## 2024 PLANS AND PRODUCTS | WASHINGTON

# Complete Suite™ plan comparison chart

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

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

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# 2024 Complete Suite™ plans

The list below includes all 2024 plan offerings. Select a plan to navigate to the full list of benefits.

Plans selected: ☐

Compare plans

| Traditional Copay | Deductible | Virtual Complete |
|---|---|---|
| ☐ TRAD PLAN A 10/1000 | ☐ DED PLAN A 250/10/10%/2000 | ☐ DED PLAN VC 2500/40/20%/5500 |
| ☐ TRAD PLAN B 20/1500 | ☐ DED PLAN A 250/15/20%/2500 | ☐ DED PLAN VC 3000/40/30%/6000 |
| ☐ TRAD PLAN C 20/2000 | ☐ DED PLAN B 500/20/10%/3000 | ☐ DED PLAN VC 4000/50/30%/7000 |
| ☐ TRAD PLAN D 30/2500 | ☐ DED PLAN B 500/10%/10%/2000 | ☐ DED PLAN VC 5000/50/40%/8000 |
| ☐ TRAD PLAN E 35/3000 | ☐ 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 | |
| | ☐ 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 | |
| | ☐ 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 K 5000/30/20%/7350 | |
| | ☐ DED PLAN L 6000/35/20%/7500 | |
| | ☐ DED PLAN M 7500/35/30%/8500 | |

Reset

Clear all plans selected

# 2024 Complete Suite™ plans

The list below includes all 2024 plan offerings. Select a plan to navigate to the full list of benefits.

Plans selected: ☐

Compare plans

| High deductible health plan (HDHP) | KP Plus | Dual Choice PPO |
|---|---|---|
| ☐ HDHP PLAN A 1600/10%/2500 | ☐ KP PLUS PLAN A 10/1000 | ☐ DUAL CHOICE PPO PLAN A 10/1500 |
| ☐ HDHP PLAN A 1600/20%/3500 | ☐ KP PLUS PLAN B 20/1500 | ☐ DUAL CHOICE PPO PLAN B 20/2000 |
| ☐ HDHP PLAN B 2000/20%/4000 | ☐ KP PLUS PLAN C 20/2000 | ☐ DUAL CHOICE PPO PLAN C 20/2500 |
| ☐ HDHP PLAN B 2000/30%/4000 | ☐ KP PLUS PLAN D 30/2500 | ☐ DUAL CHOICE PPO PLAN D 30/3000 |
| ☐ HDHP PLAN C 2500/20%/5000 | ☐ KP PLUS PLAN E 35/3000 | ☐ DUAL CHOICE PPO PLAN E 35/3500 |
| ☐ HDHP PLAN C 2500/30%/5000 | ☐ KP PLUS PLAN A 250/10/10%/2000 | ☐ DUAL CHOICE PPO PLAN A 250/10/10%/2500 |
| ☐ HDHP PLAN E 3200/10%/6000 | ☐ KP PLUS PLAN A 250/15/20%/2500 | ☐ DUAL CHOICE PPO PLAN A 250/15/20%/3000 |
| ☐ HDHP PLAN E 3200/20%/6000 | ☐ KP PLUS PLAN B 500/20/10%/3000 | ☐ DUAL CHOICE PPO PLAN B 500/20/10%/3500 |
| ☐ HDHP PLAN E 3200/30%/6000 | ☐ KP PLUS PLAN B 500/10%/10%/2000 | ☐ DUAL CHOICE PPO PLAN B 500/10%/10%/3000 |
| ☐ HDHP PLAN F 3500/20%/7000 | ☐ KP PLUS PLAN B 500/10/20%/2000 | ☐ DUAL CHOICE PPO PLAN B 500/10/20%/3000 |
| ☐ HDHP PLAN F 3500/30%/7000 | ☐ KP PLUS PLAN B 500/20/20%/3000 | ☐ DUAL CHOICE PPO PLAN B 500/20/20%/3500 |
| ☐ HDHP PLAN G 4000/20%/7000 | ☐ KP PLUS PLAN C 750/20/20%/3250 | ☐ DUAL CHOICE PPO PLAN C 750/20/20%/3500 |
| ☐ HDHP PLAN G 4000/30%/7000 | ☐ KP PLUS PLAN C 750/20%/20%/3000 | ☐ DUAL CHOICE PPO PLAN C 750/20%/20%/3500 |
| ☐ HDHP PLAN H 5000/20%/7000 | ☐ KP PLUS PLAN D 1000/20/20%/3000 | ☐ DUAL CHOICE PPO PLAN D 1000/20/20%/4000 |
| ☐ HDHP PLAN H 5000/30%/7000 | ☐ KP PLUS PLAN D 1000/25/20%/4000 | ☐ DUAL CHOICE PPO PLAN D 1000/25/20%/5000 |
| ☐ HDHP PLAN H 5000/40%/7000 | ☐ KP PLUS PLAN E 1500/25/20%/5500 | ☐ DUAL CHOICE PPO PLAN E 1500/25/20%/6000 |
| ☐ HDHP PLAN H 5000/50%/7000 | ☐ 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 K 5000/30/20%/7350 | ☐ DUAL CHOICE PPO PLAN K 5000/30/20%/8150 |
| | ☐ KP PLUS PLAN L 6000/35/20%/7500 | ☐ DUAL CHOICE PPO PLAN L 6000/35/20%/8000 |
| | ☐ KP PLUS PLAN M 7500/35/30%/8500 | ☐ DUAL CHOICE PPO PLAN M 7500/35/30%/8500 |

Reset

Clear all plans selected

# 2024 Complete Suite™ plans

The list below includes all 2024 plan offerings. Select a plan to navigate to the full list of benefits.

Plans selected: ☐

Compare plans

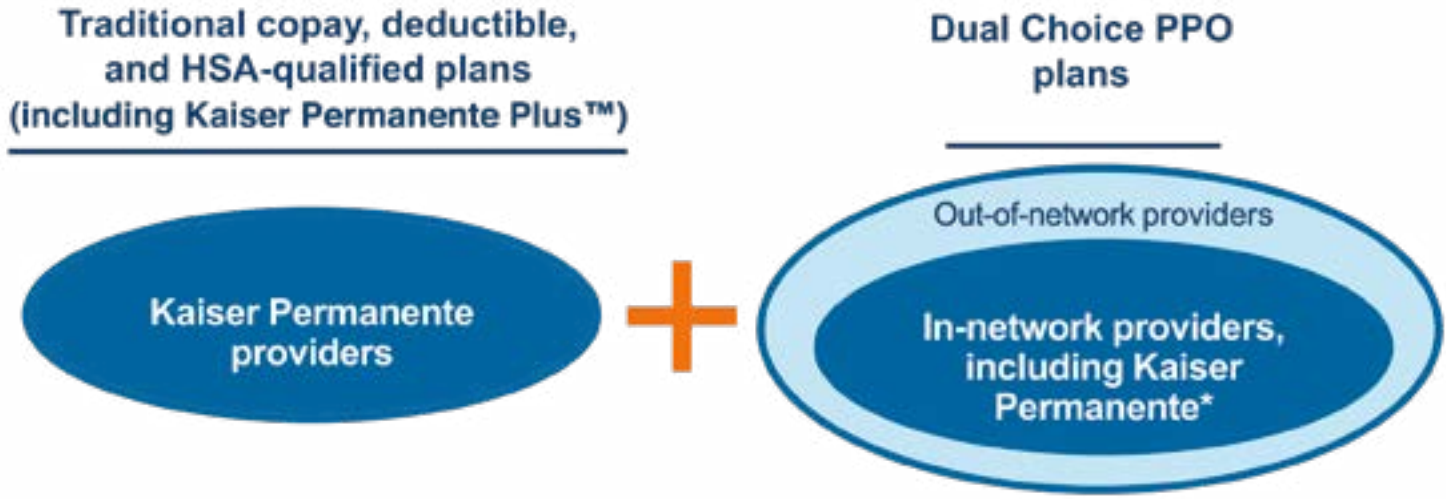
| Dual Choice PPO | Out of Area PPO Plus |
|---|---|
| ☐ DUAL CHOICE PPO PLAN VC 2500/40/20%/6500 | ☐ PPO PLUS PLAN WDB 500/20%/2500 |
| ☐ DUAL CHOICE PPO PLAN VC 3000/40/30%/7000 | ☐ PPO PLUS PLAN WDC 750/20%/3750 |
| ☐ DUAL CHOICE PPO PLAN VC 4000/50/30%/8150 | ☐ PPO PLUS PLAN WDT 1000/20%/3000 |
| ☐ DUAL CHOICE PPO PLAN VC 5000/50/40%/8150 | ☐ PPO PLUS PLAN WDE 1000/30%/4750 |
| ☐ DUAL CHOICE PPO HDHP PLAN A 1600/10%/2500 | ☐ PPO PLUS PLAN WDU 1500/20%/5500 |
| ☐ DUAL CHOICE PPO HDHP PLAN A 1600/20%/3500 | ☐ PPO PLUS PLAN WDP 1500/30%/6000 |
| ☐ DUAL CHOICE PPO HDHP PLAN B 2000/20%/4000 | ☐ PPO PLUS PLAN WDN 2000/30%/6000 |
| ☐ DUAL CHOICE PPO HDHP PLAN B 2000/30%/4000 | ☐ PPO PLUS PLAN WDX 3000/30%/6850 |
| ☐ DUAL CHOICE PPO HDHP PLAN C 2500/20%/5000 | ☐ PPO PLUS PLAN WDR 4000/30%/7350 |
| ☐ DUAL CHOICE PPO HDHP PLAN C 2500/30%/5000 | ☐ PPO PLUS PLAN WDS 5000/30%/7350 |
| ☐ DUAL CHOICE PPO HDHP PLAN E 3200/10%/6000 | ☐ PPO PLUS HDHP AA PLAN WFI 1600/20%/3500 |
| ☐ DUAL CHOICE PPO HDHP PLAN E 3200/20%/6000 | ☐ PPO PLUS HDHP AA PLAN WAS 2800/20%/4000 |
| ☐ DUAL CHOICE PPO HDHP PLAN E 3200/30%/6000 | |
| ☐ DUAL CHOICE PPO HDHP PLAN F 3500/20%/7000 | |
| ☐ DUAL CHOICE PPO HDHP PLAN F 3500/30%/7000 | |
| ☐ DUAL CHOICE PPO HDHP PLAN G 4000/20%/7000 | |
| ☐ DUAL CHOICE PPO HDHP PLAN G 4000/30%/7000 | |
| ☐ DUAL CHOICE PPO HDHP PLAN H 5000/20%/7000 | |
| ☐ DUAL CHOICE PPO HDHP PLAN H 5000/30%/7000 | |
| ☐ DUAL CHOICE PPO HDHP PLAN H 5000/40%/7000 | |

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.




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

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

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

# Accumulation types

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

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

## Aggregate accumulation:

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

## Embedded accumulation:

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

# 2024 COMPLETE SUITE™ PAIRING GUIDE

## Traditional and deductible plans

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

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

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

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



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# 2024 COMPLETE SUITE™ PAIRING GUIDE

## Traditional and deductible plans

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

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

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

| KAISER PERMANENTE PLUS™ DEDUCTIBLE PLANS | 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 |
| 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 | | | | | | | | * | | † |

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.



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# 2024 COMPLETE SUITE™ PAIRING GUIDE

## Traditional and deductible plans

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

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

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

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



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# 2024 COMPLETE SUITE™ PAIRING GUIDE

## Traditional and deductible plans

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

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

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

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

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge.
Only plans with Dual Choice PPO pairings are displayed.
Plans are paired using multiple factors including, but not limited to, traditional/deductible plan cost shares, deductibles, and out-of-pocket limits compared to the Dual Choice PPO plan.
All pairings assume alignment between the traditional/deductible plan and the Dual Choice PPO Kaiser Permanente pharmacy riders.
Approved plan pairings include KP Plus versions of the traditional and deductible plans listed above.



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# 2024 COMPLETE SUITE™ PAIRING GUIDE

## High deductible plans

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

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

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

| | | DUAL CHOICE PPO PLANS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | PPO HDHP PLAN A 1600/10%/2500 | PPO HDHP PLAN A 1600/20%/3500 | PPO HDHP PLAN B 2000/20%/4000 | PPO HDHP PLAN B 2000/30%/4000 | PPO HDHP PLAN C 2500/20%/5000 | PPO HDHP PLAN C 2500/30%/5000 | PPO HDHP PLAN E 3200/10%/6000 | PPO HDHP PLAN E 3200/20%/6000 | PPO HDHP PLAN E 3200/30%/6000 |
| HIGH DEDUCTIBLE HEALTH PLANS | HDHP PLAN A 1600/10%/2500 | * | † | † | | | | | | |
| | HDHP PLAN A 1600/20%/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.



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# 2024 COMPLETE SUITE™ PAIRING GUIDE

## High deductible plans

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

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

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

| | | DUAL CHOICE PPO PLANS | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PPO HDHP PLAN C 2500/20%/5000 | PPO HDHP PLAN C 2500/30%/5000 | PPO HDHP PLAN E 3200/10%/6000 | PPO HDHP PLAN E 3200/20%/6000 | PPO HDHP PLAN E 3200/30%/6000 | PPO HDHP PLAN F 3500/20%/7000 | PPO HDHP PLAN F 3500/30%/7000 | PPO HDHP PLAN G 4000/20%/7000 | PPO HDHP PLAN G 4000/30%/7000 | PPO HDHP PLAN H 5000/20%/7000 | PPO HDHP PLAN H 5000/30%/7000 |
| HIGH DEDUCTIBLE HEALTH PLANS | HDHP PLAN C 2500/20%/5000 | * | † | † | † | † | † | | | | | |
| | HDHP PLAN C 2500/30%/5000 | | * | | | † | | † | | † | | |
| | HDHP PLAN E 3200/10%/6000 | | | * | † | † | † | † | † | | | |
| | HDHP PLAN E 3200/20%/6000 | | | | * | † | † | † | † | | | |
| | HDHP PLAN E 3200/30%/6000 | | | | | * | | † | | † | | |
| | 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.



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# 2024 COMPLETE SUITE™ PAIRING GUIDE

## High deductible plans

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

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

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

| HIGH DEDUCTIBLE HEALTH PLANS | DUAL CHOICE PPO PLANS: PPO HDHP PLAN G 4000/20%/7000 | PPO HDHP PLAN G 4000/30%/7000 | PPO HDHP PLAN H 5000/20%/7000 | PPO HDHP PLAN H 5000/30%/7000 | PPO HDHP PLAN H 5000/40%/7000 |
|---|---|---|---|---|---|
| HDHP PLAN G 4000/20%/7000 | * | † | † | † | |
| HDHP PLAN G 4000/30%/7000 | | * | | † | |
| HDHP PLAN H 5000/20%/7000 | | | * | † | † |
| HDHP PLAN H 5000/30%/7000 | | | | * | † |
| HDHP PLAN H 5000/40%/7000 | | | | | * |
| HDHP PLAN H 5000/50%/7000 | | | | | * |

Dual Choice PPO offerings outside of the shaded combinations above require prior underwriting approval and may require an additional risk charge.
Only plans with Dual Choice PPO pairings are displayed.
Plans are paired using multiple factors including, but not limited to, high deductible plan cost shares, deductibles, and out-of-pocket limits compared to the Dual Choice PPO plan.
All pairings assume alignment between the high deductible plan and the Dual Choice PPO Kaiser Permanente pharmacy riders.



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# 2024 COMPLETE SUITE™ PAIRING GUIDE

## Virtual Complete™ plans

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

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

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

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

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.



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

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

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 – prenatal care | $0 | $0 | $0 | $0 | $0 |
| Telehealth (phone/video) | $0 | $0 | $0 | $0 | $0 |
| Office visits – primary care | $10 | $20 | $20 | $30 | $35 |
| Office visits – urgent care | $30 | $40 | $40 | $50 | $60 |
| Office visits – specialty care | $20 | $30 | $30 | $40 | $45 |
| Office visits – naturopathic care | $10 | $20 | $20 | $30 | $35 |
| Lab | $10 | $20 | $20 | $30 | $35 |
| X-ray/diagnostic tests | $10 | $20 | $20 | $30 | $35 |
| CT, MRI, and PET scans | $50 | $50 | $50 | $50 | $50 |
| Outpatient surgery | $50 | $50 | $50 | $100 | $150 |
| Inpatient hospital care | $100 per day, $500 per admission | $100 per day, $500 per admission | $200 per day, $1,000 per admission | $200 per day, $1,000 per admission | $800 per admission |
| Emergency care | $100 | $100 | $200 | $200 | $200 |
| Routine eye exam | $10 | $20 | $20 | $30 | $35 |

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KAISER PERMANENTE®

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

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

See plan comparisons

Reset

| 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 – prenatal care | $0 | $0 | $0 | $0 |
| Telehealth (phone/video) | $0 | $0 | $0 | $0 |
| Office visits – primary care | $10 | $15 | $20 | 10%* |
| Office visits – urgent care | $10 | $35 | $40 | 10%* |
| Office visits – specialty care | $10 | $25 | $30 | 10%* |
| Office visits – naturopathic care | $10 | $15 | $20 | 10%* |
| Lab | 10%* | $15 | $20 | 10%* |
| X-ray/diagnostic tests | 10%* | $15 | $20 | 10%* |
| CT, MRI, and PET scans | 10%* | $100 | $100 | 10%* |
| Outpatient surgery | 10%* | 20%* | 10%* | 10%* |
| Inpatient hospital care | 10%* | 20%* | 10%* | 10%* |
| Emergency care | $200* | 20%* | 10%* | $200* |
| Routine eye exam | $10 | $15 | $20 | 10%* |

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*After deductible.

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See plan comparisons

Reset

## 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 – prenatal care | $0 | $0 | $0 | $0 |
| Telehealth (phone/video) | $0 | $0 | $0 | $0 |
| Office visits – primary care | $10 | $20 | $20 | 20%* |
| Office visits – urgent care | $10 | $40 | $40 | 20%* |
| Office visits – specialty care | $10 | $30 | $30 | 20%* |
| Office visits – naturopathic care | $10 | $20 | $20 | 20%* |
| Lab | 20%* | $20 | $20 | 20%* |
| X-ray/diagnostic tests | 20%* | $20 | $20 | 20%* |
| CT, MRI, and PET scans | 20%* | $100 | $100 | 20%* |
| Outpatient surgery | 20%* | 20%* | 20%* | 20%* |
| Inpatient hospital care | 20%* | 20%* | 20%* | 20%* |
| Emergency care | $200* | 20%* | 20%* | $200* |
| Routine eye exam | $10 | $20 | $20 | 20%* |

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*After deductible.

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See plan comparisons

Reset

| DEDUCTIBLE | | | | |
|---|---|---|---|---|
| Plan Name | ☐ DED PLAN D 1000/20/20%/3000 | ☐ DED PLAN D 1000/25/20%/4000 | ☐ DED PLAN E 1500/25/20%/5500 | ☐ DED PLAN E 1500/20/30%/4000 |
| Annual medical deductible (IND/FAM) (per calendar year) | $1,000/$3,000 | $1,000/$3,000 | $1,500/$4,500 | $1,500/$4,500 |
| Annual out-of-pocket maximum (IND/FAM) | $3,000/$9,000 | $4,000/$12,000 | $5,500/$11,000 | $4,000/$12,000 |
| Office visits – preventive and well-child care | $0 | $0 | $0 | $0 |
| Office visits – prenatal care | $0 | $0 | $0 | $0 |
| Telehealth (phone/video) | $0 | $0 | $0 | $0 |
| Office visits – primary care | $20 | $25 | $25 | $20 |
| Office visits – urgent care | $20 | $45 | $45 | $20 |
| Office visits – specialty care | $20 | $35 | $35 | $20 |
| Office visits – naturopathic care | $20 | $25 | $25 | $20 |
| Lab | 20%* | $25 | $25 | 30%* |
| X-ray/diagnostic tests | 20%* | $25 | $25 | 30%* |
| CT, MRI, and PET scans | 20%* | $100 | $100 | 30%* |
| Outpatient surgery | 20%* | 20%* | 20%* | 30%* |
| Inpatient hospital care | 20%* | 20%* | 20%* | 30%* |
| Emergency care | $200* | 20%* | 20%* | $200* |
| Routine eye exam | $20 | $25 | $25 | $20 |

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*After deductible.

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KAISER PERMANENTE®

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See plan comparisons

Reset

## 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 – prenatal care | $0 | $0 | $0 | $0 |
| Telehealth (phone/video) | $0 | $0 | $0 | $0 |
| Office visits – primary care | $25 | $25 | $30 | $30 |
| Office visits – urgent care | $45 | $45 | $30 | $50 |
| Office visits – specialty care | $35 | $35 | $30 | $40 |
| Office visits – naturopathic care | $25 | $25 | $30 | $30 |
| Lab | $25 | $25 | 30%* | $30 |
| X-ray/diagnostic tests | $25 | $25 | 30%* | $30 |
| CT, MRI, and PET scans | $100 | $100 | 30%* | $100 |
| Outpatient surgery | 20%* | 20%* | 30%* | 20%* |
| Inpatient hospital care | 20%* | 20%* | 30%* | 20%* |
| Emergency care | 20%* | 20%* | $200* | 20%* |
| Routine eye exam | $25 | $25 | $30 | $30 |

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

*After deductible.

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KAISER PERMANENTE®

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

See plan comparisons

Reset

| 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 K 5000/30/20%/7350 |
| Annual medical deductible (IND/FAM) (per calendar year) | $3,000/$6,000 | $3,500/$10,500 | $4,000/$10,000 | $5,000/$10,000 |
| Annual out-of-pocket maximum (IND/FAM) | $6,000/$12,000 | $7,350/$14,700 | $7,500/$15,000 | $7,350/$14,700 |
| Office visits – preventive and well-child care | $0 | $0 | $0 | $0 |
| Office visits – prenatal care | $0 | $0 | $0 | $0 |
| Telehealth (phone/video) | $0 | $0 | $0 | $0 |
| Office visits – primary care | 30%* | $30 | $30 | $30 |
| Office visits – urgent care | 30%* | $50 | $50 | $50 |
| Office visits – specialty care | 30%* | $40 | $40 | $40 |
| Office visits – naturopathic care | 30%* | $30 | $30 | $30 |
| Lab | 30%* | $30 | $30 | $30 |
| X-ray/diagnostic tests | 30%* | $30 | $30 | $30 |
| CT, MRI, and PET scans | 30%* | $100 | $100 | $100 |
| Outpatient surgery | 30%* | 20%* | 20%* | 20%* |
| Inpatient hospital care | 30%* | 20%* | 20%* | 20%* |
| Emergency care | $200* | 20%* | 20%* | 20%* |
| Routine eye exam | 30%* | $30 | $30 | $30 |

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

*After deductible.

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KAISER PERMANENTE®

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

See plan comparisons

Reset

| DEDUCTIBLE | | |
|---|---|---|
| Plan Name | ☐ DED PLAN L 6000/35/20%/7500 | ☐ DED PLAN M 7500/35/30%/8500 |
| Annual medical deductible (IND/FAM) (per calendar year) | $6,000/$12,000 | $7,500/$14,500 |
| Annual out-of-pocket maximum (IND/FAM) | $7,500/$15,000 | $8,500/$17,000 |
| Office visits – preventive and well-child care | $0 | $0 |
| Office visits – prenatal care | $0 | $0 |
| Telehealth (phone/video) | $0 | $0 |
| Office visits – primary care | $35 | $35 |
| Office visits – urgent care | $55 | $55 |
| Office visits – specialty care | $45 | $45 |
| Office visits – naturopathic care | $35 | $35 |
| Lab | $35 | $35 |
| X-ray/diagnostic tests | $35 | $35 |
| CT, MRI, and PET scans | $150 | $150 |
| Outpatient surgery | 20%* | 30%* |
| Inpatient hospital care | 20%* | 30%* |
| Emergency care | 20%* | 30%* |
| Routine eye exam | $35 | $35 |

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*After deductible.

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

See plan comparisons

Reset

## VIRTUAL COMPLETE

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

*After deductible.

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

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See plan comparisons

Reset

## HIGH DEDUCTIBLE HEALTH PLAN

| Plan Name | ☐ HDHP PLAN A 1600/10%/2500 | ☐ HDHP PLAN A 1600/20%/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)** | $1,600/$3,200 | $1,600/$3,200 | $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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0* | $0* | $0* | $0* |
| **Office visits – primary care** | 10%* | 20%* | 20%* | 30%* |
| **Office visits – urgent care** | 10%* | 20%* | 20%* | 30%* |
| **Office visits – specialty care** | 10%* | 20%* | 20%* | 30%* |
| **Office visits – naturopathic care** | 10%* | 20%* | 20%* | 30%* |
| **Lab** | 10%* | 20%* | 20%* | 30%* |
| **X-ray/diagnostic tests** | 10%* | 20%* | 20%* | 30%* |
| **CT, MRI, and PET scans** | 10%* | 20%* | 20%* | 30%* |
| **Outpatient surgery** | 10%* | 20%* | 20%* | 30%* |
| **Inpatient hospital care** | 10%* | 20%* | 20%* | 30%* |
| **Emergency care** | 10%* | 20%* | 20%* | 30%* |
| **Routine eye exam** | 10%* | 20%* | 20%* | 30%* |

*After deductible.

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See plan comparisons

Reset

## HIGH DEDUCTIBLE HEALTH PLAN

| Plan Name | ☐ HDHP PLAN C 2500/20%/5000 | ☐ HDHP PLAN C 2500/30%/5000 | ☐ HDHP PLAN E 3200/10%/6000 | ☐ HDHP PLAN E 3200/20%/6000 |
|---|---|---|---|---|
| **Accumulation type** | Aggregate | Aggregate | Embedded | Embedded |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $2,500/$5,000 | $2,500/$5,000 | $3,200/$6,400 | $3,200/$6,000 |
| **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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0* | $0* | 0%* | $0* |
| **Office visits – primary care** | 20%* | 30%* | 10%* | 20%* |
| **Office visits – urgent care** | 20%* | 30%* | 10%* | 20%* |
| **Office visits – specialty care** | 20%* | 30%* | 10%* | 20%* |
| **Office visits – naturopathic care** | 20%* | 30%* | 10%* | 20%* |
| **Lab** | 20%* | 30%* | 10%* | 20%* |
| **X-ray/diagnostic tests** | 20%* | 30%* | 10%* | 20%* |
| **CT, MRI, and PET scans** | 20%* | 30%* | 10%* | 20%* |
| **Outpatient surgery** | 20%* | 30%* | 10%* | 20%* |
| **Inpatient hospital care** | 20%* | 30%* | 10%* | 20%* |
| **Emergency care** | 20%* | 30%* | 10%* | 20%* |
| **Routine eye exam** | 20%* | 30%* | 10%* | 20%* |

*After deductible.

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See plan comparisons

Reset

## HIGH DEDUCTIBLE HEALTH PLAN

| Plan Name | ☐ HDHP PLAN E 3200/30%/6000 | ☐ HDHP PLAN F 3500/20%/7000 | ☐ HDHP PLAN F 3500/30%/7000 | ☐ HDHP PLAN G 4000/20%/7000 |
|---|---|---|---|---|
| **Accumulation type** | Embedded | Embedded | Embedded | Embedded |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $3,200/$6,000 | $3,500/$7,000 | $3,500/$7,000 | $4,000/$8,000 |
| **Annual out-of-pocket maximum (IND/FAM)** | $6,000/$12,000 | $7,000/$14,000 | $7,000/$14,000 | $7,000/$14,000 |
| **Office visits – preventive and well-child care** | $0 | $0 | $0 | $0 |
| **Office visits – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0* | $0* | $0* | $0* |
| **Office visits – primary care** | 30%* | 20%* | 30%* | 20%* |
| **Office visits – urgent care** | 30%* | 20%* | 30%* | 20%* |
| **Office visits – specialty care** | 30%* | 20%* | 30%* | 20%* |
| **Office visits – naturopathic care** | 30%* | 20%* | 30%* | 20%* |
| **Lab** | 30%* | 20%* | 30%* | 20%* |
| **X-ray/diagnostic tests** | 30%* | 20%* | 30%* | 20%* |
| **CT, MRI, and PET scans** | 30%* | 20%* | 30%* | 20%* |
| **Outpatient surgery** | 30%* | 20%* | 30%* | 20%* |
| **Inpatient hospital care** | 30%* | 20%* | 30%* | 20%* |
| **Emergency care** | 30%* | 20%* | 30%* | 20%* |
| **Routine eye exam** | 30%* | 20%* | 30%* | 20%* |

*After deductible.

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

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See plan comparisons

Reset

## HIGH DEDUCTIBLE HEALTH PLAN

| Plan Name | ☐ HDHP PLAN G 4000/30%/7000 | ☐ HDHP PLAN H 5000/20%/7000 | ☐ HDHP PLAN H 5000/30%/7000 |
|---|---|---|---|
| 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) | $7,000/$14,000 | $7,000/$14,000 | $7,000/$14,000 |
| Office visits – preventive and well-child care | $0 | $0 | $0 |
| Office visits – prenatal care | $0 | $0 | $0 |
| Telehealth (phone/video) | $0* | $0* | $0* |
| Office visits – primary care | 30%* | 20%* | 30%* |
| Office visits – urgent care | 30%* | 20%* | 30%* |
| Office visits – specialty care | 30%* | 20%* | 30%* |
| Office visits – naturopathic care | 30%* | 20%* | 30%* |
| Lab | 30%* | 20%* | 30%* |
| X-ray/diagnostic tests | 30%* | 20%* | 30%* |
| CT, MRI, and PET scans | 30%* | 20%* | 30%* |
| Outpatient surgery | 30%* | 20%* | 30%* |
| Inpatient hospital care | 30%* | 20%* | 30%* |
| Emergency care | 30%* | 20%* | 30%* |
| Routine eye exam | 30%* | 20%* | 30%* |

*After deductible.

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

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See plan comparisons

Reset

| HIGH DEDUCTIBLE HEALTH PLAN | | |
|---|---|---|
| **Plan Name** | ☐ **HDHP PLAN H 5000/40%/7000** | ☐ **HDHP PLAN H 5000/50%/7000** |
| **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)** | $7,000/$14,000 | $7,000/$14,000 |
| **Office visits – preventive and well-child care** | $0 | $0 |
| **Office visits – prenatal care** | $0 | $0 |
| **Telehealth (phone/video)** | $0* | $0* |
| **Office visits – primary care** | 40%* | 50%* |
| **Office visits – urgent care** | 40%* | 50%* |
| **Office visits – specialty care** | 40%* | 50%* |
| **Office visits – naturopathic care** | 40%* | 50%* |
| **Lab** | 40%* | 50%* |
| **X-ray/diagnostic tests** | 40%* | 50%* |
| **CT, MRI, and PET scans** | 40%* | 50%* |
| **Outpatient surgery** | 40%* | 50%* |
| **Inpatient hospital care** | 40%* | 50%* |
| **Emergency care** | 40%* | 50%* |
| **Routine eye exam** | 40%* | 50%* |

*After deductible.

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

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KAISER PERMANENTE®

# KP PLUS PLANS

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

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

## KP Plus Benefit Design Summary

**Limited to 10 medical services and 5 pharmacy fills per year**

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

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See plan comparisons

Reset

## 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)** | N/A | N/A | N/A | 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $10 | $30 | $20 | $40 |
| **Office visits – urgent care** | $30 | Not covered, except for services received outside the service area[1,2] | $40 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $20 | $40 | $30 | $50 |
| **Office visits – naturopathic care** | $10 | $30 | $20 | $40 |
| **Lab** | $10 | $30 | $20 | $40 |
| **X-ray/diagnostic tests** | $10 | $30 | $20 | $40 |
| **CT, MRI, and PET scans** | $50 | Not covered | $50 | Not covered |
| **Outpatient surgery** | $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 care** | $100 | Covered at the in-network cost share[1] | $100 | Covered at the in-network cost share[1] |
| **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.

[1]The limit of 10 covered Services does not apply.

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

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See plan comparisons

Reset

| 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)** | N/A | N/A | N/A | 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $20 | $40 | $30 | $50 |
| **Office visits – urgent care** | $40 | Not covered, except for services received outside the service area[1,2] | $50 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $30 | $50 | $40 | $60 |
| **Office visits – naturopathic care** | $20 | $40 | $30 | $50 |
| **Lab** | $20 | $40 | $30 | $50 |
| **X-ray/diagnostic tests** | $20 | $40 | $30 | $50 |
| **CT, MRI, and PET scans** | $50 | Not covered | $50 | Not covered |
| **Outpatient surgery** | $50 | Not covered | $100 | Not covered |
| **Inpatient hospital care** | $200 per day, $1,000 per admission | Not covered | $200 per day, $1,000 per admission | Not covered |
| **Emergency care** | $200 | Covered at the in-network cost share[1] | $200 | Covered at the in-network cost share[1] |
| **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.

[1]The limit of 10 covered Services does not apply.

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

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See plan comparisons

Reset

## 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)** | N/A | 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $35 | $55 | $10 | $30 |
| **Office visits – urgent care** | $60 | Not covered, except for services received outside the service area[1,2] | $10 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $45 | $65 | $10 | $30 |
| **Office visits – naturopathic care** | $35 | $55 | $10 | $30 |
| **Lab** | $35 | $55 | 10%* | 20% |
| **X-ray/diagnostic tests** | $35 | $55 | 10%* | 20% |
| **CT, MRI, and PET scans** | $50 | Not covered | 10%* | Not covered |
| **Outpatient surgery** | $150 | Not covered | 10%* | Not covered |
| **Inpatient hospital care** | $800 per admission | Not covered | 10%* | Not covered |
| **Emergency care** | $200 | Covered at the in-network cost share[1] | $200* | Covered at the in-network cost share[1] |
| **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 | |

*After deductible.

[1]The limit of 10 covered Services does not apply.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $15 | $35 | $20 | $40 |
| **Office visits – urgent care** | $35 | Not covered, except for services received outside the service area[1,2] | $40 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $25 | $45 | $30 | $50 |
| **Office visits – naturopathic care** | $15 | $35 | $20 | $40 |
| **Lab** | $15 | $35 | $20 | $40 |
| **X-ray/diagnostic tests** | $15 | $35 | $20 | $40 |
| **CT, MRI, and PET scans** | $100 | Not covered | $100 | Not covered |
| **Outpatient surgery** | 20%* | Not covered | 10%* | Not covered |
| **Inpatient hospital care** | 20%* | Not covered | 10%* | Not covered |
| **Emergency care** | 20%* | Covered at the in-network cost share[1] | 10%* | Covered at the in-network cost share[1] |
| **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 | |

*After deductible.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | 10%* | 20% | $10 | $30 |
| **Office visits – urgent care** | 10%* | Not covered, except for services received outside the service area[1,2] | $10 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | 10%* | 20% | $10 | $30 |
| **Office visits – naturopathic care** | 10%* | 20% | $10 | $30 |
| **Lab** | 10%* | 20% | 20%* | 30% |
| **X-ray/diagnostic tests** | 10%* | 20% | 20%* | 30% |
| **CT, MRI, and PET scans** | 10%* | Not covered | 20%* | Not covered |
| **Outpatient surgery** | 10%* | Not covered | 20%* | Not covered |
| **Inpatient hospital care** | 10%* | Not covered | 20%* | Not covered |
| **Emergency care** | $200* | Covered at the in-network cost share[1] | $200* | Covered at the in-network cost share[1] |
| **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 | |

*After deductible.

[1]The limit of 10 covered Services does not apply.

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

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $20 | $40 | $20 | $40 |
| **Office visits – urgent care** | $40 | Not covered, except for services received outside the service area[1,2] | $40 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $30 | $50 | $30 | $50 |
| **Office visits – naturopathic care** | $20 | $40 | $20 | $40 |
| **Lab** | $20 | $40 | $20 | $40 |
| **X-ray/diagnostic tests** | $20 | $40 | $20 | $40 |
| **CT, MRI, and PET scans** | $100 | Not covered | $100 | Not covered |
| **Outpatient surgery** | 20%* | Not covered | 20%* | Not covered |
| **Inpatient hospital care** | 20%* | Not covered | 20%* | Not covered |
| **Emergency care** | 20%* | Covered at the in-network cost share[1] | 20%* | Covered at the in-network cost share[1] |
| **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.

[1]The limit of 10 covered Services does not apply.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | 20%* | 30% | $20 | $40 |
| **Office visits – urgent care** | 20%* | Not covered, except for services received outside the service area[1,2] | $20 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | 20%* | 30% | $20 | $40 |
| **Office visits – naturopathic care** | 20%* | 30% | $20 | $40 |
| **Lab** | 20%* | 30% | 20%* | 30% |
| **X-ray/diagnostic tests** | 20%* | 30% | 20%* | 30% |
| **CT, MRI, and PET scans** | 20%* | Not covered | 20%* | Not covered |
| **Outpatient surgery** | 20%* | Not covered | 20%* | Not covered |
| **Inpatient hospital care** | 20%* | Not covered | 20%* | Not covered |
| **Emergency care** | $200* | Covered at the in-network cost share[1] | $200* | Covered at the in-network cost share[1] |
| **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.

[1]The limit of 10 covered Services does not apply.

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

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $25 | $45 | $25 | $45 |
| **Office visits – urgent care** | $45 | Not covered, except for services received outside the service area[1,2] | $45 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $35 | $55 | $35 | $55 |
| **Office visits – naturopathic care** | $25 | $45 | $25 | $45 |
| **Lab** | $25 | $45 | $25 | $45 |
| **X-ray/diagnostic tests** | $25 | $45 | $25 | $45 |
| **CT, MRI, and PET scans** | $100 | Not covered | $100 | Not covered |
| **Outpatient surgery** | 20%* | Not covered | 20%* | Not covered |
| **Inpatient hospital care** | 20%* | Not covered | 20%* | Not covered |
| **Emergency care** | 20%* | Covered at the in-network cost share[1] | 20%* | Covered at the in-network cost share[1] |
| **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.

[1]The limit of 10 covered Services does not apply.

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

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $20 | $40 | $25 | $45 |
| **Office visits – urgent care** | $20 | Not covered, except for services received outside the service area[1,2] | $45 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $20 | $40 | $35 | $55 |
| **Office visits – naturopathic care** | $20 | $40 | $25 | $45 |
| **Lab** | 30%* | 40% | $25 | $45 |
| **X-ray/diagnostic tests** | 30%* | 40% | $25 | $45 |
| **CT, MRI, and PET scans** | 30%* | Not covered | $100 | Not covered |
| **Outpatient surgery** | 30%* | Not covered | 20%* | Not covered |
| **Inpatient hospital care** | 30%* | Not covered | 20%* | Not covered |
| **Emergency care** | $200* | Covered at the in-network cost share[1] | 20%* | Covered at the in-network cost share[1] |
| **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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See plan comparisons

Reset

## 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $25 | $45 | $30 | $50 |
| **Office visits – urgent care** | $45 | Not covered, except for services received outside the service area[1,2] | $30 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $35 | $55 | $30 | $50 |
| **Office visits – naturopathic care** | $25 | $45 | $30 | $50 |
| **Lab** | $25 | $45 | 30%* | 40% |
| **X-ray/diagnostic tests** | $25 | $45 | 30%* | 40% |
| **CT, MRI, and PET scans** | $100 | Not covered | 30%* | Not covered |
| **Outpatient surgery** | 20%* | Not covered | 30%* | Not covered |
| **Inpatient hospital care** | 20%* | Not covered | 30%* | Not covered |
| **Emergency care** | 20%* | Covered at the in-network cost share[1] | $200* | Covered at the in-network cost share[1] |
| **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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See plan comparisons

Reset

## 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $30 | $50 | 30%* | 40% |
| **Office visits – urgent care** | $50 | Not covered, except for services received outside the service area[1,2] | 30%* | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $40 | $60 | 30%* | 40% |
| **Office visits – naturopathic care** | $30 | $50 | 30%* | 40% |
| **Lab** | $30 | $50 | 30%* | 40% |
| **X-ray/diagnostic tests** | $30 | $50 | 30%* | 40% |
| **CT, MRI, and PET scans** | $100 | Not covered | 30%* | Not covered |
| **Outpatient surgery** | 20%* | Not covered | 30%* | Not covered |
| **Inpatient hospital care** | 20%* | Not covered | 30%* | Not covered |
| **Emergency care** | 20%* | Covered at the in-network cost share[1] | $200* | Covered at the in-network cost share[1] |
| **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.

[1]The limit of 10 covered Services does not apply.

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

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $30 | $50 | $30 | $50 |
| **Office visits – urgent care** | $50 | Not covered, except for services received outside the service area[1,2] | $50 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $40 | $60 | $40 | $60 |
| **Office visits – naturopathic care** | $30 | $50 | $30 | $50 |
| **Lab** | $30 | $50 | $30 | $50 |
| **X-ray/diagnostic tests** | $30 | $50 | $30 | $50 |
| **CT, MRI, and PET scans** | $100 | Not covered | $100 | Not covered |
| **Outpatient surgery** | 20%* | Not covered | 20%* | Not covered |
| **Inpatient hospital care** | 20%* | Not covered | 20%* | Not covered |
| **Emergency care** | 20%* | Covered at the in-network cost share[1] | 20%* | Covered at the in-network cost share[1] |
| **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 | |

*After deductible.

[1]The limit of 10 covered Services does not apply.

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See plan comparisons

Reset

## KP Plus

| Plan name | ☐ KP PLUS PLAN K 5000/30/20%/7350 | | ☐ KP PLUS PLAN L 6000/35/20%/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)** | $5,000/$10,000 | N/A | $6,000/$12,000 | 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 – prenatal care** | $0 | $0 | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $30 | $50 | $35 | $55 |
| **Office visits – urgent care** | $50 | Not covered, except for services received outside the service area[1,2] | $55 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $40 | $60 | $45 | $65 |
| **Office visits – naturopathic care** | $30 | $50 | $35 | $55 |
| **Lab** | $30 | $50 | $35 | $55 |
| **X-ray/diagnostic tests** | $30 | $50 | $35 | $55 |
| **CT, MRI, and PET scans** | $100 | Not covered | $150 | Not covered |
| **Outpatient surgery** | 20%* | Not covered | 20%* | Not covered |
| **Inpatient hospital care** | 20%* | Not covered | 20%* | Not covered |
| **Emergency care** | 20%* | Covered at the in-network cost share[1] | 20%* | Covered at the in-network cost share[1] |
| **Routine eye exam** | $30 | $50 | $35 | $55 |
| **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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See plan comparisons

Reset

| KP Plus | | |
|---|---|---|
| **Plan name** | ☐ **KP PLUS PLAN M 7500/35/30%/8500** | |
| **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)** | $8,500/$17,000 | N/A |
| **Office visits – preventive and well-child care** | $0 | $0 |
| **Office visits – prenatal care** | $0 | $0 |
| **Telehealth (phone/video)** | $0 | Cost share applicable to the service when provided in person. |
| **Office visits – primary care** | $35 | $55 |
| **Office visits – urgent care** | $55 | Not covered, except for services received outside the service area[1,2] |
| **Office visits – specialty care** | $45 | $65 |
| **Office visits – naturopathic care** | $35 | $55 |
| **Lab** | $35 | $55 |
| **X-ray/diagnostic tests** | $35 | $55 |
| **CT, MRI, and PET scans** | $150 | Not covered |
| **Outpatient surgery** | 30%* | Not covered |
| **Inpatient hospital care** | 30%* | Not covered |
| **Emergency care** | 30%* | Covered at the in-network cost share[1] |
| **Routine eye exam** | $35 | $55 |
| **Outpatient 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.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 30%* | $0 | 30%* |
| **Telehealth (phone/video)** | $0 | 30%* | $0 | 30%* |
| **Office visits – primary care** | $30 ($10 enhanced benefit) | 30%* | $40 ($20 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | $10 | 30%* | $20 | 30%* |
| **Lab** | $10 | 30%* | $20 | 30%* |
| **X-ray/diagnostic tests** | $10 | 30%* | $20 | 30%* |
| **CT, MRI, and PET scans** | $50 | 30%* | $50 | 30%* |
| **Outpatient surgery** | $50 | 30%* | $50 | 30%* |
| **Inpatient hospital care** | $100 per day, $500 per admission | 30%* | $100 per day, $500 per admission | 30%* |
| **Emergency care** | $100 | | $100 | |
| **Routine eye exam** | $30 ($10 enhanced benefit) | 30%* | $40 ($20 enhanced benefit) | 30%* |

*After deductible.

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

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 30%* | $0 | 30%* |
| **Telehealth (phone/video)** | $0 | 30%* | $0 | 30%* |
| **Office visits – primary care** | $40 ($20 enhanced benefit) | 30%* | $50 ($30 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | $20 | 30%* | $30 | 30%* |
| **Lab** | $20 | 30%* | $30 | 30%* |
| **X-ray/diagnostic tests** | $20 | 30%* | $30 | 30%* |
| **CT, MRI, and PET scans** | $50 | 30%* | $50 | 30%* |
| **Outpatient surgery** | $50 | 30%* | $100 | 30%* |
| **Inpatient hospital care** | $200 per day, $1,000 per admission | 30%* | $200 per day, $1,000 per admission | 30%* |
| **Emergency care** | $200 | | $200 | |
| **Routine eye exam** | $40 ($20 enhanced benefit) | 30%* | $50 ($30 enhanced benefit) | 30%* |

*After deductible.

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

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 30%* | $0 | 30%* |
| **Telehealth (phone/video)** | $0 | 30%* | $0 | 30%* |
| **Office visits – primary care** | $55 ($35 enhanced benefit) | 30%* | $30 ($10 enhanced benefit) | 30%* |
| **Office visits – urgent care** | $110 ($60 enhanced benefit) | 30%* | $30 ($10 enhanced benefit) | 30%* |
| **Office visits – specialty care** | $65 ($45 enhanced benefit) | 30%* | $30 ($10 enhanced benefit) | 30%* |
| **Office visits – naturopathic care** | $35 | 30%* | $10 | 30%* |
| **Lab** | $35 | 30%* | 10%* | 30%* |
| **X-ray/diagnostic tests** | $35 | 30%* | 10%* | 30%* |
| **CT, MRI, and PET scans** | $50 | 30%* | 10%* | 30%* |
| **Outpatient surgery** | $150 | 30%* | 10%* | 30%* |
| **Inpatient hospital care** | $800 per admission | 30%* | 10%* | 30%* |
| **Emergency care** | $200 | | $200* | |
| **Routine eye exam** | $55 ($35 enhanced benefit) | 30%* | 30 ($10 enhanced benefit) | 30%* |

*After deductible.

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

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 30%* | $0 | 30%* |
| **Telehealth (phone/video)** | $0 | 30%* | $0 | 30%* |
| **Office visits – primary care** | $35 ($15 enhanced benefit) | 30%* | $40 ($20 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | $15 | 30%* | $20 | 30%* |
| **Lab** | $15 | 30%* | $20 | 30%* |
| **X-ray/diagnostic tests** | $15 | 30%* | $20 | 30%* |
| **CT, MRI, and PET scans** | $100 | 30%* | $100 | 30%* |
| **Outpatient surgery** | 20%* | 30%* | 10%* | 30%* |
| **Inpatient hospital care** | 20%* | 30%* | 10%* | 30%* |
| **Emergency care** | 20%* | | 10%* | |
| **Routine eye exam** | $35 ($15 enhanced benefit) | 30%* | $40 ($20 enhanced benefit) | 30%* |

*After deductible.

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

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Reset

## 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 – prenatal care** | $0 | 30%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0 | 30%* | $0 | 40%* |
| **Office visits – primary care** | 20%* (10%* enhanced benefit) | 30%* | $30 ($10 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | 10%* | 30%* | $10 | 40%* |
| **Lab** | 10%* | 30%* | 20%* | 40%* |
| **X-ray/diagnostic tests** | 10%* | 30%* | 20%* | 40%* |
| **CT, MRI, and PET scans** | 10%* | 30%* | 20%* | 40%* |
| **Outpatient surgery** | 10%* | 30%* | 20%* | 40%* |
| **Inpatient hospital care** | 10%* | 30%* | 20%* | 40%* |
| **Emergency care** | $200* | | $200* | |
| **Routine eye exam** | 20%* (10%* enhanced benefit) | 30%* | $30 ($10 enhanced benefit) | 40%* |

*After deductible.

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

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Reset

## 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 – prenatal care** | $0 | 40%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0 | 40%* | $0 | 40%* |
| **Office visits – primary care** | $40 ($20 enhanced benefit) | 40%* | $40 ($20 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | $20 | 40%* | $20 | 40%* |
| **Lab** | $20 | 40%* | $20 | 40%* |
| **X-ray/diagnostic tests** | $20 | 40%* | $20 | 40%* |
| **CT, MRI, and PET scans** | $100 | 40%* | $100 | 40%* |
| **Outpatient surgery** | 20%* | 40%* | 20%* | 40%* |
| **Inpatient hospital care** | 20%* | 40%* | 20%* | 40%* |
| **Emergency care** | 20%* | | 20%* | |
| **Routine eye exam** | $40 ($20 enhanced benefit) | 40%* | $40 ($20 enhanced benefit) | 40%* |

*After deductible.

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

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Reset

## 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 – prenatal care** | $0 | 40%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0 | 40%* | $0 | 40%* |
| **Office visits – primary care** | 30%*(20%* enhanced benefit) | 40%* | $40 ($20 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | 20%* | 40%* | $20 | 40%* |
| **Lab** | 20%* | 40%* | 20%* | 40%* |
| **X-ray/diagnostic tests** | 20%* | 40%* | 20%* | 40%* |
| **CT, MRI, and PET scans** | 20%* | 40%* | 20%* | 40%* |
| **Outpatient surgery** | 20%* | 40%* | 20%* | 40%* |
| **Inpatient hospital care** | 20%* | 40%* | 20%* | 40%* |
| **Emergency care** | $200* | | $200* | |
| **Routine eye exam** | 30%*(20%* enhanced benefit) | 40%* | $40 ($20 enhanced benefit) | 40%* |

*After deductible.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 40%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0 | 40%* | $0 | 40%* |
| **Office visits – primary care** | $45 ($25 enhanced benefit) | 40%* | $45 ($25 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | $25 | 40%* | $25 | 40%* |
| **Lab** | $25 | 40%* | $25 | 40%* |
| **X-ray/diagnostic tests** | $25 | 40%* | $25 | 40%* |
| **CT, MRI, and PET scans** | $100 | 40%* | $100 | 40%* |
| **Outpatient surgery** | 20%* | 40%* | 20%* | 40%* |
| **Inpatient hospital care** | 20%* | 40%* | 20%* | 40%* |
| **Emergency care** | 20%* | | 20%* | |
| **Routine eye exam** | $45 ($25 enhanced benefit) | 40%* | $45 ($25 enhanced benefit) | 40%* |

*After deductible.

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Reset

## 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 – prenatal care** | $0 | 50%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0 | 50%* | $0 | 40%* |
| **Office visits – primary care** | $40 ($20 enhanced benefit) | 50%* | $45 ($25 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | $20 | 50%* | $25 | 40%* |
| **Lab** | 30%* | 50%* | $25 | 40%* |
| **X-ray/diagnostic tests** | 30%* | 50%* | $25 | 40%* |
| **CT, MRI, and PET scans** | 30%* | 50%* | $100 | 40%* |
| **Outpatient surgery** | 30%* | 50%* | 20%* | 40%* |
| **Inpatient hospital care** | 30%* | 50%* | 20%* | 40%* |
| **Emergency care** | $200* | | 20%* | |
| **Routine eye exam** | $40 ($20 enhanced benefit) | 50%* | $45 ($25 enhanced benefit) | 40%* |

*After deductible.

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See plan comparisons

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 – prenatal care** | $0 | 40%* | $0 | 50%* |
| **Telehealth (phone/video)** | $0 | 40%* | $0 | 50%* |
| **Office visits – primary care** | $45 ($25 enhanced benefit) | 40%* | $50 ($30 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | $25 | 40%* | $30 | 50%* |
| **Lab** | $25 | 40%* | 30%* | 50%* |
| **X-ray/diagnostic tests** | $25 | 40%* | 30%* | 50%* |
| **CT, MRI, and PET scans** | $100 | 40%* | 30%* | 50%* |
| **Outpatient surgery** | 20%* | 40%* | 30%* | 50%* |
| **Inpatient hospital care** | 20%* | 40%* | 30%* | 50%* |
| **Emergency care** | 20%* | | $200* | |
| **Routine eye exam** | $45 ($25 enhanced benefit) | 40%* | $50 ($30 enhanced benefit) | 50%* |

*After deductible.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 40%* | $0 | 50%* |
| **Telehealth (phone/video)** | $0 | 40%* | $0 | 50%* |
| **Office visits – primary care** | $50 ($30 enhanced benefit) | 40%* | 40%* (30%* enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | $30 | 40%* | 30%* | 50%* |
| **Lab** | $30 | 40%* | 30%* | 50%* |
| **X-ray/diagnostic tests** | $30 | 40%* | 30%* | 50%* |
| **CT, MRI, and PET scans** | $100 | 40%* | 30%* | 50%* |
| **Outpatient surgery** | 20%* | 40%* | 30%* | 50%* |
| **Inpatient hospital care** | 20%* | 40%* | 30%* | 50%* |
| **Emergency care** | 20%* | | $200* | |
| **Routine eye exam** | $50 ($30 enhanced benefit) | 40%* | 40%* (30%* enhanced benefit) | 50%* |

*After deductible.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 40%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0 | 40%* | $0 | 40%* |
| **Office visits – primary care** | $50 ($30 enhanced benefit) | 40%* | $50 ($30 enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | $30 | 40%* | $30 | 40%* |
| **Lab** | $30 | 40%* | $30 | 40%* |
| **X-ray/diagnostic tests** | $30 | 40%* | $30 | 40%* |
| **CT, MRI, and PET scans** | $100 | 40%* | $100 | 40%* |
| **Outpatient surgery** | 20%* | 40%* | 20%* | 40%* |
| **Inpatient hospital care** | 20%* | 40%* | 20%* | 40%* |
| **Emergency care** | 20%* | | 20%* | |
| **Routine eye exam** | $50 ($30 enhanced benefit) | 40%* | $50 ($30 enhanced benefit) | 40%* |

*After deductible.

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | DUAL CHOICE PPO PLAN K 5000/30/20%/8150 | | DUAL CHOICE PPO PLAN L 6000/35/20%/8000 | |
|---|---|---|---|---|
| **Network** | In-network | Out-of-network | In-network | Out-of-network |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $5,000/$10,000 | $6,500/$19,500 | $6,000/$12,000 | $7,500/$18,000 |
| **Annual out-of-pocket maximum (IND/FAM)** | $8,150/$16,300 | $15,000/$30,000 | $8,000/$16,000 | $15,000/$30,000 |
| **Office visits – preventive and well-child care** | $0 | 40%* | $0 | 40%* |
| **Office visits – prenatal care** | $0 | 40%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0 | 40%* | $0 | 40%* |
| **Office visits – primary care** | $50 ($30 enhanced benefit) | 40%* | $55 ($35 enhanced benefit) | 40%* |
| **Office visits – urgent care** | $100 ($50 enhanced benefit) | 40%* | $100 ($55 enhanced benefit) | 40%* |
| **Office visits – specialty care** | $60 ($40 enhanced benefit) | 40%* | $65 ($45 enhanced benefit) | 40%* |
| **Office visits – naturopathic care** | $30 | 40%* | $35 | 40%* |
| **Lab** | $30 | 40%* | $35 | 40%* |
| **X-ray/diagnostic tests** | $30 | 40%* | $35 | 40%* |
| **CT, MRI, and PET scans** | $100 | 40%* | $150 | 40%* |
| **Outpatient surgery** | 20%* | 40%* | 20%* | 40%* |
| **Inpatient hospital care** | 20%* | 40%* | 20%* | 40%* |
| **Emergency care** | 20%* | | 20%* | |
| **Routine eye exam** | $50 ($30 enhanced benefit) | 40%* | $55 ($35 enhanced benefit) | 40%* |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | ☐ DUAL CHOICE PPO PLAN M 7500/35/30%/8500 | |
|---|---|---|
| **Network** | In-network | Out-of-network |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $7,500/$14,500 | $8,500/$19,500 |
| **Annual out-of-pocket maximum (IND/FAM)** | $8,500/$17,000 | $17,000/$30,000 |
| **Office visits – preventive and well-child care** | $0 | 50%* |
| **Office visits – prenatal care** | $0 | 50%* |
| **Telehealth (phone/video)** | $0 | 50%* |
| **Office visits – primary care** | $55 ($35 enhanced benefit) | 50%* |
| **Office visits – urgent care** | $100 ($55 enhanced benefit) | 50%* |
| **Office visits – specialty care** | $65 ($45 enhanced benefit) | 50%* |
| **Office visits – naturopathic care** | $35 | 50%* |
| **Lab** | $35 | 50%* |
| **X-ray/diagnostic tests** | $35 | 50%* |
| **CT, MRI, and PET scans** | $150 | 50%* |
| **Outpatient surgery** | 30%* | 50%* |
| **Inpatient hospital care** | 30%* | 50%* |
| **Emergency care** | 30%* | |
| **Routine eye exam** | $55 ($35 enhanced benefit) | 50%* |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO Virtual Complete

| Plan name | ☐ DUAL CHOICE PPO PLAN VC 2500/40/20%/6500 | |
|---|---|---|
| **Network** | In-network | Out-of-network |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $2,500/$5,000 | $5,000/$15,000 |
| **Annual out-of-pocket maximum (IND/FAM)** | $6,500/$13,000 | $13,500/$27,000 |
| **Office visits – preventive and well-child care** | $0 | 40%* |
| **Office visits – prenatal care** | $0 | 40%* |
| **Telehealth (phone/video)** | $0 for the first 3 visits; then $0[1] | 40%* |
| **Office visits – primary care** | $60 ($40 enhanced benefit) for the first 3 visits; then $60* ($40* enhanced benefit)[1] | 40%* |
| **Office visits – urgent care** | $60* ($40* enhanced benefit) | 40%* |
| **Office visits – specialty care** | $60* ($40* enhanced benefit) | 40%* |
| **Office visits – naturopathic care** | $40 for the first 3 visits; then $40*[1] | 40%* |
| **Lab** | $15 | 40%* |
| **X-ray/diagnostic tests** | 20%* | 40%* |
| **CT, MRI, and PET scans** | 20%* | 40%* |
| **Outpatient surgery** | 20%* | 40%* |
| **Inpatient hospital care** | 20%* | 40%* |
| **Emergency care** | 20%* | |
| **Routine eye exam** | $60* ($40* enhanced benefit)[1] | 40%* |
| **Outpatient prescription drugs** | **Kaiser Permanente Pharmacies** | |
| | $15* generic; $40* preferred brand-name; $60* non-preferred brand-name; 20%* (up to a max of $250) specialty | Not covered |
| | **MedImpact Pharmacies** | |
| | $25* generic; $60* preferred brand-name; $90* non-preferred brand-name; 30%* specialty | Not covered |

*After deductible.

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

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See plan comparisons

Reset

# Dual Choice PPO Virtual Complete

| Plan name | ☐ DUAL CHOICE PPO PLAN VC 3000/40/30%/7000 | |
|---|---|---|
| **Network** | In-network | Out-of-network |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $3,000/$6,000 | $6,000/$18,000 |
| **Annual out-of-pocket maximum (IND/FAM)** | $7,000/$14,000 | $15,000/$30,000 |
| **Office visits – preventive and well-child care** | $0 | 50%* |
| **Office visits – prenatal care** | $0 | 50%* |
| **Telehealth (phone/video)** | $0[1] | 50%* |
| **Office visits – primary care** | $60 ($40 enhanced benefit) for the first 3 visits; then $60* ($40* enhanced benefit)[1] | 50%* |
| **Office visits – urgent care** | $60* ($40* enhanced benefit) | 50%* |
| **Office visits – specialty care** | $60* ($40* enhanced benefit) | 50%* |
| **Office visits – naturopathic care** | $40 for the first 3 visits; then $40*[1] | 50%* |
| **Lab** | $15 | 50%* |
| **X-ray/diagnostic tests** | 30%* | 50%* |
| **CT, MRI, and PET scans** | 30%* | 50%* |
| **Outpatient surgery** | 30%* | 50%* |
| **Inpatient hospital care** | 30%* | 50%* |
| **Emergency care** | 30%* | |
| **Routine eye exam** | $60* ($40* enhanced benefit)[1] | 50%* |
| **Outpatient prescription drugs** | **Kaiser Permanente Pharmacies** | |
| | $15* generic; $40* preferred brand-name; $60* non-preferred brand-name; 30%* (up to a max of $250) specialty | Not covered |
| | **MedImpact Pharmacies** | |
| | $25* generic; $60* preferred brand-name; $90* non-preferred brand-name; 40%* specialty | Not covered |

*After deductible.

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See plan comparisons

Reset

## Dual Choice PPO Virtual Complete

| Plan name | ☐ DUAL CHOICE PPO PLAN VC 4000/50/30%/8150 | |
|---|---|---|
| Network | In-network | Out-of-network |
| Annual medical deductible (IND/FAM) (per calendar year) | $4,000/$8,000 | $8,000/$16,000 |
| Annual out-of-pocket maximum (IND/FAM) | $8,150/$16,300 | $15,000/$30,000 |
| Office visits – preventive and well-child care | $0 | 50%* |
| Office visits – prenatal care | $0 | 50%* |
| Telehealth (phone/video) | $0[1] | 50%* |
| Office visits – primary care | $70 ($50 enhanced benefit) for the first 3 visits; then $70* ($50* enhanced benefit)[1] | 50%* |
| Office visits – urgent care | $70* ($50* enhanced benefit) | 50%* |
| Office visits – specialty care | $70* ($50* enhanced benefit) | 50%* |
| Office visits – naturopathic care | $50 for the first 3 visits; then $50*[1] | 50%* |
| Lab | $15 | 50%* |
| X-ray/diagnostic tests | 30%* | 50%* |
| CT, MRI, and PET scans | 30%* | 50%* |
| Outpatient surgery | 30%* | 50%* |
| Inpatient hospital care | 30%* | 50%* |
| Emergency care | 30%* | |
| Routine eye exam | $70* ($50* enhanced benefit)[1] | 50%* |
| Outpatient prescription drugs | **Kaiser Permanente Pharmacies** | |
| | $15* generic; $50* preferred brand-name; $70* non-preferred brand-name; 30%* (up to a max of $250) specialty | Not covered |
| | **MedImpact Pharmacies** | |
| | $25* generic; $70* preferred brand-name; $100* non-preferred brand-name; 40%* specialty | Not covered |

*After deductible.

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

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See plan comparisons

Reset

# Dual Choice PPO Virtual Complete

| Plan name | ☐ DUAL CHOICE PPO PLAN VC 5000/50/40%/8150 | |
|---|---|---|
| Network | In-network | Out-of-network |
| Annual medical deductible (IND/FAM) (per calendar year) | $5,000/$10,000 | $10,000/$20,000 |
| Annual out-of-pocket maximum (IND/FAM) | $8,150/$16,300 | $15,000/$30,000 |
| Office visits – preventive and well-child care | $0 | 50%* |
| Office visits – prenatal care | $0 | 50%* |
| Telehealth (phone/video) | $0[1] | 50%* |
| Office visits – primary care | $70 ($50 enhanced benefit) for the first 3 visits; then $70* ($50* enhanced benefit)[1] | 50%* |
| Office visits – urgent care | $70* ($50* enhanced benefit) | 50%* |
| Office visits – specialty care | $70* ($50* enhanced benefit) | 50%* |
| Office visits – naturopathic care | $50 for the first 3 visits; then $50*[1] | 50%* |
| Lab | $15 | 50%* |
| X-ray/diagnostic tests | 40%* | 50%* |
| CT, MRI, and PET scans | 40%* | 50%* |
| Outpatient surgery | 40%* | 50%* |
| Inpatient hospital care | 40%* | 50%* |
| Emergency care | 40%* | |
| Routine eye exam | $70* ($50* enhanced benefit)[1] | 50%* |
| Outpatient prescription drugs | **Kaiser Permanente Pharmacies** | |
| | $15* generic; $50* preferred brand-name; $70* non-preferred brand-name; 40%* (up to a max of $250) specialty | Not covered |
| | **MedImpact Pharmacies** | |
| | $25* generic; $70* preferred brand-name; $100* non-preferred brand-name; 50%* specialty | Not covered |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | ☐ DUAL CHOICE PPO HDHP PLAN A 1600/10%/2500 | | ☐ DUAL CHOICE PPO HDHP PLAN A 1600/20%/3500 | |
|---|---|---|---|---|
| **Network** | In-network | Out-of-network | In-network | Out-of-network |
| **Accumulation type** | Aggregate | | Aggregate | |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $1,600/$3,200 | $3,500/$9,750 | $1,600/$3,200 | $3,500/$9,750 |
| **Annual out-of-pocket maximum (IND/FAM)** | $2,500/$5,000 | $10,500/$21,000 | $3,500/$7,000 | $11,500/$23,000 |
| **Office visits – preventive and well-child care** | $0 | 30%* | $0 | 40%* |
| **Office visits – prenatal care** | $0 | 30%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0* | 30%* | $0* | 40%* |
| **Office visits – primary care** | 20%* (10%* enhanced benefit) | 30%* | 30%* (20%* enhanced benefit) | 40%* |
| **Office visits – urgent care** | 20%* (10%* enhanced benefit) | 30%* | 30%* (20%* enhanced benefit) | 40%* |
| **Office visits – specialty care** | 20%* (10%* enhanced benefit) | 30%* | 30%* (20%* enhanced benefit) | 40%* |
| **Office visits – naturopathic care** | 10%* | 30%* | 20%* | 40%* |
| **Lab** | 10%* | 30%* | 20%* | 40%* |
| **X-ray/diagnostic tests** | 10%* | 30%* | 20%* | 40%* |
| **CT, MRI, and PET scans** | 10%* | 30%* | 20%* | 40%* |
| **Outpatient surgery** | 10%* | 30%* | 20%* | 40%* |
| **Inpatient hospital care** | 10%* | 30%* | 20%* | 40%* |
| **Emergency care** | 10%* | | 20%* | |
| **Routine eye exam** | 20%* (10%* enhanced benefit) | 30%* | 30%* (20%* enhanced benefit) | 40%* |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | ☐ DUAL CHOICE PPO HDHP PLAN B 2000/20%/4000 | | ☐ DUAL CHOICE PPO HDHP PLAN B 2000/30%/4000 | |
|---|---|---|---|---|
| **Network** | In-network | Out-of-network | In-network | Out-of-network |
| **Accumulation type** | Aggregate | | Aggregate | |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $2,000/$4,000 | $4,000/$12,000 | $2,000/$4,000 | $4,000/$12,000 |
| **Annual out-of-pocket maximum (IND/FAM)** | $4,000/$8,000 | $12,000/$24,000 | $4,000/$8,000 | $12,000/$24,000 |
| **Office visits – preventive and well-child care** | $0 | 40%* | $0 | 50%* |
| **Office visits – prenatal care** | $0 | 40%* | $0 | 50%* |
| **Telehealth (phone/video)** | $0* | 40%* | $0* | 50%* |
| **Office visits – primary care** | 30%* (20%* enhanced benefit) | 40%* | 40%* (30%* enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | 20%* | 40%* | 30%* | 50%* |
| **Lab** | 20%* | 40%* | 30%* | 50%* |
| **X-ray/diagnostic tests** | 20%* | 40%* | 30%* | 50%* |
| **CT, MRI, and PET scans** | 20%* | 40%* | 30%* | 50%* |
| **Outpatient surgery** | 20%* | 40%* | 30%* | 50%* |
| **Inpatient hospital care** | 20%* | 40%* | 30%* | 50%* |
| **Emergency care** | 20%* | | 30%* | |
| **Routine eye exam** | 30%* (20%* enhanced benefit) | 40%* | 40%* (30%* enhanced benefit) | 50%* |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | ☐ DUAL CHOICE PPO HDHP PLAN C 2500/20%/5000 | | ☐ DUAL CHOICE PPO HDHP PLAN C 2500/30%/5000 | |
|---|---|---|---|---|
| **Network** | In-network | Out-of-network | In-network | Out-of-network |
| **Accumulation type** | Aggregate | | Aggregate | |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $2,500/$5,000 | $5,000/$15,000 | $2,500/$5,000 | $5,000/$15,000 |
| **Annual out-of-pocket maximum (IND/FAM)** | $5,000/$7,500 | $15,000/$30,000 | $5,000/$7,500 | $15,000/$30,000 |
| **Office visits – preventive and well-child care** | $0 | 40%* | $0 | 50%* |
| **Office visits – prenatal care** | $0 | 40%* | $0 | 50%* |
| **Telehealth (phone/video)** | $0* | 40%* | $0* | 50%* |
| **Office visits – primary care** | 30%* (20%* enhanced benefit) | 40%* | 40%* (30%* enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | 20%* | 40%* | 30%* | 50%* |
| **Lab** | 20%* | 40%* | 30%* | 50%* |
| **X-ray/diagnostic tests** | 20%* | 40%* | 30%* | 50%* |
| **CT, MRI, and PET scans** | 20%* | 40%* | 30%* | 50%* |
| **Outpatient surgery** | 20%* | 40%* | 30%* | 50%* |
| **Inpatient hospital care** | 20%* | 40%* | 30%* | 50%* |
| **Emergency care** | 20%* | | 30%* | |
| **Routine eye exam** | 30%* (20%* enhanced benefit) | 40%* | 40%* (30%* enhanced benefit) | 50%* |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | ☐ DUAL CHOICE PPO HDHP PLAN E 3200/10%/6000 | | ☐ DUAL CHOICE PPO HDHP PLAN E 3200/20%/6000 | |
|---|---|---|---|---|
| **Network** | In-network | Out-of-network | In-network | Out-of-network |
| **Accumulation type** | Embedded | | Embedded | |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $3,200/$6,400 | $5,000/$15,000 | $3,200/$6,000 | $5,000/$15,000 |
| **Annual out-of-pocket maximum (IND/FAM)** | $6,000/$9,000 | $15,000/$30,000 | $6,000/$12,000 | $15,000/$30,000 |
| **Office visits – preventive and well-child care** | $0 | 30%* | $0 | 40%* |
| **Office visits – prenatal care** | $0 | 30%* | $0 | 40%* |
| **Telehealth (phone/video)** | 0%* | 30%* | $0* | 40%* |
| **Office visits – primary care** | 20%* (10%* enhanced benefit) | 30%* | 30%* (20%* enhanced benefit) | 40%* |
| **Office visits – urgent care** | 20%* (10%* enhanced benefit) | 30%* | 30%* (20%* enhanced benefit) | 40%* |
| **Office visits – specialty care** | 20%* (10%* enhanced benefit) | 30%* | 30%* (20%* enhanced benefit) | 40%* |
| **Office visits – naturopathic care** | 10%* | 30%* | 20%* | 40%* |
| **Lab** | 10%* | 30%* | 20%* | 40%* |
| **X-ray/diagnostic tests** | 10%* | 30%* | 20%* | 40%* |
| **CT, MRI, and PET scans** | 10%* | 30%* | 20%* | 40%* |
| **Outpatient surgery** | 10%* | 30%* | 20%* | 40%* |
| **Inpatient hospital care** | 10%* | 30%* | 20%* | 40%* |
| **Emergency care** | 10%* | | 20%* | |
| **Routine eye exam** | 20%* (10%* enhanced benefit) | 30%* | 30%* (20%* enhanced benefit) | 40%* |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | ☐ DUAL CHOICE PPO HDHP PLAN E 3200/30%/6000 | | ☐ DUAL CHOICE PPO HDHP PLAN F 3500/20%/7000 | |
|---|---|---|---|---|
| **Network** | In-network | Out-of-network | In-network | Out-of-network |
| **Accumulation type** | Embedded | | Embedded | |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $3,200/$6,000 | $5,000/$15,000 | $3,500/$7,000 | $5,500/$16,500 |
| **Annual out-of-pocket maximum (IND/FAM)** | $6,000/$12,000 | $15,000/$30,000 | $7,000/$14,000 | $15,000/$30,000 |
| **Office visits – preventive and well-child care** | $0 | 50%* | $0 | 40%* |
| **Office visits – prenatal care** | $0 | 50%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0* | 50%* | $0* | 40%* |
| **Office visits – primary care** | 40%* (30%* enhanced benefit) | 50%* | 30%* (20%* enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | 30%* | 50%* | 20%* | 40%* |
| **Lab** | 30%* | 50%* | 20%* | 40%* |
| **X-ray/diagnostic tests** | 30%* | 50%* | 20%* | 40%* |
| **CT, MRI, and PET scans** | 30%* | 50%* | 20%* | 40%* |
| **Outpatient surgery** | 30%* | 50%* | 20%* | 40%* |
| **Inpatient hospital care** | 30%* | 50%* | 20%* | 40%* |
| **Emergency care** | 30%* | | 20%* | |
| **Routine eye exam** | 40%* (30%* enhanced benefit) | 50%* | 30%* (20%* enhanced benefit) | 40%* |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | ☐ DUAL CHOICE PPO HDHP PLAN F 3500/30%/7000 | | ☐ DUAL CHOICE PPO HDHP PLAN G 4000/20%/7000 | |
|---|---|---|---|---|
| **Network** | In-network | Out-of-network | In-network | Out-of-network |
| **Accumulation type** | Embedded | | Embedded | |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $3,500/$7,000 | $5,500/$16,500 | $4,000/$8,000 | $6,000/$12,000 |
| **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 | 50%* | $0 | 40%* |
| **Office visits – prenatal care** | $0 | 50%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0* | 50%* | $0* | 40%* |
| **Office visits – primary care** | 40%* (30%* enhanced benefit) | 50%* | 30%* (20%* enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | 30%* | 50%* | 20%* | 40%* |
| **Lab** | 30%* | 50%* | 20%* | 40%* |
| **X-ray/diagnostic tests** | 30%* | 50%* | 20%* | 40%* |
| **CT, MRI, and PET scans** | 30%* | 50%* | 20%* | 40%* |
| **Outpatient surgery** | 30%* | 50%* | 20%* | 40%* |
| **Inpatient hospital care** | 30%* | 50%* | 20%* | 40%* |
| **Emergency care** | 30%* | | 20%* | |
| **Routine eye exam** | 40%* (30%* enhanced benefit) | 50%* | 30%* (20%* enhanced benefit) | 40%* |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | ☐ DUAL CHOICE PPO HDHP PLAN G 4000/30%/7000 | | ☐ DUAL CHOICE PPO HDHP PLAN H 5000/20%/7000 | |
|---|---|---|---|---|
| **Network** | In-network | Out-of-network | In-network | Out-of-network |
| **Accumulation type** | Embedded | | Embedded | |
| **Annual medical deductible (IND/FAM) (per calendar year)** | $4,000/$8,000 | $6,000/$12,000 | $5,000/$10,000 | $7,000/$14,000 |
| **Annual out-of-pocket maximum (IND/FAM)** | $7,000/$14,000 | $15,000/$30,000 | $7,000/$14,000 | $17,000/$34,000 |
| **Office visits – preventive and well-child care** | $0 | 50%* | $0 | 40%* |
| **Office visits – prenatal care** | $0 | 50%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0* | 50%* | $0* | 40%* |
| **Office visits – primary care** | 40%* (30%* enhanced benefit) | 50%* | 30%* (20%* enhanced benefit) | 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%* |
| **Office visits – naturopathic care** | 30%* | 50%* | 20%* | 40%* |
| **Lab** | 30%* | 50%* | 20%* | 40%* |
| **X-ray/diagnostic tests** | 30%* | 50%* | 20%* | 40%* |
| **CT, MRI, and PET scans** | 30%* | 50%* | 20%* | 40%* |
| **Outpatient surgery** | 30%* | 50%* | 20%* | 40%* |
| **Inpatient hospital care** | 30%* | 50%* | 20%* | 40%* |
| **Emergency care** | 30%* | | 20%* | |
| **Routine eye exam** | 40%* (30%* enhanced benefit) | 50%* | 30%* (20%* enhanced benefit) | 40%* |

*After deductible.

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

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See plan comparisons

Reset

## Dual Choice PPO

| Plan name | ☐ DUAL CHOICE PPO HDHP PLAN H 5000/30%/7000 | | ☐ DUAL CHOICE PPO HDHP PLAN H 5000/40%/7000 | |
|---|---|---|---|---|
| **Network** | In-network | Out-of-network | In-network | Out-of-network |
| **Accumulation type** | Embedded | | Embedded | |
| **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)** | $7,000/$14,000 | $17,000/$34,000 | $7,000/$14,000 | $17,000/$34,000 |
| **Office visits – preventive and well-child care** | $0 | 50%* | $0 | 50%* |
| **Office visits – prenatal care** | $0 | 50%* | $0 | 50%* |
| **Telehealth (phone/video)** | $0* | 50%* | $0* | 50%* |
| **Office visits – primary care** | 40%* (30%* enhanced benefit) | 50%* | 50%* (40%* enhanced benefit) | 50%* |
| **Office visits – urgent care** | 40%* (30%* enhanced benefit) | 50%* | 50%* (40%* enhanced benefit) | 50%* |
| **Office visits – specialty care** | 40%* (30%* enhanced benefit) | 50%* | 50%* (40%* enhanced benefit) | 50%* |
| **Office visits – naturopathic care** | 30%* | 50%* | 40%* | 50%* |
| **Lab** | 30%* | 50%* | 40%* | 50%* |
| **X-ray/diagnostic tests** | 30%* | 50%* | 40%* | 50%* |
| **CT, MRI, and PET scans** | 30%* | 50%* | 40%* | 50%* |
| **Outpatient surgery** | 30%* | 50%* | 40%* | 50%* |
| **Inpatient hospital care** | 30%* | 50%* | 40%* | 50%* |
| **Emergency care** | 30%* | | 40%* | |
| **Routine eye exam** | 40%* (30%* enhanced benefit) | 50%* | 50%* (40%* enhanced benefit) | 50%* |

*After deductible.

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

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 35%* | $0 | 35%* |
| **Telehealth (phone/video)** | $0 | 35%* | $0 | 35%* |
| **Office visits – primary care** | $30 | 35%* | $30 | 35%* |
| **Office visits – urgent care** | $50 | 35%* | $50 | 35%* |
| **Office visits – specialty care** | $40 | 35%* | $40 | 35%* |
| **Office visits – naturopathic care** | $30 | 35%* | $30 | 35%* |
| **Lab** | $30 | 35%* | $30 | 35%* |
| **X-ray/diagnostic tests** | $30 | 35%* | $30 | 35%* |
| **CT, MRI, and PET scans** | 20%* | 35%* | 20%* | 35%* |
| **Outpatient surgery** | 20%* | 35%* | 20%* | 35%* |
| **Inpatient hospital care** | 20%* | 35%* | 20%* | 35%* |
| **Emergency care** | $200* | | $200* | |
| **Routine eye exam** | $30 | 35%* | $30 | 35%* |

*After deductible.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 45%* | $0 | 45%* |
| **Telehealth (phone/video)** | $0 | 45%* | $0 | 45%* |
| **Office visits – primary care** | $20 | 45%* | $30 | 45%* |
| **Office visits – urgent care** | $20 | 45%* | $50 | 45%* |
| **Office visits – specialty care** | $20 | 45%* | $40 | 45%* |
| **Office visits – naturopathic care** | $20 | 45%* | $30 | 45%* |
| **Lab** | 20%* | 45%* | $30 | 45%* |
| **X-ray/diagnostic tests** | 20%* | 45%* | $30 | 45%* |
| **CT, MRI, and PET scans** | 20%* | 45%* | 30%* | 45%* |
| **Outpatient surgery** | 20%* | 45%* | 30%* | 45%* |
| **Inpatient hospital care** | 20%* | 45%* | 30%* | 45%* |
| **Emergency care** | $200* | | $200* | |
| **Routine eye exam** | $20 | 45%* | $30 | 45%* |

*After deductible.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 45%* | $0 | 45%* |
| **Telehealth (phone/video)** | $0 | 45%* | $0 | 45%* |
| **Office visits – primary care** | $25 | 45%* | $30 | 45%* |
| **Office visits – urgent care** | $45 | 45%* | $50 | 45%* |
| **Office visits – specialty care** | $35 | 45%* | $40 | 45%* |
| **Office visits – naturopathic care** | $25 | 45%* | $30 | 45%* |
| **Lab** | $25 | 45%* | $30 | 45%* |
| **X-ray/diagnostic tests** | $25 | 45%* | $30 | 45%* |
| **CT, MRI, and PET scans** | $100 | 45%* | 30%* | 45%* |
| **Outpatient surgery** | 20%* | 45%* | 30%* | 45%* |
| **Inpatient hospital care** | 20%* | 45%* | 30%* | 45%* |
| **Emergency care** | 20%* | | $200* | |
| **Routine eye exam** | $25 | 45%* | $30 | 45%* |

*After deductible.

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See plan comparisons

Reset

## 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 – prenatal care** | $0 | 40%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0 | 40%* | $0 | 40%* |
| **Office visits – primary care** | $35 | 40%* | $35 | 40%* |
| **Office visits – urgent care** | $55 | 40%* | $55 | 40%* |
| **Office visits – specialty care** | $45 | 40%* | $45 | 40%* |
| **Office visits – naturopathic care** | $35 | 40%* | $35 | 40%* |
| **Lab** | $35 | 40%* | $35 | 40%* |
| **X-ray/diagnostic tests** | $35 | 40%* | $35 | 40%* |
| **CT, MRI, and PET scans** | 30%* | 40%* | 30%* | 40%* |
| **Outpatient surgery** | 30%* | 40%* | 30%* | 40%* |
| **Inpatient hospital care** | 30%* | 40%* | 30%* | 40%* |
| **Emergency care** | $200* | | $200* | |
| **Routine eye exam** | $35 | 40%* | $35 | 40%* |

*After deductible.

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See plan comparisons

Reset

## OUT-OF-AREA PPO PLUS

| Plan name | ☐ PPO PLUS PLAN WDR 4000/30%/7350 | | ☐ PPO PLUS PLAN WDS 5000/30%/7350 | |
|---|---|---|---|---|
| **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)** | $7,350/$14,700 | $9,000/$18,000 | $7,350/$14,700 | $9,000/$18,000 |
| **Office visits – preventive and well-child care** | $0 | 40%* | $0 | 40%* |
| **Office visits – prenatal care** | $0 | 40%* | $0 | 40%* |
| **Telehealth (phone/video)** | $0 | 40%* | $0 | 40%* |
| **Office visits – primary care** | $35 | 40%* | $35 | 40%* |
| **Office visits – urgent care** | $55 | 40%* | $55 | 40%* |
| **Office visits – specialty care** | $45 | 40%* | $45 | 40%* |
| **Office visits – naturopathic care** | $35 | 40%* | $35 | 40%* |
| **Lab** | $35 | 40%* | $35 | 40%* |
| **X-ray/diagnostic tests** | $35 | 40%* | $35 | 40%* |
| **CT, MRI, and PET scans** | 30%* | 40%* | 30%* | 40%* |
| **Outpatient surgery** | 30%* | 40%* | 30%* | 40%* |
| **Inpatient hospital care** | 30%* | 40%* | 30%* | 40%* |
| **Emergency care** | 20%* | | 20%* | |
| **Routine eye exam** | $35 | 40%* | $35 | 40%* |

*After deductible.

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See plan comparisons

Reset

## OUT-OF-AREA PPO PLUS

| Plan name | ☐ PPO PLUS HDHP AA PLAN WFI 1600/20%/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)** | $1,600/$3,200 | $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 – prenatal care** | $0 | 30%* | $0 | 30%* |
| **Telehealth (phone/video)** | $0* | 30%* | $0* | 30%* |
| **Office visits – primary care** | 20%* | 30%* | 20%* | 30%* |
| **Office visits – urgent care** | 20%* | 30%* | 20%* | 30%* |
| **Office visits – specialty care** | 20%* | 30%* | 20%* | 30%* |
| **Office visits – naturopathic care** | 20%* | 30%* | 20%* | 30%* |
| **Lab** | 20%* | 30%* | 20%* | 30%* |
| **X-ray/diagnostic tests** | 20%* | 30%* | 20%* | 30%* |
| **CT, MRI, and PET scans** | 20%* | 30%* | 20%* | 30%* |
| **Outpatient surgery** | 20%* | 30%* | 20%* | 30%* |
| **Inpatient hospital care** | 20%* | 30%* | 20%* | 30%* |
| **Emergency care** | 20%* | | 10%* | |
| **Routine eye exam** | 20%* | 30%* | 20%* | 30%* |

*After deductible.

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## Compare plans - traditional, deductible, HDHP

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

*After deductible.

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

Start over



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

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

*After deductible.

[1]The limit of 10 covered Services does not apply.

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

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

Start over

# SUPPLEMENTAL BENEFIT OPTIONS

## OUTPATIENT PRESCRIPTION DRUGS

### Traditional, deductible, and HSA-qualified, HDHP plans

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

#### TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

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

#### HSA-QUALIFIED, HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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

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

## Kaiser Permanente Plus Plans

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

### TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

| Kaiser 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 | $100 | $30 | $40 | $60 | $120 |
| $10 | $20 | $40 | $150 | $30 | $40 | $60 | $170 |
| $10 | $30 | $60 | 50% | $30 | $50 | $80 | 50% |
| $15 | $30 | $50 | $100 | $35 | $50 | $70 | $120 |
| $15 | $30 | $50 | $150 | $35 | $50 | $70 | $170 |
| $15 | $30 | $50 | $200 | $35 | $50 | $70 | $220 |
| $15 | $60 | $80 | 50% | $35 | $80 | $100 | 50% |
| $20 | $40 | $60 | $150 | $40 | $60 | $80 | $170 |
| $20 | $40 | $60 | $200 | $40 | $60 | $80 | $220 |

Note: Mail order only available through Kaiser Permanente Pharmacies.

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

Below are pharmacy benefit designs available for Dual Choice plans. The pharmacy option chosen for the base plan must match the option chosen for the Dual Choice PPO plan. Dual Choice members have access to Kaiser Permanente pharmacies and a broad national network of pharmacies through MedImpact.

### TRADITIONAL AND DEDUCTIBLE COST SHARE OPTIONS

| Kaiser Permanente Pharmacies | | | | MedImpact Pharmacies | | | |
|---|---|---|---|---|---|---|---|
| Generic | Preferred Brand | Non-Preferred Brand | Specialty | Generic | Preferred Brand | Non-Preferred Brand | Specialty |
| $10 | $20 | $40 | $100 | $20 | $40 | $70 | 25% |
| $10 | $20 | $40 | $150 | $20 | $40 | $70 | 30% |
| $10 | $30 | $60 | 50% | $20 | $50 | $90 | 50% |
| $15 | $30 | $50 | $100 | $25 | $50 | $80 | 25% |
| $15 | $30 | $50 | $150 | $25 | $50 | $80 | 30% |
| $15 | $30 | $50 | $200 | $25 | $50 | $80 | 35% |
| $15 | $60 | $80 | 50% | $25 | $80 | $110 | 50% |
| $20 | $40 | $60 | $150 | $30 | $60 | $90 | 30% |
| $20 | $40 | $60 | $200 | $30 | $60 | $90 | 35% |

## HSA-QUALIFIED HIGH DEDUCTIBLE 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 | $100 | $20 | $40 | $70 | 25% |
| $10 | $20 | $40 | $150 | $20 | $40 | $70 | 30% |
| $10 | $30 | $60 | 50% | $20 | $50 | $90 | 50% |
| $15 | $30 | $50 | $100 | $25 | $50 | $80 | 25% |
| $15 | $30 | $50 | $150 | $25 | $50 | $80 | 30% |
| $15 | $30 | $50 | $200 | $25 | $50 | $80 | 35% |
| $15 | $60 | $80 | 50% | $25 | $80 | $110 | 50% |
| $20 | $40 | $60 | $150 | $30 | $60 | $90 | 30% |
| $20 | $40 | $60 | $200 | $30 | $60 | $90 | 35% |
| 10% | 10% | 10% | 10% | 20% | 20% | 20% | 20% |
| 20% | 20% | 20% | 20% | 30% | 30% | 30% | 30% |
| 30% | 30% | 30% | 30% | 40% | 40% | 40% | 40% |
| 40% | 40% | 40% | 40% | 50% | 50% | 50% | 50% |

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

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

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

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

### DEDUCTIBLE COST SHARE OPTIONS

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

### HSA-QUALIFIED, HIGH DEDUCTIBLE COST SHARE OPTIONS

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

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

# ALTERNATIVE CARE

## Traditional and deductible (including KP Plus[1]), and HSA-qualified, HDHP plans

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

**Buy-up self-referred alternative care benefits**

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

*Subject to deductible on HSA-qualified, plans.

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

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

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

**Buy-up self-referred alternative care benefits**

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

*Subject to deductible on HSA-qualified, plans.

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

**Buy-up self-referred alternative care benefits**

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

*Subject to deductible on HSA-qualified, plans.

[1]Rider benefits only available in-network

Added Choice POS, Dual Choice PPO, and PPO Plus[1] members can get care from:

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

# VISION HARDWARE

## Traditional, deductible (including KP Plus[2]), and HDHP plans

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

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

| For members 18 and younger |
|---|
| Each calendar year, one pair of eyeglass lenses and a frame, or contact lenses. |

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

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

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

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

[1]PPO Plus members do not have access to The CHP Group.

[2]Rider benefits only available in-network for KP Plus plans.

## For members 19 and older

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

| | |
|---|---|
| **ALLOWANCE OPTIONS** | $100, $150, $200, $250, $300, $400, or $500 every calendar year<br>or<br>$100, $150, $200, $250, $300, $400, or $500 every 2 calendar years |

## For members 18 and younger

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

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

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

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