PLAN UPDATES

OREGON
2023

What's new for Oregon small business group plans with coverage effective on or after January 1, 2023

This booklet contains a summary of important information you will want to know about our 2023 small group plans. For more details on plan design, refer to the Medical Plans Overview for Oregon Small Businesses.

account.kp.org

KAISER PERMANENTE®

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

Your partner in good health

At Kaiser Permanente, we offer a fully integrated health care delivery system with providers, hospitals, pharmacies, and labs working together to provide coordinated care for our members.

WHAT'S NEW AT KAISER PERMANENTE

Below are some of the exciting changes over the past year

NEW – Interpreter-supported video visits

Scheduled video visits are now available in the member's preferred language, including American Sign Language.

NEW – Get care now

Kaiser Permanente clinicians are available day or night, 24/7, for urgent care needs via video and phone, no appointment necessary.[1,2,3]

Ginger – NEW in 2022 and extras for total health

Access on-demand emotional support through the Ginger app. Ginger's emotional support coaches are available 24/7 to help with stress, low mood, sleep troubles, and more.

Additionally, digital self-care apps, such as Calm, myStrength, and ClassPass are available at no additional cost to members to help support their physical and mental health and emotional well-being.[4]

Your one-stop resource for occupational health care

The right occupational health strategy can help you manage claims costs and keep your employees safe, healthy, and productive. Kaiser Permanente On-the-Job® (KPOJ) provides coordinated, effective care for work-related injuries and employment-related exams and screenings. Visit **kp.org/kpoj/nw** to learn more.

Getting dental advice from the comfort of home

Members with Kaiser Permanente dental plans can connect with their dental care teams through phone, email, and video.[1,2] Virtual dental care comes with no copay and is fully integrated with the member's electronic health record.[3]

[1]When appropriate and available.

[2]To have a video visit, members must be registered on kp.org and have a camera-equipped computer or mobile device. If you travel out of state, phone and video visits may not be available due to state laws that may prevent doctors from providing care across state lines. Laws differ by state.

[3]These features available when you get care at Kaiser Permanente facilities.

[4]Only available to Kaiser Permanente members with medical coverage. myStrength® is a trademark of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc. These services aren't covered under your health plan benefits and aren't subject to the terms set forth in your *Evidence of Coverage (EOC)* or other plan documents. These services may be discontinued at any time without notice.

WHAT'S NEW AT KAISER PERMANENTE

Below are some of the exciting changes over the past year

Top-rated cardiac care at home

Kaiser Permanente's virtual cardiac rehab program is the first and only of its kind in Oregon, giving greater flexibility and convenience for cardiac rehab from the comfort of your home. The program completion rate is over 80% – 4 times greater than the traditional center-based program.[1]

Going all-in against cancer

Our cancer care team leads the way in early detection, clinical trials, and innovative treatments, giving patients more options in the fight against cancer.

Furthering our mission with community health

We help people experiencing health inequities address the clinical, genetic, social, economic, and environmental factors that affect their ability to thrive. In 2021 alone, we invested more than $140 million in the community.[2]

Dedication that makes the grade

Kaiser Permanente didn't earn Healthgrades' America's 50 Best Hospitals overnight. It took years of proven clinical excellence. In fact, since 2012, Kaiser Permanente Sunnyside Medical Center has earned more than 20 Healthgrades honors, including excellence in pulmonary care, cardiac care, and cardiac surgery. Such dedication to safe and effective outcomes places Sunnyside in the top 1% of hospitals nationally.

[1]According to Kaiser Permanente and Northwest Permanente Virtual Cardiac Rehab Program patient completion rate.

[2]Community Health Annual Report, About Kaiser Permanente, about.kaiserpermanente.org/community-health/communities-we-serve/northwest-community/our-impact/community-health-annual-report, accessed March 15, 2022.

2023 medical plan portfolio

Our plan portfolio offers choice and flexibility with multiple plans to choose from in all 4 metal levels. We have made necessary cost-sharing changes to keep plans within their respective metal levels. This resulted in several plan name changes; however, no plans have been discontinued. New plan names and specific cost-sharing changes for each plan are provided in the 2023 Medical Plan Changes section of this document. In 2023, Kaiser Permanente Plus™ plans will be available, offering comprehensive care from Kaiser Permanente doctors and facilities as well as other participating providers. Plus, employees will have the option to see out-of-network providers for a limited number of services each year. We have also added a few new Added Choice plans with higher deductibles to offer flexibility with a variety of price points. Groups may choose to renew with their current plan or select any other plan within our portfolio. Refer to the Medical Portfolio Overview for additional details.

2023 dental plan portfolio

At Kaiser Permanente, we believe dental care is a vital part of living a balanced, healthy life. We have removed the $25 emergency dental charge on all plans, and all other plans and benefits will remain unchanged for 2023. Our dental plan portfolio offers a wide range of plans – including voluntary options. Our Family dental plans provide coverage for both adults and pediatric dependents together on one plan, including medically necessary orthodontia for members under 19 years of age and an annual out-of-pocket maximum for in-network services of $375 for an individual under 19 and $750 for a family (with 2 or more pediatric members enrolled). Coverage for cosmetic orthodontia and implants is also available on some plans when selected. Select a plan that fits your needs at any age. If you currently offer dental coverage, the same plan will be provided upon renewal; however, you may select any plan within our portfolio.

Stand-alone pediatric dental coverage is provided for groups that do not offer dental coverage to all employees.

Voluntary dental plan options

As a reminder, Voluntary family dental plan options are now being offered to small employer groups and their employees. Traditional and Dental Choice PPO plan options range from $1,000 to $2,000 benefit maximum with $50 deductible. See the Dental Product Portfolio brochure for additional details. The following rules apply:

- **Employee** contributes 51% to 100% of premium.
- Group participation minimum of 5 employees or 25%, whichever is greater.
- **Employer** sets up payroll deductions and submits premiums on behalf of employees.
- Standard open enrollment and qualifying life event change rules apply.
- Voluntary dental plans **may not** be elected in combination with nonvoluntary plans.

Pediatric dental services and coverage for your renewal

Pediatric dental coverage for members is required by law, so all of our medical plans are offered along with an ACA-compliant pediatric dental plan with a choice of Traditional and Dental Choice PPO plans. Coverage for standard orthodontia to address misaligned teeth is also offered on both Traditional and Dental Choice PPO plans. If you have an ACA-compliant pediatric dental plan offered by another carrier, you may opt out of our coverage by attesting to this fact on your New Group Application or Renewal Decision Form.

If your group previously attested to having other ACA-compliant pediatric dental coverage and waived this coverage, you must provide an updated attestation upon renewal each year, by using the Renewal Decision Form. If a plan is not selected or an updated attestation received, this coverage will be added on your behalf.

Automatic renewals

For your renewal in 2023, we will automatically provide you with coverage from one of the plans that best matches the plan or plans your business offers today. But you can choose from any of our other plans available to small employers if you prefer. Please indicate on the Renewal Decision Form whether you'd like to accept the renewal as offered or make changes.

Bundle options

As you consider alternatives to help lower your health care costs, consider offering employees a plan with 1 or 2 buy-up alternatives. These bundle plan options are provided at no additional charge and allow you to tailor your plan offerings, giving employees more choice and more control over their monthly premium cost.

You contribute the same amount toward each plan (no less than 50% of the lowest premium plan) and let your employees decide if they want to pay more for a buy-up option. For more details, refer to the Medical Plans Overview for Oregon Small Businesses.

2023 PLAN HIGHLIGHTS AND REMINDERS

Prescription drug coverage is automatically covered on all medical plans

All our plans come with built-in coverage for outpatient prescription drugs. All prescription drug plans have a 4-tiered benefit design with different cost-sharing amounts for generic, preferred brand, non-preferred brand, and specialty drugs.

Your employees can save time and money by ordering prescription refills online or by phone. Members can get a 90-day supply for only 2 times the 30-day supply copay when using Kaiser Permanente mail-order pharmacy. We can mail most prescription medications to you within 3 to 5 days, and you don't pay any extra for standard U.S. postage.

Alternative care benefits

Chiropractic and acupuncture services are essential health benefits and covered on all plans (without a referral). Cost shares for these 2 services will apply to the out-of-pocket maximum.

Chiropractic:

20 self-referred visits per year.

Acupuncture:

12 self-referred visits per year.

Naturopathic:

Unlimited self-referred visits

Refer to plan-specific Summary of Benefits for chiropractic, acupuncture, and naturopathic cost-sharing details.

Visit **chpgroup.com** for a list of providers. If purchased with Added Choice plans, these benefits may be used at CHP, PPO, and other nonparticipating providers and facilities.

Massage, routine vision eye exam and hardware benefits

All our medical plans (except the Oregon Standard plans) may be purchased with additional coverage to meet your needs. The 3 buy-up options include medical plans with self-referred massage; medical plans with adult vision hardware and routine eye exam; and medical plans with self-referred massage, vision hardware, and routine eye exam. The massage buy-up option includes a 12-visit limit per calendar year. Refer to plan-specific summaries for cost sharing details in Preferred and Non-Participating Provider networks. Members can access this benefit through the CHP network of providers.

As a reminder, to offer choice and affordability, plans purchased without the vision hardware benefit do not provide coverage for adult routine eye exams. Go to **kp2020.org** for more information, including our optical locations.

Pediatric vision coverage on all medical plans

All our plans cover pediatric vision exams and one pair of standard frames with lenses, conventional or disposable contact lenses in lieu of eyeglasses (limited to one pair per year for conventional lenses or up to a 6-month supply of disposable contact lenses per year) at no additional charge. Go to **kp2020.org** for more information, including our optical locations.

Standard plans

Our plan portfolio includes standard plans that have been designed by the state of Oregon, and all carriers are required to offer these particular plans. Because they were not designed by Kaiser Permanente, the coverage may differ slightly from our typical plans. Differences include benefits such as hospice, infertility, and dependent out of area. Please refer to your Sales Summary of Benefits for details.

Benefits that accrue to the medical out-of-pocket maximum

Most benefits, including copays and coinsurance for services not subject to deductible, as well as the deductible itself, accrue to the medical out-of-pocket maximum. Copays and coinsurance that accrue to the out-of-pocket maximum are waived once an individual or family has reached that maximum.

Underwriting guidelines

Please be sure to review the Rating and Underwriting Assumptions Policy effective January 1, 2023, for Oregon groups with 50 or fewer employees.

2023 MEDICAL PLAN CHANGES

YEAR	2022	2023
PLAN NAME	**KP OR Gold 0/30**	**KP OR Gold 0/30**
ANNUAL OUT-OF-POCKET MAXIMUM	$7,500 per individual; $15,000 per family	$8,200 per individual; $16,400 per family
BENEFITS	Member pays	
EMERGENCY DEPARTMENT VISIT	$300	$500

YEAR	2022	2023
PLAN NAME	**KP OR Platinum 500/20**	**KP OR Platinum 500/20**
ANNUAL OUT-OF-POCKET MAXIMUM	$4,000 per individual; $8,000 per family	$3,000 per individual; $6,000 per family

YEAR	2022	2023
PLAN NAME	**KP OR Gold 1000/20**	**KP OR Gold 1000/20**
ANNUAL OUT-OF-POCKET MAXIMUM	$7,500 per individual; $15,000 per family	$8,200 per individual; $16,400 per family

YEAR	2022	2023
PLAN NAME	**KP OR Gold 1500/35**	**KP OR Gold 1500/35**
ANNUAL OUT-OF-POCKET MAXIMUM	$7,500 per individual; $15,000 per family	$8,200 per individual; $16,400 per family

YEAR	2022	2023
PLAN NAME	**KP OR Gold 2000/40**	**KP OR Gold 2000/35**
ANNUAL OUT-OF-POCKET MAXIMUM	$8,000 per individual; $16,000 per family	$8,200 per individual; $16,400 per family
BENEFITS	Member pays	
PRIMARY CARE OFFICE VISIT	$40	$35
LAB	$40	$35
X-RAY/DIAGNOSTIC TEST	$40	$35

*Subject to annual medical deductible.

YEAR	2022	2023
PLAN NAME	**KP OR Silver 2500/45**	**KP OR Silver 3000/45**
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$2,500 per individual; $5,000 per family	$3,000 per individual; $6,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,900 per individual; $17,800 per family
BENEFITS	Member pays	
OUTPATIENT SURGERY	30%*	40%*
CT, MRI, AND PET SCANS	30%*	40%*
INPATIENT HOSPITAL CARE	30%*	40%*
EMERGENCY DEPARTMENT VISIT	30%*	40%*
AMBULANCE SERVICES	30%*	40%*
DURABLE MEDICAL EQUIPMENT	30%*	40%*
BRAND RX	$50	$60
OUTPATIENT ADMINISTERED MEDICATIONS	30%*	40%*
COINSURANCE	30%	40%
SKILLED NURSING	30%*	40%*

*Subject to annual medical deductible.

YEAR	2022	2023
PLAN NAME	**KP OR Silver 3500/40**	**KP OR Silver 4000/45**
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,500 per individual; $7,000 per family	$4,000 per individual; $8,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,900 per individual; $17,800 per family
BENEFITS	Member pays	
PRIMARY CARE OFFICE VISIT	$40	$45
SPECIALTY OFFICE VISIT	$55	$60
OUTPATIENT THERAPIES	$55	$60
OUTPATIENT SURGERY	35%*	40%*
LAB	$40	$45
X-RAY/DIAGNOSTIC TEST	$40	$45
CT, MRI, AND PET SCANS	35%*	40%*
INPATIENT HOSPITAL CARE	35%*	40%*
EMERGENCY DEPARTMENT VISIT	35%*	40%*
AMBULANCE SERVICES	35%*	40%*
DURABLE MEDICAL EQUIPMENT	35%*	40%*
BRAND RX	$50	$60
NON-PREFERRED BRAND RX	35%	50%
OUTPATIENT ADMINISTERED MEDICATIONS	35%*	40%*
COINSURANCE	35%	40%
SKILLED NURSING	35%*	40%*

*Subject to annual medical deductible.

YEAR	2022	2023
PLAN NAME	**KP OR Silver 4500/45**	**KP OR Silver 5000/50**
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$4,500 per individual; $9,000 per family	$5,000 per individual; $10,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,900 per individual; $17,800 per family
BENEFITS	Member pays	
PRIMARY CARE OFFICE VISIT	$45	$50
SPECIALTY OFFICE VISIT	$65	$70
OUTPATIENT THERAPIES	$65	$70
OUTPATIENT SURGERY	35%*	40%*
LAB	$45	$50
X-RAY/DIAGNOSTIC TEST	$45	$50
CT, MRI, AND PET SCANS	35%*	40%*
INPATIENT HOSPITAL CARE	35%*	40%*
EMERGENCY DEPARTMENT VISIT	35%*	40%*
AMBULANCE SERVICES	35%*	40%*
DURABLE MEDICAL EQUIPMENT	35%*	40%*
BRAND RX	$50	$60
OUTPATIENT ADMINISTERED MEDICATIONS	35%*	40%*
COINSURANCE	35%	40%
SKILLED NURSING	35%*	40%*

*Subject to annual medical deductible.

YEAR	2022	2023
PLAN NAME	**KP OR Silver 5500/50**	**KP OR Silver 6000/50**
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$5,500 per individual; $11,000 per family	$6,000 per individual; $12,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,900 per individual; $17,800 per family
BENEFITS	Member pays	
URGENT CARE VISIT	35%*	40%*
OUTPATIENT SURGERY	35%*	40%*
LAB	35%*	40%*
X-RAY/DIAGNOSTIC TEST	35%*	40%*
CT, MRI, AND PET SCANS	35%*	40%*
INPATIENT HOSPITAL CARE	35%*	40%*
EMERGENCY DEPARTMENT VISIT	35%*	40%*
AMBULANCE SERVICES	35%*	40%*
DURABLE MEDICAL EQUIPMENT	35%*	40%*
BRAND RX	$50	$60
OUTPATIENT ADMINISTERED MEDICATIONS	35%*	40%*
COINSURANCE	35%	40%
SKILLED NURSING	35%*	40%*

*Subject to annual medical deductible.

YEAR	2022	2023
PLAN NAME	**KP OR Bronze 7000/50**	**KP OR Bronze 7000/50**
RX DEDUCTIBLE	$1,000	N/A
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$9,000 per individual; $18,000 per family
BENEFITS	Member pays	
URGENT CARE VISIT	35%*	40%*
SPECIALTY OFFICE VISIT	$60*	$70*
OUTPATIENT THERAPIES	$60*	$70*
OUTPATIENT SURGERY	35%*	40%*
LAB	35%*	40%*
X-RAY/DIAGNOSTIC TEST	35%*	40%*
CT, MRI, AND PET SCANS	35%*	40%*
INPATIENT HOSPITAL CARE	35%*	40%*
EMERGENCY DEPARTMENT VISIT	35%*	40%*
AMBULANCE SERVICES	35%*	40%*
DURABLE MEDICAL EQUIPMENT	35%*	40%*
BRAND RX	$60 after $1,000 Rx deductible	$60
NON-PREFERRED BRAND RX	50% after $1,000 Rx deductible	50%*
SPECIALTY RX	50% after $1,000 Rx deductible	50%*
OUTPATIENT ADMINISTERED MEDICATIONS	35%*	40%*
COINSURANCE	35%	40%
SKILLED NURSING	35%*	40%*

*Subject to annual medical deductible.

YEAR	2022	2022
PLAN NAME	**KP OR Bronze 8550/40**	**KP OR Bronze 9000/40**
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$8,550 per individual; $17,100 per family	$9,000 per individual; $18,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$9,000 per individual; $18,000 per family

YEAR	2022	2022
PLAN NAME	**KP Oregon Standard Gold Plan**	**KP Oregon Standard Gold Plan**
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,500 per individual; $3,000 per family	$1,800 per individual; $3,600 per family

YEAR	2022	2022
PLAN NAME	**KP Oregon Standard Silver Plan**	**KP Oregon Standard Silver Plan**
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,650 per individual; $7,300 per family	$4,800 per individual; $9,600 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$9,100 per individual; $18,200 per family

YEAR	2022	2022
PLAN NAME	**KP Oregon Standard Bronze Plan**	**KP Oregon Standard Bronze Plan**
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$8,550 per individual; $17,100 per family	$8,800 per individual; $17,600 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,800 per individual; $17,600 per family

YEAR	2022	2023
PLAN NAME	**KP OR Silver 2800/25% HSA**	**KP OR Silver 3200/25% HSA**
ANNUAL MEDICAL DEDUCTIBLE	$2,800 per individual; $5,600 per family	$3,200 per individual; $6,400 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$5,400 per individual; $10,800 per family	$5,900 per individual; $11,800 per family

*Subject to annual medical deductible.

YEAR	2022			2023		
PLAN NAME	KP OR Platinum 250/20 3T POS			KP OR Platinum 250/20 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	$3,000 per individual; $6,000 per family	$4,000 per individual; $8,000 per family	$7,000 per individual; $14,000 per family	No Change	$3,800 per individual; $7,600 per family	No Change

YEAR	2022			2023		
PLAN NAME	KP OR Gold 500/35 3T POS			KP OR Gold 500/35 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	$5,000 per individual; $10,000 per family	$7,000 per individual; $14,000 per family	$9,000 per individual; $18,000 per family	$5,500 per individual; $11,000 per family	$7,500 per individual; $15,000 per family	$9,500 per individual; $19,000 per family

YEAR	2022			2023		
PLAN NAME	KP OR Gold 1000/20 3T POS			KP OR Gold 1000/20 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	$6,000 per individual; $12,000 per family	$8,000 per individual; $16,000 per family	$10,000 per individual; $20,000 per family	$6,500 per individual; $13,000 per family	$8,500 per individual; $17,000 per family	$10,500 per individual; $21,000 per family

YEAR	2022			2023		
PLAN NAME	KP OR Silver 2500/45 3T POS			KP OR Silver 3000/45 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$2,500 per individual; $5,000 per family	$4,500 per individual; $9,000 per family	$6,500 per individual; $13,000 per family	$3,000 per individual; $6,000 per family	$5,000 per individual; $10,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family	$13,000 per individual; $26,000 per family	$8,900 per individual; $17,800 per family	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays			Member pays		
OUTPATIENT SURGERY	30%*	40%*	50%*	40%*	45%*	No Change
LAB	$45 *	40%*	50%*	No Change	45%*	No Change
X-RAY/DIAGNOSTIC TEST	$45 *	40%*	50%*	No Change	45%*	No Change
CT, MRI, AND PET SCANS	30%*	40%*	50%*	40%*	45%*	No Change
INPATIENT HOSPITAL CARE	30%*	40%*	50%*	40%*	45%*	No Change
EMERGENCY DEPARTMENT VISIT	30%*			40%*		
AMBULANCE SERVICES	30%*			40%*		
DURABLE MEDICAL EQUIPMENT	30%*	40%*	50%*	40%*	45%*	No Change
BRAND RX	$40	$60	Not Covered	$60	$70	No Change
OUTPATIENT ADMINISTERED MEDICATIONS	30%*	40%*	50%*	40%*	45%*	No Change
COINSURANCE	30%	40%	50%	40%	45%	No Change
SKILLED NURSING	30%*	40%*	50%*	40%*	45%*	No Change

YEAR	2022			2023		
PLAN NAME	KP OR Gold 500/35 3T POS OOA			KP OR Gold 500/35 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	$6,000 per individual; $12,000 per family	$6,000 per individual; $12,000 per family	$10,000 per individual; $20,000 per family	$6,500 per individual; $13,000 per family	$6,500 per individual; $13,000 per family	No Change

*Subject to annual medical deductible.

YEAR	2022			2023		
PLAN NAME	KP OR Gold 1000/35 3T POS OOA			KP OR Gold 1000/35 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	$6,000 per individual; $12,000 per family	$6,000 per individual; $12,000 per family	$10,000 per individual; $20,000 per family	$6,500 per individual; $13,000 per family	$6,500 per individual; $13,000 per family	$10,500 per individual; $21,000 per family

YEAR	2022			2023		
PLAN NAME	KP OR Silver 2500/45 3T POS OOA			KP OR Silver 3000/45 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE	$2,500 per individual; $5,000 per family	$2,500 per individual; $5,000 per family	$6,500 per individual; $13,000 per family	$3,000 per individual; $6,000 per family	$3,000 per individual; $6,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family	$12,000 per individual; $24,000 per family	$8,900 per individual; $17,800 per family	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays			Member pays		
OUTPATIENT SURGERY	40%*	40%*	50%*	45%*	45%*	No Change
CT, MRI, AND PET SCANS	40%*	40%*	50%*	45%*	45%*	No Change
INPATIENT HOSPITAL CARE	40%*	40%*	50%*	45%*	45%*	No Change
EMERGENCY DEPARTMENT VISIT	40%*			45%*		
AMBULANCE SERVICES	40%*			45%*		
DURABLE MEDICAL EQUIPMENT	40%*	40%*	50%*	45%*	45%*	No Change
BRAND RX	$40	$40	Not Covered	$60	$60	No Change
OUTPATIENT ADMINISTERED MEDICATIONS	40%*	40%*	50%*	45%*	45%*	No Change
COINSURANCE	40%	40%	50%	45%	45%	No Change
SKILLED NURSING	40%*	40%*	50%*	45%*	45%*	No Change

*Subject to annual medical deductible.

NEW 2023 MEDICAL KP PLUS PLANS

PLAN NAME	KP OR Platinum 0/20 KP Plus	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	$0	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$2,000 per individual; $4,000 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$40
Urgent care	$40	Not covered, except for services received outside the service area[2,3]
Specialty care	$30	$50
Prenatal care	$0	$0
Allergy shots and other injections	$10	$30
TELEHEALTH (PHONE/VIDEO)	$0	$40
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$25[4]	$45
Chiropractic services	$25[5]	$45
Naturopathic services	$20	$40
OUTPATIENT THERAPIES	$30[6]	$50
OUTPATIENT SURGERY	$100	Not covered
LAB	$20	$40
X-RAY/DIAGNOSTIC TEST	$20	$40
CT, MRI, AND PET SCANS	$75	Not covered
INPATIENT HOSPITAL CARE	$300 per day, $1,500 per admission	Not covered
EMERGENCY DEPARTMENT VISIT	$150	Covered at the in-network cost share[2]
AMBULANCE SERVICES	$150	Covered at the in-network cost share[2]
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	$300 per day, $1,500 per admission	Not covered
Outpatient	$20	$40
DURABLE MEDICAL EQUIPMENT	20%	Not covered
INFERTILITY SERVICES (diagnosis)	50%	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$5 generic; $15 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$25 generic; $35 preferred brand-name; $70 non-preferred brand-name; 50% specialty (limited to 5 prescriptions fills per year)[2]
OUTPATIENT ADMINISTERED MEDICATIONS	20%	Not covered
MATERNITY CARE Inpatient	$300 per day, $1,500 per admission	Not covered

*Subject to annual medical deductible.

[1]These plans include a Dependent out-of-area (OOA) benefit which provides 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 billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills.

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

[3]If you are temporarily out of the service area, urgent care from a non-participating provider or non-participating Facility may be covered if the services are deemed necessary to prevent serious deterioration of health.

[4]Limited to 12 visits per year.

[5]Limited to 20 visits per year.

[6]Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP OR Gold 1000/20 KP Plus	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	$1,000 per individual; $2,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$8,200 per individual; $16,400 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$40
Urgent care	$50	Not covered, except for services received outside the service area[2,3]
Specialty care	$40	$60
Prenatal care	$0	$0
Allergy shots and other injections	$10	$30
TELEHEALTH (PHONE/VIDEO)	$0	$40
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$25[4]	$45
Chiropractic services	$25[5]	$45
Naturopathic services	$20	$40
OUTPATIENT THERAPIES	$40[6]	$60
OUTPATIENT SURGERY	25%*	Not covered
LAB	$20	$40
X-RAY/DIAGNOSTIC TEST	$20	$40
CT, MRI, AND PET SCANS	$300	Not covered
INPATIENT HOSPITAL CARE	25%*	Not covered
EMERGENCY DEPARTMENT VISIT	25%*	Covered at the in-network cost share[2]
AMBULANCE SERVICES	25%*	Covered at the in-network cost share[2]
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	25%*	Not covered
Outpatient	$20	$40
DURABLE MEDICAL EQUIPMENT	25%*	Not covered
INFERTILITY SERVICES (diagnosis)	50%	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% specialty	$30 generic; $50 preferred brand-name; 50% non-preferred brand-name; 50% specialty (limited to 5 prescriptions fills per year)[2]
OUTPATIENT ADMINISTERED MEDICATIONS	25%*	Not covered
MATERNITY CARE Inpatient	25%*	Not covered

*Subject to annual medical deductible.

[1]These plans include a Dependent out-of-area (OOA) benefit which provides 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 billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills.

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

[3]If you are temporarily out of the service area, urgent care from a non-participating provider or non-participating Facility may be covered if the services are deemed necessary to prevent serious deterioration of health.

[4]Limited to 12 visits per year.

[5]Limited to 20 visits per year.

[6]Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP OR Silver 3000/45 KP Plus	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	$3,000 per individual; $6,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$8,900 per individual; $17,800 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$45	$65
Urgent care	$65	Not covered, except for services received outside the service area[2,3]
Specialty care	$55	$75
Prenatal care	$0	$0
Allergy shots and other injections	$10	$30
TELEHEALTH (PHONE/VIDEO)	$0	$65
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$25[4]	$45
Chiropractic services	$25[5]	$45
Naturopathic services	$45	$65
OUTPATIENT THERAPIES	$55[6]	$75
OUTPATIENT SURGERY	40%*	Not covered
LAB	$45	$65
X-RAY/DIAGNOSTIC TEST	$45	$65
CT, MRI, AND PET SCANS	40%*	Not covered
INPATIENT HOSPITAL CARE	40%*	Not covered
EMERGENCY DEPARTMENT VISIT	40%*	Covered at the in-network cost share[2]
AMBULANCE SERVICES	40%*	Covered at the in-network cost share[2]
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	40%*	Not covered
Outpatient	$45	$65
DURABLE MEDICAL EQUIPMENT	40%*	Not covered
INFERTILITY SERVICES (diagnosis)	50%	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$50 generic; $80 preferred brand-name; 50% non-preferred brand-name; 50% specialty (limited to 5 prescriptions fills per year)[2]
OUTPATIENT ADMINISTERED MEDICATIONS	40%*	Not covered
MATERNITY CARE Inpatient	40%*	Not covered

*Subject to annual medical deductible.

[1]These plans include a Dependent out-of-area (OOA) benefit which provides 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 billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills.

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

[3]If you are temporarily out of the service area, urgent care from a non-participating provider or non-participating Facility may be covered if the services are deemed necessary to prevent serious deterioration of health.

[4]Limited to 12 visits per year.

[5]Limited to 20 visits per year.

[6]Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP OR Bronze 7000/50 KP Plus	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	$7,000 per individual; $14,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$9,000 per individual; $18,000 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$50	$70
Urgent care	40%*	Not covered, except for services received outside the service area[2,3]
Specialty care	$70*	$90
Prenatal care	$0	$0
Allergy shots and other injections	$10	$30
TELEHEALTH (PHONE/VIDEO)	$0	$70
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$25[4]	$45
Chiropractic services	$25[5]	$45
Naturopathic services	$50	$70
OUTPATIENT THERAPIES	$70*[6]	$90
OUTPATIENT SURGERY	40%*	Not covered
LAB	40%*	50%
X-RAY/DIAGNOSTIC TEST	40%*	50%
CT, MRI, AND PET SCANS	40%*	Not covered
INPATIENT HOSPITAL CARE	40%*	Not covered
EMERGENCY DEPARTMENT VISIT	40%*	Covered at the in-network cost share[2]
AMBULANCE SERVICES	40%*	Covered at the in-network cost share[2]
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	40%*	Not covered
Outpatient	$50	$70
DURABLE MEDICAL EQUIPMENT	40%*	Not covered
INFERTILITY SERVICES (diagnosis)	50%	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$50 generic; $80 preferred brand-name; 50% non-preferred brand-name; 50% specialty (limited to 5 prescriptions fills per year)[2]
OUTPATIENT ADMINISTERED MEDICATIONS	40%*	Not covered
MATERNITY CARE Inpatient	40%*	Not covered

*Subject to annual medical deductible.

[1]These plans include a Dependent out-of-area (OOA) benefit which provides 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 billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills.

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

[3]If you are temporarily out of the service area, urgent care from a non-participating provider or non-participating Facility may be covered if the services are deemed necessary to prevent serious deterioration of health.

[4]Limited to 12 visits per year.

[5]Limited to 20 visits per year.

[6]Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

NEW 2023 MEDICAL ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP OR Silver 4000/45 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$4,000 per individual; $8,000 per family	$6,000 per individual; $12,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,900 per individual; $17,800 per family	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$45	$60	50%*
Urgent care	$70	$90	50%*
Specialty care	$60	$70	50%*
Prenatal care	$0	$0	50%*
Allergy shots and other injections	$10	$60	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	20%	40%
Chiropractic services[2]	$25	20%	40%
Naturopathic services	$45	$60	50%*
OUTPATIENT THERAPIES[3]	$60	$70	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	$45	45%*	50%*
X-RAY/DIAGNOSTIC TEST	$45	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
AMBULANCE SERVICES	40%*		
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	40%*	45%*	50%*
Outpatient	$45	$60	50%*
DURABLE MEDICAL EQUIPMENT	40%*	45%*	50%*
INFERTILITY SERVICES (diagnosis)	50%	50%	50%
DEPENDENT OUT-OF-AREA	Not covered	Not covered	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$40 generic; $70 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not covered
OUTPATIENT ADMINISTERED MEDICATIONS	40%*	45%*	50%*
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible.

[1]Limited to 12 visits per year.

[2]Limited to 20 visits per year.

[3]Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP OR Bronze 7000/50 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$8,500 per individual; $17,000 per family	$11,000 per individual; $22,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,000 per individual; $18,000 per family	$9,000 per individual; $18,000 per family	$15,000 per individual; $30,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$50	$60	50%*
Urgent care	40%*	45%*	50%*
Specialty care	$70*	$85*	50%*
Prenatal care	$0	$0	50%*
Allergy shots and other injections	$10	$60	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	20%	40%
Chiropractic services[2]	$25	20%	40%
Naturopathic services	$50	$60	50%*
OUTPATIENT THERAPIES[3]	$70*	$85*	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	40%*	45%*	50%*
X-RAY/DIAGNOSTIC TEST	40%*	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
AMBULANCE SERVICES	40%*		
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	40%*	45%*	50%*
Outpatient	$50	$60	50%*
DURABLE MEDICAL EQUIPMENT	40%*	45%*	50%*
INFERTILITY SERVICES (diagnosis)	50%	50%	50%
DEPENDENT OUT-OF-AREA	Not covered	Not covered	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$40 generic; $80 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	Not covered
OUTPATIENT ADMINISTERED MEDICATIONS	40%*	45%*	50%*
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible.

[1]Limited to 12 visits per year.

[2]Limited to 20 visits per year.

[3]Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

NEW 2023 MEDICAL ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Silver 4000/45 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$4,000 per individual; $8,000 per family	$4,000 per individual; $8,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,900 per individual; $17,800 per family	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$45	$45	50%*
Urgent care	$70	$70	50%*
Specialty care	$60	$60	50%*
Prenatal care	$0	$0	50%*
Allergy shots and other injections	$10	$10	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	40%
Chiropractic services[2]	$25	$25	40%
Naturopathic services	$45	$45	50%*
OUTPATIENT THERAPIES[3]	$60	$60	50%*
OUTPATIENT SURGERY	45%*	45%*	50%*
LAB	$45	$45	50%*
X-RAY/DIAGNOSTIC TEST	$45	$45	50%*
CT, MRI, AND PET SCANS	45%*	45%*	50%*
INPATIENT HOSPITAL CARE	45%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	45%*		
AMBULANCE SERVICES	45%*		
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	45%*	45%*	50%*
Outpatient	$45	$45	50%*
DURABLE MEDICAL EQUIPMENT	45%*	45%*	50%*
INFERTILITY SERVICES (diagnosis)	50%	50%	50%
DEPENDENT OUT-OF-AREA	Not covered	Not covered	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$30 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not covered
OUTPATIENT ADMINISTERED MEDICATIONS	45%*	45%*	50%*
MATERNITY CARE Inpatient	45%*	45%*	50%*

*Subject to annual medical deductible.

[1]Limited to 12 visits per year.

[2]Limited to 20 visits per year.

[3]Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP OR Bronze 7000/50 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$7,000 per individual; $14,000 per family	$11,000 per individual; $22,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,000 per individual; $18,000 per family	$9,000 per individual; $18,000 per family	$15,000 per individual; $30,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$50	$50	50%*
Urgent care	45%*	45%*	50%*
Specialty care	$70*	$70*	50%*
Prenatal care	$0	$0	50%*
Allergy shots and other injections	$10	$10	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$25	$25	40%
Chiropractic services[2]	$25	$25	40%
Naturopathic services	$50	$50	50%*
OUTPATIENT THERAPIES[3]	$70*	$70*	50%*
OUTPATIENT SURGERY	45%*	45%*	50%*
LAB	45%*	45%*	50%*
X-RAY/DIAGNOSTIC TEST	45%*	45%*	50%*
CT, MRI, AND PET SCANS	45%*	45%*	50%*
INPATIENT HOSPITAL CARE	45%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	45%*		
AMBULANCE SERVICES	45%*		
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	45%*	45%*	50%*
Outpatient	$50	$50	50%*
DURABLE MEDICAL EQUIPMENT	45%*	45%*	50%*
INFERTILITY SERVICES (diagnosis)	50%	50%	50%
DEPENDENT OUT-OF-AREA	Not covered	Not covered	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$30 generic; $60 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	Not covered
OUTPATIENT ADMINISTERED MEDICATIONS	45%*	45%*	50%*
MATERNITY CARE Inpatient	45%*	45%*	50%*

*Subject to annual medical deductible.

[1]Limited to 12 visits per year.

[2]Limited to 20 visits per year.

[3]Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

2023 DENTAL PLAN CHANGES

YEAR	2022	2023
PLAN NAME	**All 2022 dental plans**	**All 2023 dental plans**
BENEFITS	Member pays	
EMERGENCY TREATMENT	For in-network at Kaiser Permanente dental offices: $25 plus the cost shares that normally apply for nonemergency dental care services.	For in-network at Kaiser Permanente dental offices: The cost shares that normally apply for nonemergency dental care services.

SUMMARY OF 2023 PLAN CHANGES

The following changes will be made to small group plans, effective at renewal or after January 1, 2023, unless stated otherwise.

This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the Group Agreement. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the previous pages in this Plan Updates document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your Group Agreement, the information contained in the Group Agreement shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your group renews in 2023. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Medical plan benefit changes and clarifications

Benefit	Summary of changes	Reason for change
Chemical dependency	"Chemical dependency" terminology will be replaced with "substance use disorder" in all 2023 plan-related documents.	Alignment with more commonly used terminology.
Dependent out-of-area (OOA) coverage	Naturopathic provider visits will be included in the services that a dependent may receive out of area from nonparticipating providers. These visits may be used toward a member's OOA coverage. This change does not impact Choice products.	Benefit enhancement.
Grievances, Claims and Appeals	Information about appeals will be enhanced to include that members will receive a decision on an appeal concerning experimental or investigational determination within 20 days of our receipt of their request.	Clarification to align with how appeals are administered.

continues

Medical plan benefit changes and clarifications (continued)

Benefit	Summary of changes	Reason for change
Insulin for treatment of diabetes	Effective 1/1/23, the cost share cap for insulin for the treatment of diabetes will be reduced to $35 for a 30-day supply, not subject to deductible.	Benefit enhancement made in Washington to comply with WA SSB 5546. Kaiser Permanente is also applying this change in Oregon for consistency, member affordability, and to promote medication adherence.
Lab, radiology, imaging, and special diagnostic procedures	The EOC will be revised to address procedures that can be preventive or diagnostic, to ensure that coverage detail is in the appropriate benefit sections.	Benefit clarification.
No Surprises Act and balance billing	Plan documents will be modified to align with the federal No Surprises Act, including: • Adding or revising definitions and benefit descriptions about emergency services and post-stabilization care services. • Clarifying that we will cover services provided by out-of-network providers at in-network facilities.	Benefit description to comply with Consolidated Appropriations Act of 2021, (HR 133, No Surprises Act) and applicable state laws.
Preventive care	We are updating our preventive care coverage policies effective 1/1/23, including: • Coverage for breast milk storage supplies and equipment to support individuals with breast feeding difficulties. • External condoms as an additional method of pregnancy protection. • Clarifying coverage for colonoscopies when performed after a positive non-invasive stool-based screening test or direct visualization screening test. • Coverage of venipuncture services for preventative lab screenings. • Coverage of behavioral counseling interventions for adults with cardiovascular disease risk factors and type 2 diabetes.	Revised HRSA Guidelines HHS, DOL and Treasury FAQ Part 51 Kaiser Permanente's national preventive care benefits package updates

High Deductible health plans only

Summary of changes	Reason for change
Telemedicine Services: The Benefit Summary language will be revised to clarify that the member cost share for telemedical services received from nonparticipating providers is the same as if the member received the services in person.	Benefit clarification.

Added Choice® point-of-service plans

Summary of changes	Reason for change
Telemedicine Services: The Benefit Summary language will be revised to clarify that the member cost share for telemedical services received from nonparticipating providers is the same as if the member received the services in person.	Benefit clarification.

Dental benefit plan changes

Benefit	Summary of changes	Reason for change
Dental third-party administrator (TPA)	Effective 1/1/23, the TPA for dental benefits will change and any references to a specific TPA name in the EOCs will be removed.	Allows for more flexibility as we continue to optimize the dental customer service experience.
Emergent and urgent visit cost share	Effective 1/1/23, the additional $25 cost share will no longer be charged when members have an emergency or urgent dental visit at a Kaiser Permanente dental office. Members will pay the applicable cost share for the dental services they receive and will not be charged additional amounts for an emergent or urgent visit.	Removing the financial barrier to dental care and improving market alignment.
PPO dental only	The benefit for amalgam and composite fillings will be enhanced from once per tooth every 36 months to once per tooth surface every 24 months. Either a complete full-mouth series or a panoramic X-ray will be covered by Kaiser Permanente once every 3 years.	Benefit enhancement. Clarifying benefit coverage for dental X-rays.

Senior Advantage plan benefit changes and clarifications

Benefit	Summary of changes	Reason for change
Insulin for treatment of diabetes cost share cap	The cost share cap for insulin for the treatment of diabetes will be $35 for each 30-day supply, no matter the drug tier.	Benefit enhancement to comply with the Inflation Reduction Act of 2022.

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