



2026 PLANS AND PRODUCTS | OREGON



Complete Suite™ plan comparison chart

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



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Complete Suite™ plans

The list below includes all plan offerings. Select a plan to navigate to the full list of benefits.

Plans selected: ☐

Compare plans

Traditional	Deductible	
TRAD PLAN A 10/1000	DED PLAN A 250/10/10%/2000	DED Everyday Care Plan \$7000
TRAD PLAN B 20/1500	DED PLAN A 250/15/20%/2500	DED Everyday Care Plan \$10/\$4000
TRAD PLAN C 20/2000	DED PLAN B 500/20/10%/3000	DED Everyday Care Plan \$10/\$5000
TRAD PLAN D 30/2500	DED PLAN B 500/10%/10%/2000	DED Everyday Care Plan \$10/\$6000
TRAD PLAN E 35/3000	DED PLAN B 500/10/20%/2000	DED Everyday Care Plan \$10/\$7000
	DED PLAN B 500/20/20%/3000	
High deductible health plan (HDHP)	DED PLAN C 750/20/20%/3250	
	DED PLAN C 750/20%/20%/3000	
HDHP PLAN A 1700/10%/2500	DED PLAN D 1000/20/20%/3000	
HDHP PLAN A 1700/20%/3500	DED PLAN D 1000/25/20%/4000	
HDHP PLAN B 2000/20%/4000	DED PLAN E 1500/25/20%/5500	
HDHP PLAN B 2000/30%/4000	DED PLAN E 1500/20/30%/4000	
HDHP PLAN C 2500/20%/5000	DED PLAN F 2000/25/20%/5000	
HDHP PLAN C 2500/30%/5000	DED PLAN G 2500/25/20%/5000	
HDHP PLAN E 3400/10%/6000	DED PLAN G 2500/30/30%/5000	
HDHP PLAN E 3400/20%/6000	DED PLAN H 3000/30/20%/7350	
HDHP PLAN E 3400/30%/6400	DED PLAN H 3000/30%/30%/6000	
HDHP PLAN F 3500/20%/7000	DED PLAN I 3500/30/20%/7350	
HDHP PLAN F 3500/30%/7000	DED PLAN J 4000/30/20%/7500	
HDHP PLAN G 4000/20%/8000	DED PLAN J 4000/40/30%/7500	
HDHP PLAN G 4000/30%/8000	DED PLAN K 5000/30/20%/8000	
HDHP PLAN H 5000/20%/8000	DED PLAN L 6000/35/20%/8500	
HDHP PLAN H 5000/30%/8000	DED PLAN L 6000/40/30%/9000	
HDHP PLAN H 5000/40%/8000	DED PLAN M 7500/35/30%/10000	
HDHP PLAN H 5000/50%/8000	DED Everyday Care Plan \$4000	
	DED Everyday Care Plan \$5000	
	DED Everyday Care Plan \$6000	

Reset

Clear all plans selected

Complete Suite™ plans

The list below includes all plan offerings. Select a plan to navigate to the full list of benefits.

Plans selected: ☐

Compare plans

KP Plus	Dual Choice PPO
KP PLUS PLAN A 10/1000	DUAL CHOICE PPO PLAN A 10/1500
KP PLUS PLAN B 20/1500	DUAL CHOICE PPO PLAN B 20/2000
KP PLUS PLAN C 20/2000	DUAL CHOICE PPO PLAN C 20/2500
KP PLUS PLAN D 30/2500	DUAL CHOICE PPO PLAN D 30/3000
KP PLUS PLAN E 35/3000	DUAL CHOICE PPO PLAN E 35/3500
KP PLUS PLAN A 250/10/10%/2000	DUAL CHOICE PPO PLAN A 250/10/10%/2500
KP PLUS PLAN A 250/15/20%/2500	DUAL CHOICE PPO PLAN A 250/15/20%/3000
KP PLUS PLAN B 500/20/10%/3000	DUAL CHOICE PPO PLAN B 500/20/10%/3500
KP PLUS PLAN B 500/10%/10%/2000	DUAL CHOICE PPO PLAN B 500/10%/10%/3000
KP PLUS PLAN B 500/10/20%/2000	DUAL CHOICE PPO PLAN B 500/10/20%/3000
KP PLUS PLAN B 500/20/20%/3000	DUAL CHOICE PPO PLAN B 500/20/20%/3500
KP PLUS PLAN C 750/20/20%/3250	DUAL CHOICE PPO PLAN C 750/20/20%/3500
KP PLUS PLAN C 750/20%/20%/3000	DUAL CHOICE PPO PLAN C 750/20%/20%/3500
KP PLUS PLAN D 1000/20/20%/3000	DUAL CHOICE PPO PLAN D 1000/20/20%/4000
KP PLUS PLAN D 1000/25/20%/4000	DUAL CHOICE PPO PLAN D 1000/25/20%/5000
KP PLUS PLAN E 1500/25/20%/5500	DUAL CHOICE PPO PLAN E 1500/25/20%/6000
KP PLUS PLAN E 1500/20/30%/4000	DUAL CHOICE PPO PLAN E 1500/20/30%/5000
KP PLUS PLAN F 2000/25/20%/5000	DUAL CHOICE PPO PLAN F 2000/25/20%/6000
KP PLUS PLAN G 2500/25/20%/5000	DUAL CHOICE PPO PLAN G 2500/25/20%/6000
KP PLUS PLAN G 2500/30/30%/5000	DUAL CHOICE PPO PLAN G 2500/30/30%/6000
KP PLUS PLAN H 3000/30/20%/7350	DUAL CHOICE PPO PLAN H 3000/30/20%/8150
KP PLUS PLAN H 3000/30%/30%/6000	DUAL CHOICE PPO PLAN H 3000/30%/30%/7000
KP PLUS PLAN I 3500/30/20%/7350	DUAL CHOICE PPO PLAN I 3500/30/20%/8000
KP PLUS PLAN J 4000/30/20%/7500	DUAL CHOICE PPO PLAN J 4000/30/20%/8150
KP PLUS PLAN J 4000/40/30%/7500	DUAL CHOICE PPO PLAN J 4000/40/30%/7500
KP PLUS PLAN K 5000/30/20%/8000	DUAL CHOICE PPO PLAN K 5000/30/20%/8500
KP PLUS PLAN L 6000/35/20%/8500	DUAL CHOICE PPO PLAN L 6000/35/20%/9000
KP PLUS PLAN L 6000/40/30%/9000	DUAL CHOICE PPO PLAN L 6000/40/30%/9000
KP PLUS PLAN M 7500/35/30%/10000	DUAL CHOICE PPO PLAN M 7500/35/30%/10000
KP Plus Everyday Care Plan \$4000	
KP Plus Everyday Care Plan \$5000	
KP Plus Everyday Care Plan \$6000	
KP Plus Everyday Care Plan \$7000	

Reset

Clear all plans selected

Complete Suite™ plans

The list below includes all plan offerings. Select a plan to navigate to the full list of benefits.

Plans selected: ☐

Compare plans

Dual Choice PPO	Out-of-Area PPO Plus
DUAL CHOICE PPO HDHP PLAN A 1700/10%/2500	PPO PLUS PLAN WDB 500/20%/2500
DUAL CHOICE PPO HDHP PLAN A 1700/20%/3500	PPO PLUS PLAN WDC 750/20%/3750
DUAL CHOICE PPO HDHP PLAN B 2000/20%/4000	PPO PLUS PLAN WDT 1000/20%/3000
DUAL CHOICE PPO HDHP PLAN B 2000/30%/4000	PPO PLUS PLAN WDE 1000/30%/4750
DUAL CHOICE PPO HDHP PLAN C 2500/20%/5000	PPO PLUS PLAN WDU 1500/20%/5500
DUAL CHOICE PPO HDHP PLAN C 2500/30%/5000	PPO PLUS PLAN WDP 1500/30%/6000
DUAL CHOICE PPO HDHP PLAN E 3400/10%/6000	PPO PLUS PLAN WDN 2000/30%/6000
DUAL CHOICE PPO HDHP PLAN E 3400/20%/6000	PPO PLUS PLAN WDX 3000/30%/6850
DUAL CHOICE PPO HDHP PLAN E 3400/30%/6400	PPO PLUS PLAN WDR 4000/30%/7500
DUAL CHOICE PPO HDHP PLAN F 3500/20%/7000	PPO PLUS PLAN WDS 5000/30%/7500
DUAL CHOICE PPO HDHP PLAN F 3500/30%/7000	PPO PLUS PLAN L 6000/35/20%/8000
DUAL CHOICE PPO HDHP PLAN G 4000/20%/8000	PPO PLUS PLAN M 7500/35/30%/9000
DUAL CHOICE PPO HDHP PLAN G 4000/30%/8000	PPO PLUS HDHP AA PLAN WFI 1700/20%/3500
DUAL CHOICE PPO HDHP PLAN H 5000/20%/8000	PPO PLUS HDHP AA PLAN WAS 2800/20%/4000
DUAL CHOICE PPO HDHP PLAN H 5000/30%/8000	PPO PLUS HDHP EE PLAN WAT 3400/20%/6000
DUAL CHOICE PPO HDHP PLAN H 5000/40%/8000	PPO PLUS HDHP EE PLAN 4000/20%/8000
	PPO PLUS HDHP EE PLAN 5000/20%/8000
	PPO PLUS HDHP EE PLAN 5000/30%/8000

Reset

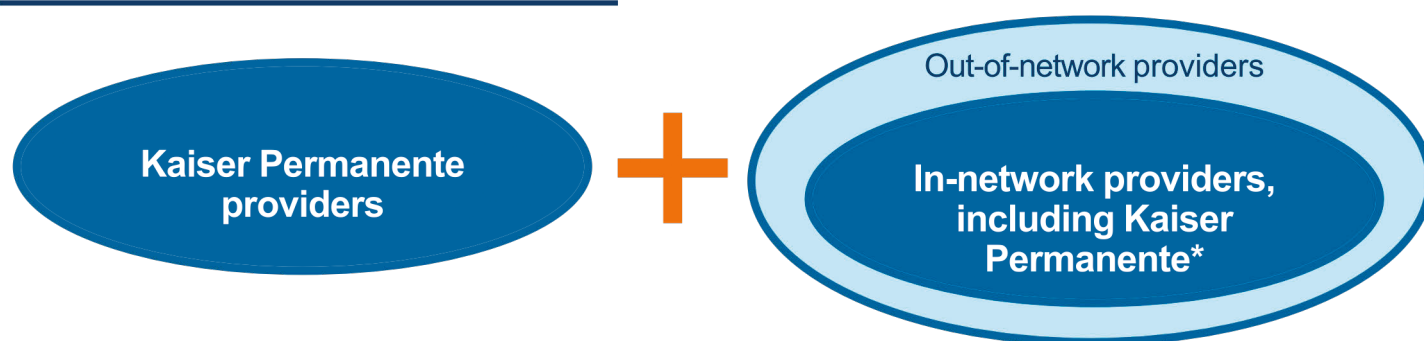
Clear all plans selected

Complete Suite™ plan pairings and plan comparisons

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

**Traditional copay, deductible, and HSA-qualified plans
(including Kaiser Permanente Plus™)**

Dual Choice PPO plans



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

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

*In states where Kaiser Permanente operates (CA, CO, GA, HI, MD, OR, VA, WA, and D.C.), members can get care from Heraya Health™ and First Choice Health providers in Oregon and Washington and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C. In all other states, members can visit Cigna PPO Network providers.

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

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

Accumulation types

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

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

Aggregate accumulation:

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

Embedded accumulation:

If there is at least one other member in your family, then you must each meet the member deductible/out-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.

COMPLETE SUITE™ PAIRING GUIDE

Traditional and deductible plans

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

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

 Green plans (†) indicate more economical pairing options.

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

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

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

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

Approved plan pairings include KP Plus versions of the traditional and deductible plans listed above.

COMPLETE SUITE™ PAIRING GUIDE

Traditional and deductible plans

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

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		DUAL CHOICE PPO PLANS									
		PPO PLAN A 250/10/10%/2500	PPO PLAN A 250/15/20%/3000	PPO PLAN B 500/20/10%/3500	PPO PLAN B 500/10%/10%/3000	PPO PLAN B 500/10/20%/3000	PPO PLAN B 500/20/20%/3500	PPO PLAN C 750/20/20%/3500	PPO PLAN C 750/20%/20%/3500	PPO PLAN D 1000/20/20%/4000	PPO PLAN D 1000/25/20%/5000
KAISER PERMANENTE PLUS™	DEDUCTIBLE PLANS	DED PLAN A 250/10/10%/2000	*	†	†						
		DED PLAN A 250/15/20%/2500		*	†		†				
		DED PLAN B 500/20/10%/3000			*	†	†	†			
		DED PLAN B 500/10%/10%/2000				*			†		
		DED PLAN B 500/10/20%/2000					*	†	†		
		DED PLAN B 500/20/20%/3000						*	†		
		DED PLAN C 750/20/20%/3250							*	†	†
		DED PLAN C 750/20%/20%/3000								*	†

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Only plans with Dual Choice PPO pairings are displayed.

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

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

Approved plan pairings include KP Plus versions of the traditional and deductible plans listed above.

COMPLETE SUITE™ PAIRING GUIDE

Traditional and deductible plans

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		DUAL CHOICE PPO PLANS							
		PPO PLAN D 1000/20/20%/4000	PPO PLAN D 1000/25/20%/5000	PPO PLAN E 1500/25/20%/6000	PPO PLAN E 1500/20/30%/4000	PPO PLAN F 2000/25/20%/5000	PPO PLAN G 2500/25/20%/5000	PPO PLAN G 2500/30/30%/5000	PPO PLAN H 3000/30/20%/8150
KAISER PERMANENTE PLUS™	DEDUCTIBLE PLANS	DED PLAN D 1000/20/20%/3000	*	†	†				
		DED PLAN D 1000/25/20%/4000		*	†				
		DED PLAN E 1500/25/20%/5500			*	†	†		
		DED PLAN E 1500/20/30%/4000				*	†	†	
		DED PLAN F 2000/25/20%/5000					*	†	
		DED PLAN G 2500/25/20%/5000						*	†
		DED PLAN G 2500/30/30%/5000							*

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge.

Only plans with Dual Choice PPO pairings are displayed.

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

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

Approved plan pairings include KP Plus versions of the traditional and deductible plans listed above.

COMPLETE SUITE™ PAIRING GUIDE

Traditional and deductible plans

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

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

		DUAL CHOICE PPO PLANS									
		PPO PLAN H 3000/30/20%/8150	PPO PLAN H 3000/30/30%/7000	PPO PLAN I 3500/30/20%/8000	PPO PLAN J 4000/30/20%/8150	DED PLAN J 4000/40/30%/7500	PPO PLAN K 5000/30/20%/8500	PPO PLAN L 6000/35/20%/9000	DED PLAN L 6000/40/30%/9000	PPO PLAN M 7500/35/30%/10000	
KAISER PERMANENTE PLUS™	DEDUCTIBLE PLANS	DED PLAN H 3000/30/20%/7350	*		†	†	†				
		DED PLAN H 3000/30/30%/6000		*	†						
		DED PLAN I 3500/30/20%/7350			*	†	†				
		DED PLAN J 4000/30/20%/7500				*	†	†	†		
		DED PLAN J 4000/40/30%/7500					*	†	†		
		DED PLAN K 5000/30/20%/8000						*	†	†	†
		DED PLAN L 6000/35/20%/8500							*	†	†
		DED PLAN L 6000/40/30%/9000								*	†
		DED PLAN M 7500/35/30%/10000									*

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

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

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


Approved plan pairings include KP Plus versions of the traditional and deductible plans listed above.

COMPLETE SUITE™ PAIRING GUIDE

High deductible plans

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

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

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

		DUAL CHOICE PPO PLANS								
		PPO HDHP PLAN A 1700/10%/2500	PPO HDHP PLAN A 1700/20%/3500	PPO HDHP PLAN B 2000/20%/4000	PPO HDHP PLAN B 2000/30%/4000	PPO HDHP PLAN C 2500/20%/5000	PPO HDHP PLAN C 2500/30%/5000	PPO HDHP PLAN E 3400/10%/6000	PPO HDHP PLAN E 3400/20%/6000	PPO HDHP PLAN E 3400/30%/6400
HIGH DEDUCTIBLE HEALTH PLANS	HDHP PLAN A 1700/10%/2500	*	†	†						
	HDHP PLAN A 1700/20%/3500		*	†						
	HDHP PLAN B 2000/20%/4000			*	†	†	†		†	
	HDHP PLAN B 2000/30%/4000				*		†			†

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

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

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

COMPLETE SUITE™ PAIRING GUIDE

High deductible plans

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

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

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		DUAL CHOICE PPO PLANS										
		PPO HDHP PLAN C 2500/20%/5000	PPO HDHP PLAN C 2500/30%/5000	PPO HDHP PLAN E 3400/10%/6000	PPO HDHP PLAN E 3400/20%/6000	PPO HDHP PLAN E 3400/30%/6400	PPO HDHP PLAN F 3500/20%/7000	PPO HDHP PLAN F 3500/30%/7000	PPO HDHP PLAN G 4000/20%/8000	PPO HDHP PLAN G 4000/30%/8000	PPO HDHP PLAN H 5000/20%/8000	PPO HDHP PLAN H 5000/30%/8000
HIGH DEDUCTIBLE HEALTH PLANS	HDHP PLAN C 2500/20%/5000	*	†	†	†	†	†					
	HDHP PLAN C 2500/30%/5000		*			†		†		†		
	HDHP PLAN E 3400/10%/6000			*	†	†	†	†	†			
	HDHP PLAN E 3400/20%/6000				*	†	†	†	†			
	HDHP PLAN E 3400/30%/6400					*		†		†		
	HDHP PLAN F 3500/20%/7000						*	†	†	†		
	HDHP PLAN F 3500/30%/7000							*		†		†

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

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

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

COMPLETE SUITE™ PAIRING GUIDE

High deductible plans

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

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

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

		DUAL CHOICE PPO PLANS				
		PPO HDHP PLAN G 4000/20%/8000	PPO HDHP PLAN G 4000/30%/8000	PPO HDHP PLAN H 5000/20%/8000	PPO HDHP PLAN H 5000/30%/8000	PPO HDHP PLAN H 5000/40%/8000
HIGH DEDUCTIBLE HEALTH PLANS	HDHP PLAN G 4000/20%/8000	*	†	†	†	
	HDHP PLAN G 4000/30%/8000		*		†	
	HDHP PLAN H 5000/20%/8000			*	†	†
	HDHP PLAN H 5000/30%/8000				*	†
	HDHP PLAN H 5000/40%/8000					*
	HDHP PLAN H 5000/50%/8000					†

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

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

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

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals.

[See plan comparisons](#)

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

[Reset](#)

TRADITIONAL					
Plan Name	TRAD PLAN A 10/1000	TRAD PLAN B 20/1500	TRAD PLAN C 20/2000	TRAD PLAN D 30/2500	TRAD PLAN E 35/3000
Annual Medical Deductible (IND/FAM) (per calendar year)	\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0
Annual out-of-pocket maximum (IND/FAM)	\$1,000/\$2,000	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$10*	\$5 for the first 3 visits; then \$20*	\$5 for the first 3 visits; then \$20*	\$5 for the first 3 visits; then \$30*	\$5 for the first 3 visits; then \$35*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$10*	\$5 for the first 3 visits; then \$20*	\$5 for the first 3 visits; then \$20*	\$5 for the first 3 visits; then \$30*	\$5 for the first 3 visits; then \$35*
Office visits – urgent care	\$30	\$40	\$40	\$50	\$60
Office visits – specialty care	\$20	\$30	\$30	\$40	\$45
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0*	\$0 for the first 3 visits; then \$0*	\$0 for the first 3 visits; then \$0*	\$0 for the first 3 visits; then \$0*	\$0 for the first 3 visits; then \$0*
Office visits – prenatal care	\$0	\$0	\$0	\$0	\$0
Outpatient surgery	\$50	\$50	\$50	\$100	\$150
X-ray/diagnostic tests	\$10	\$20	\$20	\$30	\$35
Lab	\$10	\$20	\$20	\$30	\$35
CT, MRI, and PET scans	\$50	\$50	\$50	\$50	\$50
Inpatient hospital care	\$100 per day; \$500 per admission	\$100 per day; \$500 per admission	\$200 per day; \$1,000 per admission	\$200 per day; \$1,000 per admission	\$800 per admission
Emergency department visits	\$150 ¹	\$150 ¹	\$250 ¹	\$250 ¹	\$250 ¹
Routine eye exam	\$10	\$20	\$20	\$30	\$35

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

¹Waive if admitted.

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

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

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[See plan comparisons](#)

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DEDUCTIBLE				
Plan Name	DED PLAN A 250/10/10%/2000	DED PLAN A 250/15/20%/2500	DED PLAN B 500/20/10%/3000	DED PLAN B 500/10%/10%/2000
Annual Medical Deductible (IND/FAM) (per calendar year)	\$250/\$750	\$250/\$750	\$500/\$1,500	\$500/\$1,500
Annual out-of-pocket maximum (IND/FAM)	\$2,000/\$6,000	\$2,500/\$7,500	\$3,000/\$6,000	\$2,000/\$6,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$15 ¹	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then 10%* ¹
Office visits – naturopathic care	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$15 ¹	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then 10%* ¹
Office visits – urgent care	\$10	\$35	\$40	10%*
Office visits – specialty care	\$10	\$25	\$30	10%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	10%*	20%*	10%*	10%*
X-ray/diagnostic tests	10%*	\$15	\$20	10%*
Lab	10%*	\$15	\$20	10%*
CT, MRI, and PET scans	10%*	\$100	\$100	10%*
Inpatient hospital care	10%*	20%*	10%*	10%*
Emergency department visits	\$250* ²	20%*	10%*	\$250* ²
Routine eye exam	\$10	\$15	\$20	10%*

*After deductible.

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

²Waive if admitted.

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

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DEDUCTIBLE				
Plan Name	DED PLAN B 500/10/20%/2000	DED PLAN B 500/20/20%/3000	DED PLAN C 750/20/20%/3250	DED PLAN C 750/20/20%/3000
Annual Medical Deductible (IND/FAM) (per calendar year)	\$500/\$1,500	\$500/\$1,500	\$750/\$2,250	\$750/\$2,250
Annual out-of-pocket maximum (IND/FAM)	\$2,000/\$6,000	\$3,000/\$9,000	\$3,250/\$9,750	\$3,000/\$9,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then 20%* ¹
Office visits – naturopathic care	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then 20%* ¹
Office visits – urgent care	\$10	\$40	\$40	20%*
Office visits – specialty care	\$10	\$30	\$30	20%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	20%*	20%*	20%*
X-ray/diagnostic tests	20%*	\$20	\$20	20%*
Lab	20%*	\$20	\$20	20%*
CT, MRI, and PET scans	20%*	\$100	\$100	20%*
Inpatient hospital care	20%*	20%*	20%*	20%*
Emergency department visits	\$250* ²	20%*	20%*	\$250* ²
Routine eye exam	\$10	\$20	\$20	20%*

*After deductible.

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DEDUCTIBLE				
Plan Name	DED PLAN D 1000/20/20%/3000	DED PLAN D 1000/25/20%/4000	DED PLAN E 1500/25/20%/5500	DED PLAN E 1500/20/30%/4000
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,000/\$3,000	\$1,000/\$3,000	\$1,500/\$4,500	\$1,500/\$4,500
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	\$4,000/\$12,000	\$5,500/\$11,000	\$4,000/\$12,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$20 ¹
Office visits – naturopathic care	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$20 ¹
Office visits – urgent care	\$20	\$45	\$45	\$20
Office visits – specialty care	\$20	\$35	\$35	\$20
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	20%*	20%*	30%*
X-ray/diagnostic tests	20%*	\$25	\$25	30%*
Lab	20%*	\$25	\$25	30%*
CT, MRI, and PET scans	20%*	\$100	\$100	30%*
Inpatient hospital care	20%*	20%*	20%*	30%*
Emergency department visits	\$250* ²	20%*	20%*	\$250* ²
Routine eye exam	\$20	\$25	\$25	\$20

*After deductible.

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

²Waive if admitted.

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DEDUCTIBLE				
Plan Name	DED PLAN F 2000/25/20%/5000	DED PLAN G 2500/25/20%/5000	DED PLAN G 2500/30/30%/5000	DED PLAN H 3000/30/20%/7350
Annual Medical Deductible (IND/FAM) (per calendar year)	\$2,000/\$6,000	\$2,500/\$7,500	\$2,500/\$5,000	\$3,000/\$9,000
Annual out-of-pocket maximum (IND/FAM)	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000	\$7,350/\$14,700
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$30 ¹	\$5 for the first 3 visits; then \$30 ¹
Office visits – naturopathic care	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$30 ¹	\$5 for the first 3 visits; then \$30 ¹
Office visits – urgent care	\$45	\$45	\$30	\$50
Office visits – specialty care	\$35	\$35	\$30	\$40
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	20%*	30%*	20%*
X-ray/diagnostic tests	\$25	\$25	30%*	\$30
Lab	\$25	\$25	30%*	\$30
CT, MRI, and PET scans	\$100	\$100	30%*	\$100
Inpatient hospital care	20%*	20%*	30%*	20%*
Emergency department visits	20%*	20%*	\$250* ²	20%*
Routine eye exam	\$25	\$25	\$30	\$30

*After deductible.

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

²Waive if admitted.

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DEDUCTIBLE

Plan Name	DED PLAN H 3000/30%/30%/6000	DED PLAN I 3500/30/20%/7350	DED PLAN J 4000/30/20%/7500	DED PLAN J 4000/40/30%/7500
Annual Medical Deductible (IND/FAM) (per calendar year)	\$3,000/\$6,000	\$3,500/\$10,500	\$4,000/\$10,000	\$4,000/\$8,000
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$7,350/\$14,700	\$7,500/\$15,000	\$7,500/\$15,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then 30%* ¹	\$5 for the first 3 visits; then \$30 ¹	\$5 for the first 3 visits; then \$30 ¹	\$5 for the first 3 visits; then \$40 ¹
Office visits – naturopathic care	\$5 for the first 3 visits; then 30%* ¹	\$5 for the first 3 visits; then \$30 ¹	\$5 for the first 3 visits; then \$30 ¹	\$5 for the first 3 visits; then \$40 ¹
Office visits – urgent care	30%*	\$50	\$50	\$40
Office visits – specialty care	30%*	\$40	\$40	\$40
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	30%*	20%*	20%*	30%*
X-ray/diagnostic tests	30%*	\$30	\$30	30%*
Lab	30%*	\$30	\$30	30%*
CT, MRI, and PET scans	30%*	\$100	\$100	30%*
Inpatient hospital care	30%*	20%*	20%*	30%*
Emergency department visits	\$250* ²	20%*	20%*	\$300* ²
Routine eye exam	30%*	\$30	\$30	\$40

*After deductible.

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DEDUCTIBLE				
Plan Name	DED PLAN K 5000/30/20%/8000	DED PLAN L 6000/35/20%/8500	DED PLAN L 6000/40/30%/9000	DED PLAN M 7500/35/30%/10000
Annual Medical Deductible (IND/FAM) (per calendar year)	\$5,000/\$10,000	\$6,000/\$12,000	\$6,000/\$12,000	\$7,500/\$14,500
Annual out-of-pocket maximum (IND/FAM)	\$8,000/\$16,000	\$8,500/\$17,000	\$9,000/\$18,000	\$10,000/\$20,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$30 ¹	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$40 ¹	\$5 for the first 3 visits; then \$35 ¹
Office visits – naturopathic care	\$5 for the first 3 visits; then \$30 ¹	\$5 for the first 3 visits; then \$35 ¹	\$5 for the first 3 visits; then \$40 ¹	\$5 for the first 3 visits; then \$35 ¹
Office visits – urgent care	\$50	\$55	\$40	\$55
Office visits – specialty care	\$40	\$45	\$40	\$45
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	20%*	30%*	30%*
X-ray/diagnostic tests	\$30	\$35	30%*	\$35
Lab	\$30	\$35	30%*	\$35
CT, MRI, and PET scans	\$100	\$150	30%*	\$150
Inpatient hospital care	20%*	20%*	30%*	30%*
Emergency department visits	20%*	20%*	\$300* ²	30%*
Routine eye exam	\$30	\$35	\$40	\$35

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DEDUCTIBLE EVERYDAY CARE

Plan Name	DED Everyday Care Plan \$4000	DED Everyday Care Plan \$5000	DED Everyday Care Plan \$6000	DED Everyday Care Plan \$7000
Annual Medical Deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$7,000/\$14,000
Annual out-of-pocket maximum (IND/FAM)	\$4,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$7,000/\$14,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$0	\$0	\$0	\$0
Office visits – naturopathic care	\$0	\$0	\$0	\$0
Office visits – urgent care	\$0	\$0	\$0	\$0
Office visits – specialty care	\$0	\$0	\$0	\$0
Telehealth (phone/video)	\$0 ¹	\$0 ¹	\$0 ¹	\$0 ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	0%*	0%*	0%*	0%*
X-ray/diagnostic tests	\$50	\$50	\$50	\$50
Lab	\$0	\$0	\$0	\$0
CT, MRI, and PET scans	\$500	\$500	\$500	\$500
Inpatient hospital care	0%*	0%*	0%*	0%*
Emergency department visits	\$500 ²	\$500 ²	\$500 ²	\$500 ²
Routine eye exam	\$0	\$0	\$0	\$0
Outpatient prescription drugs	\$0 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$0 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$0 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$0 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty

*After deductible.

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DEDUCTIBLE EVERYDAY CARE

Plan Name	DED Everyday Care Plan \$10/\$4000	DED Everyday Care Plan \$10/\$5000	DED Everyday Care Plan \$10/\$6000	DED Everyday Care Plan \$10/\$7000
Annual Medical Deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$7,000/\$14,000
Annual out-of-pocket maximum (IND/FAM)	\$4,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$7,000/\$14,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$10 ¹
Office visits – naturopathic care	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$10 ¹	\$5 for the first 3 visits; then \$10 ¹
Office visits – urgent care	\$10	\$10	\$10	\$10
Office visits – specialty care	\$10	\$10	\$10	\$10
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹	\$0 for the first 3 visits; then \$0 ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	0%*	0%*	0%*	0%*
X-ray/diagnostic tests	\$50	\$50	\$50	\$50
Lab	\$10	\$10	\$10	\$10
CT, MRI, and PET scans	\$500	\$500	\$500	\$500
Inpatient hospital care	0%*	0%*	0%*	0%*
Emergency department visits	\$500 ²	\$500 ²	\$500 ²	\$500 ²
Routine eye exam	\$10	\$10	\$10	\$10
Outpatient prescription drugs	\$10 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$10 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$10 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$10 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty

*After deductible.

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HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	HDHP PLAN A 1700/10%/2500	HDHP PLAN A 1700/20%/3500	HDHP PLAN B 2000/20%/4000	HDHP PLAN B 2000/30%/4000
Accumulation type	Aggregate	Aggregate	Aggregate	Aggregate
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,700/\$3,400	\$1,700/\$3,400	\$2,000/\$4,000	\$2,000/\$4,000
Annual out-of-pocket maximum (IND/FAM)	\$2,500/\$5,000	\$3,500/\$7,000	\$4,000/\$8,000	\$4,000/\$8,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5* for the first 3 visits; then 10%* ¹	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 30%* ¹
Office visits – naturopathic care	\$5* for the first 3 visits; then 10%* ¹	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 30%* ¹
Office visits – urgent care	10%*	20%*	20%*	30%*
Office visits – specialty care	10%*	20%*	20%*	30%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	10%*	20%*	20%*	30%*
X-ray/diagnostic tests	10%*	20%*	20%*	30%*
Lab	10%*	20%*	20%*	30%*
CT, MRI, and PET scans	10%*	20%*	20%*	30%*
Inpatient hospital care	10%*	20%*	20%*	30%*
Emergency department visits	10%*	20%*	20%*	30%*
Routine eye exam	10%*	20%*	20%*	30%*

*After deductible.

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

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HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	HDHP PLAN C 2500/20%/5000	HDHP PLAN C 2500/30%/5000	HDHP PLAN E 3400/10%/6000	HDHP PLAN E 3400/20%/6000
Accumulation type	Aggregate	Aggregate	Embedded	Embedded
Annual Medical Deductible (IND/FAM) (per calendar year)	\$2,500/5,000	\$2,500/\$5,000	\$3,400/\$6,800	\$3,400/\$6,800
Annual out-of-pocket maximum (IND/FAM)	\$5,000/\$7,500	\$5,000/\$7,500	\$6,000/\$9,000	\$6,000/\$12,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 30%* ¹	\$5* for the first 3 visits; then 10%* ¹	\$5* for the first 3 visits; then 20%* ¹
Office visits – naturopathic care	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 30%* ¹	\$5* for the first 3 visits; then 10%* ¹	\$5* for the first 3 visits; then 20%* ¹
Office visits – urgent care	20%*	30%*	10%*	20%*
Office visits – specialty care	20%*	30%*	10%*	20%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	30%*	10%*	20%*
X-ray/diagnostic tests	20%*	30%*	10%*	20%*
Lab	20%*	30%*	10%*	20%*
CT, MRI, and PET scans	20%*	30%*	10%*	20%*
Inpatient hospital care	20%*	30%*	10%*	20%*
Emergency department visits	20%*	30%*	10%*	20%*
Routine eye exam	20%*	30%*	10%*	20%*

*After deductible.

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

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HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	HDHP PLAN E 3400/30%/6400	HDHP PLAN F 3500/30%/7000	HDHP PLAN F 3500/20%/7000	HDHP PLAN G 4000/20%/8000
Accumulation type	Embedded	Embedded	Embedded	Embedded
Annual Medical Deductible (IND/FAM) (per calendar year)	\$3,400/\$6,800	\$3,500/\$7,000	\$3,500/\$7,000	\$4,000/\$8,000
Annual out-of-pocket maximum (IND/FAM)	\$6,400/\$12,800	\$7,000/\$14,000	\$7,000/\$14,000	\$8,000/\$16,000
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5* for the first 3 visits; then 30%* ¹	\$5* for the first 3 visits; then 30%* ¹	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 20%* ¹
Office visits – naturopathic care	\$5* for the first 3 visits; then 30%* ¹	\$5* for the first 3 visits; then 30%* ¹	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 20%* ¹
Office visits – urgent care	30%*	30%*	20%*	20%*
Office visits – specialty care	30%*	30%*	20%*	20%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	30%*	30%*	20%*	20%*
X-ray/diagnostic tests	30%*	30%*	20%*	20%*
Lab	30%*	30%*	20%*	20%*
CT, MRI, and PET scans	30%*	30%*	20%*	20%*
Inpatient hospital care	30%*	30%*	20%*	20%*
Emergency department visits	30%*	30%*	20%*	20%*
Routine eye exam	30%*	30%*	20%*	20%*

*After deductible.

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

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HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	HDHP PLAN G 4000/30%/8000	HDHP PLAN H 5000/20%/8000	HDHP PLAN H 5000/30%/8000
Accumulation type	Embedded	Embedded	Embedded
Annual Medical Deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	\$5,000/\$10,000	\$5,000/\$10,000
Annual out-of-pocket maximum (IND/FAM)	\$8,000/\$16,000	\$8,000/\$16,000	\$8,000/\$16,000
Office visits – preventive and well-child care	\$0	\$0	\$0
Office visits – primary care/mental health	\$5* for the first 3 visits; then 30%* ¹	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 30%* ¹
Office visits – naturopathic care	\$5* for the first 3 visits; then 30%* ¹	\$5* for the first 3 visits; then 20%* ¹	\$5* for the first 3 visits; then 30%* ¹
Office visits – urgent care	30%*	20%*	30%*
Office visits – specialty care	30%*	20%*	30%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹
Office visits – prenatal care	\$0	\$0	\$0
Outpatient surgery	30%*	20%*	30%*
X-ray/diagnostic tests	30%*	20%*	30%*
Lab	30%*	20%*	30%*
CT, MRI, and PET scans	30%*	20%*	30%*
Inpatient hospital care	30%*	20%*	30%*
Emergency department visits	30%*	20%*	30%*
Routine eye exam	30%*	20%*	30%*

*After deductible.

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

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HIGH DEDUCTIBLE HEALTH PLAN

Plan Name	HDHP PLAN H 5000/40%/8000	HDHP PLAN H 5000/50%/8000
Accumulation type	Embedded	Embedded
Annual Medical Deductible (IND/FAM) (per calendar year)	\$5,000/\$10,000	\$5,000/\$10,000
Annual out-of-pocket maximum (IND/FAM)	\$8,000/\$16,000	\$8,000/\$16,000
Office visits – preventive and well-child care	\$0	\$0
Office visits – primary care/mental health	\$5* for the first 3 visits; then 40%* ¹	\$5* for the first 3 visits; then 50%* ¹
Office visits – naturopathic care	\$5* for the first 3 visits; then 40%* ¹	\$5* for the first 3 visits; then 50%* ¹
Office visits – urgent care	40%*	50%*
Office visits – specialty care	40%*	50%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	0%* for the first 3 visits; then 0%* ¹
Office visits – prenatal care	\$0	\$0
Outpatient surgery	40%*	50%*
X-ray/diagnostic tests	40%*	50%*
Lab	40%*	50%*
CT, MRI, and PET scans	40%*	50%*
Inpatient hospital care	40%*	50%*
Emergency department visits	40%*	50%*
Routine eye exam	40%*	50%*

*After deductible.

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

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KP PLUS PLANS

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

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

KP Plus Benefit Design Summary

Limited to 10 medical services and 5 pharmacy fills per year out-of-network

In-Network Coverage	Out-of-Network Coverage
Medical Visits PCP Office Visit Specialty Office Visit Outpatient Mental Health and Substance Use Disorder Services Physical Therapy, Occupational Therapy, Speech Therapy, and Labs/X-Rays	\$20 higher copay (or 10% higher coinsurance) than in-network Plans include 10 out-of-network services per member, per year, combined, including preventive care, outpatient medical services, lab, and radiology.
Pharmacy Fills Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty Kaiser Permanente mail-order pharmacy: 90-day supply for 2 copays	\$20 higher copay (or 10% higher coinsurance) than in-network Plans include up to 5 out-of-network prescription fills per year. Each prescription fill can be for up to a 90-day supply. You may be asked to pay the full cost for out-of-network prescriptions and submit a claim for reimbursement. Mail-order pharmacy is not covered out-of-network
Hospital Inpatient Outpatient surgery Skilled nursing facilities Maternity care	Not covered out-of-network

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[See plan comparisons](#)

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KP PLUS				
Plan name	KP PLUS PLAN A 10/1000		KP PLUS PLAN B 20/1500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$0/\$0	N/A	\$0/\$0	N/A
Annual out-of-pocket maximum (IND/FAM)	\$1,000/\$2,000	N/A	\$1,500/\$3,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$10 ¹	\$30	\$5 for the first 3 visits; then \$20 ¹	\$40
Office visits – naturopathic care	\$5 for the first 3 visits; then \$10 ¹	\$30	\$5 for the first 3 visits; then \$20 ¹	\$40
Office visits – urgent care	\$30	Not covered, except for services received outside the service area ^{2,3}	\$40	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$20	\$40	\$30	\$50
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$30	\$0 for the first 3 visits; then \$0 ¹	\$40
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	\$50	Not covered	\$50	Not covered
X-ray/diagnostic tests	\$10	\$30	\$20	\$40
Lab	\$10	\$30	\$20	\$40
CT, MRI, and PET scans	\$50	Not covered	\$50	Not covered
Inpatient hospital care	\$100 per day; \$500 per admission	Not covered	\$100 per day; \$500 per admission	Not covered
Emergency department visits	\$150 ⁴	Covered at the in-network cost share ²	\$150 ⁴	Covered at the in-network cost share ²
Routine eye exam	\$10	\$30	\$20	\$40
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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⁴Waive if admitted.

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KP PLUS				
Plan name	KP PLUS PLAN C 20/2000		KP PLUS PLAN D 30/2500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$0/\$0	N/A	\$0/\$0	N/A
Annual out-of-pocket maximum (IND/FAM)	\$2,000/\$4,000	N/A	\$2,500/\$5,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$20 ¹	\$40	\$5 for the first 3 visits; then \$30 ¹	\$50
Office visits – naturopathic care	\$5 for the first 3 visits; then \$20 ¹	\$40	\$5 for the first 3 visits; then \$30 ¹	\$50
Office visits – urgent care	\$40	Not covered, except for services received outside the service area ^{2,3}	\$50	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$30	\$50	\$40	\$60
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$40	\$0 for the first 3 visits; then \$0 ¹	\$50
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	\$50	Not covered	\$100	Not covered
X-ray/diagnostic tests	\$20	\$40	\$30	\$50
Lab	\$20	\$40	\$30	\$50
CT, MRI, and PET scans	\$50	Not covered	\$50	Not covered
Inpatient hospital care	\$200 per day; \$1,000 per admission	Not covered	\$200 per day; \$1,000 per admission	Not covered
Emergency department visits	\$250 ⁴	Covered at the in-network cost share ²	\$250 ⁴	Covered at the in-network cost share ²
Routine eye exam	\$20	\$40	\$30	\$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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KP PLUS

Plan name	KP PLUS PLAN E 35/3000		KP PLUS PLAN A 250/10/10%/2000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$0/\$0	N/A	\$250/\$750	N/A
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$6,000	N/A	\$2,000/\$6,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$35 ¹	\$55	\$5 for the first 3 visits; then \$10 ¹	\$30
Office visits – naturopathic care	\$5 for the first 3 visits; then \$35 ¹	\$55	\$5 for the first 3 visits; then \$10 ¹	\$30
Office visits – urgent care	\$60	Not covered, except for services received outside the service area ^{2,3}	\$10	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$45	\$65	\$10	\$30
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$55	\$0 for the first 3 visits; then \$0 ¹	\$30
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	\$150	Not covered	10%*	Not covered
X-ray/diagnostic tests	\$35	\$55	10%*	20%
Lab	\$35	\$55	10%*	20%
CT, MRI, and PET scans	\$50	Not covered	10%*	Not covered
Inpatient hospital care	\$800 per admission	Not covered	10%*	Not covered
Emergency department visits	\$250 ⁴	Covered at the in-network cost share ²	\$250* ⁴	Covered at the in-network cost share ²
Routine eye exam	\$35	\$55	\$10	\$30
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

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KP PLUS				
Plan name	KP PLUS PLAN A 250/15/20%/2500		KP PLUS PLAN B 500/20/10%/3000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$250/\$750	N/A	\$500/\$1,500	N/A
Annual out-of-pocket maximum (IND/FAM)	\$2,500/\$7,500	N/A	\$3,000/\$6,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$15 ¹	\$35	\$5 for the first 3 visits; then \$20 ¹	\$40
Office visits – naturopathic care	\$5 for the first 3 visits; then \$15 ¹	\$35	\$5 for the first 3 visits; then \$20 ¹	\$40
Office visits – urgent care	\$35	Not covered, except for services received outside the service area ^{2,3}	\$40	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$25	\$45	\$30	\$50
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$35	\$0 for the first 3 visits; then \$0 ¹	\$40
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	Not covered	10%*	Not covered
X-ray/diagnostic tests	\$15	\$35	\$20	\$40
Lab	\$15	\$35	\$20	\$40
CT, MRI, and PET scans	\$100	Not covered	\$100	Not covered
Inpatient hospital care	20%*	Not covered	10%*	Not covered
Emergency department visits	20%*	Covered at the in-network cost share ²	10%*	Covered at the in-network cost share ²
Routine eye exam	\$15	\$35	\$20	\$40
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

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KP PLUS

Plan name	KP PLUS PLAN B 500/10%/10%/2000		KP PLUS PLAN B 500/10/20%/2000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$500/\$1,500	N/A	\$500/\$1,500	N/A
Annual out-of-pocket maximum (IND/FAM)	\$2,000/\$6,000	N/A	\$2,000/\$6,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then 10%* ¹	20%	\$5 for the first 3 visits; then \$10 ¹	\$30
Office visits – naturopathic care	\$5 for the first 3 visits; then 10%* ¹	20%	\$5 for the first 3 visits; then \$10 ¹	\$30
Office visits – urgent care	10%*	Not covered, except for services received outside the service area ^{2,3}	\$10	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	10%*	20%	\$10	\$30
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	20%	\$0 for the first 3 visits; then \$0 ¹	\$30
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	10%*	Not covered	20%*	Not covered
X-ray/diagnostic tests	10%*	20%	20%*	30%
Lab	10%*	20%	20%*	30%
CT, MRI, and PET scans	10%*	Not covered	20%*	Not covered
Inpatient hospital care	10%*	Not covered	20%*	Not covered
Emergency department visits	\$250* ⁴	Covered at the in-network cost share ²	\$250* ⁴	Covered at the in-network cost share ²
Routine eye exam	10%*	20%	\$10	\$30
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

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KP PLUS				
Plan name	KP PLUS PLAN B 500/20/20%/3000		KP PLUS PLAN C 750/20/20%/3250	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$500/\$1,500	N/A	\$750/\$2,250	N/A
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	N/A	\$3,250/\$9,750	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$20 ¹	\$40	\$5 for the first 3 visits; then \$20 ¹	\$40
Office visits – naturopathic care	\$5 for the first 3 visits; then \$20 ¹	\$40	\$5 for the first 3 visits; then \$20 ¹	\$40
Office visits – urgent care	\$40	Not covered, except for services received outside the service area ^{2,3}	\$40	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$30	\$50	\$30	\$50
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$40	\$0 for the first 3 visits; then \$0 ¹	\$40
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	Not covered	20%*	Not covered
X-ray/diagnostic tests	\$20	\$40	\$20	\$40
Lab	\$20	\$40	\$20	\$40
CT, MRI, and PET scans	\$100	Not covered	\$100	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency department visits	20%*	Covered at the in-network cost share ²	20%*	Covered at the in-network cost share ²
Routine eye exam	\$20	\$40	\$20	\$40
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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

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KP PLUS				
Plan name	KP PLUS PLAN C 750/20%/20%/3000		KP PLUS PLAN D 1000/20/20%/3000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$750/\$2,250	N/A	\$1,000/\$3,000	N/A
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	N/A	\$3,000/\$9,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then 20%* ¹	30%	\$5 for the first 3 visits; then \$20 ¹	\$40
Office visits – naturopathic care	\$5 for the first 3 visits; then 20%* ¹	30%	\$5 for the first 3 visits; then \$20 ¹	\$40
Office visits – urgent care	20%*	Not covered, except for services received outside the service area ^{2,3}	\$20	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	20%*	30%	\$20	\$40
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	30%	\$0 for the first 3 visits; then \$0 ¹	\$40
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	Not covered	20%*	Not covered
X-ray/diagnostic tests	20%*	30%	20%*	30%
Lab	20%*	30%	20%*	30%
CT, MRI, and PET scans	20%*	Not covered	20%*	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency department visits	\$250* ⁴	Covered at the in-network cost share ²	\$250* ⁴	Covered at the in-network cost share ²
Routine eye exam	20%*	30%	\$20	\$40
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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KP PLUS				
Plan name	KP PLUS PLAN D 1000/25/20%/4000		KP PLUS PLAN E 1500/25/20%/5500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,000/\$3,000	N/A	\$1,500/\$4,500	N/A
Annual out-of-pocket maximum (IND/FAM)	\$4,000/\$12,000	N/A	\$5,500/\$11,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$25 ¹	\$45	\$5 for the first 3 visits; then \$25 ¹	\$45
Office visits – naturopathic care	\$5 for the first 3 visits; then \$25 ¹	\$45	\$5 for the first 3 visits; then \$25 ¹	\$45
Office visits – urgent care	\$45	Not covered, except for services received outside the service area ^{2,3}	\$45	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$35	\$55	\$35	\$55
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$45	\$0 for the first 3 visits; then \$0 ¹	\$45
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	Not covered	20%*	Not covered
X-ray/diagnostic tests	\$25	\$45	\$25	\$45
Lab	\$25	\$45	\$25	\$45
CT, MRI, and PET scans	\$100	Not covered	\$100	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency department visits	20%*	Covered at the in-network cost share ²	20%*	Covered at the in-network cost share ²
Routine eye exam	\$25	\$45	\$25	\$45
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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KP PLUS				
Plan name	KP PLUS PLAN E 1500/20/30%/4000		KP PLUS PLAN F 2000/25/20%/5000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,500/\$4,500	N/A	\$2,000/\$6,000	N/A
Annual out-of-pocket maximum (IND/FAM)	\$4,000/\$12,000	N/A	\$5,000/\$10,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$20 ¹	\$40	\$5 for the first 3 visits; then \$25 ¹	\$45
Office visits – naturopathic care	\$5 for the first 3 visits; then \$20 ¹	\$40	\$5 for the first 3 visits; then \$25 ¹	\$45
Office visits – urgent care	\$20	Not covered, except for services received outside the service area ^{2,3}	\$45	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$20	\$40	\$35	\$55
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$40	\$0 for the first 3 visits; then \$0 ¹	\$45
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	30%*	Not covered	20%*	Not covered
X-ray/diagnostic tests	30%*	40%	\$25	\$45
Lab	30%*	40%	\$25	\$45
CT, MRI, and PET scans	30%*	Not covered	\$100	Not covered
Inpatient hospital care	30%*	Not covered	20%*	Not covered
Emergency department visits	\$250* ⁴	Covered at the in-network cost share ²	20%*	Covered at the in-network cost share ²
Routine eye exam	\$20	\$40	\$25	\$45
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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KP PLUS				
Plan name	KP PLUS PLAN G 2500/25/20%/5000		KP PLUS PLAN G 2500/30/30%/5000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$2,500/\$7,500	N/A	\$2,500/\$5,000	N/A
Annual out-of-pocket maximum (IND/FAM)	\$5,000/\$10,000	N/A	\$5,000/\$10,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$25 ¹	\$45	\$5 for the first 3 visits; then \$30 ¹	\$50
Office visits – naturopathic care	\$5 for the first 3 visits; then \$25 ¹	\$45	\$5 for the first 3 visits; then \$30 ¹	\$50
Office visits – urgent care	\$45	Not covered, except for services received outside the service area ^{2,3}	\$30	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$35	\$55	\$30	\$50
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$45	\$0 for the first 3 visits; then \$0 ¹	\$50
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	Not covered	30%*	Not covered
X-ray/diagnostic tests	\$25	\$45	30%*	40%
Lab	\$25	\$45	30%*	40%
CT, MRI, and PET scans	\$100	Not covered	30%*	Not covered
Inpatient hospital care	20%*	Not covered	30%*	Not covered
Emergency department visits	20%*	Covered at the in-network cost share ²	\$250* ⁴	Covered at the in-network cost share ²
Routine eye exam	\$25	\$45	\$30	\$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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KP PLUS				
Plan name	KP PLUS PLAN H 3000/30/20%/7350		KP PLUS PLAN H 3000/30%/30%/6000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$3,000/\$9,000	N/A	\$3,000/\$6,000	N/A
Annual out-of-pocket maximum (IND/FAM)	\$7,350/\$14,700	N/A	\$6,000/\$12,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$30 ¹	\$50	\$5 for the first 3 visits; then 30%* ¹	40%
Office visits – naturopathic care	\$5 for the first 3 visits; then \$30 ¹	\$50	\$5 for the first 3 visits; then 30%* ¹	40%
Office visits – urgent care	\$50	Not covered, except for services received outside the service area ^{2,3}	30%*	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$40	\$60	30%*	40%
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$50	\$0 for the first 3 visits; then \$0 ¹	40%
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	Not covered	30%*	Not covered
X-ray/diagnostic tests	\$30	\$50	30%*	40%
Lab	\$30	\$50	30%*	40%
CT, MRI, and PET scans	\$100	Not covered	30%*	Not covered
Inpatient hospital care	20%*	Not covered	30%*	Not covered
Emergency department visits	20%*	Covered at the in-network cost share ²	\$250* ⁴	Covered at the in-network cost share ²
Routine eye exam	\$30	\$50	30%*	40%
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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KP PLUS				
Plan name	KP PLUS PLAN I 3500/30/20%/7350		KP PLUS PLAN J 4000/30/20%/7500	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$3,500/\$10,500	N/A	\$4,000/\$10,000	N/A
Annual out-of-pocket maximum (IND/FAM)	\$7,350/\$14,700	N/A	\$7,500/\$15,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$30 ¹	\$50	\$5 for the first 3 visits; then \$30 ¹	\$50
Office visits – naturopathic care	\$5 for the first 3 visits; then \$30 ¹	\$50	\$5 for the first 3 visits; then \$30 ¹	\$50
Office visits – urgent care	\$50	Not covered, except for services received outside the service area ^{2,3}	\$50	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$40	\$60	\$40	\$60
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$50	\$0 for the first 3 visits; then \$0 ¹	\$50
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	Not covered	20%*	Not covered
X-ray/diagnostic tests	\$30	\$50	\$30	\$50
Lab	\$30	\$50	\$30	\$50
CT, MRI, and PET scans	\$100	Not covered	\$100	Not covered
Inpatient hospital care	20%*	Not covered	20%*	Not covered
Emergency department visits	20%*	Covered at the in-network cost share ²	20%*	Covered at the in-network cost share ²
Routine eye exam	\$30	\$50	\$30	\$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

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KP PLUS				
Plan name	KP PLUS PLAN J 4000/40/30%/7500		KP PLUS PLAN K 5000/30/20%/8000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	N/A	\$5,000/\$10,000	N/A
Annual out-of-pocket maximum (IND/FAM)	\$7,500/\$15,000	N/A	\$8,000/\$16,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$40 ¹	\$60	\$5 for the first 3 visits; then \$30 ¹	\$50
Office visits – naturopathic care	\$5 for the first 3 visits; then \$40 ¹	\$60	\$5 for the first 3 visits; then \$30 ¹	\$50
Office visits – urgent care	\$40	Not covered, except for services received outside the service area ^{2,3}	\$50	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$40	\$60	\$40	\$60
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$60	\$0 for the first 3 visits; then \$0 ¹	\$50
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	30%*	Not covered	20%*	Not covered
X-ray/diagnostic tests	30%*	40%	\$30	\$50
Lab	30%*	40%	\$30	\$50
CT, MRI, and PET scans	30%*	Not covered	\$100	Not covered
Inpatient hospital care	30%*	Not covered	20%*	Not covered
Emergency department visits	\$300* ⁴	Covered at the in-network cost share ²	20%*	Covered at the in-network cost share ²
Routine eye exam	\$40	\$60	\$30	\$50
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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KP PLUS				
Plan name	KP PLUS PLAN L 6000/35/20%/8500		KP PLUS PLAN L 6000/40/30%/9000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$6,000/\$12,000	N/A	\$6,000/\$12,000	N/A
Annual out-of-pocket maximum (IND/FAM)	\$8,500/\$17,000	N/A	\$9,000/\$18,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$35 ¹	\$55	\$5 for the first 3 visits; then \$40 ¹	\$60
Office visits – naturopathic care	\$5 for the first 3 visits; then \$35 ¹	\$55	\$5 for the first 3 visits; then \$40 ¹	\$60
Office visits – urgent care	\$55	Not covered, except for services received outside the service area ^{2,3}	\$40	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$45	\$65	\$40	\$60
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$55	\$0 for the first 3 visits; then \$0 ¹	\$60
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	20%*	Not covered	30%*	Not covered
X-ray/diagnostic tests	\$35	\$55	30%*	40%
Lab	\$35	\$55	30%*	40%
CT, MRI, and PET scans	\$150	Not covered	30%*	Not covered
Inpatient hospital care	20%*	Not covered	30%*	Not covered
Emergency department visits	20%*	Covered at the in-network cost share ²	\$300* ⁴	Covered at the in-network cost share ²
Routine eye exam	\$35	\$55	\$40	\$60
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.		A pharmacy rider must be purchased with all KP Plus plans.	

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KP PLUS		
Plan name	KP PLUS PLAN M 7500/35/30%/10000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$7,500/\$14,500	N/A
Annual out-of-pocket maximum (IND/FAM)	\$10,000/\$20,000	N/A
Office visits – preventive and well-child care	\$0	\$0
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$35 ¹	\$55
Office visits – naturopathic care	\$5 for the first 3 visits; then \$35 ¹	\$55
Office visits – urgent care	\$55	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$45	\$65
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	\$55
Office visits – prenatal care	\$0	\$0
Outpatient surgery	30%*	Not covered
X-ray/diagnostic tests	\$35	\$55
Lab	\$35	\$55
CT, MRI, and PET scans	\$150	Not covered
Inpatient hospital care	30%*	Not covered
Emergency department visits	30%*	Covered at the in-network cost share ²
Routine eye exam	\$35	\$55
Outpatient prescription drugs	In-network	Out-of-network (limited to 5 prescription fills per year)
	A pharmacy rider must be purchased with all KP Plus plans.	

*After deductible.

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

²The limit of 10 covered services does not apply.

³If 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 and that the services could not be delayed until returning to the Kaiser Permanente service area.

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KP Plus Everyday Care

Plan Name	KP PLUS Everyday Care Plan \$4000		KP PLUS Everyday Care Plan \$5000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	N/A	\$5,000/\$10,000	N/A
Annual out-of-pocket maximum (IND/FAM)	\$4,000/\$8,000	N/A	\$5,000/\$10,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$0	\$20	\$0	\$20
Office visits – naturopathic care	\$5 for the first 3 visits; then \$0 ¹	\$20	\$5 for the first 3 visits; then \$0 ¹	\$20
Office visits – urgent care	\$0	Not covered, except for services received outside the service area ^{2,3}	\$0	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$0	\$30	\$0	\$30
Telehealth (phone/video)	\$5 for the first 3 visits; then \$0 ¹	\$20	\$5 for the first 3 visits; then \$0 ¹	\$20
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	0%*	Not covered	0%*	Not covered
X-ray/diagnostic tests	\$50	\$70	\$50	\$70
Lab	\$0	\$20	\$0	\$20
CT, MRI, and PET scans	\$500	Not covered	\$500	Not covered
Inpatient hospital care	0%*	Not covered	0%*	Not covered
Emergency department visits	\$500 ⁴	Covered at the in-network cost share ²	\$500 ⁴	Covered at the in-network cost share ²
Routine eye exam	\$0	\$20	\$0	\$20
Outpatient prescription drugs	\$0 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$20 generic; \$70 preferred brand-name; \$145 non-preferred brand-name; \$270 specialty	\$0 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$20 generic; \$70 preferred brand-name; \$145 non-preferred brand-name; \$270 specialty

*After deductible.

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KP Plus Everyday Care

Plan Name	KP PLUS Everyday Care Plan \$6000		KP PLUS Everyday Care Plan \$7000	
Network	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
Annual Medical Deductible (IND/FAM) (per calendar year)	\$6,000/\$12,000	N/A	\$7,000/\$14,000	N/A
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	N/A	\$7,000/\$14,000	N/A
Office visits – preventive and well-child care	\$0	\$0	\$0	\$0
Office visits – primary care/mental health	\$0	\$20	\$0	\$20
Office visits – naturopathic care	\$5 for the first 3 visits; then \$0 ¹	\$20	\$5 for the first 3 visits; then \$0 ¹	\$20
Office visits – urgent care	\$0	Not covered, except for services received outside the service area ^{2,3}	\$0	Not covered, except for services received outside the service area ^{2,3}
Office visits – specialty care	\$0	\$30	\$0	\$30
Telehealth (phone/video)	\$5 for the first 3 visits; then \$0 ¹	\$20	\$5 for the first 3 visits; then \$0 ¹	\$20
Office visits – prenatal care	\$0	\$0	\$0	\$0
Outpatient surgery	0%*	Not covered	0%*	Not covered
X-ray/diagnostic tests	\$50	\$70	\$50	\$70
Lab	\$0	\$20	\$0	\$20
CT, MRI, and PET scans	\$500	Not covered	\$500	Not covered
Inpatient hospital care	0%*	Not covered	0%*	Not covered
Emergency department visits	\$500 ⁴	Covered at the in-network cost share ²	\$500 ⁴	Covered at the in-network cost share ²
Routine eye exam	\$0	\$20	\$0	\$20
Outpatient prescription drugs	\$0 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$20 generic; \$70 preferred brand-name; \$145 non-preferred brand-name; \$270 specialty	\$0 generic; \$50 preferred brand-name; \$125 non-preferred brand-name; \$250 specialty	\$20 generic; \$70 preferred brand-name; \$145 non-preferred brand-name; \$270 specialty

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN A 10/1500		DUAL CHOICE PPO PLAN B 20/2000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$0/\$0	\$1,500/\$3,000	\$0/\$0	\$2,000/\$4,000
Annual out-of-pocket maximum (IND/FAM)	\$1,500/\$3,000	\$4,500/\$9,000	\$2,000/\$4,000	\$6,000/\$12,000
Office visits – preventive and well-child care	\$0	30%*	\$0	30%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$30 (\$10 enhanced benefit) ¹	30%*	\$5 for the first 3 visits; then \$40 (\$20 enhanced benefit) ¹	30%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$10 ¹	30%*	\$5 for the first 3 visits; then \$20 ¹	30%*
Office visits – urgent care	\$60 (\$30 enhanced benefit)	30%*	\$80 (\$40 enhanced benefit)	30%*
Office visits – specialty care	\$40 (\$20 enhanced benefit)	30%*	\$50 (\$30 enhanced benefit)	30%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	30%*	\$0 for the first 3 visits; then \$0 ¹	30%*
Office visits – prenatal care	\$0	30%*	\$0	30%*
OUTPATIENT SURGERY	\$50	30%*	\$50	30%*
X-ray/diagnostic tests	\$10	30%*	\$20	30%*
Lab	\$10	30%*	\$20	30%*
CT, MRI, and PET scans	\$50	30%*	\$50	30%*
Inpatient hospital care	\$100 per day; \$500 per admission	30%*	\$100 per day; \$500 per admission	30%*
Emergency department visits	\$150 ²		\$150 ²	
Routine eye exam	\$30 (\$10 enhanced benefit)	30%*	\$40 (\$20 enhanced benefit)	30%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN C 20/2500		DUAL CHOICE PPO PLAN D 30/3000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$0/\$0	\$2,000/\$4,000	\$0/\$0	\$2,000/\$4,000
Annual out-of-pocket maximum (IND/FAM)	\$2,500/\$5,000	\$6,000/\$12,000	\$3,000/\$6,000	\$6,000/\$12,000
Office visits – preventive and well-child care	\$0	30%*	\$0	30%*
Office visits – primary care/ mental health	\$5 for the first 3 visits; then \$40 (\$20 enhanced benefit) ¹	30%*	\$5 for the first 3 visits; then \$50 (\$30 enhanced benefit) ¹	30%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$20 ¹	30%*	\$5 for the first 3 visits; then \$30 ¹	30%*
Office visits – urgent care	\$80 (\$40 enhanced benefit)	30%*	\$100 (\$50 enhanced benefit)	30%*
Office visits – specialty care	\$50 (\$30 enhanced benefit)	30%*	\$60 (\$40 enhanced benefit)	30%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	30%*	\$0 for the first 3 visits; then \$0 ¹	30%*
Office visits – prenatal care	\$0	30%*	\$0	30%*
OUTPATIENT SURGERY	\$50	30%*	\$100	30%*
X-ray/diagnostic tests	\$20	30%*	\$30	30%*
Lab	\$20	30%*	\$30	30%*
CT, MRI, and PET scans	\$50	30%*	\$50	30%*
Inpatient hospital care	\$200 per day; \$1,000 per admission	30%*	\$200 per day; \$1,000 per admission	30%*
Emergency department visits	\$250 ²		\$250 ²	
Routine eye exam	\$40 (\$20 enhanced benefit)	30%*	\$50 (\$30 enhanced benefit)	30%*

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN E 35/3500		DUAL CHOICE PPO PLAN A 250/10/10%/2500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$0/\$0	\$2,000/\$4,000	\$250/\$750	\$2,000/\$6,000
Annual out-of-pocket maximum (IND/FAM)	\$3,500/\$7,000	\$6,000/\$12,000	\$2,500/\$7,500	\$6,000/\$12,000
Office visits – preventive and well-child care	\$0	30%*	\$0	30%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$50 (\$35 enhanced benefit) ¹	30%*	\$5 for the first 3 visits; then \$30 (\$10 enhanced benefit) ¹	30%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$35 ¹	30%*	\$5 for the first 3 visits; then \$10 ¹	30%*
Office visits – urgent care	\$120 (\$60 enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	30%*
Office visits – specialty care	\$65 (\$45 enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	30%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	30%*	\$0 for the first 3 visits; then \$0 ¹	30%*
Office visits – prenatal care	\$0	30%*	\$0	30%*
OUTPATIENT SURGERY	\$150	30%*	10%*	30%*
X-ray/diagnostic tests	\$35	30%*	10%*	30%*
Lab	\$35	30%*	10%*	30%*
CT, MRI, and PET scans	\$50	30%*	10%*	30%*
Inpatient hospital care	\$800 per admission	30%*	10%*	30%*
Emergency department visits	\$250 ²		\$250 ²	
Routine eye exam	\$55 (\$35 enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	30%*

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN A 250/15/20%/3000		DUAL CHOICE PPO PLAN B 500/20/10%/3500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$250/\$750	\$2,000/\$6,000	\$500/\$1,500	\$2,500/\$7,500
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	\$6,000/\$12,000	\$3,500/\$10,500	\$7,500/\$15,000
Office visits – preventive and well-child care	\$0	30%*	\$0	30%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$35 (\$15 enhanced benefit) ¹	30%*	\$5 for the first 3 visits; then \$40 (\$20 enhanced benefit) ¹	30%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$15 ¹	30%*	\$5 for the first 3 visits; then \$20 ¹	30%*
Office visits – urgent care	\$55 (\$35 enhanced benefit)	30%*	\$80 (\$40 enhanced benefit)	30%*
Office visits – specialty care	\$45 (\$25 enhanced benefit)	30%*	\$50 (\$30 enhanced benefit)	30%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	30%*	\$0 for the first 3 visits; then \$0 ¹	30%*
Office visits – prenatal care	\$0	30%*	\$0	30%*
OUTPATIENT SURGERY	20%*	30%*	10%*	30%*
X-ray/diagnostic tests	\$15	30%*	\$20	30%*
Lab	\$15	30%*	\$20	30%*
CT, MRI, and PET scans	\$100	30%*	\$100	30%*
Inpatient hospital care	20%*	30%*	10%*	30%*
Emergency department visits	20%*		10%*	
Routine eye exam	\$35 (\$15 enhanced benefit)	30%*	\$40 (\$20 enhanced benefit)	30%*

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN B 500/10%/10%/3000		DUAL CHOICE PPO PLAN B 500/10/20%/3000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$500/\$1,500	\$2,500/\$7,500	\$500/\$1,500	\$2,500/\$7,500
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	\$7,500/\$15,000	\$3,000/\$9,000	\$7,500/\$15,000
Office visits – preventive and well-child care	\$0	30%*	\$0	40%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then 20%* (10%* enhanced benefit) ¹	30%*	\$5 for the first 3 visits; then \$30 (\$10 enhanced benefit) ¹	40%*
Office visits – naturopathic care	\$5 for the first 3 visits; then 10%* ¹	30%*	\$5 for the first 3 visits; then \$10 ¹	40%*
Office visits – urgent care	20%* (10%* enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	40%*
Office visits – specialty care	20%* (10%* enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	30%*	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – prenatal care	\$0	30%*	\$0	40%*
OUTPATIENT SURGERY	10%*	30%*	20%*	40%*
X-ray/diagnostic tests	10%*	30%*	20%*	40%*
Lab	10%*	30%*	20%*	40%*
CT, MRI, and PET scans	10%*	30%*	20%*	40%*
Inpatient hospital care	10%*	30%*	20%*	40%*
Emergency department visits	\$250* ²		\$250* ²	
Routine eye exam	20%* (10%* enhanced benefit)	30%*	\$30 (\$10 enhanced benefit)	40%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN B 500/20/20%/3500		DUAL CHOICE PPO PLAN C 750/20/20%/3500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$500/\$1,500	\$2,500/\$7,500	\$750/\$2,250	\$3,000/\$9,000
Annual out-of-pocket maximum (IND/FAM)	\$3,500/\$10,500	\$7,500/\$15,000	\$3,500/\$10,500	\$7,500/\$22,500
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$40 (\$20 enhanced benefit) ¹	40%*	\$5 for the first 3 visits; then \$40 (\$20 enhanced benefit) ¹	40%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$20 ¹	40%*	\$5 for the first 3 visits; then \$20 ¹	40%*
Office visits – urgent care	\$80 (\$40 enhanced benefit)	40%*	\$80 (\$40 enhanced benefit)	40%*
Office visits – specialty care	\$50 (\$30 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
OUTPATIENT SURGERY	20%*	40%*	20%*	40%*
X-ray/diagnostic tests	\$20	40%*	\$20	40%*
Lab	\$20	40%*	\$20	40%*
CT, MRI, and PET scans	\$100	40%*	\$100	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency department visits	20%*		20%*	
Routine eye exam	\$40 (\$20 enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	40%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN C 750/20%/20%/3500		DUAL CHOICE PPO PLAN D 1000/20/20%/4000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$750/\$2,250	\$3,000/\$9,000	\$1,000/\$3,000	\$3,000/\$9,000
Annual out-of-pocket maximum (IND/FAM)	\$3,500/\$10,500	\$7,500/\$22,500	\$4,000/\$12,000	\$9,000/\$27,000
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then 30%* (20%* enhanced benefit) ¹	40%*	\$5 for the first 3 visits; then \$40 (\$20 enhanced benefit) ¹	40%*
Office visits – naturopathic care	\$5 for the first 3 visits; then 20%* ¹	40%*	\$5 for the first 3 visits; then \$20 ¹	40%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	40%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
OUTPATIENT SURGERY	20%*	40%*	20%*	40%*
X-ray/diagnostic tests	20%*	40%*	20%*	40%*
Lab	20%*	40%*	20%*	40%*
CT, MRI, and PET scans	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency department visits	\$250* ²		\$250* ²	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	\$40 (\$20 enhanced benefit)	40%*

*After deductible.

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[See plan comparisons](#)

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN D 1000/25/20%/5000		DUAL CHOICE PPO PLAN E 1500/25/20%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,000/\$3,000	\$3,000/\$9,000	\$1,500/\$4,500	\$3,500/\$10,500
Annual out-of-pocket maximum (IND/FAM)	\$5,000/\$15,000	\$9,000/\$27,000	\$6,000/\$12,000	\$10,500/\$21,000
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$45 (\$25 enhanced benefit) ¹	40%*	\$5 for the first 3 visits; then \$45 (\$25 enhanced benefit) ¹	40%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$25 ¹	40%*	\$5 for the first 3 visits; then \$25 ¹	40%*
Office visits – urgent care	\$90 (\$45 enhanced benefit)	40%*	\$90 (\$45 enhanced benefit)	40%*
Office visits – specialty care	\$55 (\$35 enhanced benefit)	40%*	\$55 (\$35 enhanced benefit)	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
OUTPATIENT SURGERY	20%*	40%*	20%*	40%*
X-ray/diagnostic tests	\$25	40%*	\$25	40%*
Lab	\$25	40%*	\$25	40%*
CT, MRI, and PET scans	\$100	40%*	\$100	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency department visits	20%*		20%*	
Routine eye exam	\$45 (\$25 enhanced benefit)	40%*	\$45 (\$25 enhanced benefit)	40%*

*After deductible.

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

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN E 1500/20/30%/5000		DUAL CHOICE PPO PLAN F 2000/25/20%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,500/\$4,500	\$3,500/\$10,500	\$2,000/\$6,000	\$4,000/\$12,000
Annual out-of-pocket maximum (IND/FAM)	\$5,000/\$12,000	\$10,500/\$21,000	\$6,000/\$12,000	\$12,000/\$24,000
Office visits – preventive and well-child care	\$0	50%*	\$0	40%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$40 (\$20 enhanced benefit) ¹	50%*	\$5 for the first 3 visits; then \$45 (\$25 enhanced benefit) ¹	40%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$20 ¹	50%*	\$5 for the first 3 visits; then \$25 ¹	40%*
Office visits – urgent care	\$40 (\$20 enhanced benefit)	50%*	\$90 (\$45 enhanced benefit)	40%*
Office visits – specialty care	\$40 (\$20 enhanced benefit)	50%*	\$55 (\$35 enhanced benefit)	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	50%*	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – prenatal care	\$0	50%*	\$0	40%*
OUTPATIENT SURGERY	30%*	50%*	20%*	40%*
X-ray/diagnostic tests	30%*	50%*	\$25	40%*
Lab	30%*	50%*	\$25	40%*
CT, MRI, and PET scans	30%*	50%*	\$100	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency department visits	\$250* ²		20%*	
Routine eye exam	\$40 (\$20 enhanced benefit)	50%*	\$45 (\$25 enhanced benefit)	40%*

*After deductible.

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

²Waive if admitted.

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[Reset](#)

DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN G 2500/25/20%/6000		DUAL CHOICE PPO PLAN G 2500/30/30%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$2,500/\$7,500	\$4,500/\$13,500	\$2,500/\$5,000	\$4,500/\$13,500
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$13,500/\$27,000	\$6,000/\$12,000	\$13,500/\$27,000
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*
Office visits – primary care/ mental health	\$5 for the first 3 visits; then \$45 (\$25 enhanced benefit) ¹	40%*	\$5 for the first 3 visits; then \$50 (\$30 enhanced benefit) ¹	50%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$25 ¹	40%*	\$5 for the first 3 visits; then \$30 ¹	50%*
Office visits – urgent care	\$90 (\$45 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	50%*
Office visits – specialty care	\$55 (\$35 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	50%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*	\$0 for the first 3 visits; then \$0 ¹	50%*
Office visits – prenatal care	\$0	40%*	\$0	50%*
OUTPATIENT SURGERY	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	\$25	40%*	30%*	50%*
Lab	\$25	40%*	30%*	50%*
CT, MRI, and PET scans	\$100	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency department visits	20%*		\$250* ²	
Routine eye exam	\$45 (\$25 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	50%*

*After deductible.

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

²Waive if admitted.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN H 3000/30/20%/8150		DUAL CHOICE PPO PLAN H 3000/30%/30%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$3,000/\$9,000	\$5,000/\$15,000	\$3,000/\$6,000	\$5,000/\$15,000
Annual out-of-pocket maximum (IND/FAM)	\$8,150/\$16,300	\$15,000/\$30,000	\$7,000/\$14,000	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$50 (\$30 enhanced benefit) ¹	40%*	\$5 for the first 3 visits; then 40%* (30%* enhanced benefit) ¹	50%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$30 ¹	40%*	\$5 for the first 3 visits; then 30%* ¹	50%*
Office visits – urgent care	\$100 (\$50 enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	\$60 (\$40 enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*	\$0 for the first 3 visits; then \$0 ¹	50%*
Office visits – prenatal care	\$0	40%*	\$0	50%*
OUTPATIENT SURGERY	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	\$30	40%*	30%*	50%*
Lab	\$30	40%*	30%*	50%*
CT, MRI, and PET scans	\$100	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency department visits	20%*		\$250* ²	
Routine eye exam	\$50 (\$30 enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

*After deductible.

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²Waive if admitted.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN I 3500/30/20%/8000		DUAL CHOICE PPO PLAN J 4000/30/20%/8150	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$3,500/\$10,500	\$5,500/\$16,500	\$4,000/\$10,000	\$6,000/\$18,000
Annual out-of-pocket maximum (IND/FAM)	\$8,000/\$16,000	\$15,000/\$30,000	\$8,150/\$16,300	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$50 (\$30 enhanced benefit) ¹	40%*	\$5 for the first 3 visits; then \$50 (\$30 enhanced benefit) ¹	40%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$30 ¹	40%*	\$5 for the first 3 visits; then \$30 ¹	40%*
Office visits – urgent care	\$100 (\$50 enhanced benefit)	40%*	\$100 (\$50 enhanced benefit)	40%*
Office visits – specialty care	\$60 (\$40 enhanced benefit)	40%*	\$60 (\$40 enhanced benefit)	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
OUTPATIENT SURGERY	20%*	40%*	20%*	40%*
X-ray/diagnostic tests	\$30	40%*	\$30	40%*
Lab	\$30	40%*	\$30	40%*
CT, MRI, and PET scans	\$100	40%*	\$100	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency department visits	20%*		20%*	
Routine eye exam	\$50 (\$30 enhanced benefit)	40%*	\$50 (\$30 enhanced benefit)	40%*

*After deductible.

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²Waive if admitted.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN J 4000/40/30%/7500		DUAL CHOICE PPO PLAN K 5000/30/20%/8500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	\$6,000/\$15,000	\$5,000/\$10,000	\$6,500/\$19,500
Annual out-of-pocket maximum (IND/FAM)	\$7,500/\$15,000	\$15,000/\$30,000	\$8,500/\$17,000	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	50%*	\$0	40%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$60 (\$40 enhanced benefit) ¹	50%*	\$5 for the first 3 visits; then \$50 (\$30 enhanced benefit) ¹	40%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$40 ¹	50%*	\$5 for the first 3 visits; then \$30 ¹	40%*
Office visits – urgent care	\$60 (\$40 enhanced benefit)	50%*	\$100 (\$50 enhanced benefit)	40%*
Office visits – specialty care	\$60 (\$40 enhanced benefit)	50%*	\$60 (\$40 enhanced benefit)	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	50%*	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – prenatal care	\$0	50%*	\$0	40%*
OUTPATIENT SURGERY	30%*	50%*	20%*	40%*
X-ray/diagnostic tests	30%*	50%*	\$30	40%*
Lab	30%*	50%*	\$30	40%*
CT, MRI, and PET scans	30%*	50%*	\$100	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency department visits	\$300* ²		20%*	
Routine eye exam	\$60 (\$40 enhanced benefit)	50%*	\$50 (\$30 enhanced benefit)	40%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN L 6000/35/20%/9000		DUAL CHOICE PPO PLAN L 6000/40/30%/9000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$6,000/\$12,000	\$7,500/\$18,000	\$6,000/\$12,000	\$7,500/\$18,000
Annual out-of-pocket maximum (IND/FAM)	\$9,000/\$18,000	\$15,000/\$30,000	\$9,000/\$18,000	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$55 (\$35 enhanced benefit) ¹	40%*	\$5 for the first 3 visits; then \$60 (\$40 enhanced benefit) ¹	50%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$35 ¹	40%*	\$5 for the first 3 visits; then \$40 ¹	50%*
Office visits – urgent care	\$100 (\$55 enhanced benefit)	40%*	\$60 (\$40 enhanced benefit)	50%*
Office visits – specialty care	\$65 (\$45 enhanced benefit)	40%*	\$60 (\$40 enhanced benefit)	50%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*	\$0 for the first 3 visits; then \$0 ¹	50%*
Office visits – prenatal care	\$0	40%*	\$0	50%*
OUTPATIENT SURGERY	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	\$35	40%*	30%*	50%*
Lab	\$35	40%*	30%*	50%*
CT, MRI, and PET scans	\$150	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency department visits	20%*		\$300* ²	
Routine eye exam	\$55 (\$35 enhanced benefit)	40%*	\$60 (\$40 enhanced benefit)	50%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO PLAN M 7500/35/30%/10000		DUAL CHOICE PPO HDHP PLAN A 1700/10%/2500	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$7,500/\$14,500	\$8,500/\$19,500	\$1,700/\$3,400	\$3,500/\$9,750
Annual out-of-pocket maximum (IND/FAM)	\$10,000/\$20,000	\$17,000/\$30,000	\$2,500/\$5,000	\$10,500/\$21,000
Office visits – preventive and well-child care	\$0	50%*	\$0	30%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$55 (\$35 enhanced benefit) ¹	50%*	\$5* for the first 3 visits; then 20%* (10%* enhanced benefit) ¹	30%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$35 ¹	50%*	\$5* for the first 3 visits; then 10%* ¹	30%*
Office visits – urgent care	\$100 (\$55 enhanced benefit)	50%*	20%* (10%* enhanced benefit)	30%*
Office visits – specialty care	\$65 (\$45 enhanced benefit)	50%*	20%* (10%* enhanced benefit)	30%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	50%*	0%* for the first 3 visits; then 0%* ¹	30%*
Office visits – prenatal care	\$0	50%*	\$0	30%*
OUTPATIENT SURGERY	30%*	50%*	10%*	30%*
X-ray/diagnostic tests	\$35	50%*	10%*	30%*
Lab	\$35	50%*	10%*	30%*
CT, MRI, and PET scans	\$150	50%*	10%*	30%*
Inpatient hospital care	30%*	50%*	10%*	30%*
Emergency department visits	30%*		10%*	
Routine eye exam	\$55 (\$35 enhanced benefit)	50%*	20%* (10%* enhanced benefit)	30%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO HDHP PLAN A 1700/20%/3500		DUAL CHOICE PPO HDHP PLAN B 2000/20%/4000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,700/\$3,400	\$3,500/\$9,750	\$2,000/\$4,000	\$4,000/\$12,000
Annual out-of-pocket maximum (IND/FAM)	\$3,500/\$7,000	\$11,500/\$23,000	\$4,000/\$8,000	\$12,000/\$24,000
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 30%* (20%* enhanced benefit) ¹	40%*	\$5* for the first 3 visits; then 30%* (20%* enhanced benefit) ¹	40%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 20%* ¹	40%*	\$5* for the first 3 visits; then 20%* ¹	40%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	30%* (20%* enhanced benefit)	40%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	40%*	0%* for the first 3 visits; then 0%* ¹	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
OUTPATIENT SURGERY	20%*	40%*	20%*	40%*
X-ray/diagnostic tests	20%*	40%*	20%*	40%*
Lab	20%*	40%*	20%*	40%*
CT, MRI, and PET scans	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency department visits	20%*		20%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	30%* (20%* enhanced benefit)	40%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO HDHP PLAN B 2000/30%/4000		DUAL CHOICE PPO HDHP PLAN C 2500/20%/5000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$2,000/\$4,000	\$4,000/\$12,000	\$2,500/\$5,000	\$5,000/\$15,000
Annual out-of-pocket maximum (IND/FAM)	\$4,000/\$8,000	\$12,000/\$24,000	\$5,000/\$7,500	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	50%*	\$0	40%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 40%* (30%* enhanced benefit) ¹	50%*	\$5* for the first 3 visits; then 30%* (20%* enhanced benefit) ¹	40%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 30%* ¹	50%*	\$5* for the first 3 visits; then 20%* ¹	40%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	50%*	0%* for the first 3 visits; then 0%* ¹	40%*
Office visits – prenatal care	\$0	50%*	\$0	40%*
OUTPATIENT SURGERY	30%*	50%*	20%*	40%*
X-ray/diagnostic tests	30%*	50%*	20%*	40%*
Lab	30%*	50%*	20%*	40%*
CT, MRI, and PET scans	30%*	50%*	20%*	40%*
Inpatient hospital care	30%*	50%*	20%*	40%*
Emergency department visits	30%*		20%*	
Routine eye exam	40%* (30%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*

*After deductible.

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

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO HDHP PLAN C 2500/30%/5000		DUAL CHOICE PPO HDHP PLAN E 3400/10%/6000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$2,500/\$5,000	\$5,000/\$15,000	\$3,400/\$6,800	\$5,000/\$15,000
Annual out-of-pocket maximum (IND/FAM)	\$5,000/\$7,500	\$15,000/\$30,000	\$6,000/\$9,000	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	50%*	\$0	30%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 40%* (30%* enhanced benefit) ¹	50%*	\$5* for the first 3 visits; then 20%* (10%* enhanced benefit) ¹	30%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 30%* ¹	50%*	\$5* for the first 3 visits; then 10%* ¹	30%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	20%* (10%* enhanced benefit)	30%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	20%* (10%* enhanced benefit)	30%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	50%*	0%* for the first 3 visits; then 0%* ¹	30%*
Office visits – prenatal care	\$0	50%*	\$0	30%*
OUTPATIENT SURGERY	30%*	50%*	10%*	30%*
X-ray/diagnostic tests	30%*	50%*	10%*	30%*
Lab	30%*	50%*	10%*	30%*
CT, MRI, and PET scans	30%*	50%*	10%*	30%*
Inpatient hospital care	30%*	50%*	10%*	30%*
Emergency department visits	30%*		10%*	
Routine eye exam	40%* (30%* enhanced benefit)	50%*	20%* (10%* enhanced benefit)	30%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO HDHP PLAN E 3400/20%/6000		DUAL CHOICE PPO HDHP PLAN E 3400/30%/6400	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$3,400/\$6,800	\$5,000/\$15,000	\$3,400/\$6,800	\$5,000/\$15,000
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$15,000/\$30,000	\$6,400/\$12,800	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 30%* (20%* enhanced benefit) ¹	40%*	\$5* for the first 3 visits; then 40%* (30%* enhanced benefit) ¹	50%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 20%* ¹	40%*	\$5* for the first 3 visits; then 30%* ¹	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	40%*	0%* for the first 3 visits; then 0%* ¹	50%*
Office visits – prenatal care	\$0	40%*	\$0	50%*
OUTPATIENT SURGERY	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency department visits	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO HDHP PLAN F 3500/20%/7000		DUAL CHOICE PPO HDHP PLAN F 3500/30%/7000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$3,500/\$7,000	\$5,500/\$16,500	\$3,500/\$7,000	\$5,500/\$16,500
Annual out-of-pocket maximum (IND/FAM)	\$7,000/\$14,000	\$15,000/\$30,000	\$7,000/\$14,000	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 30%* (20%* enhanced benefit) ¹	40%*	\$5* for the first 3 visits; then 40%* (30%* enhanced benefit) ¹	50%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 20%* ¹	40%*	\$5* for the first 3 visits; then 30%* ¹	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	30%* (20%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	30%* (20%* enhanced benefit)	50%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	40%*	0%* for the first 3 visits; then 0%* ¹	50%*
Office visits – prenatal care	\$0	40%*	\$0	50%*
OUTPATIENT SURGERY	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency department visits	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO HDHP PLAN G 4000/20%/8000		DUAL CHOICE PPO HDHP PLAN G 4000/30%/8000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	\$6,000/\$12,000	\$4,000/\$8,000	\$6,000/\$12,000
Annual out-of-pocket maximum (IND/FAM)	\$8,000/\$16,000	\$15,000/\$30,000	\$8,000/\$16,000	\$15,000/\$30,000
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 30%* (20%* enhanced benefit) ¹	40%*	\$5* for the first 3 visits; then 40%* (30%* enhanced benefit) ¹	50%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 20%* ¹	40%*	\$5* for the first 3 visits; then 30%* ¹	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	40%*	0%* for the first 3 visits; then 0%* ¹	50%*
Office visits – prenatal care	\$0	40%*	\$0	50%*
OUTPATIENT SURGERY	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency department visits	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

*After deductible.

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO HDHP PLAN H 5000/20%/8000		DUAL CHOICE PPO HDHP PLAN H 5000/30%/8000	
Network	In-network	Out-of-network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$5,000/\$10,000	\$7,000/\$14,000	\$5,000/\$10,000	\$7,000/\$14,000
Annual out-of-pocket maximum (IND/FAM)	\$8,000/\$16,000	\$17,000/\$34,000	\$8,000/\$16,000	\$17,000/\$34,000
Office visits – preventive and well-child care	\$0	40%*	\$0	50%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 30%* (20%* enhanced benefit) ¹	40%*	\$5* for the first 3 visits; then 40%* (30%* enhanced benefit) ¹	50%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 20%* ¹	40%*	\$5* for the first 3 visits; then 30%* ¹	50%*
Office visits – urgent care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	40%*	0%* for the first 3 visits; then 0%* ¹	50%*
Office visits – prenatal care	\$0	40%*	\$0	50%*
OUTPATIENT SURGERY	20%*	40%*	30%*	50%*
X-ray/diagnostic tests	20%*	40%*	30%*	50%*
Lab	20%*	40%*	30%*	50%*
CT, MRI, and PET scans	20%*	40%*	30%*	50%*
Inpatient hospital care	20%*	40%*	30%*	50%*
Emergency department visits	20%*		30%*	
Routine eye exam	30%* (20%* enhanced benefit)	40%*	40%* (30%* enhanced benefit)	50%*

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DUAL CHOICE PPO

Plan name	DUAL CHOICE PPO HDHP PLAN H 5000/40%/8000	
Network	In-network	Out-of-network
Annual Medical Deductible (IND/FAM) (per calendar year)	\$5,000/\$10,000	\$7,000/\$14,000
Annual out-of-pocket maximum (IND/FAM)	\$8,000/\$16,000	\$17,000/\$34,000
Office visits – preventive and well-child care	\$0	50%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 50%* (40%* enhanced benefit) ¹	50%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 40%* ¹	50%*
Office visits – urgent care	50%* (40%* enhanced benefit)	50%*
Office visits – specialty care	50%* (40%* enhanced benefit)	50%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	50%*
Office visits – prenatal care	\$0	50%*
OUTPATIENT SURGERY	40%*	50%*
X-ray/diagnostic tests	40%*	50%*
Lab	40%*	50%*
CT, MRI, and PET scans	40%*	50%*
Inpatient hospital care	40%*	50%*
Emergency department visits	40%*	
Routine eye exam	50%* (40%* enhanced benefit)	50%*

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OUT-OF-AREA PPO PLUS

Plan name	PPO PLUS PLAN WDB 500/20%/2500		PPO PLUS PLAN WDC 750/20%/3750	
Network	PPO Providers	Nonparticipating Providers	PPO Providers	Nonparticipating Providers
Annual Medical Deductible (IND/FAM) (per calendar year)	\$500/\$1,500	\$750/\$2,250	\$750/\$2,250	\$1,125/\$3,375
Annual out-of-pocket maximum (IND/FAM)	\$2,500/\$7,500	\$3,500/\$10,500	\$3,750/\$11,250	\$5,250/\$16,875
Office visits – preventive and well-child care	\$0	35%*	\$0	35%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$30 ¹	35%*	\$5 for the first 3 visits; then \$30 ¹	35%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$30 ¹	35%*	\$5 for the first 3 visits; then \$30 ¹	35%*
Office visits – urgent care	\$50	35%*	\$50	35%*
Office visits – specialty care	\$40	35%*	\$40	35%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	35%*	\$0 for the first 3 visits; then \$0 ¹	35%*
Office visits – prenatal care	\$0	35%*	\$0	35%*
Outpatient surgery	20%*	35%*	20%*	35%*
X-ray/diagnostic tests	\$30	35%*	\$30	35%*
Lab	\$30	35%*	\$30	35%*
CT, MRI, and PET scans	20%*	35%*	20%*	35%*
Inpatient hospital care	20%*	35%*	20%*	35%*
Emergency department visits	\$250* ²		\$250* ²	
Routine eye exam	\$30	35%*	\$30	35%*

*After deductible.

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²Waive if admitted.

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OUT-OF-AREA PPO PLUS

Plan name	PPO PLUS PLAN WDT 1000/20%/3000		PPO PLUS PLAN WDE 1000/30%/4750	
Network	PPO Providers	Nonparticipating Providers	PPO Providers	Nonparticipating Providers
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,000/\$3,000	\$1,500/\$4,500	\$1,000/\$3,000	\$1,500/\$4,500
Annual out-of-pocket maximum (IND/FAM)	\$3,000/\$9,000	\$6,000/\$12,000	\$4,750/\$9,500	\$6,000/\$12,000
Office visits – preventive and well-child care	\$0	45%*	\$0	45%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$20 ¹	45%*	\$5 for the first 3 visits; then \$30 ¹	45%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$20 ¹	45%*	\$5 for the first 3 visits; then \$30 ¹	45%*
Office visits – urgent care	\$20	45%*	\$50	45%*
Office visits – specialty care	\$20	45%*	\$40	45%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	45%*	\$0 for the first 3 visits; then \$0 ¹	45%*
Office visits – prenatal care	\$0	45%*	\$0	45%*
Outpatient surgery	20%*	45%*	30%*	45%*
X-ray/diagnostic tests	20%*	45%*	\$30	45%*
Lab	20%*	45%*	\$30	45%*
CT, MRI, and PET scans	20%*	45%*	30%*	45%*
Inpatient hospital care	20%*	45%*	30%*	45%*
Emergency department visits	\$250* ²		\$250* ²	
Routine eye exam	\$20	45%*	\$30	45%*

*After deductible.

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OUT-OF-AREA PPO PLUS

Plan name	PPO PLUS PLAN WDU 1500/20%/5500		PPO PLUS PLAN WDP 1500/30%/6000	
Network	PPO Providers	Nonparticipating Providers	PPO Providers	Nonparticipating Providers
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,500/\$4,500	\$2,250/\$6,750	\$1,500/\$4,500	\$2,250/\$6,750
Annual out-of-pocket maximum (IND/FAM)	\$5,500/\$11,000	\$7,500/\$15,000	\$6,000/\$12,000	\$7,500/\$15,000
Office visits – preventive and well-child care	\$0	45%*	\$0	45%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$25 ¹	45%*	\$5 for the first 3 visits; then \$30 ¹	45%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$25 ¹	45%*	\$5 for the first 3 visits; then \$30 ¹	45%*
Office visits – urgent care	\$45	45%*	\$50	45%*
Office visits – specialty care	\$35	45%*	\$40	45%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	45%*	\$0 for the first 3 visits; then \$0 ¹	45%*
Office visits – prenatal care	\$0	45%*	\$0	45%*
Outpatient surgery	20%*	45%*	30%*	45%*
X-ray/diagnostic tests	\$25	45%*	\$30	45%*
Lab	\$25	45%*	\$30	45%*
CT, MRI, and PET scans	\$100	45%*	30%*	45%*
Inpatient hospital care	20%*	45%*	30%*	45%*
Emergency department visits	20%*		\$250* ²	
Routine eye exam	\$25	45%*	\$30	45%*

*After deductible.

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OUT-OF-AREA PPO PLUS

Plan name	PPO PLUS PLAN WDN 2000/30%/6000		PPO PLUS PLAN WDX 3000/30%/6850	
Network	PPO Providers	Nonparticipating Providers	PPO Providers	Nonparticipating Providers
Annual Medical Deductible (IND/FAM) (per calendar year)	\$2,000/\$6,000	\$3,000/\$9,000	\$3,000/\$9,000	\$4,500/\$13,500
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$7,500/\$15,000	\$6,850/\$13,700	\$8,400/\$16,800
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$35 ¹	40%*	\$5 for the first 3 visits; then \$35 ¹	40%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$35 ¹	40%*	\$5 for the first 3 visits; then \$35 ¹	40%*
Office visits – urgent care	\$55	40%*	\$55	40%*
Office visits – specialty care	\$45	40%*	\$45	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
Outpatient surgery	30%*	40%*	30%*	40%*
X-ray/diagnostic tests	\$35	40%*	\$35	40%*
Lab	\$35	40%*	\$35	40%*
CT, MRI, and PET scans	30%*	40%*	30%*	40%*
Inpatient hospital care	30%*	40%*	30%*	40%*
Emergency department visits	\$250* ²		\$250* ²	
Routine eye exam	\$35	40%*	\$35	40%*

*After deductible.

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

²Waive if admitted.

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OUT-OF-AREA PPO PLUS

Plan name	PPO PLUS PLAN WDR 4000/30%/7500		PPO PLUS PLAN WDS 5000/30%/7500	
Network	PPO Providers	Nonparticipating Providers	PPO Providers	Nonparticipating Providers
Annual Medical Deductible (IND/FAM) (per calendar year)	\$4,000/\$8,000	\$6,000/\$12,000	\$5,000/\$10,000	\$6,500/\$13,000
Annual out-of-pocket maximum (IND/FAM)	\$7,500/\$15,000	\$10,000/\$20,000	\$7,500/\$15,000	\$10,000/\$20,000
Office visits – preventive and well-child care	\$0	40%*	\$0	40%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$35 ¹	40%*	\$5 for the first 3 visits; then \$35 ¹	40%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$35 ¹	40%*	\$5 for the first 3 visits; then \$35 ¹	40%*
Office visits – urgent care	\$55	40%*	\$55	40%*
Office visits – specialty care	\$45	40%*	\$45	40%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	40%*	\$0 for the first 3 visits; then \$0 ¹	40%*
Office visits – prenatal care	\$0	40%*	\$0	40%*
Outpatient surgery	30%*	40%*	30%*	40%*
X-ray/diagnostic tests	\$35	40%*	\$35	40%*
Lab	\$35	40%*	\$35	40%*
CT, MRI, and PET scans	30%*	40%*	30%*	40%*
Inpatient hospital care	30%*	40%*	30%*	40%*
Emergency department visits	20%*		20%*	
Routine eye exam	\$35	40%*	\$35	40%*

*After deductible.

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

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

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that helps meet employee needs and business goals.

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[See plan comparisons](#)
[Reset](#)

OUT-OF-AREA PPO PLUS

Plan name	PPO PLUS PLAN L 6000/35/20%/8000		PPO PLUS PLAN M 7500/35/30%/9000	
Network	PPO Providers	Nonparticipating Providers	PPO Providers	Nonparticipating Providers
Annual Medical Deductible (IND/FAM) (per calendar year)	\$6,000/\$12,000	\$7,500/\$15,000	\$7,500/\$14,500	\$8,500/\$17,000
Annual out-of-pocket maximum (IND/FAM)	\$8,000/\$16,000	\$10,000/\$20,000	\$9,000/\$18,000	\$10,000/\$20,000
Office visits – preventive and well-child care	\$0	35%*	\$0	45%*
Office visits – primary care/mental health	\$5 for the first 3 visits; then \$35 ¹	35%*	\$5 for the first 3 visits; then \$35 ¹	45%*
Office visits – naturopathic care	\$5 for the first 3 visits; then \$35 ¹	35%*	\$5 for the first 3 visits; then \$35 ¹	45%*
Office visits – urgent care	\$55	35%*	\$55	45%*
Office visits – specialty care	\$45	35%*	\$45	45%*
Telehealth (phone/video)	\$0 for the first 3 visits; then \$0 ¹	35%*	\$0 for the first 3 visits; then \$0 ¹	45%*
Office visits – prenatal care	\$0	35%*	\$0	45%*
Outpatient surgery	20%*	35%*	30%*	45%*
X-ray/diagnostic tests	\$35	35%*	\$35	45%*
Lab	\$35	35%*	\$35	45%*
CT, MRI, and PET scans	20%*	35%*	30%*	45%*
Inpatient hospital care	20%*	35%*	30%*	45%*
Emergency department visits	20%*		20%*	
Routine eye exam	\$35	35%*	\$35	45%*

*After deductible.

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

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

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OUT-OF-AREA PPO PLUS

Plan name	PPO PLUS HDHP AA PLAN WFI 1700/20%/3500		PPO PLUS HDHP AA PLAN WAS 2800/20%/4000	
Network	PPO Providers	Nonparticipating Providers	PPO Providers	Nonparticipating Providers
Accumulation type	Aggregate		Aggregate	
Annual Medical Deductible (IND/FAM) (per calendar year)	\$1,700/\$3,400	\$3,500/\$7,000	\$2,800/\$5,600	\$3,500/\$7,000
Annual out-of-pocket maximum (IND/FAM)	\$3,500/\$7,000	\$6,000/\$12,000	\$4,000/\$8,000	\$7,000/\$14,000
Office visits – preventive and well-child care	\$0	30%*	\$0	30%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 20%* ¹	30%*	\$5* for the first 3 visits; then 20%* ¹	30%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 20%* ¹	30%*	\$5* for the first 3 visits; then 20%* ¹	30%*
Office visits – urgent care	20%*	30%*	20%*	30%*
Office visits – specialty care	20%*	30%*	20%*	30%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	30%*	0%* for the first 3 visits; then 0%* ¹	30%*
Office visits – prenatal care	\$0	30%*	\$0	30%*
Outpatient surgery	20%*	30%*	20%*	30%*
X-ray/diagnostic tests	20%*	30%*	20%*	30%*
Lab	20%*	30%*	20%*	30%*
CT, MRI, and PET scans	20%*	30%*	20%*	30%*
Inpatient hospital care	20%*	30%*	20%*	30%*
Emergency department visits	20%*		10%*	
Routine eye exam	20%*	30%*	20%*	30%*

*After deductible.

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

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

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OUT-OF-AREA PPO PLUS

Plan name	PPO PLUS HDHP EE PLAN WAT 3400/20%/6000		PPO PLUS HDHP EE PLAN 4000/20%/8000	
Network	PPO Providers	Nonparticipating Providers	PPO Providers	Nonparticipating Providers
Annual Medical Deductible (IND/FAM) (per calendar year)	\$3,400/\$6,800	\$4,500/\$9,000	\$4,000/\$8,000	\$6,000/\$12,000
Annual out-of-pocket maximum (IND/FAM)	\$6,000/\$12,000	\$7,500/\$15,000	\$8,000/\$16,000	\$9,000/\$18,000
Office visits – preventive and well-child care	\$0	30%*	\$0	30%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 20%* ¹	30%*	\$5* for the first 3 visits; then 20%* ¹	30%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 20%* ¹	30%*	\$5* for the first 3 visits; then 20%* ¹	30%*
Office visits – urgent care	20%*	30%*	20%*	30%*
Office visits – specialty care	20%*	30%*	20%*	30%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	30%*	0%* for the first 3 visits; then 0%* ¹	30%*
Office visits – prenatal care	\$0	30%*	\$0	30%*
Outpatient surgery	20%*	30%*	20%*	30%*
X-ray/diagnostic tests	20%*	30%*	20%*	30%*
Lab	20%*	30%*	20%*	30%*
CT, MRI, and PET scans	20%*	30%*	20%*	30%*
Inpatient hospital care	20%*	30%*	20%*	30%*
Emergency department visits	10%*		20%*	
Routine eye exam	20%*	30%*	20%*	30%*

*After deductible.

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

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OUT-OF-AREA PPO PLUS

Plan name	PPO PLUS HDHP EE PLAN 5000/20%/8000		PPO PLUS HDHP EE PLAN 5000/30%/8000	
Network	PPO Providers	Nonparticipating Providers	PPO Providers	Nonparticipating Providers
Annual Medical Deductible (IND/FAM) (per calendar year)	\$5,000/\$10,000	\$7,500/\$15,000	\$5,000/\$10,000	\$7,500/\$15,000
Annual out-of-pocket maximum (IND/FAM)	\$8,000/\$16,000	\$9,000/\$18,000	\$8,000/\$16,000	\$9,000/\$18,000
Office visits – preventive and well-child care	\$0	30%*	\$0	40%*
Office visits – primary care/mental health	\$5* for the first 3 visits; then 20%* ¹	30%*	\$5* for the first 3 visits; then 30%* ¹	40%*
Office visits – naturopathic care	\$5* for the first 3 visits; then 20%* ¹	30%*	\$5* for the first 3 visits; then 30%* ¹	40%*
Office visits – urgent care	20%*	30%*	30%*	40%*
Office visits – specialty care	20%*	30%*	30%*	40%*
Telehealth (phone/video)	0%* for the first 3 visits; then 0%* ¹	30%*	0%* for the first 3 visits; then 0%* ¹	40%*
Office visits – prenatal care	\$0	30%*	\$0	40%*
Outpatient surgery	20%*	30%*	30%*	40%*
X-ray/diagnostic tests	20%*	30%*	30%*	40%*
Lab	20%*	30%*	30%*	40%*
CT, MRI, and PET scans	20%*	30%*	30%*	40%*
Inpatient hospital care	20%*	30%*	30%*	40%*
Emergency department visits	20%*		30%*	
Routine eye exam	20%*	30%*	30%*	40%*

*After deductible.

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

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

Compare plans – TRADITIONAL, DEDUCTIBLE, HDHP

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

See plan pages for corresponding footnotes.

Start over

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

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

See plan pages for corresponding footnotes.

Start over

SUPPLEMENTAL BENEFIT OPTIONS

OUTPATIENT PRESCRIPTION DRUGS

View the Kaiser Permanente formulary at kp.org/formulary. Members get up to a 30-day supply of prescription medication for each cost share at Kaiser Permanente pharmacies.

Kaiser Permanente Mail-order pharmacy

Members get up to a 90-day supply of prescription maintenance medication for 2 copays when using the Kaiser Permanente mail-order pharmacy.

HSA-qualified HDHP plans will have a coinsurance reduction of 5% to 10% when utilizing the mail-order pharmacy on a 90-day supply:

- 10% reduced to 5%
- 20% reduced to 10%
- 30% reduced to 20%
- 40% reduced to 30%
- 50% reduced to 40%

Prescription drug cost shares below apply to the medical out-of-pocket maximum.

Specialty drugs

Specialty drugs are limited to a 30-day supply.

Traditional, deductible, KP Plus, and HSA-qualified HDHP plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

Generic	Preferred Brand	Non-Preferred Brand	Specialty	Pairs With Dual Choice
\$10	\$20	\$40	\$200	Yes
\$10	\$20	\$40	\$250	Yes
\$10	\$30	\$60	50%	Yes
\$15	\$30	\$50	\$200	Yes
\$15	\$30	\$50	\$250	Yes
\$15	\$30	\$50	\$300	Yes
\$15	\$60	\$80	50%	Yes
\$20	\$40	\$60	\$250	Yes
\$20	\$40	\$60	\$300	Yes

HSA-QUALIFIED HDHP COST SHARE OPTIONS

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

Generic	Preferred Brand	Non-Preferred Brand	Specialty	Pairs With Dual Choice
\$10	\$20	\$40	\$200	Yes
\$10	\$20	\$40	\$250	Yes
\$10	\$30	\$60	50%	Yes
\$15	\$30	\$50	\$200	Yes
\$15	\$30	\$50	\$250	Yes
\$15	\$30	\$50	\$300	Yes
\$15	\$60	\$80	50%	Yes
\$20	\$40	\$60	\$250	Yes
\$20	\$40	\$60	\$300	Yes
10%	10%	10%	10%	Yes
20%	20%	20%	20%	Yes
30%	30%	30%	30%	Yes
40%	40%	40%	40%	Yes
50%	50%	50%	50%	No

A prescription drug rider for HSA-qualified high deductible health plans may also be purchased with certain preventive drugs not subject to the deductible. Contact your Kaiser Permanente sales representative or account manager for details.

Kaiser Permanente Plus™ Plans

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

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

Kaiser Permanente Pharmacies				Out-of-Network Pharmacies (Limited to 5 prescription fills per year)			
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Generic	Preferred Brand	Non-Preferred Brand	Specialty
\$10	\$20	\$40	\$200	\$30	\$40	\$60	\$220
\$10	\$20	\$40	\$250	\$30	\$40	\$60	\$270
\$10	\$30	\$60	50%	\$30	\$50	\$80	50%
\$15	\$30	\$50	\$200	\$35	\$50	\$70	\$220
\$15	\$30	\$50	\$250	\$35	\$50	\$70	\$270
\$15	\$30	\$50	\$300	\$35	\$50	\$70	\$320
\$15	\$60	\$80	50%	\$35	\$80	\$100	50%
\$20	\$40	\$60	\$250	\$40	\$60	\$80	\$270
\$20	\$40	\$60	\$300	\$40	\$60	\$80	\$320

Note: Mail order only available through Kaiser Permanente pharmacies.

Dual Choice PPO plans

Below are pharmacy benefit designs available for Dual Choice PPO plans. The pharmacy option chosen for the base plan must match the option chosen for the Dual Choice PPO plan. Dual Choice members have access to Kaiser Permanente pharmacies and a broad national network of pharmacies through MedImpact. For additional information on providers, facilities, and pharmacy networks, visit kp.org/choiceproducts/nw.

TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

Kaiser Permanente Pharmacies				MedImpact Pharmacies			
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Generic	Preferred Brand	Non-Preferred Brand	Specialty
\$10	\$20	\$40	\$200	\$20	\$40	\$70	25%
\$10	\$20	\$40	\$250	\$20	\$40	\$70	30%
\$10	\$30	\$60	50%	\$20	\$50	\$90	50%
\$15	\$30	\$50	\$200	\$25	\$50	\$80	25%
\$15	\$30	\$50	\$250	\$25	\$50	\$80	30%
\$15	\$30	\$50	\$300	\$25	\$50	\$80	35%
\$15	\$60	\$80	50%	\$25	\$80	\$110	50%
\$20	\$40	\$60	\$250	\$30	\$60	\$90	30%
\$20	\$40	\$60	\$300	\$30	\$60	\$90	35%

The Kaiser Permanente formulary applies to Kaiser Permanente pharmacies as a part of Dual Choice PPO plans. View our formulary at kp.org/formulary.

(Dual Choice PPO plans continued)

HSA-QUALIFIED HDHP COST SHARE OPTIONS

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

Kaiser Permanente Pharmacies				MedImpact Pharmacies			
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Generic	Preferred Brand	Non-Preferred Brand	Specialty
\$10	\$20	\$40	\$200	\$20	\$40	\$70	25%
\$10	\$20	\$40	\$250	\$20	\$40	\$70	30%
\$10	\$30	\$60	50%	\$20	\$50	\$90	50%
\$15	\$30	\$50	\$200	\$25	\$50	\$80	25%
\$15	\$30	\$50	\$250	\$25	\$50	\$80	30%
\$15	\$30	\$50	\$300	\$25	\$50	\$80	35%
\$15	\$60	\$80	50%	\$25	\$80	\$110	50%
\$20	\$40	\$60	\$250	\$30	\$60	\$90	30%
\$20	\$40	\$60	\$300	\$30	\$60	\$90	35%
10%	10%	10%	10%	20%	20%	20%	20%
20%	20%	20%	20%	30%	30%	30%	30%
30%	30%	30%	30%	40%	40%	40%	40%
40%	40%	40%	40%	50%	50%	50%	50%

The Kaiser Permanente formulary applies to Kaiser Permanente pharmacies as a part of Dual Choice PPO plans. View our formulary at kp.org/formulary.

Out-of-Area PPO Plus plans

PPO Plus members have access to a broad national network of pharmacies through MedImpact, as well as access to Kaiser Permanente pharmacies. Members will pay the same cost share whether they use a Kaiser Permanente or MedImpact network pharmacy. Below are some examples of pharmacy benefit designs available for PPO Plus plans and HSA-qualified PPO Plus plans. The Kaiser Permanente formulary applies to Kaiser Permanente pharmacies as a part of PPO Plus plans. For additional information on providers, facilities, and pharmacy networks, visit kp.org/choiceproducts/nw.

DEDUCTIBLE COST SHARE OPTIONS

Kaiser Permanente or MedImpact Pharmacies				
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Pairs With Dual Choice
\$10	\$20	\$40	\$200	Yes
\$10	\$20	\$40	\$250	Yes
\$10	\$30	\$60	50%	Yes
\$15	\$30	\$50	\$200	Yes
\$15	\$30	\$50	\$250	Yes
\$15	\$30	\$50	\$300	Yes
\$15	\$60	\$80	50%	Yes
\$20	\$40	\$60	\$250	Yes
\$20	\$40	\$60	\$300	Yes

HSA-QUALIFIED HDHP COST SHARE OPTIONS

All cost shares shown below are after deductible for HSA-qualified HDHP PPO Plus plans.

Kaiser Permanente or MedImpact Pharmacies				
Generic	Preferred Brand	Non-Preferred Brand	Specialty	Pairs With Dual Choice
\$10	\$20	\$40	\$200	Yes
\$10	\$20	\$40	\$250	Yes
\$10	\$30	\$60	50%	Yes
\$15	\$30	\$50	\$200	Yes
\$15	\$30	\$50	\$250	Yes
\$15	\$30	\$50	\$300	Yes
\$15	\$60	\$80	50%	Yes
\$20	\$40	\$60	\$250	Yes
\$20	\$40	\$60	\$300	Yes
10%	10%	10%	10%	Yes
20%	20%	20%	20%	Yes
30%	30%	30%	30%	Yes
40%	40%	40%	40%	Yes
50%	50%	50%	50%	No

HEARING AIDS

Traditional, deductible, KP Plus, and HSA-qualified HDHP plans

Our traditional, deductible, and HSA-qualified plans offer several options for hearing aid benefits. Members can get 1 hearing aid per ear per 36, 48, or 60 months up to a \$250, \$500, \$1,000, or \$1,500 allowance per ear.

Note: The rider only covers adults. Pediatric coverage is part of the Oregon pediatric mandate. For KP Plus plans, hearing aid rider benefits are only available in-network.

Dual Choice PPO, HSA-qualified Dual Choice PPO, Out-of-Area PPO Plus, and HSA-qualified Out-of-Area PPO Plus plans

Dual Choice PPO plans (including HSA-qualified plans) offer several options for hearing aid benefits. Members may purchase hearing aids through Kaiser Permanente or direct contracted providers, in-network/PPO providers, or out-of-network/nonparticipating providers. One hearing aid per ear per 36, 48, or 60 months up to a \$250, \$500, \$1,000, or \$1,500 allowance per ear.

Dual Choice PPO and PPO Plus members may purchase hearing aids from:

In-network/PPO providers

In states where Kaiser Permanente operates, members can get care from Kaiser Permanente providers and First Choice Health providers in Oregon and Washington, and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington D.C.¹ In all other states, members can visit Cigna Healthcare PPO Network providers.²

Out-of-network/nonparticipating providers

Members can also get care from an out-of-network provider of their choice.

Note: The rider only covers adults. Pediatric coverage is part of the Oregon pediatric mandate.

ALTERNATIVE CARE

Traditional, deductible, KP Plus, and HSA-qualified HDHP plans

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

Note: For KP Plus plans, rider benefits are only available in-network.

¹Kaiser Permanente states: California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

²The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

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.

Buy-up self-referred alternative care benefits

Groups can choose to add self-referred alternative care for the following services:

Self-Referred Services	Cost Share Options*	Visit Limit Options
Chiropractic	\$10/\$25/\$40	20 or 30
Acupuncture	\$10/\$25/\$40	12 or 24
Massage	\$25	12

*Subject to deductible on HSA-qualified plans.

Services may be received from Heraya Health a broad network of alternative care providers in the Pacific Northwest. Visit herayahealth.com for a list of providers.

Dual Choice PPO and HSA-qualified Dual Choice PPO plans

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

Buy-up self-referred alternative care benefits

Groups can choose to add self-referred alternative care for the following services:

Self-Referred Services	Cost Share Options* In-Network Providers	Cost Share Options* Out-of-Network Providers	Visit Limit Options
Chiropractic	\$10/\$25/\$40	40%	20 or 30
Acupuncture	\$10/\$25/\$40	40%	12 or 24
Massage	\$25	40%	12

*Subject to deductible on HSA-qualified plans.

In-network

Dual Choice PPO members can get care from Kaiser Permanente and Heraya Health a broad network of alternative care providers in the Pacific Northwest. Visit herayahealth.com for a list of providers.

In states where Kaiser Permanente operates, Dual Choice PPO members can get care from First Choice Health providers in Oregon and Washington and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C.¹ In all other states, members can visit The Cigna Healthcare PPO Network providers.²

¹Kaiser Permanente states: California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

²The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

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Out-of-network

Members can also get care from an out-of-network provider of their choice.

Out-of-Area PPO Plus and HSA-qualified Out-of-Area PPO Plus plans

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

Buy-up self-referred alternative care benefits

Groups can choose to add self-referred alternative care for the following services:

Self-Referred Services	Cost Share Options* PPO Providers	Cost Share Options* Nonparticipating providers	Visit Limit Options
Chiropractic	\$10/\$25/\$40	40%	20 or 30
Acupuncture	\$10/\$25/\$40	40%	12 or 24
Massage	\$25	40%	12

*Subject to deductible on HSA-qualified plans.

PPO providers

PPO Plus members can get care from Kaiser Permanente, First Choice Health providers in Oregon and Washington, and First Health Network providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C.¹ In all other states, members can visit The Cigna Healthcare PPO Network providers.²

Nonparticipating providers

Members can also get care from nonparticipating providers of their choice.

VISION HARDWARE

Traditional, deductible, KP Plus, and HDHP plans

Eye exams are covered as a medical benefit at the applicable office visit cost share. Vision hardware must be purchased from Vision Essentials by Kaiser Permanente or participating facilities (for members in Eugene). For KP Plus plans, vision hardware is only available in-network. Vision exams are covered out-of-network and subject to the 10 medical visit limit per year. Visit kp2020.org for more info.

¹Kaiser Permanente states: California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

²The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

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.

For members 19 and older

An allowance is provided toward the purchase of eyeglass lenses and a frame, or contact lenses.

ALLOWANCE OPTIONS

\$150, \$200, \$250, \$300, \$400, or \$500 every calendar year
or
\$150, \$200, \$250, \$300, \$400, or \$500 every 2 calendar years

For members 18 and younger – Standard benefit

Each calendar year, one pair of eyeglass lenses and a standard frame from a specified collection of frames, or contact lenses.

For members 18 and younger – Enhanced benefit

With the enhanced benefit, the member may purchase frames outside of the specified collection. An allowance is provided toward the purchase of the eyeglass lenses/frame or contact lenses.

ALLOWANCE OPTIONS

\$150, \$200, \$250, \$300, \$400, or \$500 every calendar year

Dual Choice PPO, HSA-qualified Dual Choice PPO, Out-of-Area PPO Plus, and HSA-qualified PPO Plus plans

Eye exams are covered as a medical benefit at the applicable office visit cost share. Vision hardware may be purchased from Vision Essentials by Kaiser Permanente; First Choice Health optical providers in Oregon and Washington; First Health Network optical providers in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington D.C.; or nonparticipating optical providers.

For members 19 and older

An allowance is provided toward the purchase of eyeglass lenses and a frame, or contact lenses.

ALLOWANCE OPTIONS

\$150, \$200, \$250, \$300, \$400, or \$500 every calendar year
or
\$150, \$200, \$250, \$300, \$400, or \$500 every 2 calendar years

For members 18 and younger – Standard benefit

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

For members 18 and younger – Enhanced benefit

With the enhanced benefit, the member may purchases frames outside of the specified collection. An allowance is provided toward the purchase of the eyeglass lenses/frame or contact lenses when purchased from Vision Essentials by Kaiser Permanente or select facilities and First Choice Health optical vendors and First Health Network optical vendors.

ALLOWANCE OPTIONS

\$150, \$200, \$250, \$300, \$400, or \$500 every calendar year

SENIOR ADVANTAGE

Plan Name	Low Plan	Mid Plan	High Plan
Annual out-of-pocket maximum (IND)	\$1,500	\$1,000	\$600
Office visits – preventive	\$0	\$0	\$0
Office visits – primary care/mental health	\$20	\$15	\$10
Office visits – urgent care	\$25	\$20	\$15
Office visits – specialty care	\$25	\$20	\$15
Telehealth (phone/video)	\$0	\$0	\$0
Outpatient surgery	\$150	\$100	\$50
X-ray/diagnostic tests	\$0	\$0	\$0
Lab	\$0	\$0	\$0
CT, MRI, and PET scans	\$50	\$25	\$0
Inpatient hospital care	\$250 per admission	\$200 per admission	\$100 per admission
Emergency department visits	\$50	\$50	\$50
Routine eye exam	\$20	\$15	\$10
Outpatient perscription drugs – \$2,100 Part D out-of-pocket maximum	\$15 generic; \$30 preferred brand-name	\$10 generic; \$20 preferred brand-name	\$5 generic; \$10 preferred brand-name
Outside service area	\$1,000 maximum per year – 20%	\$1,000 maximum per year – 20%	\$1,000 maximum per year – 20%

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

Information in this brochure was accurate at the time of production. Details may have changed since publication.

For the most current information on our plans and services, check with your broker or producer or Kaiser Permanente sales executive or account manager.