

OREGON
2024

PLAN UPDATES

What's new for Oregon small business group plans
with coverage effective on or after January 1, 2024



This booklet contains a summary of important information you will want to know about our 2024 small group plans. For more details on plan design, refer to the Medical Plans Overview for Oregon Small Businesses.

account.kp.org



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

Your partner in good health

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

WHAT'S NEW AT KAISER PERMANENTE

Below are some of the exciting changes over the past year:



Interpreter-supported video visits

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



Care wherever life takes you

Your employees have many convenient options to stay on top of their health remotely. For primary care, specialty care, and mental health services, they can connect across the U.S. to:

- 24/7 care and advice from Kaiser Permanente clinicians by phone or video.
- Access care by phone, video, or e-visits.^{1,2,3,4}
- Email nonurgent questions to their care team.



Headspace Care and extras for total health

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

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



Your one-stop resource for occupational health care

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



Convenient dental services

With innovative features like the Kaiser Permanente app, virtual dentistry, nurses embedded in many of our dental offices, express check-in, Fast Pass, and more, we're helping our members save valuable time and manage their dental health more conveniently.¹ Learn more at kp.org/dental.

¹When appropriate and available. These features apply to care you get at Kaiser Permanente facilities.

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

³Applicable cost shares will apply for services or items ordered during an e-visit.

⁴If you have an HSA-qualified deductible plan, you will need to pay the full charges for e-visits and scheduled phone and video visits until you reach your deductible. Once you reach your deductible, your copay is \$0 for e-visits and scheduled phone and video visits.

2024 medical plan portfolio

Our plan portfolio offers choice and flexibility with multiple plans to choose from in all 4 metal levels (platinum, gold, silver, and bronze).

All plans now include the first 3 combined visits for primary care or primary care-related services at \$5. First 3 visits are any combination of in-person or virtual services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. Telehealth will remain at \$0; however, it is included in the 3 combined visits.

The massage-only buy-up option has been discontinued in 2024. Groups that currently have a plan with this benefit will be transitioned to a plan that includes the vision and massage buy-up together; however, groups may choose any other plan within our portfolio.

We have made necessary cost-sharing changes to keep plans within their respective metal levels. This resulted in some plan name changes. New plan names and specific cost-sharing changes for each plan are provided in the 2024 Medical Plan Changes section of this document. Groups may choose to renew with their current plan or select any other plan within our portfolio. Refer to the Medical Portfolio Overview for additional details.

Choice Product Network change

On January 1, 2024, for all Oregon situs groups with members enrolled on Added Choice® Point-of-Service or Added Choice Point-of-Service Out-of-Area plans (regardless of renewal date), the Cigna HealthcareSM PPO Network will replace the First Choice Health Network and First Health Network outside of Oregon and other states where Kaiser Permanente operates.^{1,2}

For members seeking care inside Oregon and the other states where Kaiser Permanente operates, there is no provider network change. Members will still access in-network care from First Choice Network providers in Oregon and Washington and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C.

Kaiser Permanente's relationship with the Cigna Healthcare PPO Network provides the flexibility and freedom members need, nationwide. With this improvement, members may have lower out-of-pocket costs for services with a coinsurance due to favorable contracted rates. They also should have an easier experience accessing care due to Cigna's brand recognition and gain access to a broader, stable network of providers that is actively managed across the U.S.

¹The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

²Kaiser Permanente operates in the states of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Healthcare Intellectual Property, Inc.

2024 dental plan portfolio

New dental implant coverage options! For 2024, we offer Dental Choice (PPO) Family plan options that may be purchased with dental implant coverage (for adults ages 19+). Our dental portfolio already includes plans with implant coverage on our traditional network plans when selected, as well as coverage for cosmetic orthodontia.

The annual out-of-pocket maximum for in-network services has increased from \$375 to \$400 for an individual under 19 years of age and from \$750 to \$800 for a family (with 2 or more pediatric members enrolled).

All other current plans and benefits will remain unchanged for 2024. Our dental plan portfolio offers a wide range of plans – including voluntary options. Our family dental plans provide coverage for both adults and pediatric dependents together on one plan, including medically necessary orthodontia for members under 19 years of age and an annual out-of-pocket maximum for in-network services. Select a plan that fits your needs at any age. If you currently offer dental coverage, the same plan will be provided upon renewal; however, you may select any plan within our portfolio. Stand-alone pediatric dental coverage is provided for groups that do not offer dental coverage to all employees.

Voluntary dental plan options

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

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

Pediatric dental services and coverage for your renewal

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

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

Automatic renewals

For your renewal in 2024, we will automatically provide you with coverage from one of the plans that best matches the plan or plans your business offers today. But you can choose from any of our other plans available to small employers if you prefer. Please indicate on the Renewal Decision Form whether you'd like to accept the renewal as offered or make changes.

Bundle options

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

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

2024 PLAN HIGHLIGHTS AND REMINDERS

Kaiser Permanente Plus™

In 2023, we added KP Plus plans to the portfolio – a plan that provides comprehensive care from Kaiser Permanente doctors and facilities and affiliated providers. Plus, employees have the option to see any licensed out-of-network provider for a limited number of services each year. Refer to the Medical Portfolio Overview for additional details.

Prescription drug coverage is automatically covered on all medical plans

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

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

Alternative care benefits

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

Chiropractic:

20 self-referred visits per year.

Acupuncture:

12 self-referred visits per year.

Naturopathic:

Unlimited self-referred visits.

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

Visit chpgroup.com for a list of providers. For members enrolled under Added Choice plans, these benefits may be used at CHP, PPO, and other nonparticipating providers and facilities.

For alternative care, members can choose a PPO provider from First Choice Health in Oregon and Washington or First Health Network in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C. The Cigna Healthcare PPO Network¹ can be accessed for PPO network care outside states where Kaiser Permanente operates.²

For members enrolled under KP Plus plans, benefits may be used in-network with CHP providers and any licensed out-of-network provider.

Massage, routine vision eye exam, and hardware benefits

All our medical plans (except the Oregon Standard plans) may be purchased with additional coverage to meet your needs. The 2 buy-up options include medical plans with adult vision hardware and routine eye exam and medical plans with self-referred massage, vision hardware, and routine eye exam. The massage benefit includes a 12-visit limit per calendar year. Refer to plan-specific summaries for cost-sharing details in PPO providers/in-network and nonparticipating/out-of-network provider networks. Members can access this massage benefit through the CHP network of providers.

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

Pediatric vision coverage on all medical plans

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

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Standard plans

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

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

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

For KP Plus plans, deductibles and out-of-pocket maximums do not apply to out-of-network services.

Underwriting guidelines

Please be sure to review the Rating and Underwriting Assumptions Policy effective January 1, 2024, for Oregon groups with 50 or fewer employees.

2024 MEDICAL PLAN CHANGES

YEAR	2023	2024
PLAN NAME	KP OR PLATINUM 0/20	KP OR PLATINUM 0/20
ANNUAL OUT-OF-POCKET MAXIMUM	\$2,000 per individual; \$4,000 per family	\$2,200 per individual; \$4,400 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$20	\$5 for the first 3 visits; then \$20*
TELEHEALTH	\$0	\$0*
NATUROPATHIC SERVICES	\$20	\$5 for the first 3 visits; then \$20*
X-RAY/DIAGNOSTIC TEST	\$20	\$30
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$5 for the first 3 visits; then \$20*

YEAR	2023	2024
PLAN NAME	KP OR GOLD 0/30	KP OR GOLD 0/30
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,200 per individual; \$16,400 per family	\$8,700 per individual; \$17,400 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$30	\$5 for the first 3 visits; then \$30*
TELEHEALTH	\$0	\$0*
NATUROPATHIC SERVICES	\$30	\$5 for the first 3 visits; then \$30*
OUTPATIENT SURGERY	40%	\$200
X-RAY/DIAGNOSTIC TEST	\$30	\$40
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$30	\$5 for the first 3 visits; then \$30*

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

YEAR	2023	2024
PLAN NAME	KP OR Platinum 250/20	KP OR Platinum 250/20
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,000 per individual; \$6,000 per family	\$3,300 per individual; \$6,600 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$20	\$5 for the first 3 visits; then \$20 ¹
TELEHEALTH	\$0	\$0 ¹
NATUROPATHIC SERVICES	\$20	\$5 for the first 3 visits; then \$20 ¹
X-RAY/DIAGNOSTIC TEST	\$20	\$30
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$5 for the first 3 visits; then \$20 ¹

YEAR	2023	2024
PLAN NAME	KP OR Platinum 500/20	KP OR Platinum 500/20
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,000 per individual; \$6,000 per family	\$3,200 per individual; \$6,400 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$20	\$5 for the first 3 visits; then \$20 ¹
TELEHEALTH	\$0	\$0 ¹
NATUROPATHIC SERVICES	\$20	\$5 for the first 3 visits; then \$20 ¹
X-RAY/DIAGNOSTIC TEST	\$20	\$30
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$5 for the first 3 visits; then \$20 ¹

YEAR	2023	2024
PLAN NAME	KP OR Gold 1000/20	KP OR Gold 1000/20
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,200 per individual; \$16,400 per family	\$8,700 per individual; \$17,400 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$20	\$5 for the first 3 visits; then \$20 ¹
TELEHEALTH	\$0	\$0 ¹
NATUROPATHIC SERVICES	\$20	\$5 for the first 3 visits; then \$20 ¹
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$5 for the first 3 visits; then \$20 ¹
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$30	\$40

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

YEAR	2023	2024
PLAN NAME	KP OR Gold 1500/35	KP OR Gold 1500/35
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,200 per individual; \$16,400 per family	\$8,700 per individual; \$17,400 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$35	\$5 for the first 3 visits; then \$35 ¹
TELEHEALTH	\$0	\$0 ¹
NATUROPATHIC SERVICES	\$35	\$5 for the first 3 visits; then \$35 ¹
X-RAY/DIAGNOSTIC	\$35	\$45
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$35	\$5 for the first 3 visits; then \$35 ¹
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$20	\$30

YEAR	2023	2024
PLAN NAME	KP OR Gold 2000/35	KP OR Gold 2000/35
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,200 per individual; \$16,400 per family	\$8,700 per individual; \$17,400 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$35	\$5 for the first 3 visits; then \$35 ¹
TELEHEALTH	\$0	\$0 ¹
NATUROPATHIC SERVICES	\$35	\$5 for the first 3 visits; then \$35 ¹
X-RAY/DIAGNOSTIC TEST	\$35	\$40
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$35	\$5 for the first 3 visits; then \$35 ¹

YEAR	2023	2024
PLAN NAME	KP OR Silver 3000/45	KP OR Silver 3000/45
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$45	\$5 for the first 3 visits; then \$45 ¹
TELEHEALTH	\$0	\$0 ¹
NATUROPATHIC SERVICES	\$45	\$5 for the first 3 visits; then \$45 ¹
X-RAY/DIAGNOSTIC TEST	\$45	\$50
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$45	\$5 for the first 3 visits; then \$45 ¹

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

YEAR	2023	2024
PLAN NAME	KP OR Silver 4000/45	KP OR Silver 4000/45
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	\$9,400 per individual; \$18,800 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$45	\$5 for the first 3 visits; then \$45 ²
TELEHEALTH	\$0	\$0 ²
NATUROPATHIC SERVICES	\$45	\$5 for the first 3 visits; then \$45 ²
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$45	\$5 for the first 3 visits; then \$45 ²

YEAR	2023	2024
PLAN NAME	KP OR Silver 5000/50	KP OR Silver 5000/50
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	\$9,400 per individual; \$18,800 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$50	\$5 for the first 3 visits; then \$50 ²
TELEHEALTH	\$0	\$0 ²
NATUROPATHIC SERVICES	\$50	\$5 for the first 3 visits; then \$50 ²
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$50	\$5 for the first 3 visits; then \$50 ²

YEAR	2023	2024
PLAN NAME	KP OR Silver 6000/50	KP OR Silver 6000/50
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	\$9,400 per individual; \$18,800 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$50	\$5 for the first 3 visits; then \$50 ²
SPECIALTY OFFICE VISIT	\$70	\$75
TELEHEALTH	\$0	\$0 ²
NATUROPATHIC SERVICES	\$50	\$5 for the first 3 visits; then \$50 ²
OUTPATIENT THERAPIES ¹	\$70	\$75
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$50	\$5 for the first 3 visits; then \$50 ²
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$60	\$75

¹Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

²First 3 visits are any combination of in-person or virtual services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

YEAR	2023	2024
PLAN NAME	KP OR Bronze 7000/50	KP OR Bronze 7000/60
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,000 per individual; \$18,000 per family	\$9,450 per individual; \$18,900 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$50	\$5 for the first 3 visits; then \$60 ²
SPECIALTY OFFICE VISIT	\$70*	\$80*
TELEHEALTH	\$0	\$0 ²
NATUROPATHIC SERVICES	\$50	\$5 for the first 3 visits; then \$60 ²
OUTPATIENT THERAPIES ¹	\$70*	\$80*
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$50	\$5 for the first 3 visits; then \$60 ²
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$60	\$100

YEAR	2023	2024
PLAN NAME	KP OR Bronze 9000/40	KP OR Bronze 9400/0%
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$9,000 per individual; \$18,000 per family	\$9,400 per individual; \$18,800 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,000 per individual; \$18,000 per family	\$9,400 per individual; \$18,800 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$40 copay before deductible for first 3 visits; then 0%*	\$5 for the first 3 visits; then 0%* ²
TELEHEALTH	\$0	\$0 ²
NATUROPATHIC SERVICES	0%*	\$5 for the first 3 visits; then 0%* ²
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	0%*	\$5 for the first 3 visits; then 0%* ²

YEAR	2023	2024
PLAN NAME	KP Oregon Standard Gold Plan ³	KP Oregon Standard Gold Plan ³
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,300 per individual; \$14,600 per family	\$7,550 per individual; \$15,100 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$20	\$5 for the first 3 visits; then \$20 ²
TELEHEALTH	\$0	\$0 ²
NATUROPATHIC SERVICES	\$20	\$5 for the first 3 visits; then \$20 ²
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$5 for the first 3 visits; then \$20 ²
INSULIN TREATMENT FOR DIABETES	Up to \$75 for each 30-day supply	Up to \$85 for each 30-day supply

*Subject to annual medical deductible.

¹Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

²First 3 visits are any combination of in-person or virtual services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

³These plans may not be sold with additional coverage such as adult vision hardware and eye exam and alternative care. Only medically necessary eye exams are covered. These plans exclude the following benefits: Dependent Out of Area and Fertility Diagnosis.

YEAR	2023	2024
PLAN NAME	KP Oregon Standard Silver Plan ¹	KP Oregon Standard Silver Plan ¹
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$4,800 per individual; \$9,600 per family	\$5,500 per individual; \$11,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,100 per individual; \$18,200 per family	\$9,450 per individual; \$18,900 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$40	\$5 for the first 3 visits; then \$40 ²
TELEHEALTH	\$0	\$0 ²
NATUROPATHIC SERVICES	\$40	\$5 for the first 3 visits; then \$40 ²
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$40	\$5 for the first 3 visits; then \$40 ²
INSULIN TREATMENT FOR DIABETES	Up to \$75 for each 30-day supply	Up to \$85 for each 30-day supply

YEAR	2023	2024
PLAN NAME	KP Oregon Standard Bronze Plan ¹	KP Oregon Standard Bronze Plan ¹
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$8,800 per individual; \$17,600 per family	\$9,450 per individual; \$18,900 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,800 per individual; \$17,600 per family	\$9,450 per individual; \$18,900 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$50	\$5 for the first 3 visits; then \$50 ²
SPECIALTY OFFICE VISIT	\$100	\$150
TELEHEALTH	\$0	\$0 ²
NATUROPATHIC SERVICES	\$50	\$5 for the first 3 visits; then \$50 ²
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$50	\$5 for the first 3 visits; then \$50 ²
GENERIC OUTPATIENT PRESCRIPTION DRUGS	\$20	\$25
INSULIN TREATMENT FOR DIABETES	Up to \$75 for each 30-day supply	Up to \$85 for each 30-day supply

¹These plans may not be sold with additional coverage such as adult vision hardware and eye exam and alternative care. Only medically necessary eye exams are covered. These plans exclude the following benefits: Dependent Out of Area and Fertility Diagnosis.

²First 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.

YEAR	2023	2024
PLAN NAME	KP OR Silver 3200/25% HSA	KP OR Silver 3500/25% HSA
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$3,200 per individual; \$6,400 per family	\$3,500 per individual; \$7,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$5,900 per individual; \$11,800 per family	\$7,000 per individual; \$14,000 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	25%*	\$5* for the first 3 visits; then 25%* ¹
TELEHEALTH	\$0*	\$0* ¹
NATUROPATHIC SERVICES	25%*	\$5* for the first 3 visits; then 25%* ¹
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	25%*	\$5* for the first 3 visits; then 25%* ¹
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$40*	\$50*
OUTPATIENT NON-PREFERRED BRAND- NAME PRESCRIPTION DRUGS	30%*	50%*

YEAR	2023	2024
PLAN NAME	KP OR Bronze 6900/0% HSA	KP OR Bronze 7100/0% HSA
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$6,900 per individual; \$13,800 per family	\$7,100 per individual; \$14,200 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$6,900 per individual; \$13,800 per family	\$7,100 per individual; \$14,200 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	0%*	0%* for the first 3 visits; then 0%* ¹
TELEHEALTH	0%*	\$0* ¹
NATUROPATHIC SERVICES	0%*	0%* for the first 3 visits; then 0%* ¹
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	0%*	0%* for the first 3 visits; then 0%* ¹

*Subject to annual medical deductible.

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

YEAR	2023		2024	
PLAN NAME	KP OR Platinum 0/20 KP Plus		KP OR Platinum 0/20 KP Plus	
NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL OUT-OF-POCKET MAXIMUM	\$2,000 per individual; \$4,000 per family	N/A	\$2,200 per individual; \$4,400 per family	No change
BENEFIT ¹	Member pays			
PRIMARY CARE OFFICE VISIT	\$20	\$40	\$5 for the first 3 visits; then \$20 ²	No change
TELEHEALTH	\$0	\$40	\$0 ²	No change
NATUROPATHIC SERVICES	\$20	\$40	\$5 for the first 3 visits; then \$20 ²	No change
X-RAY/DIAGNOSTIC TEST	\$20	\$40	\$30	\$50
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$40	\$5 for the first 3 visits; then \$20 ²	No change

YEAR	2023		2024	
PLAN NAME	KP OR Gold 1000/20 KP Plus		KP OR Gold 1000/20 KP Plus	
NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,200 per individual; \$16,400 per family	N/A	\$8,700 per individual; \$17,400 per family	No change
BENEFIT ¹	Member pays			
PRIMARY CARE OFFICE VISIT	\$20	\$40	\$5 for the first 3 visits; then \$20 ²	No change
TELEHEALTH	\$0	\$40	\$0 ²	No change
NATUROPATHIC SERVICES	\$20	\$40	\$5 for the first 3 visits; then \$20 ²	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$40	\$5 for the first 3 visits; then \$20 ²	No change
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$30	\$50	\$40	\$60

¹These plans include a dependent out-of-area (OOA) benefit, which provides limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% of the billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills.

²First 3 visits are any combination of in-person or virtual services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

YEAR	2023		2024	
PLAN NAME	KP OR Silver 3000/45 KP Plus		KP OR Silver 3000/45 KP Plus	
NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
BENEFIT ¹	Member pays			
PRIMARY CARE OFFICE VISIT	\$45	\$65	\$5 for the first 3 visits; then \$45 ³	No change
TELEHEALTH	\$0	\$65	\$0 ³	No change
NATUROPATHIC SERVICES	\$45	\$65	\$5 for the first 3 visits; then \$45 ³	No change
X-RAY/DIAGNOSTIC TEST	\$45	\$65	\$50	\$70
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$45	\$65	\$5 for the first 3 visits; then \$45 ³	No change

YEAR	2023		2024	
PLAN NAME	KP OR Bronze 7000/50 KP Plus		KP OR Bronze 7000/60 KP Plus	
NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,000 per individual; \$18,000 per family	N/A	\$9,450 per individual; \$18,900 per family	No change
BENEFIT ¹	Member pays			
PRIMARY CARE OFFICE VISIT	\$50	\$70	\$5 for the first 3 visits; then \$60 ³	\$80
SPECIALTY OFFICE VISIT	\$70*	\$90	\$80*	\$100
TELEHEALTH	\$0	\$70	\$0 ³	\$80
NATUROPATHIC SERVICES	\$50	\$70	\$5 for the first 3 visits; then \$60 ³	\$80
OUTPATIENT THERAPIES	\$70* ²	\$90	\$80* ²	\$100
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$50	\$70	\$5 for the first 3 visits; then \$60 ³	\$80
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$60	\$80	\$100	\$120

*Subject to annual medical deductible.

¹These plans include a dependent out-of-area (OOA) benefit, which provides limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% of the billed charges. Services are limited to 5 office visits, 5 diagnostic X-rays, and 5 prescription drug fills.

²Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

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

YEAR	2023			2024		
PLAN NAME	KP OR Platinum 250/20 3T POS			KP OR Platinum 250/20 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,000 per individual; \$6,000 per family	\$3,800 per individual; \$7,600 per family	\$7,000 per individual; \$14,000 per family	\$3,200 per individual; \$6,400 per family	\$4,500 per individual; \$9,000 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$20	\$30	35%*	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$30 ¹	No change
TELEHEALTH	\$0	\$0	35%*	\$0 ¹	\$0 ¹	No change
NATUROPATHIC SERVICES	\$20	\$30	35%*	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$30 ¹	No change
X-RAY/DIAGNOSTIC TEST	\$20	\$30	35%*	\$30	\$40	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$30	35%*	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$30 ¹	No change

YEAR	2023			2024		
PLAN NAME	KP OR Gold 500/35 3T POS			KP OR Gold 500/35 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$5,500 per individual; \$11,000 per family	\$7,500 per individual; \$15,000 per family	\$9,500 per individual; \$19,000 per family	\$6,200 per individual; \$12,400 per family	\$8,200 per individual; \$16,400 per family	\$10,200 per individual; \$20,400 per family
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$35	\$60	50%*	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$60 ¹	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ¹	\$0 ¹	No change
NATUROPATHIC SERVICES	\$35	\$60	50%*	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$60 ¹	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$35	\$60	50%*	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$60 ¹	No change

*Subject to annual medical deductible.

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

YEAR	2023			2024		
PLAN NAME	KP OR Gold 1000/20 3T POS			KP OR Gold 1000/20 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$6,500 per individual; \$13,000 per family	\$8,500 per individual; \$17,000 per family	\$10,500 per individual; \$21,000 per family	\$7,000 per individual; \$14,000 per family	\$9,000 per individual; \$18,000 per family	\$11,000 per individual; \$22,000 per family
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$20	\$40	50%*	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$40 ¹	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ¹	\$0 ¹	No change
NATUROPATHIC SERVICES	\$20	\$40	50%*	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$40 ¹	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$40	50%*	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$40 ¹	No change

YEAR	2023			2024		
PLAN NAME	KP OR Silver 3000/45 3T POS			KP OR Silver 3000/45 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	\$8,900 per individual; \$17,800 per family	\$14,000 per individual; \$28,000 per family	\$9,000 per individual; \$18,000 per family	\$9,000 per individual; \$18,000 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$45	\$60	50%*	\$5 for the first 3 visits; then \$45 ¹	\$5 for the first 3 visits; then \$60 ¹	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ¹	\$0 ¹	No change
NATUROPATHIC SERVICES	\$45	\$60	50%*	\$5 for the first 3 visits; then \$45 ¹	\$5 for the first 3 visits; then \$60 ¹	No change
X-RAY/DIAGNOSTIC TEST	\$45	45%*	50%*	\$50	No change	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$45	\$60	50%*	\$5 for the first 3 visits; then \$45 ¹	\$5 for the first 3 visits; then \$60 ¹	No change

*Subject to annual medical deductible.

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

YEAR	2023			2024		
PLAN NAME	KP OR Silver 4000/45 3T POS			KP OR Silver 4000/45 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	\$8,900 per individual; \$17,800 per family	\$14,000 per individual; \$28,000 per family	\$9,400 per individual; \$18,800 per family	\$9,400 per individual; \$18,800 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$45	\$60	50%*	\$5 for the first 3 visits; then \$45 ²	\$5 for the first 3 visits; then \$60 ²	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ²	\$0 ²	No change
NATUROPATHIC SERVICES	\$45	\$60	50%*	\$5 for the first 3 visits; then \$45 ²	\$5 for the first 3 visits; then \$60 ²	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$45	\$60	50%*	\$5 for the first 3 visits; then \$45 ²	\$5 for the first 3 visits; then \$60 ²	No change

YEAR	2023			2024		
PLAN NAME	KP OR Bronze 7000/50 3T POS			KP OR Bronze 7000/60 3T POS		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$7,000 per individual; \$14,000 per family	\$8,500 per individual; \$17,000 per family	\$11,000 per individual; \$22,000 per family	No change	\$9,000 per individual; \$18,000 per family	No change
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,000 per individual; \$18,000 per family	\$9,000 per individual; \$18,000 per family	\$15,000 per individual; \$30,000 per family	\$9,450 per individual; \$18,900 per family	\$9,450 per individual; \$18,900 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$50	\$60	50%*	\$5 for the first 3 visits; then \$60 ²	\$5 for the first 3 visits; then \$75 ²	No change
SPECIALTY OFFICE VISIT	\$70*	\$85*	50%*	\$80*	\$100*	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ²	\$0 ²	No change
NATUROPATHIC SERVICES	\$50	\$60	50%*	\$5 for the first 3 visits; then \$60 ²	\$5 for the first 3 visits; then \$75 ²	No change
OUTPATIENT THERAPIES ¹	\$70*	\$85*	50%*	\$80*	\$100*	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$50	\$60	50%*	\$5 for the first 3 visits; then \$60 ²	\$5 for the first 3 visits; then \$75 ²	No change
OUTPATIENT GENERIC PRESCRIPTION DRUGS	\$30	\$40	Not covered	No change	\$45	No change
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$60	\$80	Not covered	\$100	\$120	No change

*Subject to annual medical deductible.

¹Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

²First 3 visits are any combination of in-person or virtual services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

YEAR	2023			2024		
PLAN NAME	KP OR Platinum 250/20 3T POS OOA			KP OR Platinum 250/20 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,000 per individual; \$6,000 per family	\$3,000 per individual; \$6,000 per family	\$7,000 per individual; \$14,000 per family	\$3,200 per individual; \$6,400 per family	\$3,200 per individual; \$6,400 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$20	\$20	35%*	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$20 ¹	No change
TELEHEALTH	\$0	\$0	35%*	\$0 ¹	\$0 ¹	No change
NATUROPATHIC SERVICES	\$20	\$20	35%*	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$20 ¹	No change
X-RAY/DIAGNOSTIC TEST	\$20	\$20	35%*	\$30	\$30	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$20	\$20	35%*	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$20 ¹	No change

YEAR	2023			2024		
PLAN NAME	KP OR Gold 500/35 3T POS OOA			KP OR Gold 500/35 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$6,500 per individual; \$13,000 per family	\$6,500 per individual; \$13,000 per family	\$10,000 per individual; \$20,000 per family	\$6,900 per individual; \$13,800 per family	\$6,900 per individual; \$13,800 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$35	\$35	50%*	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$35 ¹	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ¹	\$0 ¹	No change
NATUROPATHIC SERVICES	\$35	\$35	50%*	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$35 ¹	No change
X-RAY/DIAGNOSTIC TEST	\$35	\$35	50%*	\$40	\$40	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$35	\$35	50%*	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$35 ¹	No change
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$20	\$20	Not covered	\$30	\$30	No change
OUTPATIENT NON-PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$50	\$50	Not covered	\$60	\$60	No change

*Subject to annual medical deductible.

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

YEAR	2023			2024		
PLAN NAME	KP OR Gold 1000/35 3T POS OOA			KP OR Gold 1000/35 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$6,500 per individual; \$13,000 per family	\$6,500 per individual; \$13,000 per family	\$10,500 per individual; \$21,000 per family	\$7,000 per individual; \$14,000 per family	\$7,000 per individual; \$14,000 per family	\$11,000 per individual; \$22,000 per family
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$35	\$35	50%*	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$35 ¹	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ¹	\$0 ¹	No change
NATUROPATHIC SERVICES	\$35	\$35	50%*	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$35 ¹	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$35	\$35	50%*	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$35 ¹	No change

YEAR	2023			2024		
PLAN NAME	KP OR Silver 3000/45 3T POS OOA			KP OR Silver 3000/45 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	\$8,900 per individual; \$17,800 per family	\$14,000 per individual; \$28,000 per family	\$9,000 per individual; \$18,000 per family	\$9,000 per individual; \$18,000 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$45	\$45	50%*	\$5 for the first 3 visits; then \$45 ¹	\$5 for the first 3 visits; then \$45 ¹	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ¹	\$0 ¹	No change
NATUROPATHIC SERVICES	\$45	\$45	50%*	\$5 for the first 3 visits; then \$45 ¹	\$5 for the first 3 visits; then \$45 ¹	No change
X-RAY/DIAGNOSTIC TEST	\$45	\$45	50%*	\$50	\$50	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$45	\$45	50%*	\$5 for the first 3 visits; then \$45 ¹	\$5 for the first 3 visits; then \$45 ¹	No change

*Subject to annual medical deductible.

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

YEAR	2023			2024		
PLAN NAME	KP OR Silver 4000/45 3T POS OOA			KP OR Silver 4000/45 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	\$8,900 per individual; \$17,800 per family	\$14,000 per individual; \$28,000 per family	\$9,400 per individual; \$18,800 per family	\$9,400 per individual; \$18,800 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$45	\$45	50%*	\$5 for the first 3 visits; then \$45 ²	\$5 for the first 3 visits; then \$45 ²	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ²	\$0 ²	No change
NATUROPATHIC SERVICES	\$45	\$45	50%*	\$5 for the first 3 visits; then \$45 ²	\$5 for the first 3 visits; then \$45 ²	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$45	\$45	50%*	\$5 for the first 3 visits; then \$45 ²	\$5 for the first 3 visits; then \$45 ²	No change

YEAR	2023			2024		
PLAN NAME	KP OR Bronze 7000/50 3T POS OOA			KP OR Bronze 7000/60 3T POS OOA		
NETWORK	Select Providers	PPO Providers	Nonparticipating Providers	Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,000 per individual; \$18,000 per family	\$9,000 per individual; \$18,000 per family	\$15,000 per individual; \$30,000 per family	\$9,450 per individual; \$18,900 per family	\$9,450 per individual; \$18,900 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$50	\$50	50%*	\$5 for the first 3 visits; then \$60 ²	\$5 for the first 3 visits; then \$60 ²	No change
SPECIALTY OFFICE VISIT	\$70*	\$70*	50%*	\$80*	\$80*	No change
TELEHEALTH	\$0	\$0	50%*	\$0 ²	\$0 ²	No change
NATUROPATHIC SERVICES	\$50	\$50	50%*	\$5 for the first 3 visits; then \$60 ²	\$5 for the first 3 visits; then \$60 ²	No change
OUTPATIENT THERAPIES ¹	\$70*	\$70*	50%*	\$80*	\$80*	No change
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	\$50	\$50	50%*	\$5 for the first 3 visits; then \$60 ²	\$5 for the first 3 visits; then \$60 ²	No change
OUTPATIENT PREFERRED BRAND-NAME PRESCRIPTION DRUGS	\$60	\$60	Not covered	\$100	\$100	No change

*Subject to annual medical deductible.

¹Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

²First 3 visits are any combination of in-person or virtual services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

FOR GROUPS WITH THE MASSAGE BUY-UP BENEFIT

The massage-only buy-up option has been discontinued in 2024. Groups that currently have a plan with this benefit will be transitioned to a plan that includes the vision and massage buy-up together; however, groups may choose any other plan within our portfolio. Buy-up options in 2024 will now include vision or vision and massage.

YEAR	2023	2024
PLAN NAME	Plan w/ Massage	Plan w/ VX & Massage
BENEFIT	Member pays	
MASSAGE THERAPY	\$25 per visit (up to 12 visits per year). Cost shares are after deductible for all high deductible plans. Massage on the 7100/0% HSA plan will be 0% after deductible is met.	No change
VISION HARDWARE AND OPTICAL SERVICES (for members 19 years and older)	Not covered	Vision hardware: You pay balance after \$200 allowance in a 2-year period. Optical services/eye exam: Plan primary office visit cost share.

2024 DENTAL PLAN CHANGES

YEAR	2023	2024
PLAN NAME	All 2023 dental plans	All 2024 dental plans
BENEFITS	Member pays	
ANNUAL OUT-OF-POCKET MAXIMUM Applies until the end of the month in which the member turns 19 years of age.	\$375 per member; \$750 per family	\$400 per member; \$800 per family

NEW 2024 DENTAL PLANS

PLAN NAME	KP OR Family Choice 100 - \$100 Ded/\$2500 Max + Implants		KP OR Family Choice 100 - \$2500 Max + Ortho + Implants	
NETWORK	IN	OUT	IN	OUT
Annual benefit maximum Applies to covered services the member receives on or after the first day of the month after the member turns 19 years of age.	\$2,500		\$2,500	
Out-of-pocket maximum (per member/per family) Applies until the end of the month in which the member turns 19 years of age.	\$400 per member; \$800 per family	N/A	\$400 per member; \$800 per family	N/A
BENEFITS	Member pays			
Preventive and diagnostic services* Oral exam and X-rays, cleaning (prophylaxis), fluoride treatments, instructions in the care of teeth and gums, and prescribed space maintainers.	0%	0%	0%	0%
Basic restorative services Routine fillings and plastic and stainless steel crowns.	20%	20%	20%	20%
Simple extractions Simple tooth extraction.	20%	20%	20%	20%
Oral surgery Surgical tooth extractions, including diagnosis and evaluation.	20%	20%	20%	20%
Periodontics Diagnosis, evaluation, and treatment of gum disease, including scaling and root planing.	20%	20%	20%	20%
Endodontics Root canal and related therapy, including diagnosis and evaluation.	20%	20%	20%	20%
Major restorative services Gold or porcelain crowns, inlays, bridge abutments, and pontics.	50%	50%	50%	50%
Removable prosthetic services Full and partial dentures, relines, and rebases.	50%	50%	50%	50%
Medically necessary orthodontics Diagnosis of cleft palate/lip. Covered until the end of the month in which the member turns 19 years of age.	50%	50%	50%	50%
Orthodontic treatment For abnormally aligned or positioned teeth.	Not covered	Not covered	50%	50%
Night guards* Guards that protect teeth from nighttime grinding or clenching.	10%	10%	10%	10%
Nitrous oxide* Members age 13 and older Members age 12 and younger	\$25 \$0	\$25 \$0	\$25 \$0	\$25 \$0
Emergency treatment	For in-network and out-of-network: the cost shares that normally apply for nonemergency dental care services.			

*Preventive and diagnostic services, night guards, and nitrous oxide services do not apply to the deductible and do not count toward the annual benefit maximum.

PLAN NAME	KP OR Family Choice 100 - \$100 Ded/\$2000 Max + Implants		KP OR Family Choice 100 - \$2000 Max + Ortho + Implants	
NETWORK	IN	OUT	IN	OUT
Annual benefit maximum Applies to covered services the member receives on or after the first day of the month after the member turns 19 years of age.	\$2,000		\$2,000	
Out-of-pocket maximum (per member/per family) Applies until the end of the month in which the member turns 19 years of age.	\$400 per member; \$800 per family	N/A	\$400 per member; \$800 per family	N/A
BENEFITS	Member pays			
Preventive and diagnostic services* Oral exam and X-rays, cleaning (prophylaxis), fluoride treatments, instructions in the care of teeth and gums, and prescribed space maintainers.	0%	0%	0%	0%
Basic restorative services Routine fillings and plastic and stainless steel crowns.	20%	20%	20%	20%
Simple extractions Simple tooth extraction.	20%	20%	20%	20%
Oral surgery Surgical tooth extractions, including diagnosis and evaluation.	20%	20%	20%	20%
Periodontics Diagnosis, evaluation, and treatment of gum disease, including scaling and root planing.	20%	20%	20%	20%
Endodontics Root canal and related therapy, including diagnosis and evaluation.	20%	20%	20%	20%
Major restorative services Gold or porcelain crowns, inlays, bridge abutments, and pontics.	50%	50%	50%	50%
Removable prosthetic services Full and partial dentures, relines, and rebases.	50%	50%	50%	50%
Medically necessary orthodontics Diagnosis of cleft palate/lip. Covered until the end of the month in which the member turns 19 years of age.	50%	50%	50%	50%
Orthodontic treatment For abnormally aligned or positioned teeth.	Not covered	Not covered	50%	50%
Night guards* Guards that protect teeth from nighttime grinding or clenching.	10%	10%	10%	10%
Nitrous oxide* Members age 13 and older Members age 12 and younger	\$25 \$0	\$25 \$0	\$25 \$0	\$25 \$0
Emergency treatment	For in-network and out-of-network: the cost shares that normally apply for nonemergency dental care services.			

*Preventive and diagnostic services, night guards, and nitrous oxide services do not apply to the deductible and do not count toward the annual benefit maximum.

SUMMARY OF 2024 PLAN CHANGES

The following changes will be made to small group plans, effective at renewal on or after January 1, 2024, unless stated otherwise.

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

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

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your group renews in 2024. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Medical plan benefit changes and clarifications

Benefit	Summary of changes	Reason for change
Diagnostic and supplemental breast examinations	The cost share for diagnostic and supplemental breast examinations will be \$0. For HSA-qualified high deductible health plans (HDHPs), the \$0 cost share applies after meeting the plan deductible.	To comply with OR SB 1041, which requires coverage for diagnostic and supplemental breast imaging at no cost share, except for HDHPs.
Fertility	"Infertility" terminology will be replaced with "fertility" in all 2024 plan-related documents.	Alignment with more commonly used terminology.
Group Agreement	<i>Group Agreements</i> will be revised to include a provision addressing how Kaiser Permanente is helping groups satisfy their obligations for prescription drug and health care cost reporting and other transparency activities.	Implementation of federal regulations related to Transparency in Coverage and the Consolidated Appropriations Act, 2021 (HR133), including the No Surprises Act.

continues

Medical plan benefit changes and clarifications (continued)

Benefit	Summary of changes	Reason for change
Hearing aid coverage	<p>Benefits for treatment of hearing loss will be revised:</p> <ul style="list-style-type: none"> The member's cost share will no longer be subject to deductible except for in HSA-qualified high deductible health plans. Coverage includes assistive listening devices and the components required for a device to function properly; fitting, programming, and reprogramming; and ear molds and replacement ear molds. 	Benefit clarification and enhancements to comply with OR HB 2994.
HIV post-exposure (PEP) therapy cost sharing	The cost share for PEP drugs will be \$0. Previously, the cost share followed your plan's cost sharing for prescription drugs. For HSA-qualified HDHPs, the \$0 cost share applies after meeting the plan deductible.	To comply with OR HB 2574.
Kp.org URL update for Choice Products	The existing product-specific pages (kp.org/addedchoice/nw and kp.org/ppoplus/nw) will be changed to kp.org/choiceproducts/nw , where users will be directed to the Choice Product landing page. This change impacts Added Choice and PPO Plus.	Improves the member's navigation experience and matches the information members will see on their ID cards and other member materials.
Kaiser Permanente at Home™ (KP@Home)	KP@Home is a patient-centered program that provides hospital-level acute care and clinical services to members with certain diagnoses at home under the direction of Northwest Permanente physicians.	Benefit enhancement. When clinically appropriate, this benefit will provide an alternative to hospitalization. Members will have the option to be treated and receive support in the comfort of their own home.
Behavioral health	The term "mental health" has been changed to "behavioral health" where appropriate throughout the <i>Evidence of Coverage (EOC)</i> , Benefit Summary, and Prescription Drug Rider.	To comply with changes relating to behavioral health set out in HB 3946 from the 2021 OR legislative session and subsequent rule-making.

continues

Medical plan benefit changes and clarifications (continued)

Benefit	Summary of changes	Reason for change
Primary care access	<p>Kaiser Permanente will be offering the following benefits upon plan renewals on or after January 1, 2024:</p> <ul style="list-style-type: none"> • Members will get their first preventive care visit each year, either virtually or in person, at \$0 cost share. • Members will also get their first 3 visits each year for primary care and primary care-related services at \$5 cost share per visit on most plans. Here are some important details: <ul style="list-style-type: none"> o Plan cost share is \$5 for covered services. The deductible will apply for covered services on an HSA-qualified HDHP plan but will not apply on any other plan type. o Includes any combination of in-person or virtual care. o Primary care-related services include naturopathic care and outpatient mental health and substance use disorder treatment. o This applies only when you get care from Kaiser Permanente facilities/providers or with other in-network providers. This does not apply when you get care from out-of-network providers. 	Reduces member cost share barriers to receiving preventive and primary care in accordance with OR SB 1529 (2022 legislative session) and OR HB 3008 (2023 legislative session).
Nonprescription hearing aids	Nonprescription hearing aids, including over-the-counter hearing aids, are excluded.	Benefit clarification.
Temporomandibular joint (TMJ) coverage for evaluation, treatment, appliances, and therapy	With the exception of the Standard Plans, coverage will be added for evaluation, treatment, appliances, and therapy for TMJ disorder. Language pertaining to this benefit coverage will be included under the "Benefits for Outpatient Services," "Benefits for Inpatient Hospital Services," and "External Prosthetic Devices and Orthotic Devices" sections of the <i>Evidence of Coverage (EOC)</i> , and the related exclusions will be removed from the "Exclusions and Limitations" section of the <i>EOC</i> .	Consistency across products and plans.

High deductible health plans

Summary of changes	Reason for change
For 2024, the Internal Revenue Service (IRS) changed the minimum deductible amounts for HSA-qualified high deductible health plans from \$1,500 for self-only and \$3,000 for a family to \$1,600 for self-only and \$3,200 for a family. We will adjust the minimum deductible amounts for any high deductible plans affected by the IRS changes.	The IRS increased the HDHP minimum deductible amounts for 2024.

Added Choice point-of-service plans

Summary of changes	Reason for change
The member cost share for out-of-network nonemergency medical transportation will change from the plan coinsurance to 50% coinsurance after deductible, with a \$2,000 benefit maximum each calendar year, for all Added Choice plans.	Changing to an aligned benefit across plans for simplification.
On January 1, 2024, the Cigna Healthcare PPO Network ¹ will replace the First Choice Health Network and First Health Network outside of Oregon and other states where Kaiser Permanente operates. ² Members will still get in-network care from First Choice Network providers in Oregon and Washington and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C.	Improving the member experience.

Out-of-area Added Choice plans

Summary of changes	Reason for change
The member cost share for out-of-network nonemergency medical transportation will change from the plan coinsurance to 50% coinsurance after deductible, with a \$2,000 benefit maximum each calendar year, for all PPO Plus plans.	Changing to an aligned benefit across plans for simplification.
On January 1, 2024, the Cigna Healthcare PPO Network ¹ will replace the First Choice Health Network and First Health Network outside of Oregon and other states where Kaiser Permanente operates. ² Members will still get in-network care from First Choice Network providers in Oregon and Washington and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C.	Improving the member experience.

Dental benefit plan changes

Benefit	Summary of changes	Reason for change
Dental office visits	We will add language to the dental benefit summaries letting members know that their office visit cost share is in addition to cost shares for any services provided during the dental visit.	Benefit clarification.
Annual out-of-pocket maximum	The annual out-of-pocket maximum for in-network services has increased from \$375 to \$400 for an individual under 19 years of age and from \$750 to \$800 for a family (of 2 or more pediatric members enrolled).	To comply with Centers for Medicare and Medicaid Services (CMS) final guidance.

¹The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

²Kaiser Permanente operates in the states of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Healthcare Intellectual Property, Inc.

Senior Advantage benefit plan changes

Benefit	Summary of changes	Reason for change
Prescription drug	Cost sharing will change from \$3 generic and \$7 brand to \$0 generic and \$0 brand during the catastrophic coverage stage. Members enter the catastrophic stage when their out-of-pocket drug costs have reached the \$8,000 limit for the calendar year.	To comply with CMS final guidance.

NOTES

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