

For Oregon groups with 1–50 employees

MEDICAL PLANS OVERVIEW

For coverage effective on or after January 1, 2026

OREGON
2026

WHY CHOOSE KAISER PERMANENTE



Convenience

Scheduled and no-appointment-needed 24/7 phone and video visits, e-visits, 24/7 advice, and the ability for employees to email their doctor nonurgent questions on **kp.org** are convenient alternatives that offer high-quality care, comparable with an in-person visit.¹ To find all the ways to obtain care, visit **kp.org/getcare**.



Choice

Your employees have access to more than 1,250 Kaiser Permanente providers across Oregon and Southwest Washington, plus a network of providers and specialists. Visit **kp.org/locations** for more information.



Value

Kaiser Permanente members can enjoy no-cost and discounted online apps, tools, classes, programs, and activities that can help keep your employees happy and healthy. Visit **kp.org/healthyliving** to learn more.



Quality

Kaiser Foundation Health Plan of the Northwest **ties for the highest-rated commercial** plan in Oregon and second-highest-rated in Washington according to the latest National Committee for Quality Assurance ratings.²



business.kp.org

Tools for employers: **business.kp.org**

With our online portal, **business.kp.org**, you have everything you need to take care of business in one place.

- Manage members by enrolling, terminating, and updating group membership.
- Make one-time premium payments, set up or manage recurring payments, and view payment history and transaction details.
- Manage email notification preferences for invoices and e-receipts.
- Download and save your group contracts online.

Tools for members: **kp.org** and the **Kaiser Permanente app**

Members have access to information and tools to better manage their health, so they can:

- Schedule, review, or cancel routine appointments
- Complete an e-visit, phone visit, or video visit
- Email their doctor
- Fill and refill most prescriptions
- View most test results and immunizations
- View their digital ID card
- Pay bills and see cost estimates

Give us a call or talk to your broker

We can answer your questions about medical coverage, eligibility, plan design, or renewal. Please contact us or your producer/broker if you would like a booklet with more details about our plans and options.

Toll-free	1-800-813-2630
TTY	711
Language interpretation services....	1-800-324-8010
Fax	1-877-237-5548

^{1,2}See page 30 for corresponding footnotes.



Small business tax credit

Qualified small employers who wish to claim the small business health care tax credit through the Oregon Health Insurance Marketplace must select a plan without buy-up coverage. Additionally, our Choice products are not qualified plans for this tax credit. The IRS Small Business Health Care Tax Credit helps qualified small businesses lower the cost of offering health insurance to employees. Small businesses in Oregon must also meet the minimum criteria to qualify for the tax credit, available on **Oregon.gov**.

Plan options

METAL TIER	Traditional	Deductible	HSA-qualified high deductible	Kaiser Permanente Plus™ (KP Plus)	Added Choice® point-of-service ¹
Platinum	KP OR Platinum 0	KP OR Platinum 250 KP OR Platinum 500		KP OR Platinum KP Plus 0	KP OR Platinum Added Choice 250 ² KP OR Platinum Added Choice OOA 250 ²
Gold	KP OR Gold 0	KP OR Gold 1000 KP OR Gold 1500 KP OR Gold 2000 KP Oregon Standard Gold Plan*	KP OR Gold HSA 1800	KP OR Gold KP Plus 1000	KP OR Gold Added Choice 500 ² KP OR Gold Added Choice OOA 500 ² KP OR Gold Added Choice 1000 ² KP OR Gold Added Choice OOA 1000 ²
Silver		KP OR Silver 3000 KP OR Silver 4000 KP OR Silver 5000 KP OR Silver 6000 KP Oregon Standard Silver Plan*	KP OR Silver HSA 3600	KP OR Silver KP Plus 3000	KP OR Silver Added Choice 3000 ² KP OR Silver Added Choice OOA 3000 ² KP OR Silver Added Choice 4000 ² KP OR Silver Added Choice OOA 4000 ²
Bronze		KP OR Bronze 7000 KP OR Bronze 9200 KP Oregon Standard Bronze Plan*	KP OR Bronze HSA 7100	KP OR Bronze KP Plus 7000	KP OR Bronze Added Choice 7000 ² KP OR Bronze Added Choice OOA 7000 ²

Buy-up options

Any of the above medical plans can be paired with a buy-up option listed below, with the exception of the Standard plans.

A. Vision: \$250/2-year period vision hardware benefit and vision exam (not subject to plan deductible³).

B. Vision + Massage: Bundle option A and receive \$25 massage therapy (limit 12 per year). Cost shares for massage are after deductible for all high deductible health plans. Massage on the KP OR Bronze HSA 7100 plan will be 0% after deductible is met. Added Choice plans: \$25 KP Select providers, 20% PPO providers, 40% nonparticipating providers. Added Choice out-of-area plans: \$25 KP Select providers, \$25 PPO providers, 40% nonparticipating providers.

*Oregon Standard plans do not include pediatric dental benefits. ¹If you have employees who live or work outside our service area, they may be eligible for an Added Choice out-of-area (OOA) plan. Rates and approval subject to underwriting. ²Added Choice OOA plans: Groups must meet underwriting requirements to purchase. ³Adult vision exams on the KP OR Bronze 9200 buy-up plans are subject to the plan deductible.



PLAN NAME	KP OR Platinum 0	KP OR Gold 0
ANNUAL OUT-OF-POCKET MAXIMUM	\$2,800 per individual; \$5,600 per family	\$8,800 per individual; \$17,600 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	\$0	\$0
Primary care	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$30 ⁴
Urgent care	\$40	\$60
Specialty care	\$30	\$50
TELEHEALTH (PHONE/VIDEO)	\$0 ⁵	\$0 ⁵
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25
Chiropractic services ²	\$25	\$25
Naturopathic services	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$30 ⁴
OUTPATIENT THERAPIES³	\$30	\$50
OUTPATIENT SURGERY	\$200	\$300
LAB	\$20	\$30
X-RAY/DIAGNOSTIC TEST	\$30	\$40
CT, MRI, AND PET SCANS	\$75	\$300
INPATIENT HOSPITAL CARE	\$300 per day, \$1,500 per admission	\$500 per day, \$2,500 per admission
EMERGENCY DEPARTMENT VISIT	\$200	\$500
OUTPATIENT PRESCRIPTION DRUGS	\$5 generic; \$15 preferred brand name; \$50 non-preferred brand name; 50% specialty	\$15 generic; \$50 preferred brand name; 50% non-preferred brand name; 50% specialty
MATERNITY CARE Inpatient	\$300 per day, \$1,500 per admission	\$500 per day, \$2,500 per admission

¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



DEDUCTIBLE PLANS

PLAN NAME	KP OR Platinum 250	KP OR Platinum 500
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$250 per individual; \$500 per family	\$500 per individual; \$1,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,500 per individual; \$7,000 per family	\$3,500 per individual; \$7,000 per family
BENEFITS	Member pays	
OFFICE VISITS		
Preventive care	\$0	\$0
Primary care	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$25 ⁴
Urgent care	\$40	\$40
Specialty care	\$30	\$35
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴
SELF-REFERRED ALTERNATIVE CARE		
Acupuncture services ¹	\$25	\$25
Chiropractic services ²	\$25	\$25
Naturopathic services	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$25 ⁴
OUTPATIENT THERAPIES³	\$30	\$35
OUTPATIENT SURGERY	15%*	20%*
LAB	\$20	\$20
X-RAY/DIAGNOSTIC TEST	\$30	\$30
CT, MRI, AND PET SCANS	15%*	20%*
INPATIENT HOSPITAL CARE	15%*	20%*
EMERGENCY DEPARTMENT VISIT	15%*	20%*
OUTPATIENT PRESCRIPTION DRUGS	\$5 generic; \$25 preferred brand name; \$50 non-preferred brand name; 50% specialty	\$10 generic; \$25 preferred brand name; \$50 non-preferred brand name; 50% specialty
MATERNITY CARE		
Inpatient	15%*	20%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



PLAN NAME	KP OR Gold 1000	KP OR Gold 1500	KP OR Gold 2000
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$1,000 per individual; \$2,000 per family	\$1,500 per individual; \$3,000 per family	\$2,000 per individual; \$4,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	\$8,900 per individual; \$17,800 per family	\$8,900 per individual; \$17,800 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	\$0
Primary care	\$5 for the first 3 visits; then \$25 ⁴	\$5 for the first 3 visits; then \$35 ⁴	\$5 for the first 3 visits; then \$35 ⁴
Urgent care	\$50	\$55	\$60
Specialty care	\$45	\$55	\$60
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	\$0 ⁴
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25	\$25
Chiropractic services ²	\$25	\$25	\$25
Naturopathic services	\$5 for the first 3 visits; then \$25 ⁴	\$5 for the first 3 visits; then \$35 ⁴	\$5 for the first 3 visits; then \$35 ⁴
OUTPATIENT THERAPIES³	\$45	\$55	\$60
OUTPATIENT SURGERY	25%*	30%*	30%*
LAB	\$20	\$35	\$35
X-RAY/DIAGNOSTIC TEST	\$40	\$45	\$45
CT, MRI, AND PET SCANS	\$300	\$300	\$250
INPATIENT HOSPITAL CARE	25%*	30%*	30%*
EMERGENCY DEPARTMENT VISIT	25%*	30%*	30%*
OUTPATIENT PRESCRIPTION DRUGS	\$15 generic; \$50 preferred brand name; 50% non-preferred brand name; 50% specialty	\$15 generic; \$50 preferred brand name; \$75 non-preferred brand name; 50% specialty	\$15 generic; \$50 preferred brand name; \$75 non-preferred brand name; 50% specialty
MATERNITY CARE Inpatient	25%*	30%*	30%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



DEDUCTIBLE PLANS

PLAN NAME	KP Oregon Standard Gold Plan ⁵	KP OR Silver 3000	KP OR Silver 4000
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$1,800 per individual; \$3,600 per family	\$3,000 per individual; \$6,000 per family	\$4,000 per individual; \$8,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,150 per individual; \$16,300 per family	\$9,600 per individual; \$19,200 per family	\$9,600 per individual; \$19,200 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	\$0
Primary care	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$40 ⁴	\$5 for the first 3 visits; then \$45 ⁴
Urgent care	\$60	\$65	\$70
Specialty care	\$40	\$60	\$60
TELEHEALTH (PHONE/VIDEO)	\$5 for the first 3 visits; then \$20 ⁴	\$0 ⁴	\$0 ⁴
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$20	\$25	\$25
Chiropractic services ²	\$20	\$25	\$25
Naturopathic services	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$40 ⁴	\$5 for the first 3 visits; then \$45 ⁴
OUTPATIENT THERAPIES³	\$20	\$60	\$60
OUTPATIENT SURGERY	20%*	40%*	40%*
LAB	20%*	\$40	\$40
X-RAY/DIAGNOSTIC TEST	20%*	\$50	\$45
CT, MRI, AND PET SCANS	20%*	40%*	40%*
INPATIENT HOSPITAL CARE	20%*	40%*	40%*
EMERGENCY DEPARTMENT VISIT	20%*	40%*	40%*
OUTPATIENT PRESCRIPTION DRUGS	\$10 generic; \$30 preferred brand name; 50% non-preferred brand name; 50% (up to a max of \$500) specialty	\$30 generic; \$65 preferred brand name; 50% non-preferred brand name; 50%* specialty	\$30 generic; \$60 preferred brand name; 50%* non-preferred brand name; 50%* specialty
MATERNITY CARE Inpatient	20%*	40%*	40%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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. ⁵These plans may not be sold with additional coverage such as adult vision hardware and eye exam and massage. Only medically necessary eye exams are covered. These plans exclude the following benefits: Pediatric dental benefits, Dependent Out of Area and Fertility Diagnosis.



PLAN NAME	KP OR Silver 5000	KP OR Silver 6000	KP Oregon Standard Silver Plan ⁵
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$5,000 per individual; \$10,000 per family	\$6,000 per individual; \$12,000 per family	\$6,100 per individual; \$12,200 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,600 per individual; \$19,200 per family	\$9,800 per individual; \$19,600 per family	\$9,200 per individual; \$18,400 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	\$0
Primary care	\$5 for the first 3 visits; then \$50 ⁴	\$5 for the first 3 visits; then \$50 ⁴	\$5 for the first 3 visits; then \$40 ⁴
Urgent care	\$75	40%*	\$70
Specialty care	\$70	\$75	\$100
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	\$5 for the first 3 visits; then \$40 ⁴
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25	\$40
Chiropractic services ²	\$25	\$25	\$40
Naturopathic services	\$5 for the first 3 visits; then \$50 ⁴	\$5 for the first 3 visits; then \$50 ⁴	\$5 for the first 3 visits; then \$40 ⁴
OUTPATIENT THERAPIES³	\$70	\$75	\$40
OUTPATIENT SURGERY	40%*	40%*	30%*
LAB	\$50	\$60	30%*
X-RAY/DIAGNOSTIC TEST	\$50*	40%*	30%*
CT, MRI, AND PET SCANS	40%*	40%*	30%*
INPATIENT HOSPITAL CARE	40%*	40%*	30%*
EMERGENCY DEPARTMENT VISIT	40%*	40%*	30%*
OUTPATIENT PRESCRIPTION DRUGS	\$30 generic; \$60 preferred brand name; 50%* non-preferred brand name; 50%* specialty	\$30 generic; \$75 preferred brand name; 50%* non-preferred brand name; 50%* specialty	\$15 generic; \$60 preferred brand name; 50% non-preferred brand name; 50% specialty
MATERNITY CARE Inpatient	40%*	40%*	30%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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. ⁵These plans may not be sold with additional coverage such as adult vision hardware and eye exam and massage. Only medically necessary eye exams are covered. These plans exclude the following benefits: Pediatric dental benefits, Dependent Out of Area and Fertility Diagnosis.



DEDUCTIBLE PLANS

PLAN NAME	KP OR Bronze 7000	KP OR Bronze 9200	KP Oregon Standard Bronze Plan ⁵
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$7,000 per individual; \$14,000 per family	\$9,200 per individual; \$18,400 per family	\$9,200 per individual; \$18,400 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,200 per individual; \$18,400 per family	\$9,200 per individual; \$18,400 per family	\$9,200 per individual; \$18,400 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	\$0
Primary care	\$5 for the first 3 visits; then \$60 ⁴	\$5 for the first 3 visits; then 0%* ⁴	\$5 for the first 3 visits; then \$50 ⁴
Urgent care	40%*	0%*	\$100
Specialty care	\$80*	0%*	\$150
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	\$5 for the first 3 visits; then \$50 ⁴
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25	\$50
Chiropractic services ²	\$25	\$25	\$50
Naturopathic services	\$5 for the first 3 visits; then \$60 ⁴	\$5 for the first 3 visits; then 0%* ⁴	\$5 for the first 3 visits; then \$50 ⁴
OUTPATIENT THERAPIES³	\$80*	0%*	\$50
OUTPATIENT SURGERY	40%*	0%*	0%*
LAB	40%*	0%*	0%*
X-RAY/DIAGNOSTIC TEST	40%*	0%*	0%*
CT, MRI, AND PET SCANS	40%*	0%*	0%*
INPATIENT HOSPITAL CARE	40%*	0%*	0%*
EMERGENCY DEPARTMENT VISIT	40%*	0%*	0%*
OUTPATIENT PRESCRIPTION DRUGS	\$30 generic; \$100 preferred brand name; 50%* non-preferred brand name; 50%* specialty	\$30 generic; \$0* preferred brand name; \$0* non-preferred brand name; \$0* specialty	\$25 generic; 0%* preferred brand name; 0%* non-preferred brand name; 0%* specialty
MATERNITY CARE Inpatient	40%*	0%*	0%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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. ⁵These plans may not be sold with additional coverage such as adult vision hardware and eye exam and massage. Only medically necessary eye exams are covered. These plans exclude the following benefits: Pediatric dental benefits, Dependent Out of Area and Fertility Diagnosis.



PLAN NAME	KP OR Gold HSA 1800	KP OR Silver HSA 3600	KP OR Bronze HSA 7100
ACCUMULATION TYPE	Aggregate deductible; embedded out-of-pocket maximum	Embedded	Embedded
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$1,800 per individual; \$3,600 per family	\$3,600 per individual; \$7,200 per family	\$7,100 per individual; \$14,200 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$5,500 per individual; \$11,000 per family	\$7,800 per individual; \$15,600 per family	\$7,100 per individual; \$14,200 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	0%	0%
Primary care	\$5* for the first 3 visits; then 20%* ⁴	\$5* for the first 3 visits; then 25%* ⁴	0%* for the first 3 visits; then 0%* ⁴
Urgent care	20%*	25%*	0%*
Specialty care	20%*	25%*	0%*
TELEHEALTH (PHONE/VIDEO)	0%* ⁴	0%* ⁴	0%* ⁴
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25*	\$25*	0%*
Chiropractic services ²	\$25*	\$25*	0%*
Naturopathic services	\$5* for the first 3 visits; then 20%* ⁴	\$5* for the first 3 visits; then 25%* ⁴	0%* for the first 3 visits; then 0%* ⁴
OUTPATIENT THERAPIES³	20%*	25%*	0%*
OUTPATIENT SURGERY	20%*	25%*	0%*
LAB	20%*	25%*	0%*
X-RAY/DIAGNOSTIC TEST	20%*	25%*	0%*
CT, MRI, AND PET SCANS	20%*	25%*	0%*
INPATIENT HOSPITAL CARE	20%*	25%*	0%*
EMERGENCY DEPARTMENT VISIT	20%*	25%*	0%*
OUTPATIENT PRESCRIPTION DRUGS	\$20* generic; 20%* preferred brand name; 50%* non-preferred brand name; 50%* specialty	\$20* generic; \$50* preferred brand name; 50%* non-preferred brand name; 50%* specialty	0%* generic; 0%* preferred brand name; 0%* non-preferred brand name; 0%* specialty
MATERNITY CARE Inpatient	20%*	25%*	0%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



KP PLUS PLANS

PLAN NAME	KP OR Platinum KP Plus 0	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	\$0	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	\$2,800 per individual; \$5,600 per family	N/A
BENEFITS ¹	Member pays	
OFFICE VISITS	\$0	\$0
Preventive care		
Primary care	\$5 for the first 3 visits; then \$20 ²	\$40
Urgent care	\$40	Not covered, except for services received outside the service area ^{3,4}
Specialty care	\$30	\$50
TELEHEALTH (PHONE/VIDEO)	\$0 ²	\$40
SELF-REFERRED ALTERNATIVE CARE	\$25 ⁵	\$45
Acupuncture services		
Chiropractic services	\$25 ⁶	\$45
Naturopathic services	\$5 for the first 3 visits; then \$20 ²	\$40
OUTPATIENT THERAPIES	\$30 ⁷	\$50
OUTPATIENT SURGERY	\$200	Not covered
LAB	\$20	\$40
X-RAY/DIAGNOSTIC TEST	\$30	\$50
CT, MRI, AND PET SCANS	\$75	Not covered
INPATIENT HOSPITAL CARE	\$300 per day, \$1,500 per admission	Not covered
EMERGENCY DEPARTMENT VISIT	\$200	Covered at the in-network cost share ³
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: \$5 generic; \$15 preferred brand name; \$50 non-preferred brand name; 50% specialty	Out-of-network pharmacies: \$25 generic; \$35 preferred brand name; \$70 non-preferred brand name; 50% specialty (limited to 5 prescriptions fills per year) ³
MATERNITY CARE	\$300 per day, \$1,500 per admission	Not covered
Inpatient		

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 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. 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. ³The limit of 10 covered services does not apply. ⁴If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating facility may be covered if the services are deemed necessary to prevent serious deterioration of health. ⁵Limited to 12 visits per year. ⁶Limited to 20 visits per year. ⁷Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.



PLAN NAME	KP OR Gold KP Plus 1000	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	\$1,000 per individual; \$2,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	\$8,900 per individual; \$17,800 per family	N/A
BENEFITS¹	Member pays	
OFFICE VISITS Preventive care	\$0	\$0
Primary care	\$5 for the first 3 visits; then \$25 ²	\$45
Urgent care	\$50	Not covered, except for services received outside the service area ^{3,4}
Specialty care	\$45	\$65
TELEHEALTH (PHONE/VIDEO)	\$0 ²	\$45
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	\$25 ⁵	\$45
Chiropractic services	\$25 ⁶	\$45
Naturopathic services	\$5 for the first 3 visits; then \$25 ²	\$45
OUTPATIENT THERAPIES	\$45 ⁷	\$65
OUTPATIENT SURGERY	25%*	Not covered
LAB	\$20	\$40
X-RAY/DIAGNOSTIC TEST	\$40	\$60
CT, MRI, AND PET SCANS	\$300	Not covered
INPATIENT HOSPITAL CARE	25%*	Not covered
EMERGENCY DEPARTMENT VISIT	25%*	Covered at the in-network cost share ³
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: \$15 generic; \$50 preferred brand name; 50% non-preferred brand name; 50% specialty	Out-of-network pharmacies: \$35 generic; \$70 preferred brand name; 50% non-preferred brand name; 50% specialty (limited to 5 prescriptions fills per year) ³
MATERNITY CARE Inpatient	25%*	Not covered

*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 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. 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. ³The limit of 10 covered services does not apply. ⁴If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating facility may be covered if the services are deemed necessary to prevent serious deterioration of health. ⁵Limited to 12 visits per year. ⁶Limited to 20 visits per year. ⁷Rehabilitative 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.



KP PLUS PLANS

PLAN NAME	KP OR Silver KP Plus 3000	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	\$3,000 per individual; \$6,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	\$9,600 per individual; \$19,200 per family	N/A
BENEFITS¹	Member pays	
OFFICE VISITS Preventive care	\$0	\$0
Primary care	\$5 for the first 3 visits; then \$40 ²	\$60
Urgent care	\$65	Not covered, except for services received outside the service area ^{3,4}
Specialty care	\$60	\$80
TELEHEALTH (PHONE/VIDEO)	\$0 ²	\$60
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	\$25 ⁵	\$45
Chiropractic services	\$25 ⁶	\$45
Naturopathic services	\$5 for the first 3 visits; then \$40 ²	\$60
OUTPATIENT THERAPIES	\$60 ⁷	\$80
OUTPATIENT SURGERY	40%*	Not covered
LAB	\$40	\$60
X-RAY/DIAGNOSTIC TEST	\$50	\$70
CT, MRI, AND PET SCANS	40%*	Not covered
INPATIENT HOSPITAL CARE	40%*	Not covered
EMERGENCY DEPARTMENT VISIT	40%*	Covered at the in-network cost share ³
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: \$30 generic; \$65 preferred brand name; 50% non-preferred brand name; 50%* specialty	Out-of-network pharmacies: \$50 generic; \$85 preferred brand name; 50% non-preferred brand name; 50% specialty (limited to 5 prescriptions fills per year) ³
MATERNITY CARE Inpatient	40%*	Not covered

*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 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. 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. ³The limit of 10 covered services does not apply. ⁴If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating facility may be covered if the services are deemed necessary to prevent serious deterioration of health. ⁵Limited to 12 visits per year. ⁶Limited to 20 visits per year. ⁷Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.



PLAN NAME	KP OR Bronze KP Plus 7000	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (IND/FAM)	\$7,000 per individual; \$14,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	\$9,200 per individual; \$18,400 per family	N/A
BENEFITS¹	Member pays	
OFFICE VISITS Preventive care	\$0	\$0
Primary care	\$5 for the first 3 visits; then \$60 ²	\$80
Urgent care	40%*	Not covered, except for services received outside the service area ^{3,4}
Specialty care	\$80*	\$100
TELEHEALTH (PHONE/VIDEO)	\$0 ²	\$80
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	\$25 ⁵	\$45
Chiropractic services	\$25 ⁶	\$45
Naturopathic services	\$5 for the first 3 visits; then \$60 ²	\$80
OUTPATIENT THERAPIES	\$80* ⁷	\$100
OUTPATIENT SURGERY	40%*	Not covered
LAB	40%*	50%
X-RAY/DIAGNOSTIC TEST	40%*	50%
CT, MRI, AND PET SCANS	40%*	Not covered
INPATIENT HOSPITAL CARE	40%*	Not covered
EMERGENCY DEPARTMENT VISIT	40%*	Covered at the in-network cost share ³
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: \$30 generic; \$100 preferred brand name; 50%* non-preferred brand name; 50%* specialty	Out-of-network pharmacies: \$50 generic; \$120 preferred brand name; 50% non-preferred brand name; 50% specialty (limited to 5 prescriptions fills per year) ³
MATERNITY CARE Inpatient	40%*	Not covered

*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 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. 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. ³The limit of 10 covered services does not apply. ⁴If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating facility may be covered if the services are deemed necessary to prevent serious deterioration of health. ⁵Limited to 12 visits per year. ⁶Limited to 20 visits per year. ⁷Rehabilitative 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.



ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP OR Platinum Added Choice 250		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$250 per individual; \$500 per family	\$500 per individual; \$1,000 per family	\$750 per individual; \$1,500 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,500 per individual; \$7,000 per family	\$5,000 per individual; \$10,000 per family	\$7,000 per individual; \$14,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	35%*
Primary care	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$30 ⁴	35%*
Urgent care	\$40	\$60	35%*
Specialty care	\$30	\$40	35%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	35%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	20%	40%
Chiropractic services ²	\$25	20%	40%
Naturopathic services	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$30 ⁴	35%*
OUTPATIENT THERAPIES³	\$30	\$40	35%*
OUTPATIENT SURGERY	15%*	25%*	35%*
LAB	\$20	\$30	35%*
X-RAY/DIAGNOSTIC TEST	\$30	\$40	35%*
CT, MRI, AND PET SCANS	15%*	25%*	35%*
INPATIENT HOSPITAL CARE	15%*	25%*	35%*
EMERGENCY DEPARTMENT VISIT	15%*		
OUTPATIENT PRESCRIPTION DRUGS	<p>Kaiser Permanente pharmacies: \$10 generic; \$25 preferred brand name; \$50 non-preferred brand name; 50% specialty</p> <p>MedImpact network pharmacies: \$15 generic; \$35 preferred brand name; 50% non-preferred brand name; 50% specialty</p>		
MATERNITY CARE Inpatient	15%*	25%*	35%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



PLAN NAME	KP OR Gold Added Choice 500		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$500 per individual; \$1,000 per family	\$1,500 per individual; \$3,000 per family	\$4,500 per individual; \$9,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,000 per individual; \$14,000 per family	\$9,200 per individual; \$18,400 per family	\$10,500 per individual; \$21,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$35 ⁴	\$5 for the first 3 visits; then \$60 ⁴	50%*
Urgent care	\$60	\$80	50%*
Specialty care	\$55	\$80	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	20%	40%
Chiropractic services ²	\$25	20%	40%
Naturopathic services	\$5 for the first 3 visits; then \$35 ⁴	\$5 for the first 3 visits; then \$60 ⁴	50%*
OUTPATIENT THERAPIES³	\$55	\$80	50%*
OUTPATIENT SURGERY	30%*	50%*	50%*
LAB	\$35	40%*	50%*
X-RAY/DIAGNOSTIC TEST	\$45	40%*	50%*
CT, MRI, AND PET SCANS	30%*	50%*	50%*
INPATIENT HOSPITAL CARE	30%*	50%*	50%*
EMERGENCY DEPARTMENT VISIT	30%*		
OUTPATIENT PRESCRIPTION DRUGS	<p>Kaiser Permanente pharmacies: \$10 generic; \$25 preferred brand name; \$50 non-preferred brand name; 50% specialty</p> <p>MedImpact network pharmacies: \$25 generic; \$75 preferred brand name; 50% non-preferred brand name; 50% specialty</p>		
MATERNITY CARE Inpatient	30%*	50%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP OR Gold Added Choice 1000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$1,000 per individual; \$2,000 per family	\$2,000 per individual; \$4,000 per family	\$6,000 per individual; \$12,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,500 per individual; \$15,000 per family	\$9,500 per individual; \$19,000 per family	\$11,000 per individual; \$22,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$25 ⁴	\$5 for the first 3 visits; then \$45 ⁴	50%*
Urgent care	\$50	\$100	50%*
Specialty care	\$45	\$65	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	20%	40%
Chiropractic services ²	\$25	20%	40%
Naturopathic services	\$5 for the first 3 visits; then \$25 ⁴	\$5 for the first 3 visits; then \$45 ⁴	50%*
OUTPATIENT THERAPIES³	\$45	\$65	50%*
OUTPATIENT SURGERY	25%*	40%*	50%*
LAB	\$20	40%*	50%*
X-RAY/DIAGNOSTIC TEST	\$20	40%*	50%*
CT, MRI, AND PET SCANS	\$300	40%*	50%*
INPATIENT HOSPITAL CARE	25%*	40%*	50%*
EMERGENCY DEPARTMENT VISIT	25%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: \$15 generic; \$50 preferred brand name; 50% non-preferred brand name; 50% specialty MedImpact network pharmacies: \$30 generic; \$75 preferred brand name; 50% non-preferred brand name; 50% specialty		
MATERNITY CARE Inpatient	25%*	40%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



PLAN NAME	KP OR Silver Added Choice 3000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$3,000 per individual; \$6,000 per family	\$5,000 per individual; \$10,000 per family	\$7,000 per individual; \$14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,200 per individual; \$18,400 per family	\$9,800 per individual; \$19,600 per family	\$14,000 per individual; \$28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$45 ⁴	\$5 for the first 3 visits; then \$60 ⁴	50%*
Urgent care	\$65	\$80	50%*
Specialty care	\$60	\$75	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	20%	40%
Chiropractic services ²	\$25	20%	40%
Naturopathic services	\$5 for the first 3 visits; then \$45 ⁴	\$5 for the first 3 visits; then \$60 ⁴	50%*
OUTPATIENT THERAPIES³	\$60	\$75	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	\$45	45%*	50%*
X-RAY/DIAGNOSTIC TEST	\$50	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
OUTPATIENT PRESCRIPTION DRUGS	<p>Kaiser Permanente pharmacies: \$30 generic; \$65 preferred brand name; 50% non-preferred brand name; 50%* specialty</p> <p>MedImpact network pharmacies: \$40 generic; \$75 preferred brand name; 50% non-preferred brand name; 50%* specialty</p>		
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP OR Silver Added Choice 4000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$4,000 per individual; \$8,000 per family	\$6,000 per individual; \$12,000 per family	\$7,000 per individual; \$14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,200 per individual; \$18,400 per family	\$9,200 per individual; \$18,400 per family	\$14,000 per individual; \$28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$45 ⁴	\$5 for the first 3 visits; then \$60 ⁴	50%*
Urgent care	\$70	\$90	50%*
Specialty care	\$60	\$70	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	20%	40%
Chiropractic services ²	\$25	20%	40%
Naturopathic services	\$5 for the first 3 visits; then \$45 ⁴	\$5 for the first 3 visits; then \$60 ⁴	50%*
OUTPATIENT THERAPIES³	\$60	\$70	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	\$45	45%*	50%*
X-RAY/DIAGNOSTIC TEST	\$45	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: \$30 generic; \$60 preferred brand name; 50%* non-preferred brand name; 50%* specialty MedImpact network pharmacies: \$40 generic; \$70 preferred brand name; 50%* non-preferred brand name; 50%* specialty		
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



PLAN NAME	KP OR Bronze Added Choice 7000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$7,000 per individual; \$14,000 per family	\$9,000 per individual; \$18,000 per family	\$11,000 per individual; \$22,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,200 per individual; \$18,400 per family	\$9,200 per individual; \$18,400 per family	\$15,000 per individual; \$30,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$60 ⁴	\$5 for the first 3 visits; then \$75 ⁴	50%*
Urgent care	40%*	45%*	50%*
Specialty care	\$80*	\$100*	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	20%	40%
Chiropractic services ²	\$25	20%	40%
Naturopathic services	\$5 for the first 3 visits; then \$60 ⁴	\$5 for the first 3 visits; then \$75 ⁴	50%*
OUTPATIENT THERAPIES³	\$80*	\$100*	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	40%*	45%*	50%*
X-RAY/DIAGNOSTIC TEST	40%*	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
OUTPATIENT PRESCRIPTION DRUGS	<p>Kaiser Permanente pharmacies: \$30 generic; \$100 preferred brand name; 50%* non-preferred brand name; 50%* specialty</p> <p>MedImpact network pharmacies: \$45 generic; \$120 preferred brand name; 50%* non-preferred brand name; 50%* specialty</p>		
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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. ⁴First 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.



ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Platinum Added Choice OOA 250		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$250 per individual; \$500 per family	\$250 per individual; \$500 per family	\$750 per individual; \$1,500 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,600 per individual; \$7,200 per family	\$3,600 per individual; \$7,200 per family	\$7,000 per individual; \$14,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	35%*
Primary care	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$20 ⁴	35%*
Urgent care	\$40	\$40	35%*
Specialty care	\$30	\$30	35%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	35%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25	40%
Chiropractic services ²	\$25	\$25	40%
Naturopathic services	\$5 for the first 3 visits; then \$20 ⁴	\$5 for the first 3 visits; then \$20 ⁴	35%*
OUTPATIENT THERAPIES³	\$30	\$30	35%*
OUTPATIENT SURGERY	15%*	15%*	35%*
LAB	\$20	\$20	35%*
X-RAY/DIAGNOSTIC TEST	\$30	\$30	35%*
CT, MRI, AND PET SCANS	\$100	\$100	35%*
INPATIENT HOSPITAL CARE	15%*	15%*	35%*
EMERGENCY DEPARTMENT VISIT	15%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente and MedImpact network pharmacies: \$10 generic; \$25 preferred brand name; \$50 non-preferred brand name; 50% specialty		
MATERNITY CARE Inpatient	15%*	15%*	35%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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.

⁴First 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.



PLAN NAME	KP OR Gold Added Choice OOA 500		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$500 per individual; \$1,000 per family	\$500 per individual; \$1,000 per family	\$4,500 per individual; \$9,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,500 per individual; \$15,000 per family	\$7,500 per individual; \$15,000 per family	\$10,000 per individual; \$20,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$35 ⁴	\$5 for the first 3 visits; then \$35 ⁴	50%*
Urgent care	\$60	\$60	50%*
Specialty care	\$55	\$55	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25	40%
Chiropractic services ²	\$25	\$25	40%
Naturopathic services	\$5 for the first 3 visits; then \$35 ⁴	\$5 for the first 3 visits; then \$35 ⁴	50%*
OUTPATIENT THERAPIES³	\$55	\$55	50%*
OUTPATIENT SURGERY	35%*	35%*	50%*
LAB	\$35	\$35	50%*
X-RAY/DIAGNOSTIC TEST	\$40	\$40	50%*
CT, MRI, AND PET SCANS	\$250*	\$250*	50%*
INPATIENT HOSPITAL CARE	35%*	35%*	50%*
EMERGENCY DEPARTMENT VISIT	35%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente and MedImpact network pharmacies: \$15 generic; \$30 preferred brand name; \$60 non-preferred brand name; 50% specialty		
MATERNITY CARE Inpatient	35%*	35%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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.

⁴First 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.



ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Gold Added Choice OOA 1000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$1,000 per individual; \$2,000 per family	\$1,000 per individual; \$2,000 per family	\$6,000 per individual; \$12,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,500 per individual; \$15,000 per family	\$7,500 per individual; \$15,000 per family	\$11,000 per individual; \$22,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$35 ⁴	\$5 for the first 3 visits; then \$35 ⁴	50%*
Urgent care	\$75	\$75	50%*
Specialty care	\$55	\$55	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25	40%
Chiropractic services ²	\$25	\$25	40%
Naturopathic services	\$5 for the first 3 visits; then \$35 ⁴	\$5 for the first 3 visits; then \$35 ⁴	50%*
OUTPATIENT THERAPIES³	\$55	\$55	50%*
OUTPATIENT SURGERY	35%*	35%*	50%*
LAB	\$35	\$35	50%*
X-RAY/DIAGNOSTIC TEST	\$35	\$35	50%*
CT, MRI, AND PET SCANS	\$300	\$300	50%*
INPATIENT HOSPITAL CARE	35%*	35%*	50%*
EMERGENCY DEPARTMENT VISIT	35%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente and MedImpact network pharmacies: \$15 generic; \$30 preferred brand name; \$60 non-preferred brand name; 50% specialty		
MATERNITY CARE Inpatient	35%*	35%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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.

⁴First 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.



PLAN NAME	KP OR Silver Added Choice OOA 3000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$3,000 per individual; \$6,000 per family	\$3,000 per individual; \$6,000 per family	\$7,000 per individual; \$14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,600 per individual; \$19,200 per family	\$9,600 per individual; \$19,200 per family	\$14,000 per individual; \$28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$45 ⁴	\$5 for the first 3 visits; then \$45 ⁴	50%*
Urgent care	\$65	\$65	50%*
Specialty care	\$60	\$60	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25	40%
Chiropractic services ²	\$25	\$25	40%
Naturopathic services	\$5 for the first 3 visits; then \$45 ⁴	\$5 for the first 3 visits; then \$45 ⁴	50%*
OUTPATIENT THERAPIES³	\$60	\$60	50%*
OUTPATIENT SURGERY	45%*	45%*	50%*
LAB	\$45	\$45	50%*
X-RAY/DIAGNOSTIC TEST	\$50	\$50	50%*
CT, MRI, AND PET SCANS	45%*	45%*	50%*
INPATIENT HOSPITAL CARE	45%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	45%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente and MedImpact network pharmacies: \$30 generic; \$75 preferred brand name; 50% non-preferred brand name; 50%* specialty		
MATERNITY CARE Inpatient	45%*	45%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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.

⁴First 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.



ADDED CHOICE POINT-OF-SERVICE OUT-OF-AREA PLANS

PLAN NAME	KP OR Silver Added Choice OOA 4000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$4,000 per individual; \$8,000 per family	\$4,000 per individual; \$8,000 per family	\$7,000 per individual; \$14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,200 per individual; \$18,400 per family	\$9,200 per individual; \$18,400 per family	\$14,000 per individual; \$28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$45 ⁴	\$5 for the first 3 visits; then \$45 ⁴	50%*
Urgent care	\$70	\$70	50%*
Specialty care	\$60	\$60	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25	40%
Chiropractic services ²	\$25	\$25	40%
Naturopathic services	\$5 for the first 3 visits; then \$45 ⁴	\$5 for the first 3 visits; then \$45 ⁴	50%*
OUTPATIENT THERAPIES³	\$60	\$60	50%*
OUTPATIENT SURGERY	45%*	45%*	50%*
LAB	\$45	\$45	50%*
X-RAY/DIAGNOSTIC TEST	\$45	\$45	50%*
CT, MRI, AND PET SCANS	45%*	45%*	50%*
INPATIENT HOSPITAL CARE	45%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	45%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente and MedImpact network pharmacies: \$30 generic; \$60 preferred brand name; 50%* non-preferred brand name; 50%* specialty		
MATERNITY CARE Inpatient	45%*	45%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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.

⁴First 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.



PLAN NAME	KP OR Bronze Added Choice OOA 7000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$7,000 per individual; \$14,000 per family	\$7,000 per individual; \$14,000 per family	\$11,000 per individual; \$22,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,200 per individual; \$18,400 per family	\$9,200 per individual; \$18,400 per family	\$15,000 per individual; \$30,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	\$0	\$0	50%*
Primary care	\$5 for the first 3 visits; then \$60 ⁴	\$5 for the first 3 visits; then \$60 ⁴	50%*
Urgent care	45%*	45%*	50%*
Specialty care	\$80*	\$80*	50%*
TELEHEALTH (PHONE/VIDEO)	\$0 ⁴	\$0 ⁴	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25	\$25	40%
Chiropractic services ²	\$25	\$25	40%
Naturopathic services	\$5 for the first 3 visits; then \$60 ⁴	\$5 for the first 3 visits; then \$60 ⁴	50%*
OUTPATIENT THERAPIES³	\$80*	\$80*	50%*
OUTPATIENT SURGERY	45%*	45%*	50%*
LAB	45%*	45%*	50%*
X-RAY/DIAGNOSTIC TEST	45%*	45%*	50%*
CT, MRI, AND PET SCANS	45%*	45%*	50%*
INPATIENT HOSPITAL CARE	45%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	45%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente and MedImpact network pharmacies: \$30 generic; \$100 preferred brand name; 50%* non-preferred brand name; 50%* specialty		
MATERNITY CARE Inpatient	45%*	45%*	50%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative 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.

⁴First 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.



SENIOR ADVANTAGE PLAN

PLAN NAME	SENIOR ADVANTAGE
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$0
ANNUAL OUT-OF-POCKET MAXIMUM	\$1,000 per individual
BENEFITS	Member pays
OFFICE VISITS — PREVENTIVE CARE	\$0
Primary care	\$20
Urgent care	\$25
Specialty care	\$20
TELEHEALTH (PHONE/VIDEO)	\$0
OUTPATIENT THERAPIES	\$20
LAB	\$0
X-RAY/DIAGNOSTIC TEST	\$0
CT, MRI, AND PET SCANS	\$0
OUTPATIENT SURGERY	\$50
INPATIENT HOSPITAL CARE	\$200 per admission
EMERGENCY CARE	\$50
SELF-REFERRED ALTERNATIVE CARE	\$20 copay covers self-referred chiropractic, naturopathic, and acupuncture visits. \$25 copay for massage therapy up to 12 visits per calendar year. \$1,000 benefit max per calendar year for all services combined.
OUTPATIENT PRESCRIPTION DRUGS	\$20 generic; \$40 brand name and specialty. \$0 generic/brand name and specialty in the catastrophic coverage stage.*

Senior Advantage plans cannot be modified. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

*Catastrophic coverage begins when the member's annual out-of-pocket costs (how much the member and those paying on member's behalf) reach \$2,100.



Pediatric dental (benefits included in all medical plans)

All small business medical plans include Dental Choice (PPO) certified pediatric coverage, except for Oregon Standard medical plans. Orthodontia coverage is available for pediatric members by enrolling on a family dental plan that includes this coverage. For dependents to enroll, the subscriber must also enroll.

For groups enrolled on an Oregon Standard Plan, to obtain certified pediatric dental coverage for members 18 and younger, employers may offer a family dental plan or other certified pediatric dental coverage from another carrier.

PREVENTIVE AND DIAGNOSTIC SERVICES (Oral exam, X-rays, teeth cleaning, fluoride treatments)	\$0
BASIC RESTORATIVE SERVICES (Routine fillings, basic crowns, simple extractions)	50%*
MAJOR RESTORATIVE SERVICES (Gold or porcelain crowns, inlays, bridge abutments, pontics)	50%*

Plan highlights

Out-of-pocket maximum:

All benefits displayed accumulate to the out-of-pocket maximum.

Pediatric vision and vision hardware benefits:

All plans include pediatric vision exams at \$0 and pediatric vision hardware at no charge for 1 pair of standard frames with lenses or conventional or disposable contact lenses in lieu of eyeglasses (limited to 1 pair per year for conventional lenses or up to a 6-month supply of disposable contact lenses per year); no charge for low vision aid from selected list or medically necessary contact lenses.

HSA plans:

Pediatric dental services are subject to the medical deductible, up to the maximum out of pocket, on HSA-qualified plans.

Integrated eye health

We treat eye health as a component of total health, not in isolation. When you choose the vision option, you're choosing the option that is more convenient and connected, which can help uncover major health issues and lead to better health outcomes. Learn more at kp2020.org/nw.

Dental coverage

Our unique medical-dental integration helps improve quality of care and patient safety while boosting member satisfaction. Choose from our cost-effective Traditional plans or flexible Choice PPO plans. We have a range of options with comprehensive coverage to meet the needs of your employees. Learn more at kp.org/dental/nw.



*Pediatric dental services are subject to the annual medical deductible, up to the maximum out of pocket, on HSA-qualified plans.

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.



HSA plan accumulation types:

Our new high deductible health plan, KP OR Gold HSA 1800, uses aggregate accumulation for the deductible and embedded accumulation for the out-of-pocket maximum. 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-of-pocket 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.

Dependent out-of-area (OOA) benefit:

Your dependent children have access to care beyond urgent and emergency care outside the Kaiser Permanente network. This benefit covers limited coverage for routine, continuing, and follow-up care for dependent children residing outside the service area. Services are limited to 10 office visits, a combination of 10 diagnostic X-rays (excluding specialty scans) and labs, and 10 prescription drug fills. For covered services, the member pays 20% of the billed charges. (Does not apply to Standard plans, Added Choice, or Senior Advantage plans.)

Standard plans:

Standard plans are designed by the state of Oregon and cover only essential health benefits.* These plans have the same benefits from one company to the next so consumers can compare like plans across carriers that offer qualified health plans to small employers.

Outpatient prescription drugs

The Kaiser Permanente formulary applies to all plans. Members get up to a 30-day supply for each copay (up to a 90-day supply of eligible drugs for 2 copays when using our mail-order pharmacy). View our formulary at kp.org/formulary.

KP Plus outpatient prescription drugs

KP Plus members have access to 5 prescription fills per year at any licensed out-of-network pharmacy.

Additional prescription options for Added Choice plans

Members on an Added Choice plan have the option of filling their prescriptions through MedImpact. When a member fills a prescription at a MedImpact pharmacy, the plan covers up to a 30-day supply of drugs. To locate a pharmacy, go to kp.org/choiceproducts/nw.

*These plans may not be sold with additional coverage such as adult vision hardware and eye exam and massage. Only medically necessary eye exams are covered. These plans exclude the following benefits: pediatric dental, physician referred alternative care, dependent out-of-area, and fertility diagnosis.

Alternative care (self-referred)

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

PPO networks include First Choice Network and First Health Network in states where Kaiser Permanente operates and the Cigna HealthcareSM PPO Network in all other states.^{1,2} Visit kp.org/choiceproducts/nw for additional network information.

Explanation of Added Choice benefits

Services under the first tier are provided by KP Select providers at Kaiser facilities. *The Evidence of Coverage (EOC)* provides a complete definition of KP Select providers and KP Select facilities and explains when KP Select provider services are provided by other providers and facilities.

PPO provider services are provided by PPO providers and facilities. Refer to the *EOC* for a complete definition of PPO providers and facilities.

Nonparticipating provider services are provided by nonparticipating providers and facilities. Refer to the *EOC* for a complete definition of nonparticipating providers and facilities.

Deductible and out-of-pocket maximum amounts cross-accumulate between KP Select providers and PPO providers. There is a separate deductible and out-of-pocket maximum amount for nonparticipating providers, which does not accumulate across any other provider networks.

Visit kp.org/choiceproducts/nw for more information.

Explanation of KP Plus Benefits

KP Plus is an affordable option that gives your employees access to high-quality care from Kaiser Permanente and affiliated providers, plus the flexibility to receive certain types of care from out-of-network providers for a limited number of visits per year.

Visit kp.org/choiceproducts/nw for more information.

Bundled plan options when you purchase coverage outside the health insurance exchange

You can offer up to 3 medical plans in a bundle, with the limitation that there can only be 1 Added Choice plan per bundle. For groups that qualify, Added Choice out-of-area plans are not counted toward the 3-plan limit. Once you select your plan offerings, employees choose the plan that best meets their needs.



NOTES

*When appropriate and available. These features apply to care you get at Kaiser Permanente facilities. For high deductible health plan members, e-visits, phone visits, and video visits are subject to your plan's annual deductible. 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. To have a video visit, members must be registered on kp.org and have a camera-equipped computer or mobile device. Applicable cost shares will apply for services or items ordered during an e-visit. For high deductible health plan members, e-visits, phone visits, and video visits are subject to your plan's annual deductible.

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This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

