2024 PLANS AND PRODUCTS | WASHINGTON



Complete Suite[™] plan comparison chart

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





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

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

Reset

Clear all plans selected

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

Reset

Clear all plans selected

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

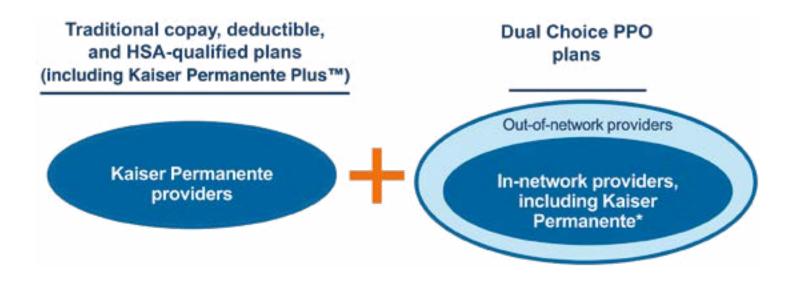
Reset Clear all plans selected

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

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Complete Suite[™] plan pairings and plan comparisons

Dual Choice PPO® plans must be paired with a traditional, deductible, or HSA-qualified, high deductible base plan.



To see all available plan pairings, view our Complete Suite Pairing Guide. Out-of-Area PPO Plus[®] and Kaiser Permanente Senior Advantage plans are also available for group coverage.

All traditional copay and deductible plans are available with limited out-of-network benefits, called Kaiser Permanente Plus™ (KP Plus) plans. See the KP Plus tab for additional details.

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



Accumulation types

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

For services that are subject to the deductible/out-of-pocket maximum, you must pay charges for the services when you receive them until you meet your deductible/out-of-pocket maximum. If you are the only member in your family, then you must meet the member deductible/out-of-pocket maximum.

Aggregate accumulation:

If you are a member in a family of 2 or more members, you meet the deductible/out-of-pocket maximum when your entire family meets the family deductible/out-of-pocket maximum amount. Every member in your family must pay charges during the year until the entire family meets the family deductible/out-of-pocket maximum.

Embedded accumulation:

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



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

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

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

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

				DUAL (CHOICE PPO	PLANS	
			PPO PLAN A 10/1500	PPO PLAN B 20/2000	PPO PLAN C 20/2500	PPO PLAN D 30/3000	PPO PLAN E 35/3500
		TRAD PLAN A 10/1000	*	t			
MT SU14	ANS	TRAD PLAN B 20/1500		*	t		
KAISER PERMANENTE PLUS TM	TRADITIONAL PLANS	TRAD PLAN C 20/2000			*	t	t
KAISER	TRA	TRAD PLAN D 30/2500				*	t
		TRAD PLAN E 35/3000					*

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

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

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



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

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

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

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

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

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

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

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





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

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

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

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

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

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

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

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



VC

PPO

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

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

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

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

			DUAL CHOICE PPO PLANS										
			PPO PLAN H 3000/30/20%/8150	PPO PLAN H 3000/30%/30%/7000	PPO PLAN I 3500/30/20%/8000	PPO PLAN J 4000/30/20%/8150	PPO PLAN K 5000/30/20%/8150	PPO PLAN L 6000/35/20%/8000	PPO PLAN M 7500/35/30%/8500				
		DED PLAN H 3000/30/20%/7350	*		†	t							
		DED PLAN H 3000/30%/30%/6000		*	t								
IE PLUS TM	-ANS	DED PLAN I 3500/30/20%/7350			*	t							
KAISER PERMANENTE PLUS TM	DEDUCTIBLE PLANS	DED PLAN J 4000/30/20%/7500				*	t	†					
KAISER P	DEDI	DED PLAN K 5000/30/20%/7350					*	+	t				
		DED PLAN L 6000/35/20%/7500						*	t				
		DED PLAN M 7500/35/30%/8500							*				

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

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

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



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2024 COMPLETE SUITE[™] PAIRING GUIDE High deductible plans

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

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

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

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

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

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



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2024 COMPLETE SUITE[™] PAIRING GUIDE High deductible plans

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

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

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

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

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

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



VC

2024 COMPLETE SUITE[™] PAIRING GUIDE High deductible plans

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

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

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

			DUAL (CHOICE PPO	PLANS	
		PPO HDHP PLAN G 4000/20%/7000	PPO HDHP PLAN G 4000/30%/7000	PPO HDHP PLAN H 5000/20%/7000	PPO HDHP PLAN H 5000/30%/7000	PPO HDHP PLAN H 5000/40%/7000
	HDHP PLAN G 4000/20%/7000	*	t	t	t	
NS	HDHP PLAN G 4000/30%/7000		*		t	
HIGH DEDUCTIBLE HEALTH PLANS	HDHP PLAN H 5000/20%/7000			*	t	t
GH DEDUCTIBI	HDHP PLAN H 5000/30%/7000				*	t
Ξ	HDHP PLAN H 5000/40%/7000					*
	HDHP PLAN H 5000/50%/7000					*

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

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



VC

PPO

2024 COMPLETE SUITE[™] PAIRING GUIDE Virtual Complete[™] plans

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

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

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

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

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

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





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

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

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OVERVIEW TRAD	DED	VC H	DHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights of the you the flexibility to choos business goals. To compare the benefits o plan and then select "See	e a plan th f up to any	at helps me	et emplo	oyee needs a	nd	ach		comparisons Reset
			DEDU	CTIBLE				
Plan Name		D PLAN A 0/10%/2000		ED PLAN A 15/20%/2500		ED PLAN B 20/10%/3000		D PLAN B %/10%/2000
Annual medical deductible (IND/FAM) (per calendar year)	\$2	250/\$750	9	\$250/\$750	\$!	500/\$1,500	\$50	0/\$1,500
Annual out-of-pocket maximum (IND/FAM)	\$2,0	00/\$6,000	\$2	,500/\$7,500	\$3	,000/\$6,000	\$2,0	00/\$6,000
Office visits - preventive and well-child care		\$0		\$0		\$0		\$0
Office visits – prenatal care		\$0		\$0		\$0		\$0
Telehealth (phone/video)		\$0		\$0		\$0		\$0
Office visits – primary care		\$10		\$15		\$20		10%*
Office visits – urgent care		\$10		\$35		\$40		10%*
Office visits – specialty care		\$10		\$25		\$30		10%*
Office visits – naturopathic care		\$10		\$15		\$20		10%*
Lab		10%*		\$15		\$20		10%*
X-ray/diagnostic tests		10%*		\$15		\$20		10%*
CT, MRI, and PET scans		10%*		\$100		\$100		10%*
Outpatient surgery		10%*		20%*		10%*		10%*
Inpatient hospital care		10%*		20%*		10%*		10%*
Emergency care		\$200*		20%*		10%*		\$200*
Routine eye exam		\$10		\$15		\$20		10%*

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*After deductible.

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OVERVIEW TRAD	DED VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights of the you the flexibility to choose business goals. To compare the benefits of plan and then select "See p	a plan that helps up to any 3 plans	, check the	ployee needs a	and	ch		comparisons Reset
		DEDI	JCTIBLE				
Plan Name	DED PLAN B 500/10/20%/200	00 50	DED PLAN B 0/20/20%/3000		ED PLAN C 20/20%/3250		0 PLAN C %/20%/3000
Annual medical deductible (IND/FAM) (per calendar year)	\$500/\$1,500		\$500/\$1,500	\$7	50/\$2,250	\$75	0/\$2,250
Annual out-of-pocket maximum (IND/FAM)	\$2,000/\$6,000		\$3,000/\$9,000	\$3,	250/\$9,750	\$3,0	00/\$9,000
Office visits – preventive and well-child care	\$0		\$0		\$0		\$0
Office visits - prenatal care	\$0		\$0		\$0		\$0
Telehealth (phone/video)	\$0		\$0		\$0		\$0
Office visits - primary care	\$10		\$20		\$20		20%*
Office visits - urgent care	\$10		\$40		\$40		20%*
Office visits - specialty care	\$10		\$30		\$30		20%*
Office visits - naturopathic care	\$10		\$20		\$20		20%*
Lab	20%*		\$20		\$20		20%*
X-ray/diagnostic tests	20%*		\$20		\$20		20%*
CT, MRI, and PET scans	20%*		\$100		\$100		20%*
Outpatient surgery	20%*		20%*		20%*		20%*
Inpatient hospital care	20%*		20%*		20%*		20%*
Emergency care	\$200*		20%*		20%*		\$200*
Routine eye exam	\$10		\$20		\$20		20%*

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*After deductible.



Below are highlights of the benefits for each plan. A variety of options gives rou the flexibility to choose a plan that helps meet employee needs and business goals. To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."												
DEDUCTIBLE												
Plan Name	DED PLAN D 1000/20/20%/3000	DED PLAN D 1000/25/20%/4000	DED PLAN E 1500/25/20%/5500	DED PLAN E 1500/20/30%/4000								
Annual medical deductible (IND/FAM) (per calendar year)	\$1,000/\$3,000	\$1,000/\$3,000	\$1,500/\$4,500	\$1,500/\$4,500								
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	\$4,000/\$12,000	\$5,500/\$11,000	\$4,000/\$12,000								
Office visits - preventive and well-child care	\$0	\$0	\$0	\$0								
Office visits - prenatal care	\$0	\$0	\$0	\$0								
Telehealth (phone/video)	\$0	\$0	\$0	\$0								
Office visits – primary care	\$20	\$25	\$25	\$20								
Office visits – urgent care	\$20	\$45	\$45	\$20								
Office visits – specialty care	\$20	\$35	\$35	\$20								
Office visits – naturopathic care	\$20	\$25	\$25	\$20								
Lab	20%*	\$25	\$25	30%*								
X-ray/diagnostic tests	20%*	\$25	\$25	30%*								
CT, MRI, and PET scans	20%*	\$100	\$100	30%*								
Outpatient surgery	20%*	20%*	20%*	30%*								
Inpatient hospital care	20%*	20%*	20%*	30%*								
Emergency care	\$200*	20%*	20%*	\$200*								
Routine eye exam	\$20	\$25	\$25	\$20								

VC

HDHP

KP PLUS

PPO

OOA

RIDERS

SR. ADV.

DED

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

*After deductible.

OVERVIEW

TRAD



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highli you the flexibilit business goals. To compare the plan and then se	y to choose benefits of	a plan th up to any	at helps m v 3 plans, c	ieet emp	oloyee needs a	nd	ch		comparisons Reset
				DEDL	JCTIBLE				
Plan Na	ime		D PLAN F 25/20%/5000) 250	DED PLAN G 0/25/20%/5000		ED PLAN G 30/30%/5000		D PLAN H 80/20%/7350
Annual medical de (IND/FAM) (per cal		\$2,0	00/\$6,000	9	52,500/\$7,500	\$2,	500/\$5,000	\$3,0	00/\$9,000
Annual out-of-poc maximum (IND/FA		\$5,00	00/\$10,000	\$	5,000/\$10,000	\$5,0	000/\$10,000	\$7,3	50/\$14,700
Office visits - prev well-child care	entive and		\$0		\$0		\$0		\$0
Office visits - pren	atal care		\$0		\$0		\$0		\$0
Telehealth (phone	/video)		\$0		\$0		\$0		\$0
Office visits - prim	ary care		\$25		\$25		\$30		\$30
Office visits - urge	ent care		\$45		\$45		\$30		\$50
Office visits - spec	ialty care		\$35		\$35		\$30		\$40
Office visits - natu	ropathic care		\$25		\$25		\$30		\$30
Lab			\$25		\$25		30%*		\$30
X-ray/diagnostic te	ests		\$25		\$25		30%*		\$30
CT, MRI, and PET s	cans		\$100		\$100		30%*		\$100
Outpatient surger	у		20%*		20%*		30%*		20%*
Inpatient hospital	care		20%*		20%*		30%*		20%*
Emergency care			20%*		20%*		\$200*		20%*
Routine eye exam			\$25		\$25		\$30		\$30

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*After deductible.



OVERVIEW TRAD	DED VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights of the you the flexibility to choose business goals. To compare the benefits of plan and then select "See p	a plan that helps i up to any 3 plans,	meet emp	oloyee needs a	nd	ich		comparisons Reset
		DEDL	JCTIBLE				
Plan Name	DED PLAN H 3000/30%/30%/60	00 350	DED PLAN I 00/30/20%/7350		ED PLAN J /30/20%/7500		0 PLAN K 0/20%/7350
Annual medical deductible (IND/FAM) (per calendar year)	\$3,000/\$6,000	\$	3,500/\$10,500	\$4,0	000/\$10,000	\$5,00	0/\$10,000
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$	7,350/\$14,700	\$7,5	500/\$15,000	\$7,35	50/\$14,700
Office visits – preventive and well-child care	\$0		\$0		\$0		\$0
Office visits - prenatal care	\$0		\$0		\$0		\$0
Telehealth (phone/video)	\$0		\$0		\$0		\$0
Office visits - primary care	30%*		\$30		\$30		\$30
Office visits – urgent care	30%*		\$50		\$50		\$50
Office visits - specialty care	30%*		\$40		\$40		\$40
Office visits – naturopathic care	30%*		\$30		\$30		\$30
Lab	30%*		\$30		\$30		\$30
X-ray/diagnostic tests	30%*		\$30		\$30		\$30
CT, MRI, and PET scans	30%*		\$100		\$100		\$100
Outpatient surgery	30%*		20%*		20%*		20%*
Inpatient hospital care	30%*		20%*		20%*		20%*
Emergency care	\$200*		20%*		20%*		20%*
Routine eye exam	30%*		\$30		\$30		\$30

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*After deductible.



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

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*After deductible.



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

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

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



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

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

Emergency care

Routine eye exam

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30%*

30%*

10%*

10%*

20%*

20%*

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC)*. To get a copy of the EOC, please visit account.kp.org or contact your Kaiser Permanente representative.



20%*

20%*

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

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

Emergency care

Routine eye exam

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

Outpatient surgery

Lab

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

20%*

20%*

20%*

20%*

20%*

20%*

20%*

30%*

30%*

30%*

30%*

30%*

30%*

30%*

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC)*. To get a copy of the EOC, please visit account.kp.org or contact your Kaiser Permanente representative.



30%*

30%*

30%*

30%*

30%* 30%*

30%*

OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.				
you the flexibility business goals.	Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals. To compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."												
plan and then se	elect "See pl	an compa	arisons										
HIGH DEDUCTIBLE HEALTH PLAN													
Plan Name HDHP PLAN H 5000/40%/7000 5000/50%/7000													
Accumulation type	;			Embedded			l	Embedded					
Annual medical de (IND/FAM) (per cal			\$	5,000/\$10,000	0		\$5,	000/\$10,000					
Annual out-of-poc maximum (IND/FA			\$	7,000/\$14,000)	\$7,000/\$14,000							
Office visits – prev well-child care	entive and			\$0				\$0					
Office visits – pren	atal care			\$0				\$0					
Telehealth (phone	/video)			\$0*				\$0*					
Office visits – prim	ary care			40%*				50%*					
Office visits – urge	ent care			40%*				50%*					
Office visits – spec	ialty care			40%*				50%*					
Office visits – natu	ropathic care			40%*				50%*					
Lab				40%*				50%*					
X-ray/diagnostic te	ests			40%*		50%*							
CT, MRI, and PET se	ans			40%*				50%*					
Outpatient surger	y			40%*				50%*					
Inpatient hospital	care			40%*				50%*					
Emergency care				40%*		50%*							
Routine eye exam			40%* 50%*										

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



KP PLUS PLANS

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

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

KP Plus Benefit Design Summary									
Limited to 10 medical services and 5 pharmacy fills per year									
Services	Out-of-Network coverage								
Medical Visits PCP Office Visit Specialty Office Visit Outpatient Mental Health and Substance Use Disorder Services Physical Therapy, Occupational Therapy, Speech Therapy, and Labs/X-Rays	\$20 higher copay (or 10% higher coinsurance) than in-network 10 visits per member per year								
Pharmacy Fills Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty Kaiser Permanente mail-order pharmacy: 90-day supply for 2 copays	\$20 higher copay (or 10% higher coinsurance) than in-network 5 pharmacy fills per member per year Mail-order pharmacy is not covered out of network.								
Hospital Inpatient Outpatient surgery Skilled nursing facilities Maternity care	Not covered out-of-network								

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

¹The limit of 10 covered Services does not apply.

²If you are temporarily out of the service area, urgent care from a non-participating provider or non-participating facility may be covered if the services are deemed necessary to prevent serious deterioration of health and that the services could not be delayed until returning to the Kaiser Permanente service area.



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

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

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

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

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

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

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OVERVIEW T	RAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlight you the flexibility to business goals. To compare the ber	choose	a plan th	at helps r	neet emp	loyee needs a	nd	ach		comparisons Reset					
plan and then selec	t "See pl	an comp	arisons."											
KP Plus														
Plan name KP PLUS PLAN D 1000/25/20%/4000 KP PLUS PLAN E 1500/25/20%/5500														
Network		In-	network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)					
Annual medical deduc (IND/FAM) (per calenda		\$1,00	00/\$3,000		N/A	\$1,	500/\$4,500		N/A					
Annual out-of-pocket maximum (IND/FAM)		\$4,00	0/\$12,000		N/A	\$5,	500/\$11,000		N/A					
Office visits – preventiv well-child care	ve and		\$0		\$0		\$0		\$0					
Office visits – prenatal	care		\$0		\$0		\$0	\$0						
Telehealth (phone/vide	eo)		\$0		are applicable to the when provided in person.	!	\$0	service w	applicable to the hen provided in person.					
Office visits – primary	care		\$25		\$45		\$25		\$45					
Office visits – urgent ca	are		\$45	services	overed, except for received outside the ervice area ^{1,2}	e	\$45	services rec	ered, except for reived outside the vice area ^{1,2}					
Office visits – specialty	care		\$35		\$55		\$35		\$55					
Office visits – naturopa	athic care		\$25		\$45		\$25		\$45					
Lab			\$25		\$45		\$25		\$45					
X-ray/diagnostic tests			\$25		\$45		\$25		\$45					
CT, MRI, and PET scans			\$100		Not covered		\$100	No	t covered					
Outpatient surgery			20%*		Not covered		20%*	No	t covered					
Inpatient hospital care	9		20%*		Not covered		20%*	No	t covered					
Emergency care			20%*	Covere	d at the in-network cost share ¹		20%*		t the in-network st share ¹					
Routine eye exam			\$25		\$45		\$25		\$45					
Outpatient prescription	n drugs	In-network Out-of-network (limited to 5 prescription fills per year)				I	n-network		Out-of-network (limited to 5 prescription fills per year)					
		A pharmacy	y rider must b	e purchased w	rith all KP Plus plans	A pharma	acy rider must be	e purchased with	all KP Plus plans					

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OVERVIEW TRA	٩D	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.				
Below are highlights of you the flexibility to ch business goals. To compare the bene	hoose	a plan th	at helps	meet emp	loyee needs a	nd	ach		comparisons Reset				
plan and then select "	See p	lan comp	arisons."										
KP Plus													
Plan name KP PLUS PLAN E 1500/20/30%/4000 KP PLUS PLAN F 2000/25/20%/500													
Network		In-	network	(limi	out-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)				
Annual medical deductib (IND/FAM) (per calendar		\$1,50	0/\$4,500		N/A	\$2	,000/\$6,000		N/A				
Annual out-of-pocket maximum (IND/FAM)		\$4,00	0/\$12,000		N/A	\$5,	000/\$10,000		N/A				
Office visits – preventive well-child care	and		\$0		\$0		\$0		\$0				
Office visits – prenatal ca	re		\$0		\$0		\$0		\$0				
Telehealth (phone/video))		\$0		are applicable to the e when provided in person.		\$0	service w	applicable to the hen provided in person.				
Office visits – primary car	re		\$20		\$40		\$25		\$45				
Office visits – urgent care	;		\$20	services	overed, except for received outside th service area ^{1,2}	e	\$45	services rec	ered, except for ceived outside the vice area ^{1,2}				
Office visits – specialty ca	are		\$20		\$40		\$35		\$55				
Office visits – naturopath	ic care		\$20		\$40		\$25		\$45				
Lab			30%*		40%		\$25		\$45				
X-ray/diagnostic tests			30%*		40%		\$25		\$45				
CT, MRI, and PET scans			30%*		Not covered		\$100	No	t covered				
Outpatient surgery			30%*		Not covered		20%*	No	t covered				
Inpatient hospital care			30%*		Not covered		20%*	No	t covered				
Emergency care		\$	5200*	Covere	ed at the in-network cost share ¹		20%*		at the in-network ost share ¹				
Routine eye exam			\$20		\$40		\$25		\$45				
Outpatient prescription of	tion drugs In-network Out-of-network (limited to 5 prescription fills per year) In-network				n-network	Out-of-network (limited to 5 prescription fills per year)							
	5	A pharmacy	/ rider must	be purchased v	vith all KP Plus plans	A pharma	acy rider must b	e purchased with	all KP Plus plans				

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

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OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.						
				-										
Below are highlights of the you the flexibility to choos business goals.				y	0		See plan	comparisons						
To compare the benefits c plan and then select "See		•	check the	checkboxes n	ext to ea	ch		Reset						
KP Plus														
Plan name														
Network	In-1	network	(limit	ut-of-network ed to 10 covered per year, combined)		n-network	(limited	of-network I to 10 covered er year, combined)						
Annual medical deductible (IND/FAM) (per calendar year)	\$3,00	00/\$9,000		N/A	\$3,	000/\$6,000		N/A						
Annual out-of-pocket maximum (IND/FAM)	\$7,35	0/\$14,700		N/A	\$6,0	000/\$12,000		N/A						
Office visits – preventive and well-child care		\$0		\$0		\$0		\$0						
Office visits – prenatal care		\$0		\$0		\$0		\$0						
Telehealth (phone/video)		\$0		re applicable to the when provided in person.		\$0	service w	applicable to the hen provided in person.						
Office visits – primary care		\$30		\$50		30%*		40%						
Office visits – urgent care		\$50	services	overed, except for received outside the ervice area ^{1,2}		30%*	services re	ered, except for ceived outside the vice area ^{1,2}						
Office visits – specialty care		\$40		\$60		30%*		40%						
Office visits – naturopathic car	e	\$30		\$50		30%*		40%						
Lab		\$30		\$50		30%*		40%						
X-ray/diagnostic tests		\$30		\$50		30%*		40%						
CT, MRI, and PET scans		\$100		Not covered		30%*	No	ot covered						
Outpatient surgery		20%*		Not covered		30%*	No	ot covered						
Inpatient hospital care		20%*		Not covered		30%*	No	ot covered						
Emergency care		20%*	Covere	d at the in-network cost share ¹		\$200*		at the in-network ost share ¹						
Routine eye exam		\$30		\$50		30%*		40%						
Outpatient prescription drugs		network		network (limited to iption fills per year)	Ir	n-network		twork (limited to tion fills per year)						
, , , , , , , , , , , , , , , , , , ,		/ rider must b	e purchased w	ith all KP Plus plans	A pharma	cy rider must b	e purchased with	all KP Plus plans						

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

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OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
Below are highlights of you the flexibility to cho business goals.	ose a plan tł	nat helps	meet emp	loyee needs a	nd			comparisons Reset					
To compare the benefit: plan and then select "Se			спеск тпе	checkboxes n	lext to ea	icn							
KP Plus													
Plan name KP PLUS PLAN K 5000/30/20%/7350 KP PLUS PLAN L 6000/35/20%/750													
Network		-network	(limi	ut-of-network ted to 10 covered per year, combined		n-network	(limited	of-network to 10 covered r year, combined)					
Annual medical deductible (IND/FAM) (per calendar yea	\$5.0	00/\$10,000		N/A	\$6,0	000/\$12,000		N/A					
Annual out-of-pocket maximum (IND/FAM)	\$7,3	50/\$14,700		N/A	\$7,5	500/\$15,000		N/A					
Office visits – preventive an well-child care	ıd	\$0		\$0		\$0		\$0					
Office visits – prenatal care		\$0		\$0		\$0		\$0					
Telehealth (phone/video)		\$0		are applicable to the when provided in person.	!	\$0	service w	applicable to the hen provided in person.					
Office visits – primary care		\$30		\$50		\$35		\$55					
Office visits – urgent care		\$50	services	overed, except for received outside the service area ^{1,2}	e	\$55	services rec	ered, except for ceived outside the vice area ^{1,2}					
Office visits – specialty care		\$40		\$60		\$45		\$65					
Office visits – naturopathic	care	\$30		\$50		\$35		\$55					
Lab		\$30		\$50		\$35		\$55					
X-ray/diagnostic tests		\$30		\$50		\$35		\$55					
CT, MRI, and PET scans		\$100		Not covered		\$150	No	t covered					
Outpatient surgery		20%*		Not covered		20%*	No	t covered					
Inpatient hospital care		20%*		Not covered		20%*	No	t covered					
Emergency care		20%*	Covere	d at the in-network cost share ¹		20%*		t the in-network st share ¹					
Routine eye exam		\$30		\$50		\$35		\$55					
Outpatient prescription dru	ugs In-network Out-of-network (limited to 5 prescription fills per year) In-network			Out-of-network (limited to 5 prescription fills per year									
, , , , , , , , , , , , , , , , , , , ,		cy rider must l	be purchased w	vith all KP Plus plans	A pharma	acy rider must b	e purchased with	all KP Plus plans					

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

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OVERVIEW TR	RAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.					
you the flexibility to o business goals. To compare the bend	o compare the benefits of up to any 3 plans, check the checkboxes next to each plan and then select "See plan comparisons."													
			ĺ	Dual Cl	noice PPO									
Plan name														
Network		ln-n	etwork	Οι	ıt-of-network	l	n-network	Out-	of-network					
Annual medical deducti (IND/FAM) (per calendar		\$	0/\$0	\$1	,500/\$3,000		\$0/\$0	\$2,0	00/\$4,000					
Annual out-of-pocket maximum (IND/FAM)		\$1,50	0/\$3,000	\$4	,500/\$9,000	\$2,	000/\$4,000	\$6,00	00/\$12,000					
Office visits – preventive well-child care	e and		\$0		30%*		\$0		30%*					
Office visits – prenatal c	are		\$0		30%*		\$0		30%*					
Telehealth (phone/video	0)		\$0		30%*		\$0		30%*					
Office visits – primary ca	are		D enhanced mefit)		30%*	\$40 (\$20 enhanced benefit)		30%*					
Office visits – urgent ca	re		0 enhanced nefit)		30%*	\$80 (\$40 enhanced benefit)		30%*					
Office visits – specialty of	care		0 enhanced nefit)		30%*	\$50 (\$30 enhanced benefit)		30%*					
Office visits – naturopat care	hic		\$10		30%*		\$20		30%*					
Lab			\$10		30%*		\$20		30%*					
X-ray/diagnostic tests			\$10		30%*		\$20		30%*					
CT, MRI, and PET scans			\$50		30%*		\$50		30%*					
Outpatient surgery			\$50		30%*		\$50		30%*					
Inpatient hospital care		·	day, \$500 pe nission	er	30%*		\$100 per day, \$500 per admission 30%*							
Emergency care				\$100				\$100						
Routine eye exam			D enhanced mefit)		30%*	\$40 (\$20 enhanced benefit)		30%*					

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



OVERVIEW TR	RAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
Below are highlights you the flexibility to o business goals. To compare the bene plan and then select	choose efits o [.]	e a plan th f up to any	iat helps / 3 plans,	, check the	loyee needs a	and	ach		comparisons Reset
	5001				noice PPO				
Plan name		D		CE PPO PLAN				E PPO PLAN D	30/3000
Network			etwork		it-of-network		n-network		of-network
Annual medical deducti (IND/FAM) (per calendar			0/\$0		,000/\$4,000		\$0/\$0		00/\$4,000
Annual out-of-pocket maximum (IND/FAM)		\$2,50	0/\$5,000	\$6	000/\$12,000	\$3,	000/\$6,000	\$6,00	0/\$12,000
Office visits – preventive well-child care	e and		\$0		30%*		\$0		30%*
Office visits – prenatal c	are		\$0		30%*		\$0		30%*
Telehealth (phone/vide	0)		\$0		30%*		\$0		30%*
Office visits – primary ca	are	-	0 enhanced nefit)		30%*	\$50 (\$30 enhanced benefit)		30%*
Office visits – urgent ca	re		0 enhanced nefit)		30%*	\$100	(\$50 enhanced benefit)		30%*
Office visits – specialty of	care		0 enhanced nefit)		30%*	\$60 (\$40 enhanced benefit)		30%*
Office visits – naturopat care	hic		\$20		30%*		\$30		30%*
Lab			\$20		30%*		\$30		30%*
X-ray/diagnostic tests			\$20		30%*		\$30		30%*
CT, MRI, and PET scans			\$50		30%*		\$50		30%*
Outpatient surgery			\$50		30%*		\$100		30%*
Inpatient hospital care			day, \$1,00 dmission	0	30%*		per day, \$1,000 r admission	30%*	
Emergency care				\$200				\$200	
Routine eye exam		-	0 enhanced nefit)		30%*	\$50 (\$30 enhanced benefit)		30%*

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

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



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

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



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

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



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

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



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

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



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

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



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

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



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

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



OVERVIEW TRAD	DED	VC	HDHP	KP PLUS	PPO	PPO OOA		SR. ADV.
Below are highlights of t you the flexibility to choo business goals.	ose a plan th	nat helps m	neet emp	loyee needs a	nd			i comparisons
To compare the benefits plan and then select "Se			heck the	checkboxes r	iext to ea	ich		Reset
		D)ual Ch	oice PPO				
Plan name	DUAL CH	IOICE PPO PI	LAN H 3000	0/30/20%/8150	DUAL C	80%/30%/7000		
Network	In-network Out-of-network In-						Out	-of-network
Annual medical deductible (IND/FAM) (per calendar yea	r) \$3,00	00/\$9,000	\$5,	000/\$15,000	\$3,	000/\$6,000	\$5,0	00/\$15,000
Annual out-of-pocket maximum (IND/FAM)	\$8,15	0/\$16,300	\$15	,000/\$30,000	\$7,0	00/\$14,000	\$15,0	000/\$30,000
Office visits – preventive and well-child care	Ł	\$0		40%*		\$0		50%*
Office visits – prenatal care		\$0		40%*		\$0	50%*	
Telehealth (phone/video)		\$0		40%*		\$0		50%*
Office visits – primary care		0 enhanced enefit)		40%*		30%* enhance benefit)	d	50%*
Office visits – urgent care		50 enhanced enefit)		40%*		40%* (30%* enhanced benefit)		50%*
Office visits – specialty care		0 enhanced enefit)		40%*		30%* enhance benefit)	d	50%*
Office visits – naturopathic c	are	\$30		40%*		30%*		50%*
Lab		\$30		40%*		30%*		50%*
X-ray/diagnostic tests		\$30		40%*		30%*		50%*
CT, MRI, and PET scans		\$100		40%*		30%*		50%*
Outpatient surgery	2	20%*	40%* 30%*					50%*
Inpatient hospital care		20%*		40%*		30%*		50%*
Emergency care			20%*				\$200*	
Routine eye exam		40%*		30%* enhance benefit)	d	50%*		

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



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

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



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

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



OVERVIEW -	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.				
Below are highligh you the flexibility to business goals. To compare the be	o choose	e a plan th	at helps	s meet emp	loyee needs a	and	ich		comparisons eset				
plan and then sele													
	Dual Choice PPO												
Plan name	Plan name DUAL CHOICE PPO PLAN M 7500/35/30%/8500												
Network		In-network Out-of-network											
Annual medical dedu (IND/FAM) (per calend			\$7,	,500/\$14,500			\$8,	500/\$19,500					
Annual out-of-pocket maximum (IND/FAM)			\$8	,500/\$17,000			\$17,	000/\$30,000					
Office visits – prevent well-child care	tive and			\$0				50%*					
Office visits – prenata	al care			\$0				50%*					
Telehealth (phone/vio	deo)			\$0				50%*					
Office visits – primary	y care		\$55 (\$35	5 enhanced be	nefit)			50%*					
Office visits – urgent	care		\$100 (\$5	5 enhanced be	enefit)			50%*					
Office visits – specialt	ty care		\$65 (\$45	5 enhanced be	nefit)			50%*					
Office visits – naturop care	oathic			\$35				50%*					
Lab				\$35				50%*					
X-ray/diagnostic tests	;			\$35				50%*					
CT, MRI, and PET scan	S			\$150		50%*							
Outpatient surgery				30%*		50%*							
Inpatient hospital car	re			30%*		50%*							
Emergency care					3	0%*							
Routine eye exam			\$55 (\$35	5 enhanced be	nefit)			50%*					

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



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

outpatient surgery	2070	4070				
Inpatient hospital care	20%*	40%*				
Emergency care	20%*					
Routine eye exam	\$60* (\$40* enhanced benefit) ¹	40%*				
Outpatient prescription drugs	Kaiser Permanente Pharmacies					
	\$15* generic; \$40* preferred brand-name; \$60* non-preferred brand-name; 20%* (up to a max of \$250) specialty	Not covered				
	MedImpact Pharmacies					
	\$25* generic; \$60* preferred brand- name; \$90* non-preferred brand-name; 30%* specialty	Not covered				

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



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

Outpatient surgery
Inpatient hospital care
Emergency care
Routine eye exam

CT, MRI, and PET scans

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

30%*

30%*

30%*

*After deductible.

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

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.



50%*

50%*

50%*

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

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

40%* specialty

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

Not covered

50%*

50%*

50%*

Not covered

*After deductible.

Outpatient surgery

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



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

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

CT, MRI, and PET scans

Emergency care	40	%*
Routine eye exam	\$70* (\$50* enhanced benefit) ¹	50%*
Outpatient prescription drugs	Kaiser Permane	nte Pharmacies
	 \$15* generic; \$50* preferred brand-name; \$70* non-preferred brand-name; 40%* (up to a max of \$250) specialty 	Not covered
	MedImpact	Pharmacies
	\$25* generic; \$70* preferred brand- name; \$100* non-preferred brand-name; 50%* specialty	Not covered

40%*

40%*

*After deductible.

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

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50%*

50%*

50%*

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

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

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

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



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

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

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

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

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

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

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

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



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

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



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

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



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

35%*

35%*

35%*

35%*

35%*

35%*

\$30

\$30

\$30

20%*

20%*

20%*

\$30

*After	deductible.	

Emergency care

Routine eye exam

Lab

Office visits – naturopathic care

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

Outpatient surgery

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC)*. To get a copy of the EOC, please visit account.kp.org or contact your Kaiser Permanente representative.

\$200*

\$30

\$30

\$30

20%*

20%*

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\$30



35%*

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35%*

\$200*

Network	PPO providers	Nonparticipating providers	PPO providers	Nonparticipating providers
Annual medical deductible (IND/FAM) (per calendar year)	\$1,000/\$3,000	\$1,000/\$3,000 \$1,500/\$4,500 \$1,		\$1,500/\$4,500
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	\$6,000/\$12,000	\$4,750/\$9,500 \$6,000/\$12,	
Office visits – preventive and well-child care	\$0	45%*	\$0	45%*
Office visits – prenatal care	\$0	45%*	\$0	45%*
Telehealth (phone/video)	\$0	45%*	\$0	45%*
Office visits – primary care	\$20	45%*	\$30	45%*
Office visits – urgent care	\$20	45%*	\$50	45%*
Office visits – specialty care	\$20	45%*	\$40	45%*
Office visits – naturopathic care	\$20	45%*	\$30	45%*
Lab	20%*	45%*	\$30	45%*
X-ray/diagnostic tests	20%*	45%*	\$30	45%*
CT, MRI, and PET scans	20%*	45%*	30%*	45%*
Outpatient surgery	20%*	45%*	30%*	45%*

45%*

30%*

\$30

*After deductible.

Emergency care

Routine eye exam

Inpatient hospital care

business goals.

Plan name

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). To get a copy of the EOC, please visit account.kp.org or contact your Kaiser Permanente representative.

\$200*



OUT-OF-AREA PPO PLUS

PPO PLUS PLAN WDT 1000/20%/3000

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

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

20%*

\$20

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

plan and then select "See plan comparisons."

SR. ADV.

See plan comparisons

Reset

PPO PLUS PLAN WDE 1000/30%/4750



45%*

45%*

\$200*

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

45%*

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\$45

\$35

\$25

\$25

\$25

\$100

20%*

20%*

\$25

*After deductible.

Lab

Telehealth (phone/video)

Office visits – primary care

Office visits – urgent care

Office visits - specialty care

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

Outpatient surgery

Emergency care

Routine eye exam

Office visits – naturopathic care

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC)*. To get a copy of the EOC, please visit account.kp.org or contact your Kaiser Permanente representative.

20%*



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

40%*

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Telehealth (phone/video)

Office visits – primary care

Office visits – urgent care

X-ray/diagnostic tests

CT, MRI, and PET scans

Inpatient hospital care

Outpatient surgery

Emergency care

*After deductible.

Routine eye exam

Lab

Office visits – specialty care

Office visits – naturopathic care

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\$200*



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

maximum (IND/FAM)	\$7,330/\$1 4 ,700	\$7,0007\$10,000	ψ1,550/ψ14,700	ψ7,000/ψ10,000
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
Telehealth (phone/video)	\$0	40%*	\$0	40%*
Office visits – primary care	\$35	40%*	\$35	40%*
Office visits – urgent care	\$55	40%*	\$55	40%*
Office visits – specialty care	\$45	40%*	\$45	40%*
Office visits – naturopathic care	\$35	40%*	\$35	40%*
Lab	\$35	40%*	\$35	40%*
X-ray/diagnostic tests	\$35	40%*	\$35	40%*
CT, MRI, and PET scans	30%*	40%*	30%*	40%*
Outpatient surgery	30%*	40%*	30%*	40%*
Inpatient hospital care	30%*	40%*	30%*	40%*
Emergency care	20	%*	20)%*
Routine eye exam	\$35	40%*	\$35	40%*

*After deductible.

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

*After deductible.

These plans are subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage (EOC)*. To get a copy of the EOC, please visit account.kp.org or contact your Kaiser Permanente representative.



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

Compare plans - traditional, deductible, HDHP

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

*After deductible.

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





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

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

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

*After deductible.

¹The limit of 10 covered Services does not apply.

²If you are temporarily out of the service area, urgent care from a non-participating provider or non-participating facility may be covered if the services are deemed necessary to prevent serious deterioration of health and that the services could not be delayed until returning to the Kaiser Permanente service area. ³First 3 visits are any combination of in-person or telemedicine services for primary care, non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.

Start over



TRAD

OOA

RIDERS

SUPPLEMENTAL BENEFIT OPTIONS OUTPATIENT PRESCRIPTION DRUGS

VC

Traditional, deductible, and HSA-qualified, HDHP plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

HSA-QUALIFIED, HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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

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



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

Kaiser Permanente Plus Plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

Note: Mail order only available through Kaiser Permanente Pharmacies.



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
						A BETT	TER WAY TO	O TAKE CARE	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 Kaiser Permanente pharmacies and a broad national network of pharmacies through MedImpact.

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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



OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
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HSA-QUALIFIED HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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

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

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

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

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

DEDUCTIBLE COST SHARE OPTIONS

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

HSA-QUALIFIED, HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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



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

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

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

Buy-up self-referred alternative care benefits

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

*Subject to deductible on HSA-qualified, plans.

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

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

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

Buy-up self-referred alternative care benefits

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

*Subject to deductible on HSA-qualified, plans.

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

Buy-up self-referred alternative care benefits

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

*Subject to deductible on HSA-qualified, plans.

¹Rider benefits only available in-network



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

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

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

VISION HARDWARE

Traditional, deductible (including KP Plus²), and HDHP plans

Eye exams are covered as a medical benefit at the applicable office visit cost share. Vision hardware must be purchased from Vision Essentials by Kaiser Permanente or participating facilities. Visit **kp2020.org** for more info.

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

For members 18 and younger

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

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

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

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

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

¹PPO Plus members do not have access to The CHP Group. ²Rider benefits only available in-network for KP Plus plans.





OVERVIEW	TRAD	DED	VC	HDHP	KP PLUS	PPO	OOA	RIDERS	SR. ADV.
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For members 19 and older						
An allowance is provided toward the purchase of eyeglass lenses and a frame, or contact lenses.						
ALLOWANCE OPTIONS	\$100, \$150, \$200, \$250, \$300, \$400, or \$500 every calendar year or \$100, \$150, \$200, \$250, \$300, \$400, or \$500 every 2 calendar years					

For members 18 and younger

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



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

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

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



