\$20	\$25		\$25

*After deductible.



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
-	lity to choose a	enefits for each p I plan that helps I				See pla	n comparisons
0		p to any 3 plans,	check the	checkboxes ne	ext to each		Reset
plan and then	select "See pla	in comparisons."					
			DEDU	CTIBLE			
Plan	Name	DED PLAN E 1500/20/30%/400		DED PLAN E /30%/30%/4000	DED PLAN F 2000/25/20%/5000		ED PLAN G /25/20%/5000
Annual medical (IND/FAM) (per o		\$1,500/\$4,500	\$,500/\$4,500	\$2,000/\$6,000	\$2	,500/\$7,500
Annual out-of-p maximum (IND/		\$4,000/\$12,000	\$4	,000/\$12,000	\$5,000/\$10,000	\$5,	000/\$10,000
Office visits – pr well-child care	eventive and	\$0		\$0	\$0		\$0
Office visits - pr	enatal care	\$0		\$0	\$0		\$0
Telehealth (pho	ne/video)	\$0		\$0	\$0		\$0
Office visits – pr	imary care	\$20		30%*	\$25		\$25
Office visits – ur	gent care	\$20		30%*	\$45		\$45
Office visits – sp	ecialty care	\$20		30%*	\$35		\$35
Office visits – na	turopathic care	\$20		30%*	\$25		\$25
Lab		30%*		30%*	\$25		\$25
X-ray/diagnostic	: tests	30%*		30%*	\$25		\$25
CT, MRI, and PE	l scans	30%*		30%*	\$100		\$100
Outpatient surg	ery	\$20*		30%*	20%*		20%*
Inpatient hospi	tal care	30%*		30%*	20%*		20%*
Emergency care		\$200*		\$200*	20%*		20%*
Routine eye exa	m	\$20		30%*	\$25		\$25

*After deductible.



Overview	r TRAD DED		VC HDHP	РРО	OOA SR. ADV.
you the flexibi business goals To compare th	lity to choose a s. ne benefits of u	plan that helps me p to any 3 plans, ch	n. A variety of options eet employee needs an eck the checkboxes ne	nd	See plan comparisons Reset
plan and then	select "See pla	an comparisons."			
			DEDUCTIBLE		
Plan	Name	DED PLAN G 2500/30/30%/5000	DED PLAN G 2500/30%/30%/5000	DED PLAN H 3000/30/20%/7350	DED PLAN H 3000/30%/30%/6000
Annual medical (IND/FAM) (per o		\$2,500/\$5,000	\$2,500/\$5,000	\$3,000/\$9,000	\$3,000/\$6,000
Annual out-of-p maximum (IND/		\$5,000/\$10,000	\$5,000/\$10,000	\$7,350/\$14,700	\$6,000/\$12,000
Office visits – pr well-child care	eventive and	\$0	\$0	\$0	\$0
Office visits - pr	enatal care	\$0	\$0	\$0	\$0
Telehealth (pho	ne/video)	\$0	\$0	\$0	\$0
Office visits - pr	imary care	\$30	30%*	\$30	30%*
Office visits - ur	gent care	\$30	30%*	\$50	30%*
Office visits – sp	ecialty care	\$30	30%*	\$40	30%*
Office visits – na	turopathic care	\$30	30%*	\$30	30%*
Lab		30%*	30%*	\$30	30%*
X-ray/diagnostic	: tests	30%*	30%*	\$30	30%*
CT, MRI, and PE	l scans	30%*	30%*	\$100	30%*
Outpatient surg	ery	\$30*	30%*	20%*	30%*
Inpatient hospi	tal care	30%*	30%*	20%*	30%*
Emergency care		\$200*	\$200*	20%*	\$200*
Routine eye exa	m	\$30	30%*	\$30	30%*

*After deductible.



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
you the flexibi	lity to choose a		ach plan. A varie Ips meet emplo			See pla	n comparisons
business goals							Reset
	select "See pla		ans, check the c ms."	checkboxes nex	kt to each		
			DEDU				
			DEDU	CTIBLE			
Plan I	Name	DED PLAN I 35	00/30/20%/7350	DED PLAN J 400	0/30/20%/7500	DED PLAN K 500	0/30/20%/7350
Annual medical (IND/FAM) (per o		\$3,500)/\$10,500	\$4,000/\$	510,000	\$5,000/	\$10,000
Annual out-of-p maximum (IND/		\$7,350)/\$14,700	\$7,500/\$15,000		\$7,350/\$14,700	
Office visits - pr well-child care	eventive and		\$0	\$()	\$	0
Office visits - pr	enatal care		\$0	\$0)	\$	0
Telehealth (pho	ne/video)		\$0	\$0)	\$	0
Office visits - pr	imary care		\$30	\$3	0	\$3	80
Office visits - ur	gent care		\$50	\$5	0	\$5	50
Office visits – sp	ecialty care		\$40	\$4	0	\$4	0
Office visits – na	turopathic care		\$30	\$3	0	\$3	30
Lab			\$30	\$3	0	\$3	80
X-ray/diagnostic	: tests		\$30	\$3	0	\$3	80
CT, MRI, and PE	l scans	\$	100	\$10	00	\$1	00
Outpatient surg	ery	2	0%*	20%	/ ₀ *	20	%*
Inpatient hospit	al care	2	0%*	20%	/o*	20	%*
Emergency care		2	0%*	20%	%*	20	%*
Routine eye exa	m		\$30	\$3	0	\$3	30

*After deductible.



Overview	TRAD	DED V	C HDHP	PPO C	DOA SR. ADV.					
you the flexibilit business goals. To compare the	ty to choose benefits of u	a plan that helps mee up to any 3 plans, che	. A variety of options o t employee needs an ck the checkboxes ne	d	See plan comparisons Reset					
plan and then select "See plan comparisons." VIRTUAL COMPLETE										
Plan N	ame	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 d (IND/FAM) (per ca		\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000					
Annual out-of-poo maximum (IND/F		\$5,500/\$11,000	\$6,000/\$12,000	\$7,000/\$14,000	\$8,000/\$16,000					
Office visits – prew well-child care	ventive and	\$0	\$0	\$0	\$0					
Office visits – pre	natal care	\$0	\$0	\$0	\$0					
Telehealth (phone	e/video)	\$0	\$0	\$0	\$0					
Office visits – prir	mary care	\$40*1	\$40*1	\$50* ¹	\$50* ¹					
Office visits – urg	ent care	\$40*	\$40*	\$50*	\$50*					
Office visits – spe	cialty care	\$40*	\$40*	\$50*	\$50*					
Office visits – nat	uropathic care	\$40*1	\$40*1	\$50* ¹	\$50* ¹					
Lab		\$15	\$15	\$15	\$15					
X-ray/diagnostic t	ests	20%*	30%*	30%*	40%*					
CT, MRI, and PET s	scans	20%*	30%*	30%*	40%*					
Outpatient surge	ry	20%*	30%*	30%*	40%*					
Inpatient hospita	l care	20%*	30%*	30%*	40%*					
Emergency care		20%*	30%*	30%*	40%*					
Routine eye exam	ı	\$40*1	\$40*1	\$50* ¹	\$50*1					
Outpatient prescr	iption 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					

¹Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).

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



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
you the flexibi business goals To compare th	lity to choose a s. ne benefits of u	enefits for each pl plan that helps m p to any 3 plans, c n comparisons."	neet employ	ee needs an	d	See pla	n comparisons Reset
		HIGH DEI	DUCTIBL	E HEALTH	I PLAN		
Plan	Name	HDHP PLAN A 1500/10%/2500		P PLAN A 20%/3500	HDHP PLAN B 2000/20%/4000		0HP PLAN B 0/30%/4000
Accumulation ty	/ре	Aggregate	Agg	gregate	Aggregate		Aggregate
Annual medical (IND/FAM) (per o		\$1,500/\$3,000	\$1,50	0/\$3,000	\$2,000/\$4,000	\$2,	000/\$4,000
Annual out-of-p maximum (IND/		\$2,500/\$5,000	\$3,50	0/\$7,000	\$4,000/\$8,000	\$4,	000/\$8,000
Office visits – pr well-child care	reventive and	\$0		\$0	\$0		\$0
Office visits – pr	renatal care	\$0		\$0	\$0		\$0
Telehealth (pho	ne/video)	\$0*		\$0*	\$0*		\$0*
Office visits – pr	rimary care	10%*	2	20%*	20%*		30%*
Office visits – ur	rgent care	10%*	2	20%*	20%*		30%*
Office visits – sp	ecialty care	10%*	2	20%*	20%*		30%*
Office visits – na	aturopathic care	10%*	2	20%*	20%*		30%*
Lab		10%*	2	20%*	20%*		30%*
X-ray/diagnostic	: tests	10%*	2	20%*	20%*		30%*
CT, MRI, and PE	F scans	10%*	2	20%*	20%*		30%*
Outpatient surg	ery	10%*	2	20%*	20%*		30%*
Inpatient hospit	tal care	10%*	2	20%*	20%*		30%*
Emergency care		10%*	2	20%*	20%*		30%*
Routine eye exa	m	10%*	2	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	PPO	OOA SR. ADV	
0	0	enefits for each pl	-		0	See pla	n comparisons
ousiness goals o compare th	s. e benefits of u	a plan that helps m p to any 3 plans, c an comparisons."					Reset
		HIGH DEI	DUCTIBL	E HEALTH	I PLAN		
Plan I	Name	HDHP Plan C 2500/20%/5000		IP Plan C 30%/5000	HDHP Plan D 2800/20%/5600		0HP Plan D 0/30%/5600
Accumulation ty	ире	Aggregate	Ag	gregate	Embedded	E	mbedded
Annual medical (IND/FAM) (per c		\$2,500/\$5,000	\$2,50	00/\$5,000	\$2,800/\$5,600	\$2,	800/\$5,600
Annual out-of-po maximum (IND/		\$5,000/\$7,500	\$5,00	00/\$7,500	\$5,600/\$11,200	\$5,6	500/\$11,200
Office visits – pr well-child care	eventive and	\$0		\$0	\$0		\$0
Office visits – pr	enatal care	\$0		\$0	\$0		\$0
Telehealth (pho	ne/video)	\$0*		\$0*	\$0*		\$0*
Office visits – pr	imary care	20%*		30%*	20%*		30%*
Office visits – ur	gent care	20%*		30%*	20%*		30%*
Office visits – sp	ecialty care	20%*		30%*	20%*		30%*
Office visits – na	turopathic care	20%*		30%*	20%*		30%*
Lab		20%*		30%*	20%*		30%*
X-ray/diagnostic	tests	20%*		30%*	20%*		30%*
CT, MRI, and PET	scans	20%*		30%*	20%*		30%*
Outpatient surg	ery	20%*		30%*	20%*		30%*
Inpatient hospit	al care	20%*		30%*	20%*		30%*
Emergency care		20%*		30%*	20%*		30%*
Routine eye exa	m	20%*		30%*	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	PPO	OOA	SR. ADV.
-	•	enefits for each pla plan that helps m				See pla	n comparisons
ousiness goals	-				4		
		p to any 3 plans, c	heck the che	eckboxes ne	ext to each		Reset
olan and then	select "See pla	an comparisons."					
		HIGH DEE	DUCTIBLE	HEALTH	PLAN		
Plan I	Name	HDHP Plan E 3000/20%/6000		P Plan E 30%/6000	HDHP Plan F 3500/20%/7000		0HP Plan F 0/30%/7000
Accumulation ty	ре	Embedded	Emb	bedded	Embedded	E	mbedded
Annual medical (IND/FAM) (per c		\$3,000/\$6,000	\$3,00	0/\$6,000	\$3,500/\$7,000	\$3,	500/\$7,000
Annual out-of-po maximum (IND/		\$6,000/\$12,000	\$6,000)/\$12,000	\$7,000/\$14,000	\$7,0	000/\$14,000
Office visits – pr well-child care	eventive and	\$0		\$0	\$0		\$0
Office visits – pr	enatal care	\$0		\$0	\$0		\$0
Telehealth (pho	ne/video)	\$0*		\$0*	\$0*		\$0*
Office visits – pr	imary care	20%*	3	0%*	20%*		30%*
Office visits – ur	gent care	20%*	3	0%*	20%*		30%*
Office visits – sp	ecialty care	20%*	3	0%*	20%*		30%*
Office visits – na	turopathic care	20%*	3	0%*	20%*		30%*
Lab		20%*	3	0%*	20%*		30%*
X-ray/diagnostic	tests	20%*	3	0%*	20%*		30%*
CT, MRI, and PET	scans	20%*	3	0%*	20%*		30%*
Outpatient surg	ery	20%*	3	0%*	20%*		30%*
Inpatient hospit	al care	20%*	3	0%*	20%*		30%*
Emergency care		20%*	3	0%*	20%*		30%*
Routine eye exa	m	20%*	3	0%*	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	PPO	OOA	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 ousiness goals. To compare the benefits of up to any 3 plans, check the checkboxes next to each olan and then select "See plan comparisons."									
HIGH DEDUCTIBLE HEALTH PLAN									
Plan I	Name	HDHP Plan G 4000/20%/7000		0HP Plan G 0/30%/7000	HDHP Plan G 4000/40%/7000		DHP Plan H 0/20%/7000		
Accumulation ty	ре	Embedded	E	mbedded	Embedded	E	Embedded		
Annual medical (IND/FAM) (per o		\$4,000/\$8,000	\$4,	000/\$8,000	\$4,000/\$8,000	\$5,	000/\$10,000		
Annual out-of-po maximum (IND/		\$7,000/\$14,000	\$7,0	000/\$14,000	\$7,000/\$14,000	\$7,	000/\$14,000		
Office visits – pr well-child care	eventive and	\$0		\$0	\$0		\$0		
Office visits – pr	enatal care	\$0		\$0	\$0		\$0		
Telehealth (pho	ne/video)	\$0*		\$0*	\$0*		\$0*		
Office visits – pr	imary care	20%*		30%*	40%*		20%*		
Office visits – ur	gent care	20%*		30%*	40%*		20%*		
Office visits – sp	ecialty care	20%*		30%*	40%*		20%*		
Office visits – na	turopathic care	20%*		30%*	40%*		20%*		
Lab		20%*		30%*	40%*		20%*		
X-ray/diagnostic	tests	20%*		30%*	40%*		20%*		
CT, MRI, and PET	scans	20%*		30%*	40%*		20%*		
Outpatient surg	ery	20%*		30%*	40%*		20%*		
Inpatient hospit	al care	20%*		30%*	40%*		20%*		
Emergency care		20%*		30%*	40%*		20%*		
Routine eye exa	m	20%*		30%*	40%*		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	РРО	OOA	SR. ADV.			
Below are high you the flexibil business goals To compare the	ity to choose :	a plan that hel _l	os meet emplo	oyee needs ar	nd	See pla	n comparisons Reset			
plan and then select "See plan comparisons."										
HIGH DEDUCTIBLE HEALTH PLAN										
Plan Name HDHP PLAN H 5000/30%/7000 HDHP PLAN H 5000/40%/70					5000/40%/7000	HDHP PLAN H 5	000/50%/7000			
Accumulation ty	ре	Embe	dded	Emb	edded	Embe	dded			
Annual medical (IND/FAM) (per c		\$5,000/	\$10,000	\$5,000	/\$10,000	\$5,000/\$10,000				
Annual out-of-po maximum (IND/		\$7,000/	\$7,000/\$14,000 \$7,			\$14,000 \$7,000/\$14,000				
Office visits – pre well-child care	eventive and	\$	\$0 \$0			\$0				
Office visits – pre	enatal care	\$	0		\$0	\$0				
Telehealth (phor	ie/video)	\$()*	\$	\$0*		*			
Office visits – pri	mary care	30	%*	40%*		500	%*			
Office visits – urg	gent care	30	%*	40%*		509	%*			
Office visits – sp	ecialty care	30	%*	4()%*	500	%*			
Office visits – na	turopathic care	30	%*	40)%*	500	%*			
Lab		30	%*	4()%*	509	%*			
X-ray/diagnostic	tests	30	%*	4()%*	509	%*			
CT, MRI, and PET	scans	30	%*	4()%*	509	%*			
Outpatient surge	ery	30	%*	4()%*	509	%*			
Inpatient hospita	al care	30	%*	40)%*	509	%*			
Emergency care 30%* 40%* 50					509	%*				
Routine eye exa	n	30	%*	4()%*	509	%*			

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	PPO	OOA	SR. ADV.		
Below are hig you the flexib	See plar	comparisons							

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

Reset

Dual Choice PPO									
Plan name	PPO PLAI	N A 10/1500	PPO PLAN B 20/2000						
Network	In-network	Out-of-network	In-network	Out-of-network					
Annual medical deductible (IND/FAM) (per calendar year)	\$0/\$0	\$1,500/\$3,000	\$0/\$0	\$2,000/\$4,000					
Annual out-of-pocket maximum (IND/FAM)	\$1,500/\$3,000	\$4,500/\$9,000	\$2,000/\$4,000	\$6,000/\$12,000					
Office visits – preventive and well-child care	\$0	30%*	\$0	30%*					
Office visits – prenatal care	\$0 30%*		\$0	30%*					
Telehealth (phone/video)	\$0	30%*	\$0	30%*					
Office visits – primary care	ice visits – primary care \$30 (\$10 enhanced benefit)		\$40 (\$20 enhanced benefit)	30%*					
Office visits – urgent care	\$60 (\$30 enhanced benefit)	30%*	\$80 (\$40 enhanced benefit)	30%*					
Office visits – specialty care	\$40 (\$20 enhanced benefit)	30%*	\$50 (\$30 enhanced benefit)	30%*					
Office visits – naturopathic care	\$10	30%*	\$20	30%*					
Lab	\$10	30%*	\$20	30%*					
X-ray/diagnostic tests	\$10	30%*	\$20	30%*					
CT, MRI, and PET scans	\$50	30%*	\$50	30%*					
Outpatient surgery	\$50	30%*	\$50	30%*					
Inpatient hospital care	\$100 per day, \$500 per admission	30%*	\$100 per day, \$500 per admission	30%*					
Emergency care	\$10	00	\$10	00					
Routine eye exam	\$30 (\$10 enhanced benefit)	30%*	\$40 (\$20 enhanced benefit)	30%*					

*After deductible.

business goals.

plan and then select "See plan comparisons."



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
Below are hig	See pla	n comparisons					

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."

	Du	al Choice PPO			
Plan name	PPO PLA	N C 20/2500	PPO PLAN	N D 30/3000	
Network	In-network	Out-of-network	In-network	Out-of-network	
Annual medical deductible (IND/FAM) (per calendar year)	\$0/\$0	\$2,000/\$4,000	\$0/\$0	\$2,000/\$4,000	
Annual out-of-pocket maximum (IND/FAM)	\$2,500/\$5,000	\$6,000/\$12,000	\$3,000/\$6,000	\$6,000/\$12,000	
Office visits – preventive and well-child care	\$0	\$0 30%*		30%*	
Office visits – prenatal care	\$0	\$0 30%*		30%*	
Telehealth (phone/video)	\$0	30%*	\$0	30%*	
Office visits – primary care	e visits – primary care \$40 (\$20 enhanced benefit)		\$50 (\$30 enhanced benefit)	30%*	
Office visits – urgent care\$80 (\$40 enhanced benefit)		30%*	\$100 (\$50 enhanced benefit)	30%*	
Office visits – specialty care	\$50 (\$30 enhanced benefit)	30%*	\$60 (\$40 enhanced benefit)	30%*	
Office visits – naturopathic care	\$20	30%*	\$30	30%*	
Lab	\$20	30%*	\$30	30%*	
X-ray/diagnostic tests	\$20	30%*	\$30	30%*	
CT, MRI, and PET scans	\$50	30%*	\$50	30%*	
Outpatient surgery	\$50	30%*	\$100	30%*	
Inpatient hospital care	\$200 per day, \$1,000 per admission	30%*	\$200 per day, \$1,000 per admission	30%*	
Emergency care	\$20	00	\$20	00	
Routine eye exam	\$40 (\$20 enhanced		\$50 (\$30 enhanced benefit)	30%*	

*After deductible.

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



Reset

Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.			
0	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."										
Dual Choice PPO										

	Du	al Choice PPU			
Plan name	PPO PLAN	N E 35/3500	PPO PLAN A 2	50/10/10%/2500	
Network	In-network	Out-of-network	In-network	Out-of-network	
Annual medical deductible (IND/FAM) (per calendar year)	\$0/\$0	\$2,000/\$4,000	\$250/\$750	\$2,000/\$6,000	
Annual out-of-pocket maximum (IND/FAM)	\$3,500/\$7,000	\$6,000/\$12,000	\$2,500/\$7,500	\$6,000/\$12,000	
Office visits – preventive and well-child care	\$0	30%*	\$0	30%*	
Office visits – prenatal care	\$0	30%*	\$0	30%*	
Telehealth (phone/video)\$0		30%*	\$0	30%*	
Office visits – primary care \$55 (\$35 enhanced benefit)		30%*	\$30 (\$10 enhanced benefit)	30%*	
Office visits – urgent care \$110 (\$60 enhance benefit)		30%*	\$30 (\$10 enhanced benefit)	30%*	
Office visits – specialty care	\$65 (\$45 enhanced benefit)	30%* \$30 (\$10 enhanced benefit)		30%*	
Office visits – naturopathic care	\$35	30%* \$10		30%*	
Lab	\$35	30%*	10%*	30%*	
X-ray/diagnostic tests	\$35	30%*	10%*	30%*	
CT, MRI, and PET scans	\$50	30%*	10%*	30%*	
Outpatient surgery	\$150	30%*	\$10*	30%*	
Inpatient hospital care	\$800 per admission	30%*	10%*	30%*	
Emergency care	\$20	00	\$20	\$200*	
Routine eye exam	\$55 (\$35 enhanced benefit)	30%*	30 (\$10 enhanced benefit)	30%*	



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.	
Below are hig	See plar	n comparisons						
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."								
Dual Chaiza DDO								

	Du	al Choice PPO			
Plan name	PPO PLAN A 2	50/15/20%/3000	PPO PLAN B 50	00/20/10%/3500	
Network	In-network	Out-of-network	In-network	Out-of-network	
Annual medical deductible (IND/FAM) (per calendar year)	\$250/\$750	\$2,000/\$6,000	\$500/\$1,500	\$2,500/\$7,500	
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	\$6,000/\$12,000	\$3,500/\$10,500	\$7,500/\$15,000	
Office visits – preventive and well-child care	• \$()		\$0	30%*	
Office visits – prenatal care \$0		30%*	\$0	30%*	
Telehealth (phone/video) \$0		30%*	\$0	30%*	
Office visits – primary care	\$35 (\$15 enhanced benefit)	30%*	\$40 (\$20 enhanced benefit)	30%*	
Office visits – urgent care \$55 (\$35 enhance benefit)		30%*	\$80 (\$40 enhanced benefit)	30%*	
Office visits – specialty care	\$45 (\$25 enhanced benefit)	30%*	\$50 (\$30 enhanced benefit)	30%*	
Office visits – naturopathic care	\$15	30%*	\$20	30%*	
Lab	\$15	30%*	\$20	30%*	
X-ray/diagnostic tests	\$15	30%*	\$20	30%*	
CT, MRI, and PET scans	\$100	30%*	\$100	30%*	
Outpatient surgery	20%*	30%*	10%*	30%*	
Inpatient hospital care	20%*	30%*	10%*	30%*	
Emergency care	209	/o*	109	/* 0 [*]	
Routine eye exam	\$35 (\$15 enhanced benefit)	30%*	\$40 (\$20 enhanced benefit)	30%*	



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.
Below are hig you the flexibi	See plar	n comparisons					
	ne benefits of u	up to any 3 plar an comparison		checkboxes next	t to each		Reset

	Du	al Choice PPO		
Plan name	PPO PLAN B 50	0/10%/10%/3000	PPO PLAN B 5	00/10/20%/3000
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	\$500/\$1,500	\$2,500/\$7,500	\$500/\$1,500	\$2,500/\$7,500
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	\$7,500/\$15,000	\$3,000/\$9,000	\$7,500/\$15,000
Office visits – preventive and well-child care	\$0	30%*	\$0	40%*
Office visits – prenatal care	\$0	30%*	\$0	40%*
Telehealth (phone/video)	\$0	30%*	\$0	40%*
Office visits – primary care	20%* (10%* enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	40%*
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	40%*
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	40%*
Office visits – naturopathic care	10%*	30%*	\$10	40%*
Lab	10%*	30%*	20%*	40%*
X-ray/diagnostic tests	10%*	30%*	20%*	40%*
CT, MRI, and PET scans	10%*	30%*	20%*	40%*
Outpatient surgery	10%*	30%*	\$10*	40%*
Inpatient hospital care	10%*	30%*	20%*	40%*
Emergency care	\$20	0*	\$20	0*
Routine eye exam	20%* (10%* enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	40%*



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
you the flexib business goal To compare th	lity to choose s. ne benefits of t	a plan that hel	ps meet empl ns, check the	ety of options giv oyee needs and checkboxes next			n comparisons Reset
			Dual Ch	oice PPO			

Plan name	PPO PLAN B 5	00/20/20%/3500	PPO PLAN C 75 (w/SPLIT (50/20/20%/3500 COPAYS)
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	\$500/\$1,500	\$2,500/\$7,500	\$750/\$2,250	\$3,000/\$9,000
Annual out-of-pocket maximum (IND/FAM)	\$3,500/\$10,500	\$7,500/\$15,000	\$3,500/\$10,500	\$7,500/\$22,500
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
Telehealth (phone/video)	\$0	40%*	\$0	40%*
Office visits – primary care	\$40 (\$20 enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	40%*
Office visits – urgent care	\$80 (\$40 enhanced benefit)	40%*	\$80 (\$40 enhanced benefit)	40%*
Office visits – specialty care	\$50 (\$30 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	40%*
Office visits – naturopathic care	\$20	40%*	\$20	40%*
Lab	\$20	40%*	\$20	40%*
X-ray/diagnostic tests	\$20	40%*	\$20	40%*
CT, MRI, and PET scans	\$100	40%*	\$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	209	%*	20%	/o*
Routine eye exam	\$40 (\$20 enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	40%*



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
you the flexibil business goals	lity to choose s. e benefits of u	a plan that help up to any 3 pla	os meet emp ns, check the	iety of options gi loyee needs and checkboxes nex			n comparisons Reset
			Dual Ch	oice PPO			

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



Overview	TRAD	DED	VC	HDHP	РРО	OOA	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							
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."							
			Dual Ch	oice PPO			

Plan name	PPO PLAN D 10	000/20/20%/4000	PPO PLAN D 10	00/25/20%/5000				
Network	In-network	Out-of-network	In-network	Out-of-network				
Annual medical deductible (IND/FAM) (per calendar year)	\$1,000/\$3,000	\$3,000/\$9,000	\$1,000/\$3,000	\$3,000/\$9,000				
Annual out-of-pocket maximum (IND/FAM)	\$4,000/\$12,000	\$9,000/\$27,000	\$5,000/\$15,000	\$9,000/\$27,000				
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*				
Office visits – prenatal care	\$0	40%*	\$0	40%*				
Telehealth (phone/video)	\$0	40%*	\$0	40%*				
Office visits – primary care	\$40 (\$20 enhanced benefit)	40%*	\$45 (\$25 enhanced benefit)	40%*				
Office visits – urgent care	\$40 (\$20 enhanced benefit)	40%*	\$90 (\$45 enhanced benefit)	40%*				
Office visits – specialty care	\$40 (\$20 enhanced benefit)	40%*	\$55 (\$35 enhanced benefit)	40%*				
Office visits – naturopathic care	\$20	40%*	\$25	40%*				
Lab	20%*	40%*	\$25	40%*				
X-ray/diagnostic tests	20%*	40%*	\$25	40%*				
CT, MRI, and PET scans	20%*	40%*	\$100	40%*				
Outpatient surgery	20%*	40%*	20%*	40%*				
Inpatient hospital care	20%*	40%*	20%*	40%*				
Emergency care	\$20	0*	209	/o*				
Routine eye exam	\$40 (\$20 enhanced benefit)	40%*	\$45 (\$25 enhanced benefit)	40%*				



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.	
you the flexib business goal	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							
		an comparison	is."	oice PPO				

Plan name	PPO PLAN E 1	500/25/20%/6000	PPO PLAN E 15	500/20/30%/5000
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	\$1,500/\$4,500	\$3,500/\$10,500	\$1,500/\$4,500	\$3,500/\$10,500
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$10,500/\$21,000	\$5,000/\$12,000	\$10,500/\$21,000
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*
Office visits – prenatal care	\$0	40%*	\$0	50%*
Telehealth (phone/video)	\$0	40%*	\$0	50%*
Office visits – primary care	\$45 (\$25 enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	50%*
Office visits – urgent care	\$90 (\$45 enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	50%*
Office visits – specialty care	\$55 (\$35 enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	50%*
Office visits – naturopathic care	\$25	40%*	\$20	50%*
Lab	\$25	40%*	30%*	50%*
X-ray/diagnostic tests	\$25	40%*	30%*	50%*
CT, MRI, and PET scans	\$100	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	\$20*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20	%*	\$20	00*
Routine eye exam	\$45 (\$25 enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	50%*



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.
Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals.							
To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."							
			Dual Ch	oice PPO			

Plan name	PPO PLAN E 150	00/30%/30%/5000	PPO PLAN F 20	00/25/20%/6000				
Network	In-network	Out-of-network	In-network	Out-of-network				
Annual medical deductible (IND/FAM) (per calendar year)	\$1,500/\$4,500	\$3,500/\$10,500	\$2,000/\$6,000	\$4,000/\$12,000				
Annual out-of-pocket maximum (IND/FAM)	\$5,000/\$12,000	\$10,500/\$21,000	\$6,000/\$12,000	\$12,000/\$24,000				
Office visits – preventive and well-child care	\$0	50%*	\$0	40%*				
Office visits – prenatal care	\$0	50%*	\$0	40%*				
Telehealth (phone/video)	\$0	50%*	\$0	40%*				
Office visits – primary care	40%*(30%* enhanced benefit)	50%*	\$45 (\$25 enhanced benefit)	40%*				
Office visits – urgent care	40%*(30%* enhanced benefit)	50%*	\$90 (\$45 enhanced benefit)	40%*				
Office visits – specialty care	40%*(30%* enhanced benefit)	50%*	\$55 (\$35 enhanced benefit)	40%*				
Office visits – naturopathic care	30%*	50%*	\$25	40%*				
Lab	30%*	50%*	\$25	40%*				
X-ray/diagnostic tests	30%*	50%*	\$25	40%*				
CT, MRI, and PET scans	30%*	50%*	\$100	40%*				
Outpatient surgery	30%*	50%*	20%*	40%*				
Inpatient hospital care	30%*	50%*	20%*	40%*				
Emergency care	\$20	0*	20%*					
Routine eye exam	40%*(30%* enhanced benefit)	50%*	\$45 (\$25 enhanced benefit)	40%*				



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.
you the flexibi business goal To compare th	ility to choose s. ne benefits of t	a plan that hel	ps meet empl ns, check the	ety of options giv oyee needs and checkboxes next		See pla	n comparisons Reset
			Dual Ch	oice PPO			

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



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.		
you the flexibi business goal To compare th	ility to choose s. ne benefits of t	a plan that hel	ps meet empl ns, check the	ety of options giv oyee needs and checkboxes next		See pla	n comparisons Reset		
Dual Choice PPO									

Plan name	PPO PLAN G 25	00/30%/30%/6000	PPO PLAN H 3000/30/20%/8150						
Network	In-network	Out-of-network	In-network	Out-of-network					
Annual medical deductible (IND/FAM) (per calendar year)	\$2,500/\$5,000	\$4,500/\$13,500	\$3,000/\$9,000	\$5,000/\$15,000					
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$13,500/\$27,000	\$8,150/\$16,300	\$15,000/\$30,000					
Office visits – preventive and well-child care	\$0	50%*	\$0	40%*					
Office visits – prenatal care	\$0	50%*	\$0	40%*					
Telehealth (phone/video)	\$0	50%*	\$0	40%*					
Office visits – primary care	40%* (30%* enhanced benefit)	50%*	\$50 (\$30 enhanced benefit)	40%*					
Office visits – urgent care	40%* (30%* enhanced benefit)	50%* \$100 (\$50 enhan benefit)		40%*					
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	\$60 (\$40 enhanced benefit)	40%*					
Office visits – naturopathic care	30%*	50%*	\$30	40%*					
Lab	30%*	50%*	\$30	40%*					
X-ray/diagnostic tests	30%*	50%*	\$30	40%*					
CT, MRI, and PET scans	30%*	50%*	\$100	40%*					
Outpatient surgery	30%*	50%*	20%*	40%*					
Inpatient hospital care	30%*	50%*	20%*	40%*					
Emergency care	\$20)0*	20'	%*					
Routine eye exam	40%* (30%* enhanced benefit)	50%*	\$50 (\$30 enhanced benefit)	40%*					



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.				
0	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."											
Dual Choice PPO											

	Du					
Plan name	PPO PLAN H 30	00/30%/30%/7000	PPO PLAN I 3500/30/20%/8000			
Network	In-network	Out-of-network	In-network	Out-of-network		
Annual medical deductible (IND/FAM) (per calendar year)	\$3,000/\$6,000	\$5,000/\$15,000	\$3,500/\$10,500	\$5,500/\$16,500		
Annual out-of-pocket maximum (IND/FAM)	\$7,000/\$14,000	\$15,000/\$30,000	\$8,000/\$16,000	\$15,000/\$30,000		
Office visits – preventive and well-child care	\$0	50%*	\$0	40%*		
Office visits – prenatal care	\$0	50%*	\$0	40%*		
Telehealth (phone/video)	\$0	50%*	\$0	40%*		
Office visits – primary care	40%* (30%* enhanced benefit)	50%*	\$50 (\$30 enhanced benefit)	40%*		
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	\$100 (\$50 enhanced benefit)	40%*		
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	\$60 (\$40 enhanced benefit)	40%*		
Office visits – naturopathic care	30%*	50%*	\$30	40%*		
Lab	30%*	50%*	\$30	40%*		
K-ray/diagnostic tests	30%*	50%*	\$30	40%*		
CT, MRI, and PET scans	30%*	50%*	\$100	40%*		
Outpatient surgery	30%*	50%*	20%*	40%*		
npatient hospital care	30%*	50%*	20%*	40%*		
Emergency care	\$20	0*	209	%*		
Routine eye exam	40%* (30%* enhanced benefit)	50%*	\$50 (\$30 enhanced benefit)	40%*		



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
you the flexib business goal To compare th	ility to choose s. ne benefits of u	a plan that help	os meet empl ns, check the	ety of options giv oyee needs and checkboxes next			n comparisons Reset
			Dual Ch	oice PPO			

Plan name	PPO PLAN J 4000/30/20%/8150		PPO PLAN K 50	000/30/20%/8150
Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible (IND/FAM) (per calendar year)	\$4,000/\$10,000	\$6,000/\$18,000	\$5,000/\$10,000	\$6,500/\$19,500
Annual out-of-pocket maximum (IND/FAM)	\$8,150/\$16,300	\$15,000/\$30,000	\$8,150/\$16,300	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
Telehealth (phone/video)	\$0	40%*	\$0	40%*
Office visits – primary care	\$50 (\$30 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	40%*
Office visits – urgent care	\$100 (\$50 enhanced benefit)	40%*	\$100 (\$50 enhanced benefit)	40%*
Office visits – specialty care	\$60 (\$40 enhanced benefit)	40%*	\$60 (\$40 enhanced benefit)	40%*
Office visits – naturopathic care	\$30	40%*	\$30	40%*
Lab	\$30	40%*	\$30	40%*
X-ray/diagnostic tests	\$30	40%*	\$30	40%*
CT, MRI, and PET scans	\$100	40%*	\$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	209	%*	209	%*
Routine eye exam	\$50 (\$30 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	40%*



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
					-		
0	lity to choose			iety of options gi loyee needs and		See pla	n comparisons
To compare th	e benefits of	up to any 3 plan lan comparisons		e checkboxes next	t to each		Reset
		Dual Ch	oice PPC) Virtual Con	nplete		
	Plan nam	ie		PPO	PLAN VC 250	0/40/20%/6500	
Network				In-network		Out-of-net	work
Annual medical	deductible (IND/	FAM) (per calendar	year)	\$2,500/\$5,000		\$5,000/\$1	5,000
Annual out-of-p	ocket maximum	(IND/FAM)		\$6,500/\$13,000		\$13,500/\$2	7,000
Office visits – pr	eventive and we	ll-child care		\$0		40%*	
Office visits – pr	enatal care			\$0		40%*	
Telehealth (pho	ne/video)			\$0		40%*	
Office visits – pr	imary care		\$6	0* (\$40* enhanced be	nefit) ¹	40%*	
Office visits – ur	gent care		\$6	0* (\$40* enhanced be	enefit)	40%*	
Office visits – sp	ecialty care		\$6	0* (\$40* enhanced be	enefit)	40%*	
Office visits – na	turopathic care			\$40*1		40%*	
Lab				\$15		40%*	
X-ray/diagnostic	: tests			20%*		40%*	

CT, MRI, and PET scans	20%*	40%*			
Outpatient surgery	20%*	40%*			
Inpatient hospital care	20%*	40%*			
Emergency care	20%*				
Routine eye exam	\$60* (\$40* enhanced benefit) ¹	40%*			
Outpatient prescription drugs	Kaiser Permane	Permanente Pharmacies			
	\$15* generic; \$40* preferred brand-name; \$60* non-preferred brand-name;20%* (up to a max of \$250) specialty				
	MedImpact	Pharmacies			
	\$25* generic; \$60* preferred brand- name; \$90* non-preferred brand- name; 30%* specialty	Not covered			

¹Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).



Overview	TRAD	DED	VC HDHP	PPO	OOA	SR. ADV.
•	ility to choose		n. A variety of options give et employee needs and	es		n comparisons
		up to any 3 plans, ch lan comparisons."	eck the checkboxes next	to each		Reset
		·	DDO Winterel Com	nlata		
		Dual Choic	e PPO Virtual Com	piete		
	Plan nan	ne	PPO P	2LAN VC 3000/4	10/30%/7000	
Network			In-network		Out-of-net	work
Annual medica	deductible (IND/	FAM) (per calendar year)	\$3,000/\$6,000		\$6,000/\$18	3,000
Annual out-of-p	ocket maximum	(IND/FAM)	\$7,000/\$14,000		\$15,000/\$3	0,000
Office visits – p	reventive and we	ll-child care	\$0		50%*	
Office visits – p	renatal care		\$0		50%*	
Telehealth (pho	one/video)		\$0		50%*	
Office visits – p	rimary care		\$60* (\$40* enhanced ben	efit)1	50%*	
Office visite	raont coro		¢40*/¢10* onbanced bon	of:+)	E00/*	

Office visits – urgent care	\$60* (\$40* enhanced benefit)	50%*			
Office visits – specialty care	\$60* (\$40* enhanced benefit)	50%*			
Office visits – naturopathic care	\$40*1	50%*			
Lab	\$15	50%*			
X-ray/diagnostic tests	30%*	50%*			
CT, MRI, and PET scans	30%*	50%*			
Outpatient surgery	30%*	50%*			
Inpatient hospital care	30%*	50%*			
Emergency care	30%*				
Routine eye exam	\$60* (\$40* enhanced benefit) ¹	50%*			
Outpatient prescription drugs	Kaiser Permanente Pharmacies				
	\$15* generic; \$40* preferred brand- name; \$60* non-preferred brand-name; 30%* (up to a max of \$250) specialty	Not covered			
	MedImpact Ph	armacies			
	\$25* generic; \$60* preferred brand- name; \$90* non-preferred brand- name; 40%* specialty	Not covered			

¹Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.			
Delow ere biel	hliabto of the l	penefits for each pl		isty of options of						
you the flexibi business goals	lity to choose	See plan comparisons								
To compare th	To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."									
Dual Choice PPO Virtual Complete										
	Plan nam	ie		PPO	PLAN VC 400	00/50/30%/8150				
Network				In-network		Out-of-n	etwork			
Annual medical	deductible (IND/	FAM) (per calendar year)	\$4,000/\$8,000		\$8,000/\$	16,000			
Annual out-of-p	ocket maximum	(IND/FAM)		\$8,150/\$16,300		\$15,000/\$30,000				
Office visits – pr	reventive and we	ll-child care		\$0		50%	5*			
Office visits – pr	renatal care			\$0		50%	ʻo*			
Telehealth (pho	Telehealth (phone/video)\$050%*						,*)			
Office visits – pr	rimary care		\$7	0* (\$50* enhanced ber	nefit)1	50%	/*			
Office visits – ur	rgent care		\$7	0* (\$50* enhanced be	nefit)	50%	b*			

\$70* (\$50* enhanced benefit) 50%*			
\$50*1 50%*			
\$15 50%*			
30%*	50%*		
30%* 50%*			
30%*	50%*		
30%* 50%*			
30%*			
\$70* (\$50* enhanced benefit) ¹ 50%*			
Kaiser Permanente Pharmacies			
\$15* generic; \$50* preferred brand- name; \$70* non-preferred brand-name; 30%* (up to a max of \$250) specialty	Not covered		
MedImpact P	harmacies		
\$25* generic; \$70* preferred brand- name; \$100* non-preferred brand- name; 40%* specialty	Not covered		
	\$70* (\$50* enhanced benefit) \$50*1 \$15 30%* 30%* 30%* 30%* 30%* 30%* 30%* 30%* 30%* 30%* \$15* generic; \$50* preferred brand-name; 30%* (up to a max of \$250) specialty MedImpact P \$25* generic; \$70* preferred brand-name; \$100* non-preferred brand-name; \$10		

¹Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.	
you the flexibi business goal To compare th	ility to choose s. ne benefits of	benefits for each pl a plan that helps m up to any 3 plans, c lan comparisons."	eet empl	oyee needs and		See plan	n comparisons Reset	
			ce PPO	Virtual Con	nplete			
	Plan nan	ne		РРО	PLAN VC 5000	/50/40%/8150		
Network				In-network Ou			work	
Annual medical	deductible (IND/	/FAM) (per calendar year)	\$5,000/\$10,000		\$10,000/\$20,000		
Annual out-of-p	ocket maximum	n (IND/FAM)		\$8,150/\$16,300		\$15,000/\$30,000		
Office visits – p	- preventive and well-child care \$0			\$0		50%*		
Office visits – prenatal care			\$0		50%*			
Telehealth (phone/video)			\$0		50%*			
Office visits – primary care		\$70	* (\$50* enhanced be	enefit)1	50%*			
Office visits – u	rgent care		\$70	* (\$50* enhanced be	enefit)	50%*		
Office visits – s	pecialty care		\$70	* (\$50* enhanced be	enefit)	50%*		
Office visits – specialty care			\$70	* (\$50* enhanced be	enefit)	50%*		

Office visits – naturopathic care	\$50* ¹	50%*		
Lab	\$15	50%*		
X-ray/diagnostic tests	40%*	50%*		
CT, MRI, and PET scans	40%*	50%*		
Outpatient surgery	40%* 50%*			
Inpatient hospital care	40%*	50%*		
Emergency care	40	%*		
Routine eye exam	\$70* (\$50* enhanced benefit) ¹ 50%*			
Outpatient prescription drugs	Kaiser Permanente Pharmacies			
	\$15* generic; \$50* preferred brand- name; \$70* non-preferred brand-name; 40%* (up to a max of \$250) specialty	Not covered		
	MedImpact Pharmacies			
	\$25* generic; \$70* preferred brand- name; \$100* non-preferred brand- name; 50%* specialty	Not covered		

¹Plan deductible doesn't apply to the first 3 visits combined for primary care, naturopathic care, routine eye exam, and mental health and substance use disorder treatment (individual and group visits).



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.
you the flexib business goal To compare th	ility to choose s. ne benefits of t	a plan that hel	os meet empl ns, check the	ety of options giv oyee needs and checkboxes next			n comparisons Reset
			Dual Ch	oice PPO			

	Du	al Choice PPU			
Plan name	PPO HDHP PLAN	N A 1500/10%/2500	PPO HDHP PLAN A 1500/20%/3500		
Network	In-network	Out-of-network	In-network	Out-of-network	
Accumulation type	Aggr	egate	Aggregate		
Annual medical deductible (IND/FAM) (per calendar year)	\$1,500/\$3,000	\$3,500/\$9,750	\$1,500/\$3,000	\$3,500/\$9,750	
Annual out-of-pocket maximum (IND/FAM)	\$2,500/\$5,000	\$10,500/\$21,000	\$3,500/\$7,000	\$11,500/\$23,000	
Office visits – preventive and well-child care	\$0	30%*	\$0	40%*	
Office visits – prenatal care	\$0	30%*	\$0	40%*	
Telehealth (phone/video)	\$0*	30%*	\$0*	40%*	
Office visits – primary care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*	
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*	
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	30%* (20%* enhanced benefit)	40%*	
Office visits – naturopathic care	10%*	30%*	20%*	40%*	
Lab	10%*	30%*	20%*	40%*	
X-ray/diagnostic tests	10%*	30%*	20%*	40%*	
CT, MRI, and PET scans	10%*	30%*	20%*	40%*	
Outpatient surgery	10%*	30%*	20%*	40%*	
Inpatient hospital care	10%*	30%*	20%*	40%*	
Emergency care	10	%*	20%*		
Routine eye exam 20%* (10%* enhanced benefit)		30%*	30%* (20%* enhanced benefit)	40%*	



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
you the flexib business goal To compare th	ility to choose s. ne benefits of t	a plan that help	os meet empl ns, check the	ety of options gi oyee needs and checkboxes nex			n comparisons Reset
			Dual Ch	oice PPO			

	Du				
Plan name	PPO HDHP PLAN	I B 2000/20%/4000	PPO HDHP PLAN B 2000/30%/4000		
Network	In-network	Out-of-network	In-network	Out-of-network	
Accumulation type	Aggre	egate	Aggregate		
Annual medical deductible (IND/FAM) (per calendar year)			\$2,000/\$4,000	\$4,000/\$12,000	
Annual out-of-pocket maximum (IND/FAM)	\$4,000/\$8,000	\$12,000/\$24,000	\$4,000/\$8,000	\$12,000/\$24,000	
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*	
Office visits – prenatal care	\$0	40%*	\$0	50%*	
Telehealth (phone/video)	\$0*	40%*	\$0*	50%*	
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*	
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*	
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*	
Office visits – naturopathic care	20%*	40%*	30%*	50%*	
Lab	20%*	40%*	30%*	50%*	
X-ray/diagnostic tests	20%*	40%*	30%*	50%*	
CT, MRI, and PET scans	20%*	40%*	30%*	50%*	
Outpatient surgery	20%*	40%*	30%*	50%*	
Inpatient hospital care	20%*	40%*	30%*	50%*	
Emergency care	20	%*	30%*		
Routine eye exam30%* (20%* enhanced benefit)		40%*	40%* (30%* enhanced benefit)	50%*	



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.
Below are hig you the flexib	See plar	n comparisons					
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."							
			Dual Ch	oice PPO			

	Du	al Choice PPO				
Plan name	PPO HDHP PLAN	I C 2500/20%/5000	PPO HDHP PLAN	PPO HDHP PLAN C 2500/30%/5000		
Network	In-network Out-of-network		In-network	Out-of-network		
Accumulation type	Aggre	egate	Aggre	gate		
Annual medical deductible (IND/FAM) (per calendar year)	\$2,500/\$5,000	\$5,000/\$15,000	\$2,500/\$5,000	\$5,000/\$15,000		
Annual out-of-pocket maximum (IND/FAM)	\$5,000/\$7,500	\$15,000/\$30,000	\$5,000/\$7,500	\$15,000/\$30,000		
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*		
Office visits – prenatal care	\$0	40%*	\$0	50%*		
Telehealth (phone/video)	\$0*	40%*	\$0*	50%*		
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*		
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*		
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*		
Office visits – naturopathic care	20%*	40%*	30%*	50%*		
Lab	20%*	40%*	30%*	50%*		
X-ray/diagnostic tests	20%*	40%*	30%*	50%*		
CT, MRI, and PET scans	20%*	40%*	30%*	50%*		
Outpatient surgery	20%*	40%*	30%*	50%*		
Inpatient hospital care	20%*	40%*	30%*	50%*		
Emergency care	20	%*	309	%*		
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*		



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.	
0	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							
To compare t	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."							
			Dual Ch	oice PPO				

Plan name	PPO HDHP PLAN	N D 2800/20%/5600	PPO HDHP PLAN D 2800/30%/5600					
Network	In-network	Out-of-network	In-network	Out-of-network				
Accumulation type	Embe	edded	Embec	ded				
Annual medical deductible (IND/FAM) (per calendar year)	\$2,800/\$5,600	\$5,000/\$15,000	\$2,800/\$5,600	\$5,000/\$15,000				
Annual out-of-pocket maximum (IND/FAM)	\$5,600/\$11,200	\$15,000/\$30,000	\$5,600/\$11,200	\$15,000/\$30,000				
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*				
Office visits – prenatal care	\$0	40%*	\$0	50%*				
Telehealth (phone/video)	\$0*	40%*	\$0*	50%*				
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*				
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*				
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*				
Office visits – naturopathic care	20%*	40%*	30%*	50%*				
Lab	20%*	40%*	30%*	50%*				
X-ray/diagnostic tests	20%*	40%*	30%*	50%*				
CT, MRI, and PET scans	20%*	40%*	30%*	50%*				
Outpatient surgery	20%*	40%*	30%*	50%*				
Inpatient hospital care	20%*	40%*	30%*	50%*				
Emergency care	20	%*	30%	/* 0				
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*				

Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
you the flexib business goal To compare tl	ility to choose s. ne benefits of t	a plan that hel _l	ps meet empl ns, check the	ety of options gi oyee needs and checkboxes next			n comparisons Reset
			Dual Ch	oice PPO			

Plan name	PPO HDHP PLAN	N E 3000/20%/6000	PPO HDHP PLAN	PPO HDHP PLAN E 3000/30%/6000		
Network	In-network	Out-of-network	In-network	Out-of-network		
Accumulation type	Embe	dded	Embe	Embedded		
Annual medical deductible (IND/FAM) (per calendar year)	\$3,000/\$6,000	\$5,000/\$15,000	\$3,000/\$6,000	\$5,000/\$15,000		
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$15,000/\$30,000	\$6,000/\$12,000	\$15,000/\$30,000		
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*		
Office visits – prenatal care	\$0	40%*	\$0	50%*		
Telehealth (phone/video)	\$0*	40%*	\$0*	50%*		
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*		
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*		
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*		
Office visits – naturopathic care	20%*	40%*	30%*	50%*		
Lab	20%*	40%*	30%*	50%*		
X-ray/diagnostic tests	20%*	40%*	30%*	50%*		
CT, MRI, and PET scans	20%*	40%*	30%*	50%*		
Outpatient surgery	20%*	40%*	30%*	50%*		
Inpatient hospital care	20%*	40%*	30%*	50%*		
Emergency care	20	%*	309	%*		
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*		



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.
you the flexib business goal To compare th	ility to choose s. ne benefits of t	a plan that hel _l	ps meet empl ns, check the	ety of options gi loyee needs and checkboxes next			n comparisons Reset
			Dual Ch	oice PPO			

Plan name	PPO HDHP PLAN	N F 3500/20%/7000	PPO HDHP PLAN	F 3500/30%/7000
Network	In-network	Out-of-network	In-network	Out-of-network
Accumulation type	Embe	dded	Embe	dded
Annual medical deductible (IND/FAM) (per calendar year)	\$3,500/\$7,000	\$5,500/\$16,500	\$3,500/\$7,000	\$5,500/\$16,500
Annual out-of-pocket maximum (IND/FAM)	\$7,000/\$14,000	\$15,000/\$30,000	\$7,000/\$14,000	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*
Office visits – prenatal care	\$0	40%*	\$0	50%*
Telehealth (phone/video)	\$0*	40%*	\$0*	50%*
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – naturopathic care	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Outpatient surgery	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency care	20	%*	30	%*
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.	
0	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							
To compare tl	Pour the next bindy to choose a plan that helps meet employee needs and pousiness goals. To compare the benefits of up to any 3 plans, check the checkboxes next to each Reset plan comparisons."							
			Dual Ch	oice PPO				

Plan name	PPO HDHP PLAN	I G 4000/20%/7000	PPO HDHP PLAN G 4000/30%/7000		
Network	In-network	Out-of-network	In-network	Out-of-network	
Accumulation type	Embe	dded	Embec	ded	
Annual medical deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	\$6,000/\$12,000	\$4,000/\$8,000	\$6,000/\$12,000	
Annual out-of-pocket maximum (IND/FAM)	\$7,000/\$14,000	\$15,000/\$30,000	\$7,000/\$14,000	\$15,000/\$30,000	
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*	
Office visits – prenatal care	\$0	40%*	\$0	50%*	
Telehealth (phone/video)	\$0*	40%*	\$0*	50%*	
Office visits – primary care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*	
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*	
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*	
Office visits – naturopathic care	20%*	40%*	30%*	50%*	
Lab	20%*	40%*	30%*	50%*	
X-ray/diagnostic tests	20%*	40%*	30%*	50%*	
CT, MRI, and PET scans	20%*	40%*	30%*	50%*	
Outpatient surgery	20%*	40%*	30%*	50%*	
Inpatient hospital care	20%*	40%*	30%*	50%*	
Emergency care	20	%*	30%	/* 0	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*	



Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.
you the flexib business goal To compare th	ility to choose s. ne benefits of t	a plan that hel _l	ps meet empl ns, check the	ety of options giv loyee needs and checkboxes next			n comparisons Reset
			Dual Ch	oice PPO			

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



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
you the flexib business goal To compare th	ility to choose s. ne benefits of u	a plan that hel	ps meet empl ns, check the	ety of options giv oyee needs and checkboxes next			n comparisons Reset
			Dual Ch	oice PPO			

Plan name	PPO HDHP PLAN	H 5000/30%/7000	PPO HDHP PLAN H 5000/40%/7000		
Network	In-network	ork Out-of-network In-network		Out-of-network	
Accumulation type	Embe	dded	Embe	dded	
Annual medical deductible (IND/FAM) (per calendar year)	\$5,000/\$10,000	\$7,000/\$14,000	\$5,000/\$10,000	\$7,000/\$14,000	
Annual out-of-pocket maximum (IND/FAM)	\$7,000/\$14,000	\$17,000/\$34,000	\$7,000/\$14,000	\$17,000/\$34,000	
Office visits – preventive and well-child care	\$0	50%*	\$0	50%*	
Office visits – prenatal care	\$0	50%*	\$0	50%*	
Telehealth (phone/video)	\$0*	50%*	\$0*	50%*	
Office visits – primary care	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*	
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*	
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	50%* (40%* enhanced benefit)	50%*	
Office visits – naturopathic care	30%*	50%*	40%*	50%*	
Lab	30%*	50%*	40%*	50%*	
X-ray/diagnostic tests	30%*	50%*	40%*	50%*	
CT, MRI, and PET scans	30%*	50%*	40%*	50%*	
Outpatient surgery	30%*	50%*	40%*	50%*	
Inpatient hospital care	30%*	50%*	40%*	50%*	
Emergency care	30	%*	409	%*	
Routine eye exam	40%* (30%* enhanced benefit)	5(1%*		50%*	

Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.

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

OUT-OF-AREA PPO PLUS									
Plan name	PPO PLUS DED PLA	N WDB 500/20%/2500	PPO PLUS DED PLA	N WDC 750/20%/3750					
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers					
Annual medical deductible (IND/FAM) (per calendar year)	\$500/\$1,500	\$750/\$2,250	\$750/\$2,250	\$1,125/\$3,375					
Annual out-of-pocket maximum (IND/FAM)	\$2,500/\$7,500	\$3,500/\$10,500	\$3,750/\$11,250	\$5,250/\$16,875					
Office visits – preventive and well-child care	\$0	35%*	\$0	35%*					
Office visits – prenatal care	\$0	35%*	\$0	35%*					
Telehealth (phone/video)	\$0	35%*	\$0	35%*					
Office visits – primary care	\$30	35%*	\$30	35%*					
Office visits – urgent care	\$50	35%*	\$50	35%*					
Office visits – specialty care	\$40	35%*	\$40	35%*					
Office visits – naturopathic care	\$30	35%*	\$30	35%*					
Lab	\$30	35%*	\$30	35%*					
X-ray/diagnostic tests	\$30	35%*	\$30	35%*					
CT, MRI, and PET scans	20%*	35%*	20%*	35%*					
Outpatient surgery	20%*	35%*	20%*	35%*					
Inpatient hospital care	20%*	35%*	20%*	35%*					
Emergency care	\$2	00*	\$200*						
Routine eye exam	\$30	35%*	\$30	35%*					

*After deductible.

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



See plan comparisons

Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.

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

OUT-OF-AREA PPO PLUS										
Plan name	PPO PLUS DED PLA	N WDE 1000/30%/4750	PPO PLUS DED PLA	N WDP 1500/30%/6000						
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers						
Annual medical deductible (IND/FAM) (per calendar year)	\$1,000/\$3,000	\$1,500/\$4,500	\$1,500/\$4,500	\$2,250/\$6,750						
Annual out-of-pocket maximum (IND/FAM)	\$4,750/\$9,500	\$6,000/\$12,000	\$6,000/\$12,000	\$7,500/\$15,000						
Office visits – preventive and well-child care	\$0	45%*	\$0	45%*						
Office visits – prenatal care	\$0	45%*	\$0	45%*						
Telehealth (phone/video)	\$0	45%*	\$0	45%*						
Office visits – primary care	\$30	45%*	\$30	45%*						
Office visits – urgent care	\$50	45%*	\$50	45%*						
Office visits – specialty care	\$40	45%*	\$40	45%*						
Office visits – naturopathic care	\$30	45%*	\$30	45%*						
Lab	\$30	45%*	\$30	45%*						
X-ray/diagnostic tests	\$30	45%*	\$30	45%*						
CT, MRI, and PET scans	30%*	45%*	30%*	45%*						
Outpatient surgery	30%*	45%*	30%*	45%*						
Inpatient hospital care	30%*	45%*	30%*	45%*						
Emergency care	\$2	00*	\$200*							
Routine eye exam	\$30	45%*	\$30	45%*						

*After deductible.

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



See plan comparisons

Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.

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

OUT-OF-AREA PPO PLUS									
Plan name	PPO PLUS DED PLAI	N WDN 2000/30%/6000	PPO PLUS DED PLAI	N WDX 3000/30%/6850					
Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers					
Annual medical deductible (IND/FAM) (per calendar year)	\$2,000/\$6,000	\$3,000/\$9,000	\$3,000/\$9,000	\$4,500/\$13,500					
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$7,500/\$15,000	\$6,850/\$13,700	\$8,400/\$16,800					
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*					
Office visits – prenatal care	\$0	40%*	\$0	40%*					
Telehealth (phone/video)	\$0	40%*	\$0	40%*					
Office visits – primary care	\$35	40%*	\$35	40%*					
Office visits – urgent care	\$55	40%*	\$55	40%*					
Office visits – specialty care	\$45	40%*	\$45	40%*					
Office visits – naturopathic care	\$35	40%*	\$35	40%*					
Lab	\$35	40%*	\$35	40%*					
X-ray/diagnostic tests	\$35	40%*	\$35	40%*					
CT, MRI, and PET scans	30%*	40%*	30%*	40%*					
Outpatient surgery	30%*	40%*	30%*	40%*					
Inpatient hospital care	30%*	40%*	30%*	40%*					
Emergency care	\$2	00*	\$200*						
Routine eye exam	\$35	40%*	\$35	40%*					

*After deductible.

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



See plan comparisons

Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.

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

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

*After deductible.

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



See plan comparisons

Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV		
-	-	enefits for each p a plan that helps n			-	See pla	an comparisons		
ousiness goals	5.						Decet		
		p to any 3 plans, o an comparisons."	check the	checkboxes ne	ext to each		Reset		
					10				
			OF-AR	EA PPO PLU	JS				
Plan ı	name		5 HDHP AA F 0/20%/3500			PPO PLUS HDHP AA PLAN WAS 2800/20%/4000 PPO providers			
Network		PPO providers	No	nparticipating providers	PPO providers	No	nparticipating providers		
Accumulation ty	/ре	A	ggregate			Aggregate			
Annual medical (IND/FAM) (per		\$1,500/\$3,000	\$3	500/\$7,000	\$2,800/\$5,600	\$3	3,500/\$7,000		
Annual out-of-p maximum (IND		\$3,500/\$7,000	\$6	.000/\$12,000	\$4,000/\$8,000	\$7	,000/\$14,000		
Office visits – pr well-child care	reventive and	\$0		30%*	\$0		30%*		
Office visits – pr	renatal care	\$0		30%*	\$0		30%*		
Telehealth (pho	ne/video)	\$0*		30%*	\$0*		30%*		
Office visits – pi	rimary care	20%*		30%*	20%*		30%*		
Office visits – u	rgent care	20%*		30%*	20%*		30%*		
Office visits – sp	ecialty care	20%*		30%*	20%*		30%*		
Office visits – na	aturopathic care	20%*		30%*	20%*		30%*		
Lab		20%*		30%*	20%*		30%*		
X-ray/diagnosti	: tests	20%*		30%*	20%*		30%*		
CT, MRI, and PE	l scans	20%*		30%*	20%*		30%*		
Outpatient surg	ery	20%*		30%*	20%*		30%*		
Inpatient hospi	tal care	20%*		30%*	20%*		30%*		
Emergency care			20%*			10%*			
Routine eye exa	im	20%*		30%*	20%*		30%*		



Overview	TRAD	DED	VC	HDHP	PPO	OOA	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.

Start over



	Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
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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.

Start over



TRAD

OOA

SUPPLEMENTAL BENEFIT OPTIONS OUTPATIENT PRESCRIPTION DRUGS

Traditional, deductible, and HSA-qualified HDHP plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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

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



Overview	TRAD	DED	VC	HDHP	PPO	OOA	SR. ADV.
					A BETTER WAY	TO TAKE CARE	E OF BUSINESS

Dual Choice PPO[™] and HSA-qualified Dual Choice PPO[™] plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

Overview	TRAD	DED	VC	HDHP	РРО	OOA	SR. ADV.
					A BETTER WAY	TO TAKE CAR	E OF BUSINESS

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

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

	Kaiser Pei	rmanente Ph	armacies	MedImpact Pharmacies			
Generic	Preferred Brand	Non Preferred Brand	Specialty	Generic	Preferred Brand	Non Preferred Brand	Specialty
\$10	\$20	\$40	\$100	\$20	\$40	\$70	25%
\$10	\$20	\$40	\$150	\$20	\$40	\$70	30%
\$10	\$30	\$60	50%	\$20	\$50	\$90	50%
\$15	\$30	\$50	\$100	\$25	\$50	\$80	25%
\$15	\$30	\$50	\$150	\$25	\$50	\$80	30%
\$15	\$30	\$50	\$200	\$25	\$50	\$80	35%
\$15	\$60	\$80	50%	\$25	\$80	\$110	50%
\$20	\$40	\$60	\$150	\$30	\$60	\$90	30%
\$20	\$40	\$60	\$200	\$30	\$60	\$90	35%
10%	10%	10%	10%	20%	20%	20%	20%
20%	20%	20%	20%	30%	30%	30%	30%
30%	30%	30%	30%	40%	40%	40%	40%
40%	40%	40%	40%	50%	50%	50%	50%

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

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

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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.

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

Medimpact or Kaiser Permanente Pharmacies								
Generic	Preferred Brand	Pairs With Dual Choice						
\$10	\$20	\$40	\$100	Yes				
\$10	\$20	\$40	\$150	Yes				
\$10	\$30	\$60	50%	Yes				
\$15	\$30	\$50	\$100	Yes				
\$15	\$30	\$50	\$150	Yes				
\$15	\$30	\$50	\$200	Yes				
\$15	\$60	\$80	50%	Yes				
\$20	\$40	\$60	\$150	Yes				
\$20	\$40	\$60	\$200	Yes				

HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

All cost shares shown below are after deductible for HSA-qualified PPO Plus plans. The Kaiser Permanente formulary applies to Kaiser Permanente pharmacies as a part of PPO Plus plans.

	MedImpact or Kaiser Permanente Pharmacies								
Generic	Preferred Brand	Non Preferred Brand	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					



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HEARING AIDS

Traditional, deductible, and HSA-qualified HDHP plans

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

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

Dual Choice PPO[™], HSA-qualified Dual Choice PPO[™], Out-of-Area PPO Plus, and HSA-qualified Out-of-Area PPO Plus plans

Dual Choice PPO plans (including HSA-qualified plans) offer several options for hearing aid benefits. Members may purchase hearing aids through Kaiser Permanente or direct contracted providers, First Choice Health, First Health Network, or out-of-network providers. One hearing aid per ear per 36, 48, or 60 months up to a \$250, \$500, \$1,000, or \$1,500 allowance per ear.

ALTERNATIVE CARE

OREGON Traditional, deductible, and HSA-qualified HDHP plan

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

Buy-up self-referred alternative care benefits

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

Self-Referred Services	Cost Share Options*	Visit Limit Options
Chiropractic	\$10/\$25/\$40	20 or 30
Acupuncture	\$10/\$25/\$40	12 or 24
Massage	\$25	12

*Subject to deductible on HSA-qualified plans.

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



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Dual Choice PPO[™] and HSA-qualified Dual Choice PPO[™] plans

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

Buy-up self-referred alternative care benefits

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

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

*Subject to deductible on HSA-qualified plans.

Dual Choice PPO members may select:

- In-network providers from The CHP Group, First Choice Health, and First Health Network
- Out-of-network providers

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

Buy-up self-referred alternative care benefits

Self-Referred Services	Cost Share Options* PPO Providers	Cost Share Options* Nonparticipating Providers	Visit Limit Options
Chiropractic	\$10/\$25/\$40	40%	20 or 30
Acupuncture	\$10/\$25/\$40	40%	12 or 24
Massage	\$25	40%	12

*Subject to deductible on HSA-qualified plans.

PPO Plus members may select:

- PPO providers from First Choice Health or First Health Network
- Nonparticipating providers



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VISION HARDWARE

Traditional, deductible, and HSA-qualified 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 providers. Visit **kp2020.org** for more info.

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

For members 18 and younger – Standard benefit

Each calendar year, 1 pair of eyeglass lenses and a standard frame from a specified collection of frames, or contact lenses.

For members 18 and younger – Enhanced benefit

With the enhanced benefit, the member may purchase frames outside of the specified collection. An allowance is provided toward the purchase of the eyeglass lenses/frame or contact lenses.

ALLOWANCE OPTIONS

\$100, \$150, \$200, \$250, \$300, \$400, or \$500 every calendar year

Dual Choice PPO[™] and HSA-qualified Dual Choice PPO[™] 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 other in-network providers, First Choice Health optical providers, First Health Network optical providers, or out-of-network optical providers.

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

For members 18 and younger

Each calendar year, 1 pair of eyeglass lenses and a standard frame from a specified collection of frames or contact lenses are covered in full when purchased from Vision Essentials by Kaiser Permanente or other in-network providers, First Choice Health optical providers, and First Health Network optical providers. Vision hardware purchased from out-of-network optical providers is covered at 50%.



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

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

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

For members 18 and younger

Each calendar year, 1 pair of eyeglass lenses and a standard frame from a specified collection of frames or contact lenses are covered in full when purchased from Vision Essentials by Kaiser Permanente or other PPO providers, First Choice Health optical providers, and First Health Network optical providers. Vision hardware purchased from nonparticipating optical providers is covered at 50%.



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





kp.org/dualchoice/nw/producers 722158533_LBG_07-21