2020 PLAN UPDATES

What's new for Oregon small business group plans

OREGON
2020

This booklet contains a summary of important information you will want to know about our 2020 small group plans. For more details on plan design, refer to the Medical Plans Overview for Oregon Small Businesses.

account.kp.org

KAISER PERMANENTE®

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

Your partner in good health

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

WHAT'S NEW AT KAISER PERMANENTE

Below are some of the exciting changes over the past year

Service area

- Kaiser Permanente Dental Office at Keizer Station is now open in the Mid-Valley. This newest location offers a state-of-the-art oral surgery suite with 22 exam/operatories to provide general and pediatric dentistry, including hygiene services, specialty dentistry, and orthodontic services.
- Kaiser Permanente Chase Gardens Medical Office is scheduled to open in 2020. All primary care and lab services currently located at Kaiser Permanente's Downtown Eugene Medical Office will move to the new 18,697-square-foot location. In addition, Kaiser Permanente Chase Gardens Medical Office will offer members a nurse treatment area, new imaging and pharmacy services, and additional on-site lab services.
- Vision Essentials by Kaiser Permanente brings collaborative optometrists, ophthalmologists, and opticians together within an integrated care delivery system and is able to connect to our larger team of medical professionals and services. The 10 Vision Essentials locations are within most Kaiser Permanente medical offices. Saturday hours are available at Beaverton Medical Office, Cascade Park Medical Office, and Clackamas Eye Care.

kp.org and the Kaiser Permanente app

- E-visits: Get online, on-demand treatment from a Kaiser Permanente physician, including prescriptions, in under an hour. No additional cost through 2020.
- Bill Management: Pay and view medical bills, track payment history, and generate a summary of up to 2 years of past medical payments.
- Easier Online Scheduling: Schedule primary and specialty care appointments online at **kp.org**.

2020 medical plan portfolio

Our plan portfolio offers choice and flexibility. We have multiple plans to choose from in all 4 metal levels. For our 2020 plans, we have made changes that create stronger alignment between product types, allowing for better plan pairing. A new, lean Silver plan has been created to give customers a leaner option in this metal tier. The KP OR Gold 500/20 plan has been enriched to the KP OR Platinum 500/20 plan to provide another Platinum option and to create more differentiation from the KP OR Gold 1000/20 plan – the Gold 500/20 plan is therefore considered discontinued. Groups currently on the Gold 500/20 plan will be mapped to the Gold 1000/20 plan to remain in the Gold metal tier, but may select any other plan within our portfolio.

Alternative care, routine vision eye exam and hardware benefits

Naturopathic care is now provided on all plans (except the Oregon Standard plans) as a core benefit and includes 6 self-referred visits per year at the Specialty Office Visit cost share. Members can access this benefit through the CHP network of providers. With the addition of naturopathic care as a core benefit, we will no longer include naturopathic care in the Oregon buy-up options.

All our medical plans (except the Oregon Standard plans) may be purchased with additional coverage to meet your needs. The 3 buy-up options include medical plans with self-referred alternative care; medical plans with adult vision hardware and routine eye exam; and medical plans with self-referred alternative care, vision hardware, and routine eye exam. The alternative care buy-up option includes acupuncture, chiropractic, and massage, with a 12-visit limit per calendar year and a $1,000 benefit maximum for all services combined.

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 10 optical locations.

2020 dental plan portfolio

As groups renew in 2020, all adult-only dental plans are being discontinued and replaced with a "like" family dental plan. For groups that offer adult dental coverage, benefit levels for adults will not change, and those benefits will be extended to cover pediatric dependents together on one plan, including medically necessary orthodontia for members under 19 and an annual out-of-pocket maximum for in-network services of $350 for an individual under 19 and $700 for a family (of 2 or more pediatric members enrolled). Existing pediatric members' coverage will transition to their parent's family dental plan. Please note, some pediatric members may transition from their existing Choice PPO dental plan to a traditional dental plan. We offer both traditional and Choice PPO dental family plans, and the group may select any plan within our portfolio.

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

Automatic renewals

For your renewal in 2020, 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 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.

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-tier 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 twice the 30-day supply copay when we mail your prescription. We can mail most prescription drugs to you within 10 days, and you don't pay any extra cost for standard U.S. postage.

Pediatric vision coverage on all medical plans

All our plans cover pediatric vision exams and one pair of standard frames w/lenses, conventional or disposable contact lenses in lieu of eyeglasses (limited to one pair per year for conventional lenses or up to a 6-month supply of disposable contact lenses per year) at no additional charge.

Pediatric dental services and coverage for your renewal

Pediatric dental coverage for members is required by law, so all our medical plans are offered along with an ACA-compliant pediatric dental plan. All 3 of our stand-alone pediatric dental plans are Dental Choice (PPO) plans, which means you will get a choice of preferred providers, including those in our dental facilities and non-participating dentists. One of the 3 pediatric plans provides coverage for standard orthodontia to address misaligned teeth. 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 using the Renewal Decision Form. If a plan is not selected or an updated attestation received, coverage will be added.

Standard plans

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

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

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

Underwriting guidelines

Please be sure to review the Rating and Underwriting Assumptions Policy effective January 1, 2020, for Oregon groups with 50 or fewer employees.

TRADITIONAL, DEDUCTIBLE, HIGH DEDUCTIBLE (HSA-QUALIFIED), AND ADDED CHOICE® MEDICAL PLANS

Small group medical plans

METAL TIER	Traditional	Deductible	HSA-qualified high deductible	Added Choice® point-of-service[1]
PLATINUM	KP OR Platinum 0/20	KP OR Platinum 250/20 KP OR Platinum 500/20		KP OR Platinum 250/20 3T POS[2] KP OR Platinum 250/20 3T POS OOA[2]
GOLD	KP OR Gold 0/30	KP Oregon Standard Gold Plan KP OR Gold 1000/20 KP OR Gold 1500/35		KP OR Gold 600/35 3T POS[2] KP OR Gold 650/35 3T POS OOA[2] KP OR Gold 1000/20 3T POS[2] KP OR Gold 1000/35 3T POS OOA[2]
SILVER		KP Oregon Standard Silver Plan KP OR Silver 2500/45 KP OR Silver 3500/40 KP OR Silver 4500/45	KP OR Silver 2800/25% HSA	KP OR Silver 2500/45 3T POS[2] KP OR Silver 2500/45 3T POS OOA[2]
BRONZE		KP Oregon Standard Bronze Plan KP OR Bronze 5500/50 KP OR Bronze 8150/40	KP OR Bronze 5200/20% HSA	

Buy-up options	Any of the above medical plans, when purchased directly through Kaiser Permanente, can be paired with a buy-up option listed below, with the exception of the Standard plans. A. **Vision:** $200/2-year period vision hardware benefit and vision exam B. **Alternative Care:** $20 chiropractic, acupuncture, and $25 massage therapy (limit 12 per year)/$1,000 maximum C. **Vision + Alternative Care:** Bundle of Options A and B above

[1]If 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.

[2]Offered only outside the health insurance exchange. Added Choice OOA plans: Groups must meet underwriting requirements to purchase.

2020 MEDICAL PLAN CHANGES

YEAR	2019	2020
PLAN NAME	**KP OR Platinum 0/20**	**KP OR Platinum 0/20**
ANNUAL OUT-OF-POCKET MAXIMUM	$3,000 per individual; $6,000 per family	$2,000 per individual; $4,000 per family

YEAR	2019	2020
PLAN NAME	**KP OR Gold 0/30**	**KP OR Gold 0/30**
ANNUAL OUT-OF-POCKET MAXIMUM	$6,500 per individual; $13,000 per family	$6,750 per individual; $13,500 per family
BENEFITS	Member pays	
Urgent care	$50	$60
Specialty care	$40	$50
OUTPATIENT THERAPIES[1]	$40	$50
OUTPATIENT SURGERY	35%	40%
DURABLE MEDICAL EQUIPMENT	35%	40%
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	$40	$50
OUTPATIENT ADMINISTERED MEDICATIONS	20%	40%

YEAR	2019	2020
PLAN NAME	**KP OR Platinum 250/20**	**KP OR Platinum 250/20**
ANNUAL OUT-OF-POCKET MAXIMUM	$2,000 per individual; $4,000 per family	$2,500 per individual; $5,000 per family
BENEFITS	Member pays	
LAB	$10	$20
X-RAY/DIAGNOSTIC TEST	$10	$20
CT, MRI, AND PET SCANS	$75	10%*

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019	2020
PLAN NAME	**KP OR Gold 500/20**	**KP OR Gold 1000/20**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$500 per individual; $1,000 per family	$1,000 per individual; $2,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$6,100 per individual; $12,200 per family	$6,500 per individual; $13,000 per family
BENEFITS	Member pays	
Urgent care	$40	$50
Specialty care	$30	$40
OUTPATIENT THERAPIES[1]	$30	$40
OUTPATIENT SURGERY	25%*	20%*
INPATIENT HOSPITAL CARE	25%*	20%*
EMERGENCY DEPARTMENT VISIT	25%*	20%*
AMBULANCE SERVICES	25%*	20%*
MENTAL HEALTH SERVICES Inpatient psychiatric care	25%*	20%*
Residential treatment	25%*	20%*
CHEMICAL DEPENDENCY SERVICES Inpatient psychiatric care	25%*	20%*
Residential treatment	25%*	20%*
DURABLE MEDICAL EQUIPMENT	25%*	20%*
OUTPATIENT PRESCRIPTION DRUGS	$15 generic; $60 nonpreferred brand-name	$10 generic; 50% nonpreferred brand-name
OUTPATIENT ADMINISTERED MEDICATIONS	25%*	20%*
MATERNITY CARE Inpatient	25%*	20%*

YEAR	2019	2020
PLAN NAME	**KP OR Gold 1000/20**	**KP OR Gold 1000/20**
BENEFITS	Member pays	
Urgent care	$40	$50
Specialty care	$30	$40
OUTPATIENT THERAPIES[1]	$30	$40
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	$30	$40
OUTPATIENT PRESCRIPTION DRUGS	$20 preferred brand-name; $60 nonpreferred brand-name	$30 preferred brand-name; 50% nonpreferred brand-name

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019	2020
PLAN NAME	**KP OR Gold 1500/35**	**KP OR Gold 1500/35**
ANNUAL OUT-OF-POCKET MAXIMUM	$6,000 per individual; $12,000 per family	$7,000 per individual; $14,000 per family
BENEFITS	Member pays	
LAB	$40	$35
X-RAY/DIAGNOSTIC TEST	$40	$35

YEAR	2019	2020
PLAN NAME	**KP OR Platinum 250/20**	**KP OR Platinum 500/20**
ANNUAL OUT-OF-POCKET MAXIMUM	$6,850 per individual; $13,700 per family	$7,300 per individual; $14,600 per family

YEAR	2019	2020
PLAN NAME	**KP OR Silver 2500/40**	**KP OR Silver 2500/45**
ANNUAL OUT-OF-POCKET MAXIMUM	$7,900 per individual; $15,800 per family	$8,150 per individual; $16,300 per family
BENEFITS	Member pays	
Primary care	$40	$45
Urgent care	$50	$65
Specialty care	$50	$55
OUTPATIENT THERAPIES[1]	$50	$55
LAB	$40	$45
X-RAY/DIAGNOSTIC TEST	$40	$45
MENTAL HEALTH SERVICES Outpatient/day treatment	$40	$45
CHEMICAL DEPENDENCY SERVICES Outpatient/day treatment	$40	$45
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	$50	$55
OUTPATIENT PRESCRIPTION DRUGS	30% nonpreferred brand-name; 50% specialty	50% nonpreferred brand-name; 50%* specialty

YEAR	2019	2020
PLAN NAME	**KP OR Silver 3500/40**	**KP OR Silver 3500/40**
ANNUAL OUT-OF-POCKET MAXIMUM	$7,350 per individual; $14,700 per family	$8,150 per individual; $16,300 per family

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019	2020
PLAN NAME	**KP Oregon Standard Silver Plan**	**KP Oregon Standard Silver Plan**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$2,850 per individual; $5,700 per family	$3,550 per individual; $7,100 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$7,900 per individual; $15,800 per family	$8,150 per individual; $16,300 per family

YEAR	2019	2020
PLAN NAME	**KP OR Bronze 5000/50**	**KP OR Bronze 5500/50**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$5,000 per individual; $10,000 per family	$5,500 per individual; $11,000 per family
PRESCRIPTION DRUG DEDUCTIBLE	$700	$900
ANNUAL OUT-OF-POCKET MAXIMUM	$7,900 per individual; $15,800 per family	$8,150 per individual; $16,300 per family
BENEFITS	Member pays	
Urgent care	30%*	35%*
OUTPATIENT SURGERY	30%*	35%*
LAB	30%*	35%*
X-RAY/DIAGNOSTIC TEST	30%*	35%*
CT, MRI, AND PET SCANS	30%*	35%*
INPATIENT HOSPITAL CARE	30%*	35%*
EMERGENCY DEPARTMENT VISIT	30%*	35%*
AMBULANCE SERVICES	30%*	35%*
MENTAL HEALTH SERVICES Inpatient psychiatric care	30%*	35%*
Residential treatment	30%*	35%*
CHEMICAL DEPENDENCY SERVICES Inpatient psychiatric care	30%*	35%*
Residential treatment	30%*	35%*
DURABLE MEDICAL EQUIPMENT	30%*	35%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[1]	$60	$60*
OUTPATIENT ADMINISTERED MEDICATIONS	30%*	35%*
MATERNITY CARE Inpatient	30%*	35%*

*Subject to annual medical deductible.
[1]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019	2020
PLAN NAME	**KP OR Bronze 6600/40**	**KP OR Bronze 8150/40**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$6,600 per individual; $13,200 per family	$8,150 per individual; $16,300 per family
PRESCRIPTION DRUG DEDUCTIBLE	$400	None
ANNUAL OUT-OF-POCKET MAXIMUM	$7,150 per individual; $14,300 per family	$8,150 per individual; $16,300 per family
BENEFITS	Member pays	
Urgent care	$100*	0%*
Specialty care	50%*	0%*
OUTPATIENT THERAPIES[1]	50%*	0%*
OUTPATIENT SURGERY	50%*	0%*
LAB	50%*	0%*
X-RAY/DIAGNOSTIC TEST	50%*	0%*
CT, MRI, AND PET SCANS	50%*	0%*
INPATIENT HOSPITAL CARE	50%*	0%*
EMERGENCY DEPARTMENT VISIT	50%*	0%*
AMBULANCE SERVICES	50%*	0%*
MENTAL HEALTH SERVICES Inpatient psychiatric care	50%*	0%*
Residential treatment	50%*	0%*
Outpatient/day treatment	50%*	0%*
CHEMICAL DEPENDENCY SERVICES Inpatient psychiatric care	50%*	0%*
Residential treatment	50%*	0%*
Outpatient/day treatment	50%*	0%*
DURABLE MEDICAL EQUIPMENT	50%*	0%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	50%*	0%*
OUTPATIENT PRESCRIPTION DRUGS	30% preferred brand-name; 50% nonpreferred brand-name; 50% specialty	0%* preferred brand-name; 0%* nonpreferred brand-name; 0%* specialty
OUTPATIENT ADMINISTERED MEDICATIONS	50%*	0%*
MATERNITY CARE Inpatient	50%*	0%*

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019	2020
PLAN NAME	**KP Oregon Standard Bronze Plan**	**KP Oregon Standard Bronze Plan**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$6,550 per individual; $13,100 per family	$7,900 per individual; $15,800 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$6,550 per individual; $13,100 per family	$7,900 per individual; $15,800 per family
BENEFITS	Member pays	
Primary care	0%*	$45
Specialty care	0%*	$90
OUTPATIENT THERAPIES[1]	0%*	$45
MENTAL HEALTH SERVICES Outpatient/day treatment	0%*	$45
CHEMICAL DEPENDENCY SERVICES Outpatient/day treatment	0%*	$45
OUTPATIENT PRESCRIPTION DRUGS	0%* generic	$15 generic

YEAR	2019	2020
PLAN NAME	**KP OR Silver 2700/25% HSA**	**KP OR Silver 2800/25% HSA**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$2,700 per individual; $5,400 per family	$2,800 per individual; $5,600 per family

YEAR	2019	2020
PLAN NAME	**KP OR Bronze 5200/20 HSA**	**KP OR Bronze 5200/20% HSA**
ANNUAL OUT-OF-POCKET MAXIMUM	$6,550 per individual; $13,100 per family	$6,900 per individual; $13,800 per family
BENEFITS	Member pays	
Primary care	$20*	20%*
Specialty care	$30*	30%*
OUTPATIENT THERAPIES[1]	$30*	30%*
MENTAL HEALTH SERVICES Outpatient/day treatment	$20*	20%*
CHEMICAL DEPENDENCY SERVICES Outpatient/day treatment	$20*	20%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	$30*	30%*

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019			2020		
PLAN NAME	KP OR Platinum 250/10 3T POS			KP OR Platinum 250/20 3T POS		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL OUT-OF-POCKET MAXIMUM	$2,000 per individual; $4,000 per family	$3,000 per individual; $6,000 per family	$6,000 per individual; $12,000 per family	$2,500 per individual; $5,000 per family	$3,500 per individual; $7,000 per family	$7,000 per individual; $14,000 per family
BENEFITS	Member pays			Member pays		
Primary care	$10	$25	35%*	$20	$30	35%*
Urgent care	$40	$55	35%*	$40	$60	35%*
Specialty care	$20	$35	35%*	$30	$40	35%*
OUTPATIENT THERAPIES[1]	$20	$35	35%*	$30	$40	35%*
LAB	10%*	25%*	35%*	$20	$30	35%*
X-RAY/DIAGNOSTIC TEST	$10	$25	35%*	$20	$30	35%*
CT, MRI, AND PET SCANS	$100	25%*	35%*	10%*	25%*	35%*
EMERGENCY DEPARTMENT VISIT	$100*			10%*		
MENTAL HEALTH SERVICES Outpatient/day treatment	$10	$25	35%*	$20	$30	35%*
CHEMICAL DEPENDENCY SERVICES Outpatient/day treatment	$10	$25	35%*	$20	$30	35%*
DURABLE MEDICAL EQUIPMENT	20%*	35%*	45%*	10%*	25%*	35%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	$20	Not covered	Not covered	$30	Not covered	Not covered

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019			2020		
PLAN NAME	KP OR Gold 600/35 3T POS			KP OR Gold 600/35 3T POS		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL OUT-OF-POCKET MAXIMUM	$3,000 per individual; $6,000 per family	$6,000 per individual; $12,000 per family	$8,000 per individual; $16,000 per family	$4,000 per individual; $8,000 per family	$6,000 per individual; $12,000 per family	$8,000 per individual; $16,000 per family
BENEFITS	Member pays			Member pays		
X-RAY/DIAGNOSTIC TEST	30%	40%*	50%*	$35	40%*	50%*
CT, MRI, AND PET SCANS	$200*	50%*	50%*	30%*	50%*	50%*
OUTPATIENT PRESCRIPTION DRUGS	$60 nonpreferred brand-name	50% nonpreferred brand-name	Not covered	$50 nonpreferred brand-name	50% nonpreferred brand-name	Not covered

YEAR	2019			2020		
PLAN NAME	KP OR Gold 1000/35 3T POS			KP OR Gold 1000/20 3T POS		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL OUT-OF-POCKET MAXIMUM	$3,000 per individual; $6,000 per family	$5,000 per individual; $10,000 per family	$9,000 per individual; $18,000 per family	$5,000 per individual; $10,000 per family	$7,500 per individual; $15,000 per family	$10,000 per individual; $20,000 per family
BENEFITS	Member pays			Member pays		
Primary care	$35	$60	50%*	$20	$40	50%*
Urgent care	$75	$100	50%*	$50	$100	50%*
Specialty care	$45	$70	50%*	$40	$60	50%*
OUTPATIENT THERAPIES[1]	$45	$70	50%*	$40	$60	50%*
LAB	$35	40%*	50%*	$20	40%*	50%*
X-RAY/DIAGNOSTIC TEST	$35	40%*	50%*	$20	40%*	50%*
CT, MRI, AND PET SCANS	$200	40%*	50%*	$300	40%*	50%*
AMBULANCE SERVICES	20%			25%*		
MENTAL HEALTH SERVICES Outpatient/day treatment	$35	$60	50%*	$20	$40	50%*
CHEMICAL DEPENDENCY SERVICES Outpatient/day treatment	$35	$60	50%*	$20	$40	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	$45	Not covered	Not covered	$40	Not covered	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$20 preferred brand-name; $60 nonpreferred brand-name	$75 preferred brand-name; 50% nonpreferred brand-name	Not covered	$30 preferred brand-name; 50% nonpreferred brand-name	$75 preferred brand-name; 50% nonpreferred brand-name	Not covered

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019			2020		
PLAN NAME	KP OR Silver 2500/40 3T POS			KP OR Silver 2500/45 3T POS		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL OUT-OF-POCKET MAXIMUM	$7,000 per individual; $14,000 per family	$7,500 per individual; $15,000 per family	$12,500 per individual; $25,000 per family	$8,150 per individual; $16,300 per family	$8,150 per individual; $16,300 per family	$13,000 per individual; $26,000 per family
BENEFITS	Member pays			Member pays		
Primary care	$40	$60	50%*	$45	$60	50%*
Urgent care	$55	$75	50%*	$65	$80	50%*
Specialty care	$50	$70	50%*	$55	$70	50%*
OUTPATIENT THERAPIES[1]	$50	$70	50%*	$55	$70	50%*
LAB	$40	40%*	50%*	$45	40%*	50%*
X-RAY/DIAGNOSTIC TEST	$40	40%*	50%*	$45	40%*	50%*
AMBULANCE SERVICES	20%			30%*		
MENTAL HEALTH SERVICES Outpatient/day treatment	$40	$60	50%*	$45	$60	50%*
CHEMICAL DEPENDENCY SERVICES Outpatient/day treatment	$40	$60	50%*	$45	$60	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	$50	Not covered	Not covered	$55	Not covered	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $50 nonpreferred brand-name; 50% specialty	$30 generic; 50% nonpreferred brand-name; 50% specialty	Not covered	$30 generic; 50% nonpreferred brand-name; 50%* specialty	$40 generic; 50% nonpreferred brand-name; 50%* specialty	Not covered

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019			2020		
PLAN NAME	KP OR Platinum 250/10 3T POS OOA			KP OR Platinum 250/20 3T POS OOA		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL OUT-OF-POCKET MAXIMUM	$2,000 per individual; $4,000 per family	$2,000 per individual; $4,000 per family	$6,000 per individual; $12,000 per family	$2,500 per individual; $5,000 per family	$2,500 per individual; $5,000 per family	$7,000 per individual; $14,000 per family
BENEFITS	Member pays			Member pays		
Primary care	$10	$10	35%*	$20	$20	35%*
Specialty care	$20	$20	35%*	$30	$30	35%*
OUTPATIENT THERAPIES[1]	$20	$20	35%*	$30	$30	35%*
LAB	10%*	10%*	35%*	$20	$20	35%*
X-RAY/DIAGNOSTIC TEST	10%*	10%*	35%*	$20	$20	35%*
EMERGENCY DEPARTMENT VISIT	$100*			10%*		
MENTAL HEALTH SERVICES Outpatient/day treatment	$10	$10	35%*	$20	$20	35%*
CHEMICAL DEPENDENCY SERVICES Outpatient/day treatment	$10	$10	35%*	$20	$20	35%*
DURABLE MEDICAL EQUIPMENT	20%*	20%*	45%*	10%*	10%*	35%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	$20	Not covered	Not covered	$30	Not covered	Not covered

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

YEAR	2019			2020		
PLAN NAME	KP OR Gold 600/35 3T POS OOA			KP OR Gold 650/35 3T POS OOA		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$600 per individual; $1,200 per family	$600 per individual; $1,200 per family	$4,500 per individual; $9,000 per family	$650 per individual; $1,300 per family	$650 per individual; $1,300 per family	$4,500 per individual; $9,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$3,100 per individual; $6,200 per family	$5,100 per individual; $10,200 per family	$8,000 per individual; $16,000 per family	$5,000 per individual; $10,000 per family	$5,000 per individual; $10,000 per family	$10,000 per individual; $20,000 per family
BENEFITS	Member pays			Member pays		
OUTPATIENT SURGERY	30%*	30%*	50%*	35%*	35%*	50%*
X-RAY/DIAGNOSTIC TEST	30%	30%	50%*	$35	$35	50%*
CT, MRI, AND PET SCANS	$200*	$200*	50%*	$250*	$250*	50%*
INPATIENT HOSPITAL CARE	30%*	30%*	50%*	35%*	35%*	50%*
EMERGENCY DEPARTMENT VISIT	30%*			35%*		
AMBULANCE SERVICES	30%*			35%*		
MENTAL HEALTH SERVICES Inpatient psychiatric care	30%*	30%*	50%*	35%*	35%*	50%*
Residential treatment	30%*	30%*	50%*	35%*	35%*	50%*
CHEMICAL DEPENDENCY SERVICES Inpatient psychiatric care	30%*	30%*	50%*	35%*	35%*	50%*
Residential treatment	30%*	30%*	50%*	35%*	35%*	50%*
DURABLE MEDICAL EQUIPMENT	30%*	30%*	50%*	35%*	35%*	50%*
OUTPATIENT ADMINISTERED MEDICATIONS	30%*	30%*	50%*	35%*	35%*	50%*
MATERNITY CARE Inpatient	30%*	30%*	50%*	35%*	35%*	50%*

*Subject to annual medical deductible.

YEAR	2019			2020		
PLAN NAME	KP OR Gold 1000/35 3T POS OOA			KP OR Gold 1000/35 3T POS OOA		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL OUT-OF-POCKET MAXIMUM	$4,500 per individual; $9,000 per family	$4,500 per individual; $9,000 per family	$9,000 per individual; $18,000 per family	$5,000 per individual; $10,000 per family	$5,000 per individual; $10,000 per family	$10,000 per individual; $20,000 per family
BENEFITS	Member pays			Member pays		
AMBULANCE SERVICES	20%			30%*		

YEAR	2019			2020		
PLAN NAME	KP OR Silver 3000/40 3T POS OOA			KP OR Silver 2500/45 3T POS OOA		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$3,000 per individual; $6,000 per family	$3,000 per individual; $6,000 per family	$5,000 per individual; $10,000 per family	$2,500 per individual; $5,000 per family	$2,500 per individual; $5,000 per family	$6,500 per individual; $13,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$7,000 per individual; $14,000 per family	$7,900 per individual; $15,800 per family	$12,000 per individual; $24,000 per family	$8,150 per individual; $16,300 per family	$8,150 per individual; $16,300 per family	$12,000 per individual; $24,000 per family
BENEFITS	Member pays			Member pays		
Primary care	$40	$40	50%*	$45	$45	50%*
Urgent care	$55	$55	50%*	$65	$65	50%*
Specialty care	$50	$50	50%*	$55	$55	50%*
OUTPATIENT THERAPIES[1]	$50	$50	50%*	$55	$55	50%*
LAB	40%*	40%*	50%*	$45	$45	50%*
X-RAY/DIAGNOSTIC TEST	40%*	40%*	50%*	$45	$45	50%*
AMBULANCE SERVICES	20%			40%*		
MENTAL HEALTH SERVICES Outpatient/day treatment	$40	$40	50%*	$45	$45	50%*
CHEMICAL DEPENDENCY SERVICES Outpatient/day treatment	$40	$40	50%*	$45	$45	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[2]	$50	Not covered	Not covered	$55	Not covered	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$20 generic; $50 nonpreferred brand-name; 50% specialty	$20 generic; $50 nonpreferred brand-name; 50% specialty	Not covered	$30 generic; 50% nonpreferred brand-name; 50%* specialty	$30 generic; 50% nonpreferred brand-name; 50%* specialty	Not covered

*Subject to annual medical deductible.

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

[2]Referred chiropractic/naturopathic/acupuncture based upon medical criteria.

2020 *GROUP AGREEMENT* AND EVIDENCE OF COVERAGE SUMMARY OF CHANGES AND CLARIFICATIONS FOR OREGON SMALL EMPLOYER GROUPS

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the Evidence of Coverage (EOC), benefit summary, and any applicable endorsement documents. 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 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 2020. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to Traditional, Deductible, High Deductible, and Added Choice® medical plans

Changes and clarifications that apply to **Senior Advantage** plans are explained at the end of this summary.

Benefit changes

- **Referrals to Participating Providers and Participating Facilities.** A referral will now be required to schedule an appointment for ophthalmology Services.
- **Alternative Care Services.** Self-referred naturopathic medicine services are now covered under all small group plans, except the Oregon Standard plans, for up to 6 visits per year. Naturopathic medicine services no longer accumulate to the benefit maximum for plans that include the Alternative Care Services buy-up – which covers self-referred acupuncture, chiropractic, and massage therapy services.

Benefit clarifications

- **What You Pay.** This section of the EOC has been modified to provide clarification to members for deductible and out-of-pocket accumulations by distinguishing the difference between self-only and an individual in a family. Aggregate and embedded types are now discerned by the amounts listed on the benefit summary for each of the categories.
- **Emergency Services.** Emergency services may be received anywhere in the world as long as the services would have been covered under the "Benefits" section if received by a participating provider or at a participating facility.
- **Preventive Care Services.** Services to diagnose current or ongoing signs and symptoms are not considered preventive and may be subject to applicable cost shares.
- **Hearing Aid Services.** Language has been added to 2020 contract documents for member clarity. A new section has been added to describe the limited coverage of replacement ear molds and hearing aid batteries, as stated under House Bill 4104. Hearing aids are limited to one per ear every 36 months.
- **Outpatient Durable Medical Equipment (DME).** Lancets and injection aids are covered under the DME benefit.

- **Reconstructive Surgery Services.** Traditional, Deductible, and High Deductible Health Plans specify that services are covered when prescribed by a participating physician and are subject to Utilization Review.
- **Deductible.** The phrase "not subject to deductible" has been removed from several rows of the benefit summary. Our contract convention is to specify when benefits are subject to the deductible and to not reference the deductible when it does not apply.

Administrative changes or clarifications

- **Medical Directory.** Revised throughout the Traditional, Deductible, and High Deductible Health Plans to "Medical Facility Directory."
- **Advice Nurses.** Reflects that an advice nurse may be reached by contacting the Member Services number during normal business hours, as well as evenings, weekends, and holidays. Additionally, the Member Services number has been removed.
- **Outpatient Prescription Drugs and Supplies.** All refills must be obtained at a pharmacy owned and operated by Kaiser Permanente (including our mail-order pharmacy), or at another participating pharmacy designated for covered refills. First fill of a prescription may be obtained at any participating pharmacy.
- **Help with Your Claim and/or Appeal.** Consumer Advocacy Unit is now Consumer Advocacy Section, a fax number has been added, and the URL has been updated.
- **Grievances, Claims, Appeals, and External Review.** The Member Relations' fax number has changed and can accommodate a new digital fax process.
- **Nondiscrimination.** We do not discriminate based on marital status.
- **Termination for Nonpayment.** Reflects that notices for nonpayment of premium are sent by the 15th day of the month (if a group has not paid the full premium by that date).

Additional changes and clarifications that apply to Added Choice® medical plans only

Benefit changes

- **Referrals to Select Providers and Select Facilities.** A referral is now required to schedule an appointment for ophthalmology services. Ophthalmology has been removed from the departments that do not require a referral for outpatient services.

Benefit clarifications

- **Reconstructive Surgery Services.** Services are covered when prescribed by a select or nonparticipating provider. Additionally, services are subject to Utilization Review.
- **Optometric Vision Therapy and Orthoptics (Eye Exercises).** Services related to optometric vision therapy and orthoptics (eye exercises) are excluded.
- **Benefit Summary.** Applicable visit limits and benefit maximums are combined across tiers, unless otherwise indicated.
- **Outpatient Prescription Drugs and Supplies.** Self-administered intravenous drugs and self-administered chemotherapy medications are now on both the Select and MedImpact tables to reflect that they may be obtained from Select Pharmacies or MedImpact Pharmacies.

2020 DENTAL PLAN CHANGES AND REMINDERS

The Affordable Care Act requires health insurance marketplace–certified pediatric dental coverage for all subscribers and dependents regardless of age. Groups may select a stand-alone pediatric dental plan or have the option of adding family dental coverage to cover all employees and dependents. Both coverage options include medically necessary orthodontia for members under 19 and an annual out-of-pocket maximum for in-network services of $350 for an individual under 19 and $700 for a family (of 2 or more pediatric members enrolled).

OREGON HEALTH INSURANCE MARKETPLACE CERTIFIED PEDIATRIC PLANS AND FAMILY DENTAL PLANS

PPO pediatric plans

KP OR Choice 80 Pediatric Dental Plan
KP OR Choice 100 Pediatric Dental Plan
KP OR Choice 100 + Ortho Pediatric Dental Plan

Traditional family plans

KP OR Family Traditional 80 – $1,000 Max
KP OR Family Traditional 80 – $50 Ded/$1,000 Max
KP OR Family Traditional 80 – $100 Ded/$1,000 Max
KP OR Family Traditional 80 – $1,000 Max + Ortho
KP OR Family Traditional 100 – $1,000 Max
KP OR Family Traditional 100 – $50 Ded/$1,000 Max
KP OR Family Traditional 100 – $100 Ded/$1,000 Max
KP OR Family Traditional 100 – $1,000 Max + Ortho
KP OR Family Traditional 100 – $1,500 Max
KP OR Family Traditional 100 – $50 Ded/$1,500 Max
KP OR Family Traditional 100 – $100 Ded/$1500 Max
KP OR Family Traditional 100 – $1,500 Max + Ortho
KP OR Family Traditional 100 – $2,000 Max
KP OR Family Traditional 100 – $50 Ded/$2,000 Max
KP OR Family Traditional 100 – $100 Ded/$2,000 Max
KP OR Family Traditional 100 – $2,000 Max + Ortho
KP OR Family Traditional 100 – $50 Ded/$2,500 Max
KP OR Family Traditional 100 – $100 Ded/$2,500 Max
KP OR Family Traditional 100 – $2,500 Max + Ortho

PPO family plans

KP OR Family Choice 80 – $50 Ded/$1,000 Max
KP OR Family Choice 80 – $100 Ded/$1,000 Max
KP OR Family Choice 80 – $1,000 Max + Ortho
KP OR Family Choice 100 – $50 Ded/$1,000 Max
KP OR Family Choice 100 – $100 Ded/$1,000 Max
KP OR Family Choice 100 – $1,000 Max + Ortho
KP OR Family Choice 100 – $50 Ded/$1,500 Max
KP OR Family Choice 100 – $100 Ded/$1,500 Max
KP OR Family Choice 100 – $1,500 Max + Ortho
KP OR Family Choice 100 – $50 Ded/$2,000 Max
KP OR Family Choice 100 – $100 Ded/$2,000 Max
KP OR Family Choice 100 – $2,000 Max + Ortho
KP OR Family Choice 100 – $50 Ded/$2,500 Max
KP OR Family Choice 100 – $100 Ded/$2,500 Max
KP OR Family Choice 100 – $2,500 Max + Ortho

For specific information about the plans referred to in this brochure, go to **kp.org/plandocuments**.

CHANGES AND CLARIFICATIONS THAT APPLY TO DENTAL PLANS

Benefit clarifications

- **Oral Surgery Services, Periodontic Services, and Endodontic Services.** All exams, including diagnosis and evaluation, are subject to the Preventive and Diagnostic Services cost share.

Administrative changes or clarifications

- **10-day cancellation notice.** Removed because it applies to individual plans and not group plans.
- **Dental Provider Directory.** Previously named "Dental Facility Directory."
- **Definitions.** The dental PPO Third Party Administrator (TPA) name has changed from Scion Dental, Inc. to SKYGEN USA, LLC (SKYGEN).
- **Adding New Dependents to an Existing Account.** Enrollment application is required to add new dependents in the case of an additional premium.
- **Prior Authorization.** Providers can now request prior authorization electronically on your behalf (in the PPO plans).
- **Post-Service Claims – Services Already Received.** Non-PPO dental claim forms should be sent to our local dental claims office in Portland, Oregon.
- **Help with Your Claim and/or Appeal.** The Consumer Advocacy Unit has been updated to the Consumer Advocacy Section – a fax number has been added, and the URL has been updated.
- **Grievances, Claims, and Appeals.** The Member Relations fax number has changed and can accommodate a new digital fax process.
- **How You Terminate Your Membership.** You can cancel your coverage as early as the date the termination is received.
- **Termination for Cause.** You may only be terminated for fraud and misrepresentation.
- **Nondiscrimination.** We do not discriminate based on marital status.
- **Termination for Nonpayment.** Reflects that notices for nonpayment of premium are sent by the 15th day of the month (if a group has not paid the full premium by that date).

CHANGES AND CLARIFICATIONS THAT APPLY TO SENIOR ADVANTAGE PLANS

- **Outpatient prescription drugs.** True out-of-pocket cost for Part D covered drugs in a calendar year has increased from $5,100 to $6,350.

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