A BETTER WAY TO TAKE CARE OF BUSINESS

2021 PLANS AND PRODUCTS (FOR EFFECTIVE DATES STARTING JULY 1, 2021 OR LATER) | OREGON

Complete Suite™ plan comparison chart

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

kp.org/choosebetter

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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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Complete Suite™ plan pairings and plan comparisons

The plans displayed below are the approved Dual Choice PPO plan pairings for each of our traditional, deductible, and HSA-qualified high deductible base plans.

To see plan pairings, choose the "Pairing" checkbox next to the row you want to review, then select "See plan pairings."

See plan pairings

	Base Plan	Benefit Pairing (provides the best benefit parity with the base plan)	Value Pairing (provides the best total premium option)
Pairing	**Traditional**	**Dual Choice PPO™**	
☐	TRAD PLAN A 10/1000	PPO PLAN A 10/1500	PPO PLAN B 20/2000
☐	TRAD PLAN B 20/1500	PPO PLAN B 20/2000	PPO PLAN C 20/2500
☐	TRAD PLAN C 20/2000	PPO PLAN C 20/2500	PPO PLAN D 30/3000
☐	TRAD PLAN D 30/2500	PPO PLAN D 30/3000	PPO PLAN E 35/3500
☐	TRAD PLAN E 35/3000	PPO PLAN E 35/3500	
Pairing	**Deductible**	**Dual Choice PPO™**	
☐	DED PLAN A 250/10/10%/2000	PPO PLAN A 250/10/10%/2500	PPO PLAN B 500/20/10%/3500
☐	DED PLAN A 250/15/20%/2500	PPO PLAN A 250/15/20%/3000	PPO PLAN B 500/20/20%/3500
☐	DED PLAN B 500/20/10%/3000	PPO PLAN B 500/20/10%/3500	PPO PLAN C 750/20/20%/3500 (W/SPLIT COPAYS)
☐	DED PLAN B 500/10%/10%/2000	PPO PLAN B 500/10%/10%/3000	PPO PLAN C 750/20%/20%/3500
☐	DED PLAN B 500/10/20%/2000	PPO PLAN B 500/10/20%/3000	PPO PLAN C 750/20/20%/3500 (W/SPLIT COPAYS)
☐	DED PLAN B 500/20/20%/3000	PPO PLAN B 500/20/20%/3500	PPO PLAN C 750/20/20%/3500 (W/SPLIT COPAYS)
☐	DED PLAN C 750/20/20%/3250	PPO PLAN C 750/20/20%/3500 (W/SPLIT COPAYS)	PPO PLAN D 1000/25/20%/5000
☐	DED PLAN C 750/20/20%/3000	PPO PLAN C 750/20/20%/3500 (W/O SPLIT COPAYS)	PPO PLAN D 1000/20/20%/4000
☐	DED PLAN C 750/20%/20%/3000	PPO PLAN C 750/20%/20%/3500	PPO PLAN D 1000/25/20%/5000
☐	DED PLAN D 1000/20/20%/3000	PPO PLAN D 1000/20/20%/4000	PPO PLAN E 1500/25/20%/6000
☐	DED PLAN D 1000/25/20%/4000	PPO PLAN D 1000/25/20%/5000	PPO PLAN E 1500/25/20%/6000

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	Base Plan	Benefit Pairing (provides the best benefit parity with the base plan)	Value Pairing (provides the best total premium option)
Pairing	**Deductible** *(con't)*	**Dual Choice PPO™**	
☐	DED PLAN E 1500/25/20%/5500	PPO PLAN E 1500/25/20%/6000	PPO PLAN F 2000/25/20%/6000
☐	DED PLAN E 1500/20/30%/4000	PPO PLAN E 1500/20/30%/5000	PPO PLAN F 2000/25/20%/6000
☐	DED PLAN E 1500/30%/30%/4000	PPO PLAN E 1500/30%/30%/5000	PPO PLAN F 2000/25/20%/6000
☐	DED PLAN F 2000/25/20%/5000	PPO PLAN F 2000/25/20%/6000	PPO PLAN G 2500/25/20%/6000
☐	DED PLAN G 2500/25/20%/5000	PPO PLAN G 2500/25/20%/6000	PPO PLAN H 3000/30/20%/8150
☐	DED PLAN G 2500/30/30%/5000	PPO PLAN G 2500/30/30%/6000	PPO PLAN H 3000/30/20%/8150
☐	DED PLAN G 2500/30%/30%/5000	PPO PLAN G 2500/30%/30%/6000	PPO PLAN H 3000/30%/30%/7000
☐	DED PLAN H 3000/30/20%/7350	PPO PLAN H 3000/30/20%/8150	PPO PLAN I 3500/30/20%/8000
☐	DED PLAN H 3000/30%/30%/6000	PPO PLAN H 3000/30%/30%/7000	PPO PLAN I 3500/30/20%/8000
☐	DED PLAN I 3500/30/20%/7350	PPO PLAN I 3500/30/20%/8000	PPO PLAN J 4000/30/20%/8150
☐	DED PLAN J 4000/30/20%/7500	PPO PLAN J 4000/30/20%/8150	PPO PLAN K 5000/30/20%/8150
☐	DED PLAN K 5000/30/20%/7350	PPO PLAN K 5000/30/20%/8150	
Pairing	**HDHP** (aggregate accumulation)	**Dual Choice PPO™ – HSA-Qualified HDHP** (aggregate accumulation)	
☐	HDHP PLAN A 1500/10%/2500	PPO HDHP PLAN A 1500/10%/2500	PPO HDHP PLAN B 2000/20%/4000
☐	HDHP PLAN A 1500/20%/2500	PPO HDHP PLAN A 1500/20%/2500	PPO HDHP PLAN B 2000/20%/4000
☐	HDHP PLAN B 2000/20%/4000	PPO HDHP PLAN B 2000/20%/4000	PPO HDHP PLAN C 2500/20%/5000
☐	HDHP PLAN B 2000/30%/4000	PPO HDHP PLAN B 2000/30%/4000	PPO HDHP PLAN C 2500/30%/5000
☐	HDHP PLAN C 2500/20%/5000	PPO HDHP PLAN C 2500/20%/5000	PPO HDHP PLAN E 3000/20%/6000
☐	HDHP PLAN C 2500/30%/5000	PPO HDHP PLAN C 2500/30%/5000	PPO HDHP PLAN E 3000/30%/6000

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See plan pairings

	Base Plan	Benefit Pairing (provides the best benefit parity with the base plan)	Value Pairing (provides the best total premium option)
Pairing	**HDHP** (embedded accumulation)	**Dual Choice PPO™ – HSA-Qualified HDHP** (embedded accumulation)	
☐	HDHP PLAN D 2800/20%/5600	PPO HDHP PLAN D 2800/20%/5600	
☐	HDHP PLAN D 2800/30%/5600	PPO HDHP PLAN D 2800/30%/5600	
☐	HDHP PLAN E 3000/20%/6000	PPO HDHP PLAN E 3000/20%/6000	PPO HDHP PLAN F 3500/20%/6900
☐	HDHP PLAN E 3000/30%/6000	PPO HDHP PLAN E 3000/30%/6000	PPO HDHP PLAN F 3500/30%/6900
☐	HDHP PLAN F 3500/20%/6900	PPO HDHP PLAN F 3500/20%/6900	PPO HDHP PLAN G 4000/20%/6900
☐	HDHP PLAN F 3500/30%/6900	PPO HDHP PLAN F 3500/30%/6900	PPO HDHP PLAN G 4000/30%/6900
☐	HDHP PLAN G 4000/20%/6900	PPO HDHP PLAN G 4000/20%/6900	PPO HDHP PLAN H 5000/20%/6900
☐	HDHP PLAN G 4000/30%/6900	PPO HDHP PLAN G 4000/30%/6900	PPO HDHP PLAN H 5000/30%/6900
☐	HDHP PLAN G 4000/40%/6900	PPO HDHP PLAN G 4000/40%/6900	PPO HDHP PLAN H 5000/40%/6900
☐	HDHP PLAN H 5000/20%/6900	PPO HDHP PLAN H 5000/20%/6900	
☐	HDHP PLAN H 5000/30%/6900	PPO HDHP PLAN H 5000/30%/6900	
☐	HDHP PLAN H 5000/40%/6900	PPO HDHP PLAN H 5000/40%/6900	

Below are other plans available for group coverage.

Out-of-area PPO Plus	
PPO PLUS DED PLAN WDB 500/20%/2500	PPO PLUS DED PLAN WDX 3000/30%/6850
PPO PLUS DED PLAN WDC 750/20%/3750	PPO PLUS DED PLAN WDR 4000/30%/7350
PPO PLUS DED PLAN WDE 1000/30%/4750	PPO PLUS DED PLAN WDS 5000/30%/7350
PPO PLUS DED PLAN WDP 1500/30%/6000	PPO PLUS HDHP AA PLAN WFI 1500/20%/2500
PPO PLUS DED PLAN WDN 2000/30%/6000	PPO PLUS HDHP AA PLAN WAS 2800/20%/4000

Senior Advantage
Low Plan
Mid Plan
High Plan

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that meets 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 Options	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
Deductible (IND/FAM) (per calendar year)	$0/$0	$0/$0	$0/$0	$0/$0	$0/$0
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
Lab and X-ray procedures	$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 admit	$100 per day, $500 per admit	$200 per day, $1,000 per admit	$200 per day, $1,000 per admit	$800 per admit
Emergency care	$100	$100	$200	$200	$200
Routine eye exam	$10	$20	$20	$30	$35

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

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See plan comparisons

Reset

DEDUCTIBLE

Plan Options	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
Deductible (IND/FAM) (per calendar year)	$250/$750	$250/$750	$500/$1,500	$500/$1,500
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%*
Lab and X-ray procedures	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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See plan comparisons

Reset

DEDUCTIBLE

Plan Options	DED PLAN B 500/10/20%/2000	DED PLAN B 500/20/20%/3000	DED PLAN C 750/20/20%/3000	DED PLAN C 750/20%/20%/3000
Deductible (IND/FAM) (per calendar year)	$500/$1,500	$500/$1,500	$750/$2,250	$750/$2,250
Out-of-pocket maximum (IND/FAM)	$2,000/$6,000	$3,000/$9,000	$3,000/$9,000	$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	$20	20%*
Office visits – specialty care	$10	$30	$20	20%*
Lab and X-ray procedures	20%*	$20	20%*	20%*
CT, MRI and PET scans	20%*	$100	20%*	20%*
Outpatient surgery	$10*	20%*	$20*	20%*
Inpatient hospital care	20%*	20%*	20%*	20%*
Emergency care	$200*	20%*	$200*	$200*
Routine eye exam	$10	$20	$20	20%*

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KAISER PERMANENTE®

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See plan comparisons

Reset

DEDUCTIBLE

Plan Options	DED PLAN C 750/20/20%/3250	DED PLAN D 1000/20/20%/3000	DED PLAN D 1000/25/20%/4000	DED PLAN E 1500/25/20%/5500
Deductible (IND/FAM) (per calendar year)	$750/$2,250	$1,000/$3,000	$1,000/$3,000	$1,500/$4,500
Out-of-pocket maximum (IND/FAM)	$3,250/$9,750	$3,000/$9,000	$4,000/$12,000	$5,500/$11,000
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	$20	$25	$25
Office visits – urgent care	$40	$20	$45	$45
Office visits – specialty care	$30	$20	$35	$35
Lab and X-ray procedures	$20	20%*	$25	$25
CT, MRI and PET scans	$100	20%*	$100	$100
Outpatient surgery	20%*	$20*	20%*	20%*
Inpatient hospital care	20%*	20%*	20%*	20%*
Emergency care	20%*	$200*	20%*	20%*
Routine eye exam	$20	$20	$25	$25

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See plan comparisons

Reset

DEDUCTIBLE

Plan Options	DED PLAN E 1500/20/30%/4000	DED PLAN E 1500/30%/30%/4000	DED PLAN F 2000/25/20%/5000	DED PLAN G 2500/25/20%/5000
Deductible (IND/FAM) (per calendar year)	$1,500/$4,500	$1,500/$4,500	$2,000/$6,000	$2,500/$7,500
Out-of-pocket maximum (IND/FAM)	$4,000/$12,000	$4,000/$12,000	$5,000/$10,000	$5,000/$10,000
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%*	$25	$25
Office visits – urgent care	$20	30%*	$45	$45
Office visits – specialty care	$20	30%*	$35	$35
Lab and X-ray procedures	30%*	30%*	$25	$25
CT, MRI and PET scans	30%*	30%*	$100	$100
Outpatient surgery	$20*	30%*	20%*	20%*
Inpatient hospital care	30%*	30%*	20%*	20%*
Emergency care	$200*	$200*	20%*	20%*
Routine eye exam	$20	30%*	$25	$25

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See plan comparisons

Reset

DEDUCTIBLE

Plan Options	DED PLAN G 2500/30/30%/5000	DED PLAN G 2500/30%/30%/5000	DED PLAN H 3000/30/20%/7350	DED PLAN H 3000/30%/30%/6000
Deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$2,500/$5,000	$3,000/$9,000	$3,000/$6,000
Out-of-pocket maximum (IND/FAM)	$5,000/$10,000	$5,000/$10,000	$7,350/$14,700	$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	$30	30%*	$30	30%*
Office visits – urgent care	$30	30%*	$50	30%*
Office visits – specialty care	$30	30%*	$40	30%*
Lab and X-ray procedures	30%*	30%*	$30	30%*
CT, MRI and PET scans	30%*	30%*	$100	30%*
Outpatient surgery	$30*	30%*	20%*	30%*
Inpatient hospital care	30%*	30%*	20%*	30%*
Emergency care	$200*	$200*	20%*	$200*
Routine eye exam	$30	30%*	$30	30%*

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Reset

DEDUCTIBLE

Plan Options	DED PLAN I 3500/30/20%/7350	DED PLAN J 4000/30/20%/7500	DED PLAN K 5000/30/20%/7350
Deductible (IND/FAM) (per calendar year)	$3,500/$10,500	$4,000/$10,000	$5,000/$10,000
Out-of-pocket maximum (IND/FAM)	$7,350/$14,700	$7,500/$15,000	$7,350/$14,700
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	$30	$30
Office visits – urgent care	$50	$50	$50
Office visits – specialty care	$40	$40	$40
Lab and X-ray procedures	$30	$30	$30
CT, MRI and PET scans	$100	$100	$100
Outpatient surgery	20%*	20%*	20%*
Inpatient hospital care	20%*	20%*	20%*
Emergency care	20%*	20%*	20%*
Routine eye exam	$30	$30	$30

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See plan comparisons

Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Options	HDHP Plan A 1500/10%/2500	HDHP Plan A 1500/20%/2500	HDHP Plan B 2000/20%/4000	HDHP Plan B 2000/30%/4000
Deductible (IND/FAM) (per calendar year)	$1,500/$3,000	$1,500/$3,000	$2,000/$4,000	$2,000/$4,000
Out-of-pocket maximum (IND/FAM)	$2,500/$5,000	$2,500/$5,000	$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%*
Lab and X-ray procedures	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%*

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See plan comparisons

Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Options	HDHP Plan C 2500/20%/5000	HDHP Plan C 2500/30%/5000	HDHP Plan D 2800/20%/5600	HDHP Plan D 2800/30%/5600
Deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$2,500/$5,000	$2,800/$5,600	$2,800/$5,600
Out-of-pocket maximum (IND/FAM)	$5,000/$7,500	$5,000/$7,500	$5,600/$11,200	$5,600/$11,200
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%*	20%*	30%*
Office visits – urgent care	20%*	30%*	20%*	30%*
Office visits – specialty care	20%*	30%*	20%*	30%*
Lab and X-ray procedures	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%*	30%*	20%*	30%*
Routine eye exam	20%*	30%*	20%*	30%*

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See plan comparisons

Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Options	HDHP Plan E 3000/20%/6000	HDHP Plan E 3000/30%/6000	HDHP Plan F 3500/20%/6900	HDHP Plan F 3500/30%/6900
Deductible (IND/FAM) (per calendar year)	$3,000/$6,000	$3,000/$6,000	$3,500/$7,000	$3,500/$7,000
Out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$6,000/$12,000	$6,900/$13,800	$6,900/$13,800
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%*	20%*	30%*
Office visits – urgent care	20%*	30%*	20%*	30%*
Office visits – specialty care	20%*	30%*	20%*	30%*
Lab and X-ray procedures	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%*	30%*	20%*	30%*
Routine eye exam	20%*	30%*	20%*	30%*

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See plan comparisons

Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Options	HDHP Plan G 4000/20%/6900	HDHP Plan G 4000/30%/6900	HDHP Plan G 4000/40%/6900	HDHP Plan H 5000/20%/6900
Deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000	$5,000/$10,000
Out-of-pocket maximum (IND/FAM)	$6,900/$13,800	$6,900/$13,800	$6,900/$13,800	$6,900/$13,800
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%*	40%*	20%*
Office visits – urgent care	20%*	30%*	40%*	20%*
Office visits – specialty care	20%*	30%*	40%*	20%*
Lab and X-ray procedures	20%*	30%*	40%*	20%*
CT, MRI and PET scans	20%*	30%*	40%*	20%*
Outpatient surgery	20%*	30%*	40%*	20%*
Inpatient hospital care	20%*	30%*	40%*	20%*
Emergency care	20%*	30%*	40%*	20%*
Routine eye exam	20%*	30%*	40%*	20%*

*After deductible.

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See plan comparisons

Reset

HIGH DEDUCTIBLE HEALTH PLAN

Plan Options	HDHP Plan H 5000/30%/6900	HDHP Plan H 5000/40%/6900
Deductible (IND/FAM) (per calendar year)	$5,000/$10,000	$5,000/$10,000
Out-of-pocket maximum (IND/FAM)	$6,900/$13,800	$6,900/$13,800
Office visits – preventive and well-child care	$0	$0
Office visits – prenatal care	$0	$0
Telehealth (phone/video)	$0*	$0*
Office visits – primary care	30%*	40%*
Office visits – urgent care	30%*	40%*
Office visits – specialty care	30%*	40%*
Lab and X-ray procedures	30%*	40%*
CT, MRI and PET scans	30%*	40%*
Outpatient surgery	30%*	40%*
Inpatient hospital care	30%*	40%*
Emergency care	30%*	40%*
Routine eye exam	30%*	40%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN A 10/1500		PPO PLAN B 20/2000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$0/$0	$1,500/$3,000	$0/$0	$2,000/$4,000
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%*
Lab and X-ray procedures	$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 admit	30%*	$100 per day, $500 per admit	30%*
Emergency care	$100		$100	
Routine eye exam	$30 ($10 enhanced benefit)	30%*	$40 ($20 enhanced benefit)	30%*

*After deductible.

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN C 20/2500		PPO PLAN D 30/3000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$0/$0	$2,000/$4,000	$0/$0	$2,000/$4,000
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%*
Lab and X-ray procedures	$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 admit	30%*	$200 per day, $1,000 per admit	30%*
Emergency care	$200		$200	
Routine eye exam	$40 ($20 enhanced benefit)	30%*	$50 ($30 enhanced benefit)	30%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN E 35/3500		PPO PLAN A 250/10/10%/2500	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$0/$0	$2,000/$4,000	$250/$750	$2,000/$6,000
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%*
Lab and X-ray procedures	$35	30%*	10%*	30%*
CT, MRI and PET scans	$50	30%*	10%*	30%*
Outpatient surgery	$150	30%*	$10*	30%*
Inpatient hospital care	$800 per admit	30%*	10%*	30%*
Emergency care	$200		$200*	
Routine eye exam	$55 ($35 enhanced benefit)	30%*	$30 ($10 enhanced benefit)	30%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN A 250/15/20%/3000		PPO PLAN B 500/20/10%/3500	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$250/$750	$2,000/$6,000	$500/$1500	$2,500/$7,500
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%*
Lab and X-ray procedures	$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%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN B 500/10%/10%/3000		PPO PLAN B 500/10/20%/3000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$500/$1500	$2,500/$7,500	$500/$1500	$2,500/$7,500
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%*
Lab and X-ray procedures	10%*	30%*	20%*	40%*
CT, MRI and PET scans	10%*	30%*	20%*	40%*
Outpatient surgery	10%*	30%*	$10*	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%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN B 500/20/20%/3500		PPO PLAN C 750/20/20%/3500 (w/SPLIT COPAYS)	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$500/$1500	$2,500/$7,500	$750/$2250	$3,000/$9,000
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%*
Lab and X-ray procedures	$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%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN C 750/20/20%/3500 (w/o SPLIT COPAYS)		PPO PLAN C 750/20%/20%/3500	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$750/$2250	$3,000/$9,000	$750/$2250	$3,000/$9,000
Out-of-pocket maximum (IND/FAM)	$3,500/$10,500	$7,500/$22,500	$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%*	30%* (20%* enhanced benefit)	40%*
Office visits – urgent care	$40 ($20 enhanced benefit)	40%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	$40 ($20 enhanced benefit)	40%*	30%* (20%* enhanced benefit)	40%*
Lab and X-ray procedures	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	$40 ($20 enhanced benefit)	40%*	30%* (20%* enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN D 1000/20/20%/4000		PPO PLAN D 1000/25/20%/5000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$1,000/$3,000	$3,000/$9,000	$1,000/$3,000	$3,000/$9,000
Out-of-pocket maximum (IND/FAM)	$4,000/$12,000	$9,000/$27,000	$5,000/$15,000	$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	$40 ($20 enhanced benefit)	40%*	$45 ($25 enhanced benefit)	40%*
Office visits – urgent care	$40 ($20 enhanced benefit)	40%*	$90 ($45 enhanced benefit)	40%*
Office visits – specialty care	$40 ($20 enhanced benefit)	40%*	$55 ($35 enhanced benefit)	40%*
Lab and X-ray procedures	20%*	40%*	$25	40%*
CT, MRI and PET scans	20%*	40%*	$100	40%*
Outpatient surgery	20%*	40%*	20%*	40%*
Inpatient hospital care	20%*	40%*	20%*	40%*
Emergency care	$200*		20%*	
Routine eye exam	$40 ($20 enhanced benefit)	40%*	$45 ($25 enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN E 1500/20/30%/5000		PPO PLAN E 1500/30%/30%/5000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$1,500/$4,500	$3,500/$10,500	$1,500/$4,500	$3,500/$10,500
Out-of-pocket maximum (IND/FAM)	$5,000/$12,000	$10,500/$21,000	$5,000/$12,000	$10,500/$21,000
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 ($20 enhanced benefit)	50%*	40%* (30%* enhanced benefit)	50%*
Office visits – urgent care	$40 ($20 enhanced benefit)	50%*	40%* (30%* enhanced benefit)	50%*
Office visits – specialty care	$40 ($20 enhanced benefit)	50%*	40%* (30%* enhanced benefit)	50%*
Lab and X-ray procedures	30%*	50%*	30%*	50%*
CT, MRI and PET scans	30%*	50%*	30%*	50%*
Outpatient surgery	$20*	50%*	30%*	50%*
Inpatient hospital care	30%*	50%*	30%*	50%*
Emergency care	$200*		$200*	
Routine eye exam	$40 ($20 enhanced benefit)	50%*	40%* (30%* enhanced benefit)	50%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN E 1500/25/20%/6000		PPO PLAN F 2000/25/20%/6000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$1,500/$4,500	$3,500/$10,500	$2,000/$6,000	$4,000/$12,000
Out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$10,500/$21,000	$6,000/$12,000	$12,000/$24,000
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%*
Lab and X-ray procedures	$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%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO PLAN G 2500/25/20%/6000		PPO PLAN G 2500/30/30%/6000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$2,500/$7,500	$4,500/$13,500	$2,500/$5,000	$4,500/$13,500
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%*
Lab and X-ray procedures	$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 Options	PPO PLAN G 2500/30%/30%/6000		PPO PLAN H 3000/30/20%/8150	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$4,500/$13,500	$3,000/$9,000	$5,000/$15,000
Out-of-pocket maximum (IND/FAM)	$6,000/12,000	$13,500/$27,000	$8,150/$16,300	$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%*	$50 ($30 enhanced benefit)	40%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	$100 ($50 enhanced benefit)	40%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	$60 ($40 enhanced benefit)	40%*
Lab and X-ray procedures	30%*	50%*	$30	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%* (30%* enhanced benefit)	50%*	$50 ($30 enhanced benefit)	40%*

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Reset

Dual Choice PPO

Plan Options	PPO PLAN H 3000/30%/30%/7000		PPO PLAN I 3500/30/20%/8000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$3,000/$6,000	$5,000/$15,000	$3,500/$10,500	$5,500/$16,500
Out-of-pocket maximum (IND/FAM)	$7,000/$14,000	$15,000/$30,000	$8,000/$16,000	$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%*	$50 ($30 enhanced benefit)	40%*
Office visits – urgent care	40%* (30%* enhanced benefit)	50%*	$100 ($50 enhanced benefit)	40%*
Office visits – specialty care	40%* (30%* enhanced benefit)	50%*	$60 ($40 enhanced benefit)	40%*
Lab and X-ray procedures	30%*	50%*	$30	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%* (30%* enhanced benefit)	50%*	$50 ($30 enhanced benefit)	40%*

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Reset

Dual Choice PPO

Plan Options	PPO PLAN J 4000/30/20%/8150		PPO PLAN K 5000/30/20%/8150	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$4,000/$10,000	$6,000/$18,000	$5,000/$10,000	$6,500/$19,500
Out-of-pocket maximum (IND/FAM)	$8,150/$16,300	$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%*
Lab and X-ray procedures	$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%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO HDHP PLAN A 1500/10%/2500		PPO HDHP PLAN A 1500/20%/2500	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$1,500/$3,000	$3,500/$9,750	$1,500/$3,000	$3,500/$9,750
Out-of-pocket maximum (IND/FAM)	$2,500/$5,000	$10,500/$21,000	$2,500/$5,000	$10,500/$21,000
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%*
Lab and X-ray procedures	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%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO HDHP PLAN B 2000/20%/4000		PPO HDHP PLAN B 2000/30%/4000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$2,000/$4,000	$4,000/$12,000	$2,000/$4,000	$4,000/$12,000
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%*
Lab and X-ray procedures	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.

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO HDHP PLAN C 2500/20%/5000		PPO HDHP PLAN C 2500/30%/5000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$2,500/$5,000	$5,000/$15,000	$2,500/$5,000	$5,000/$15,000
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%*
Lab and X-ray procedures	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.

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO HDHP PLAN D 2800/20%/5600		PPO HDHP PLAN D 2800/30%/5600	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$2,800/$5,600	$5,000/$15,000	$2,800/$5,600	$5,000/$15,000
Out-of-pocket maximum (IND/FAM)	$5,600/$11,200	$15,000/$30,000	$5,600/$11,200	$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%*
Lab and X-ray procedures	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.

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO HDHP PLAN E 3000/20%/6000		PPO HDHP PLAN E 3000/30%/6000	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$3,000/$6,000	$5,000/$15,000	$3,000/$6,000	$5,000/$15,000
Out-of-pocket maximum (IND/FAM)	$6,000/$12,000	$15,000/$30,000	$6,000/$12,000	$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	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%*
Lab and X-ray procedures	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%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO HDHP PLAN F 3500/20%/6900		PPO HDHP PLAN F 3500/30%/6900	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$3,500/$7,000	$5,500/$16,500	$3,500/$7,000	$5,500/$16,500
Out-of-pocket maximum (IND/FAM)	$6,900/$13,800	$15,000/$30,000	$6,900/$13,800	$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%*
Lab and X-ray procedures	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%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO HDHP PLAN G 4000/20%/6900		PPO HDHP PLAN G 4000/30%/6900	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$6,000/$12,000	$4,000/$8,000	$6,000/$12,000
Out-of-pocket maximum (IND/FAM)	$6,900/$13,800	$15,000/$30,000	$6,900/$13,800	$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%*
Lab and X-ray procedures	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%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO HDHP PLAN G 4000/40%/6900		PPO HDHP PLAN H 5000/20%/6900	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$6,000/$12,000	$5,000/$10,000	$7,000/$14,000
Out-of-pocket maximum (IND/FAM)	$6,900/$13,800	$15,000/$30,000	$6,900/$13,800	$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	50%* (40%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – urgent care	50%* (40%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Office visits – specialty care	50%* (40%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*
Lab and X-ray procedures	40%*	50%*	20%*	40%*
CT, MRI and PET scans	40%*	50%*	20%*	40%*
Outpatient surgery	40%*	50%*	20%*	40%*
Inpatient hospital care	40%*	50%*	20%*	40%*
Emergency care	40%*		20%*	
Routine eye exam	50%* (40%* enhanced benefit)	50%*	30%* (20%* enhanced benefit)	40%*

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See plan comparisons

Reset

Dual Choice PPO

Plan Options	PPO HDHP PLAN H 5000/30%/6900		PPO HDHP PLAN H 5000/40%/6900	
Tiers	In-network	Out-of-network	In-network	Out-of-network
Deductible (IND/FAM) (per calendar year)	$5,000/$10,000	$7,000/$14,000	$5,000/$10,000	$7,000/$14,000
Out-of-pocket maximum (IND/FAM)	$6,900/$13,800	$17,000/$34,000	$6,900/$13,800	$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%*
Lab and X-ray procedures	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.

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See plan comparisons

Reset

OUT-OF-AREA PPO PLUS

Plan Options	PPO PLUS DED PLAN WDB 500/20%/2500		PPO PLUS DED PLAN WDC 750/20%/3750	
Tiers	PPO Providers	Non-Participating Providers	PPO Providers	Non-Participating Providers
Deductible (IND/FAM) (per calendar year)	$500/$1,500	$750/$2,250	$750/$2,250	$1,125/$3,375
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%*
Lab and X-ray procedures	$30	35%*	$30	35%*
X-RAY / DIAGNOSTIC TEST	$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.

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.

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that meets 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

OUT-OF-AREA PPO PLUS

Plan Options	PPO PLUS DED PLAN WDE 1000/30%/4750		PPO PLUS DED PLAN WDP 1500/30%/6000	
Tiers	PPO Providers	Non-Participating Providers	PPO Providers	Non-Participating Providers
Deductible (IND/FAM) (per calendar year)	$1,000/$3,000	$1,500/$4,500	$1,500/$4,500	$2,250/$6,750
Out-of-pocket maximum (IND/FAM)	$4,750/$9,500	$6,000/$12,000	$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	$30	45%*	$30	45%*
Office visits – urgent care	$50	45%*	$50	45%*
Office visits – specialty care	$40	45%*	$40	45%*
Lab and X-ray procedures	$30	45%*	$30	45%*
X-RAY / DIAGNOSTIC TEST	$30	45%*	$30	45%*
CT, MRI and PET scans	30%*	45%*	30%*	45%*
Outpatient surgery	30%*	45%*	30%*	45%*
Inpatient hospital care	30%*	45%*	30%*	45%*
Emergency care	$200*		$200*	
Routine eye exam	$30	45%*	$30	45%*

*After deductible.

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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 meets 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

OUT-OF-AREA PPO PLUS

Plan Options	PPO PLUS DED PLAN WDN 2000/30%/6000		PPO PLUS DED PLAN WDX 3000/30%/6850	
Tiers	PPO Providers	Non-Participating Providers	PPO Providers	Non-Participating Providers
Deductible (IND/FAM) (per calendar year)	$2,000/$6,000	$3,000/$9,000	$3,000/$9,000	$4,500/$13,500
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%*
Lab and X-ray procedures	$35	40%*	$35	40%*
X-RAY / DIAGNOSTIC TEST	$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.

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.

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that meets 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

OUT-OF-AREA PPO PLUS

Plan Options	PPO PLUS DED PLAN WDR 4000/30%/7350		PPO PLUS DED PLAN WDS 5000/30%/7350	
Tiers	PPO Providers	Non-Participating Providers	PPO Providers	Non-Participating Providers
Deductible (IND/FAM) (per calendar year)	$4,000/$8,000	$6,000/$12,000	$5,000/$10,000	$6,500/$13,000
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%*
Lab and X-ray procedures	$35	40%*	$35	40%*
X-RAY / DIAGNOSTIC TEST	$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.

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.

Below are highlights of the benefits for each plan. A variety of options gives you the flexibility to choose a plan that meets 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

OUT-OF-AREA PPO PLUS

Plan Options	PPO PLUS HDHP AA PLAN WFI 1500/20%/2500		PPO PLUS HDHP AA PLAN WAS 2800/20%/4000	
Tiers	PPO Providers	Non-Participating Providers	PPO Providers	Non-Participating Providers
Deductible (IND/FAM) (per calendar year)	$1,500/$3,000	$3,500/$7,000	$2,800/$5,600	$3,500/$7,000
Out-of-pocket maximum (IND/FAM)	$2,500/$5,000	$5,000/$10,000	$4,000/$8,000	$5,000/$10,000
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%*
Lab and X-ray procedures	20%*	30%*	20%*	30%*
X-RAY / DIAGNOSTIC TEST	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.

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.

Compare plans - Traditional, Deductible, HDHP

See plan pairings

Plan Options			
Deductible (IND/FAM) (per calendar year)			
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			
Lab and X-ray procedures			
CT, MRI and PET scans			
Outpatient surgery			
Inpatient hospital care			
Emergency care			
Routine eye exam			

*After deductible.

Start over

Compare plans - Dual Choice PPO, Out-of-area PPO Plus

See plan pairings

Plan Options						
Deductible (IND/FAM) (per calendar year)						
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						
Lab and X-ray procedures						
CT, MRI and PET scans						
Outpatient surgery						
Inpatient hospital care						
Emergency care						
Routine eye exam						

*After deductible.

Start over

Plan pairings

Plan Options					
Deductible (IND/FAM) (per calendar year)					
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					
Lab and X-ray procedures					
CT, MRI and PET scans					
Outpatient surgery					
Inpatient hospital care					
Emergency care					
Routine eye exam					

*After deductible.

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
$10	$20	$40	$150
$10	$20	$40	20% or 50% (up to a max of $100 or $150)
$10	$30	$50	$150
$15	$30	$50	$150
$15	$30	$50	20% or 50% (up to a max of $100 or $150)
$15	$40	$60	$150
$20	$40	$60	$150
$20	$40	$60	20% or 50% (up to a max of $100 or $150)
$25	$50	$75	$150

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
$10	$20	$40	20% or 50% (up to a max of $100 or $150)
$10	$30	$50	$150
$15	$30	$50	20% or 50% (up to a max of $100 or $150)
$15	$40	$60	$150
$20	$40	$60	20% or 50% (up to a max of $100 or $150)
$25	$50	$75	$150
10%	10%	10%	10%
20%	20%	20%	20%
30%	30%	30%	30%
40%	40%	40%	40%

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.

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 a broad national network of pharmacies through MedImpact, as well as access to Kaiser Permanente pharmacies.

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	$150	$20	$40	$70	30%
$10	$20	$40	20% up to a max of $100 or $150	$20	$40	$70	30%
$10	$20	$40	50% up to a max of $100 or $150	$20	$40	$70	50%
$10	$30	$50	$150	$20	$50	$80	30%
$15	$30	$50	$150	$25	$50	$80	30%
$15	$30	$50	20% up to a max of $100 or $150	$25	$50	$80	30%
$15	$30	$50	50% up to a max of $100 or $150	$25	$50	$80	50%
$15	$40	$60	$150	$25	$60	$90	30%
$20	$40	$60	$150	$30	$60	$90	30%
$20	$40	$60	20% up to a max of $100 or $150	$30	$60	$90	30%
$20	$40	$60	50% up to a max of $100 or $150	$30	$60	$90	50%
$25	$50	$75	$150	$35	$70	$105	30%

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	20% up to a max of $100 or $150	$20	$40	$70	30%
$10	$20	$40	50% up to a max of $100 or $150	$20	$40	$70	50%
$10	$30	$50	$150	$20	$50	$80	30%
$15	$30	$50	20% up to a max of $100 or $150	$25	$50	$80	30%
$15	$30	$50	50% up to a max of $100 or $150	$25	$50	$80	50%
$15	$40	$60	$150	$25	$60	$90	30%
$20	$40	$60	20% up to a max of $100 or $150	$30	$60	$90	30%
$20	$40	$60	50% up to a max of $100 or $150	$30	$60	$90	50%
$25	$50	$75	$150	$35	$70	$105	30%
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

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.

COST SHARE OPTIONS

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.

Medimpact or Kaiser Permanente Pharmacies			
Generic	Preferred Brand	Non-Preferred Brand	Specialty
$10	$20	$40	20% (up to a max of $100 or $150)
$10	$20	$40	50% (up to a max of $100 or $150)
$15	$30	$50	20% (up to a max of $100 or $150)
$15	$30	$50	50% (up to a max of $100 or $150)
$20	$40	$60	20% (up to a max of $100 or $150)
$20	$40	$60	50% (up to a max of $100 or $150)

ADULT HEARING AIDS

Traditional, deductible, and HSA-qualified HDHP plans

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

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

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

ALTERNATIVE CARE

Traditional, deductible, and HSA-qualified HDHP plans

Physician-referred alternative care benefits included as standard in plans

When medically necessary, Kaiser Permanente doctors may refer members for acupuncture, chiropractic care, and naturopathic treatment at the same cost share as a specialty care office visit.

Buy-up self-referred alternative care benefits

Members will pay the same cost share per treatment as a primary care office visit. Coverage applies an annual benefit maximum of $1,000, $1,500, or $2,000. Note: Massage office copay is always $25 (subject to deductible on HSA-qualified plans) with a 12-visit limit per calendar year. 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.

Self-referred alternative care without prior authorization is available for the following bundles:

- Chiropractic only
- Naturopathic only
- Chiropractic and acupuncture
- Chiropractic, acupuncture, naturopathic, and massage therapy

Dual Choice PPO™ and HSA-qualified Dual Choice PPO™ plans

Buy-up self-referred alternative care benefits

Self-referred alternative care without prior authorization is available for the following bundles:

- Chiropractic only
- Chiropractic and acupuncture
- Chiropractic, acupuncture, and massage therapy

Coverage applies an annual benefit maximum of $1,000, $1,500, or $2,000. Members will pay the same cost share as a primary office visit. Note: Massage office copay is always $25 (subject to deductible on HSA-qualified plans) with a 12-visit limit per calendar year. Dual Choice members may select providers from the CHP Group, First Choice Health, First Health Network, or out-of-network providers.

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

Buy-up self-referred alternative care benefits

Self-referred alternative care without prior authorization is available for the following bundles:

- Chiropractic only
- Naturopathic only
- Chiropractic and acupuncture
- Chiropractic, acupuncture, naturopathic, and massage therapy

Coverage may apply annual benefit maximums of $1,000, $1,500, or $2,000. Note: Massage office copay is always $25 (subject to deductible on HDHP plans) with a 12-visit limit per calendar year. PPO Plus members may select providers from First Choice Health, First Health Network, or nonparticipating providers.

VISION HARDWARE

Traditional, deductible, and HSA-qualified 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 or $100, $150, $200, $250, $300, $400, or $500 every 2 calendar years

For members 18 and younger – Standard benefit	
Each calendar year, 1 pair of eyeglass lenses and a standard frame from a specified collection of frames, or contact lenses.	
For members 18 and younger – Enhanced benefit	
With the enhanced benefit, the member may purchase frames outside of the specified collection. An allowance is provided toward the purchase of the eyeglass lenses/frame or contact lenses.	
ALLOWANCE OPTIONS	$100, $150, $200, $250, $300, $400, or $500 every calendar year

Dual Choice PPO™ and HSA-qualified Dual Choice PPO™ 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, First Choice Health optical providers, First Health Network optical providers, or nonparticipating optical providers.

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

For members 18 and younger
Each calendar year, 1 pair of eyeglass lenses and a standard frame from a specified collection of frames or contact lenses are covered in full when purchased from Vision Essentials by Kaiser Permanente or participating facilities, and First Choice Health optical vendors and First Health Network optical vendors. Vision hardware purchased from nonparticipating optical vendors is covered at 50%.

Out-of-area PPO Plus, and HSA-qualified Out-of-area PPO Plus 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 select facilities. First Choice Health optical providers, First Health Network optical providers, or nonparticipating optical providers.

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

For members 18 and younger
Each calendar year, 1 pair of eyeglass lenses and a standard frame from a specified collection of frames or contact lenses are covered in full when purchased from Vision Essentials by Kaiser Permanente or participating 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 Options	**LOW PLAN**	**MID PLAN**	**HIGH PLAN**
Deductible (IND/FAM) (per calendar year)	$0	$0	$0
Out-of-pocket maximum (IND/FAM)	$1,500	$1,000	$600
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	$20	$15	$10
Office visits – urgent care	$25	$20	$15
Office visits – specialty care	$25	$20	$15
Lab and X-ray procedures	$0	$0	$0
CT, MRI and PET scans	$50	$25	$0
Outpatient surgery	$150	$100	$50
Outpatient therapies	$25	$20	$15
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
Outside service area	$1,000 maximum per year - 20% coinsurance	$1,000 maximum per year - 20% coinsurance	$1,000 maximum per year - 20% coinsurance
Pharmacy	$15 generic/$30 brand	$10 generic/$20 brand	$5 generic/$10 brand

Outpatient therapies include physical, occupational, speech, rehabilitative, and habilitative services (25 visits combined per calendar year plus additional 25 visits for neurodevelopmental therapy).

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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