PLAN UPDATES

What's new for Oregon small business group plans with coverage effective on or after January 1, 2021

OREGON
2021

This booklet contains a summary of important information you will want to know about our 2021 small group plans. For more details on plan design, refer to the Medical Plans Overview for Oregon Small Businesses.

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KAISER PERMANENTE®

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

WHAT'S NEW AT KAISER PERMANENTE

Below are some of the exciting changes over the past year

Care from the comfort of home	Your employees can rest assured knowing they can continue to get the high-quality care they depend on for all their health care needs. For primary care, specialty care, and mental health services, they can connect with their care team with e-visits, video visits, or phone appointments.
Self-care at your fingertips – at no additional cost to members	Kaiser Permanente is now offering 2 digital self-care apps, Calm and myStrength, at no additional cost to members to help support their mental health and emotional well-being.[1,2] Visit **kp.org/selfcareapps** for more information.
Access to on-demand exercise videos	Your employees get no-cost access to thousands of on-demand workout videos at classpass.com,[3] plus free trials and reduced rates on ClassPass membership to access live-streaming and in-person exercise classes from top studios worldwide. Visit **kp.org/exercise** for more information.
Now open – Chase Gardens Medical Office	The new state-of-the-art medical office, which opened in May, gives Kaiser Permanente Northwest members in Lane County greater access to primary care and additional on-site services, including pharmacy, lab, and imaging.
Dental advice at home	Members with medical and dental plans can send photos and communicate with their dental team via email through **kp.org** and the Kaiser Permanente app.
Getting connected to an interpreter, made easier	Members calling the language interpretation services number **1-800-324-8010**, listed on the back of their Kaiser Permanente ID card, will go through a new flow that connects them with an interpreter before contacting the call center.

[1]Calm and myStrength are only available to Kaiser Permanente members with medical coverage.
[2]myStrength is a wholly owned subsidiary of Livongo Health, Inc.
[3]Only available to Kaiser Permanente members with medical coverage.

Below are some of the exciting changes over the past year

Improved billing experience for visiting members getting care in Kaiser Permanente Washington	Kaiser Permanente Northwest members seeking care in our Washington Region will get the same financial experience as when they receive care here in Oregon and Southwest Washington.
Bringing healing home with virtual cardiac rehabilitation	Kaiser Permanente is home to Oregon's first virtual cardiac rehab program. In its first year, 87% of participants completed Kaiser Permanente's 8-week virtual rehab program using wearable technology, compared with a less than 50% national average completion rate for those attending in-person rehab programs.*
Seeking tomorrow's cure, today	Our cancer team is at the forefront of clinical trials, testing immunotherapy and other treatments that help give patients more options for leading-edge care. In fact, Kaiser Permanente is a part of one of the largest cancer clinical research groups in the country.
Vision Essentials by Kaiser Permanente – working toward a sustainable future	Vision Essentials optical has been consolidated to 6 retail locations – Beaverton Medical and Dental Office, Clackamas Eye Care, Interstate Medical Office Central, Longview-Kelso Medical Office, North Lancaster Medical Office, and Salmon Creek Medical Office. This helps create a more sustainable model and fulfills our mission of providing high-quality, affordable health care for our members.

*Kaiser Permanente internal data, data covering the period from June 2019 through December 2019.

2021 medical plan portfolio

Our plan portfolio offers choice and flexibility. We have multiple plans to choose from in all 4 metal levels. As actuarial values update each year, we have made necessary cost-sharing changes to help keep plans within their respective metal levels as well as additional changes to ensure portfolio balance for 2021. No plans have been discontinued; however, our most notable plan change is to the KP OR Bronze 5200/20% HSA, which has been changed to the KP OR Bronze 6900/0% HSA. Additionally, we have added 2 leaner plan options in the gold and silver metal levels: KP OR Gold 2000/40 and KP OR Silver 5500/50. Specific cost-sharing changes for each plan are provided in the 2021 Medical Plan Changes section of this document. Groups may choose to renew with their current plan or select any other plan within our portfolio.

2021 dental plan portfolio

New dental implant coverage options! For 2021, we will offer 2 Traditional Family Dental plan options that may be purchased with dental implant coverage for adults ages 19+. We also offer plan options with cosmetic orthodontia coverage. As a reminder, our Family dental plans provide coverage for adults and pediatric dependents together on one plan, including medically necessary orthodontia for members under 19 and an annual out-of-pocket maximum for in-network services of $350 for an individual under 19 and $700 for a family (of 2 or more pediatric members enrolled). We offer both Traditional and Choice (PPO) Family Dental plans. If you currently offer dental coverage, the same plan will be provided upon renewal; however, you may select any plan within our portfolio.

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

Pediatric dental services and coverage for your renewal

Pediatric dental coverage for members is required by law, so all of our medical plans are offered along with an ACA-compliant pediatric dental plan. We now offer a choice of Traditional stand-alone pediatric plans and Dental Choice (PPO) plans, which means you can choose a plan that provides access to one of our 21 Kaiser Permanente Dental office locations or a plan that gives you a choice of preferred providers, including those in our dental facilities and nonparticipating dentists. Coverage for standard orthodontia to address misaligned teeth is also offered among our Traditional and Dental Choice plans. If you have an ACA-compliant pediatric dental plan offered by another carrier, you may opt out of our coverage by attesting to this fact on your New Group Application or Renewal Decision Form.

If your group previously attested to having other ACA-compliant pediatric dental coverage and waived this coverage, you must provide an updated attestation upon renewal using the Renewal Decision Form. If a plan is not selected or an updated attestation is not received, coverage will be added.

Group Medicare Senior Advantage

Upon renewal in 2021, stand-alone Kaiser Permanente Senior Advantage plan subgroups will be eliminated. Senior Advantage members who have dependents or who are dependents of an employee will rejoin their families. Subscribers without dependents will be placed on the subgroup with all other members or the lowest-cost plan being offered. This new practice will help alleviate administrative issues with regards to billing and benefits administration some groups may have experienced but **will not affect the member's current benefits.**

It's important to note that this change **may result in a premium change.** If your group health plan is subject to Medicare Secondary/TEFRA 2 Payer rules, the plan rate for your members who enroll in Senior Advantage will be the same as the rate for the plan you offer to employees under age 65. If your group offers multiple plans and the member has their subscriber or dependents enrolled on a buy-up plan, their rate will be based on that plan, rather than the lowest offered plan. Medicare Primary/TEFRA 1 groups will continue to pay the Senior Advantage rate listed in the renewal packet. Letters will be mailed directly to groups that are affected by this change with additional detail.

For groups that do not currently have Senior Advantage plan enrollment, this change will not affect your members. Should you have members who become Medicare eligible and wish to enroll in Senior Advantage, rate details are included in your renewal packet.

Automatic renewals

For your renewal in 2021, we will automatically provide you with coverage from one of the plans that best matches the plan or plans your business offers today. But you can choose from any of our other plans available to small employers if you prefer. Please indicate on the Renewal Decision Form whether you'd like to accept the renewal as offered or make changes.

Bundle options

As you consider alternatives to lower your health care costs, consider offering employees a plan with 1 or 2 buy-up alternatives. These bundle plan options are provided at no additional charge and allow you to tailor your plan offerings, giving employees more choice and more control over their monthly premium cost.

You contribute the same amount toward each plan (no less than 50% of the lowest premium plan) and let your employees decide if they want to pay more for a buy-up option. For more details, refer to the Medical Plans Overview for Oregon Small Businesses.

Prescription drug coverage is automatically covered on all medical plans

All our plans come with built-in coverage for outpatient prescription drugs. All prescription drug plans have a 4-tier benefit design with different cost-sharing amounts for generic, preferred brand-name, non-preferred brand-name, and specialty drugs.

Your employees can save time and money by ordering prescription refills online or by phone. Members can get a 90-day supply for only twice the 30-day supply copay when we mail their prescription drugs. We can mail most prescription drugs within 10 days, and there's no extra cost for standard U.S. postage.

Alternative care, routine vision eye exam and hardware benefits

Naturopathic care is provided on all plans (except the Oregon Standard plans) as a core benefit and includes 6 self-referred visits per year at the Specialty Office Visit cost share. Members can access this benefit through the CHP network of providers.

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

As a reminder, to offer choice and affordability, plans purchased without the vision hardware benefit do not provide coverage for adult routine eye exams. Go to **kp2020.org** for more information, including our 6 optical locations.

Pediatric vision coverage on all medical plans

All our plans cover pediatric vision exams and 1 pair of standard frames with lenses or conventional or disposable contact lenses in lieu of eyeglasses (limited to 1 pair per year for conventional lenses or up to a 6-month supply of disposable contact lenses per year) at no additional charge.

Standard plans

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

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

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

Underwriting guidelines

Please be sure to review the Rating and Underwriting Assumptions Policy effective January 1, 2021, for Oregon groups with 50 or fewer employees.

2021 MEDICAL PLAN CHANGES

YEAR	2020	2021
PLAN NAME	**KP OR Gold 0/30**	**KP OR Gold 0/30**
ANNUAL OUT-OF-POCKET MAXIMUM	$6,750 per individual; $13,500 per family	$7,500 per individual; $15,000 per family
BENEFITS	Member pays	
OUTPATIENT PRESCRIPTION DRUGS	$30 preferred brand-name	$40 preferred brand-name

YEAR	2020	2021
PLAN NAME	**KP OR Gold 1000/20**	**KP OR Gold 1000/20**
ANNUAL OUT-OF-POCKET MAXIMUM	$6,500 per individual; $13,000 per family	$7,500 per individual; $15,000 per family
BENEFITS	Member pays	
OUTPATIENT SURGERY	20%*	25%*
INPATIENT HOSPITAL CARE	20%*	25%*
EMERGENCY DEPARTMENT VISIT	20%*	25%*
AMBULANCE SERVICES	20%*	25%*
MENTAL HEALTH SERVICES Inpatient psychiatric care	20%*	25%*
Residential treatment	20%*	25%*
CHEMICAL DEPENDENCY SERVICES Inpatient psychiatric care	20%*	25%*
Residential treatment	20%*	25%*
DURABLE MEDICAL EQUIPMENT	20%*	25%*
OUTPATIENT ADMINISTERED MEDICATIONS	20%*	25%*
MATERNITY CARE Inpatient	20%*	25%*

YEAR	2020	2021
PLAN NAME	**KP Oregon Standard Gold Plan**	**KP Oregon Standard Gold Plan**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$1,000 per individual; $2,000 per family	$1,500 per individual; $3,000 per family

YEAR	2020	2021
PLAN NAME	**KP OR Silver 2500/45**	**KP OR Silver 2500/45**
ANNUAL OUT-OF-POCKET MAXIMUM	$8,150 per individual; $16,300 per family	$8,550 per individual; $17,100 per family

*Subject to annual medical deductible.

YEAR	2020	2021
PLAN NAME	**KP OR Silver 3500/40**	**KP OR Silver 3500/40**
ANNUAL OUT-OF-POCKET MAXIMUM	$8,150 per individual; $16,300 per family	$8,550 per individual; $ 17,100 per family

YEAR	2020	2021
PLAN NAME	**KP OR Silver 4500/45**	**KP OR Silver 4500/45**
ANNUAL OUT-OF-POCKET MAXIMUM	$8,150 per individual; $16,300 per family	$8,550 per individual; $17,100 per family

YEAR	2020	2021
PLAN NAME	**KP Oregon Standard Silver Plan**	**KP Oregon Standard Silver Plan**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$3,550 per individual; $7,100 per family	$3,650 per individual; $7,300 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,150 per individual; $16,300 per family	$8,550 per individual; $17,100 per family

YEAR	2020	2021
PLAN NAME	**KP OR Bronze 5500/50**	**KP OR Bronze 7000/50**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$5,500 per individual; $11,000 per family	$7,000 per individual; $14,000 per family
PRESCRIPTION DRUG DEDUCTIBLE	$900	$1,000
ANNUAL OUT-OF-POCKET MAXIMUM	$8,150 per individual; $16,300 per family	$8,550 per individual; $17,100 per family

YEAR	2020	2021
PLAN NAME	**KP OR Bronze 8150/40**	**KP OR Bronze 8550/40**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$8,150 per individual; $16,300 per family	$8,550 per individual; $17,100 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,150 per individual; $16,300 per family	$8,550 per individual; $17,100 per family

YEAR	2020	2021
PLAN NAME	**KP Oregon Standard Bronze Plan**	**KP Oregon Standard Bronze Plan**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$7,900 per individual; $15,800 per family	$8,550 per individual; $17,100 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$7,900 per individual; $15,800 per family	$8,550 per individual; $17,100 per family
BENEFITS	Member pays	
OFFICE VISITS Primary care	$45	$50
Urgent care	0%*	$100
Specialty care	$90	$100
OUTPATIENT THERAPIES	$45	$50
MENTAL HEALTH SERVICES Outpatient/day treatment	$45	$50
CHEMICAL DEPENDENCY SERVICES Outpatient/day treatment	$45	$50
OUTPATIENT PRESCRIPTION DRUGS	$15 generic	$20 generic

*Subject to annual medical deductible.

YEAR	2020	2021
PLAN NAME	**KP OR Bronze 5200/20% HSA**	**KP OR Bronze 6900/0% HSA**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$5,200 per individual; $10,400 per family	$6,900 per individual; $13,800 per family
BENEFITS	Member pays	
OFFICE VISITS Primary care	20%*	0%*
Urgent care	50%*	0%*
Specialty care	30%*	0%*
Allergy shots and other injections	50%*	0%*
OUTPATIENT THERAPIES	30%*	0%*
OUTPATIENT SURGERY	50%*	0%*
LAB	50%*	0%*
X-RAY/DIAGNOSTIC TEST	50%*	0%*
CT, MRI, AND PET SCANS	50%*	0%*
INPATIENT HOSPITAL CARE	50%*	0%*
EMERGENCY DEPARTMENT VISIT	50%*	0%*
AMBULANCE SERVICES	50%*	0%*
MENTAL HEALTH SERVICES Inpatient psychiatric care	50%*	0%*
Residential treatment	50%*	0%*
Outpatient/day treatment	20%*	0%*
CHEMICAL DEPENDENCY SERVICES Inpatient psychiatric care	50%*	0%*
Residential treatment	50%*	0%*
Outpatient/day treatment	20%*	0%*
DURABLE MEDICAL EQUIPMENT	50%*	0%*
INFERTILITY SERVICES (diagnosis)	50%*	0%*
DEPENDENT OUT-OF-AREA	20%*	0%*
PHYSICIAN-REFERRED ALTERNATIVE CARE	30%*	0%*
OUTPATIENT PRESCRIPTION DRUGS	$20* generic; 50%* preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	0%* generic; 0%* preferred brand-name; 0%* non-preferred brand-name; 0%* specialty
OUTPATIENT ADMINISTERED MEDICATIONS	50%*	0%*
MATERNITY CARE Inpatient	50%*	0%*

*Subject to annual medical deductible.

YEAR	2020			2021		
PLAN NAME	KP OR Gold 600/35 3T POS			KP OR Gold 500/35 3T POS		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$600 per individual; $1,200 per family	$1,800 per individual; $3,600 per family	$4,500 per individual; $9,000 per family	$500 per individual; $1,000 per family	$1,500 per individual; $3,000 per family	No change
ANNUAL OUT-OF-POCKET MAXIMUM	$4,000 per individual; $8,000 per family	$6,000 per individual; $12,000 per family	$8,000 per individual; $16,000 per family	$5,000 per individual; $10,000 per family	$7,000 per individual; $14,000 per family	$9,000 per individual; $18,000 per family
BENEFITS	Member pays			Member pays		
OFFICE VISITS Specialty care	$45	$70	50%*	$55	$80	No change
OUTPATIENT THERAPIES	$45	$70	50%*	$55	$80	No change

YEAR	2020		2021	
PLAN NAME	KP OR Gold 1000/20 3T POS		KP OR Gold 1000/20 3T POS	
Tier	Tier 1	Tier 2	Tier 1	Tier 2
ANNUAL OUT-OF-POCKET MAXIMUM	$5,000 per individual; $10,000 per family	$7,500 per individual; $15,000 per family	$6,000 per individual; $12,000 per family	$8,000 per individual; $16,000 per family

YEAR	2020		2021	
PLAN NAME	KP OR Silver 2500/45 3T POS		KP OR Silver 2500/45 3T POS	
Tier	Tier 1	Tier 2	Tier 1	Tier 2
ANNUAL OUT-OF-POCKET MAXIMUM	$8,150 per individual; $16,300 per family	$8,150 per individual; $16,300 per family	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family

YEAR	2020		2021	
PLAN NAME	KP OR Gold 650/35 3T POS OOA		KP OR Gold 500/35 3T POS OOA	
Tier	Tier 1	Tier 2	Tier 1	Tier 2
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$650 per individual; $1,300 per family	$650 per individual; $1,300 per family	$500 per individual; $1,000 per family	$500 per individual; $1,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$5,000 per individual; $10,000 per family	$5,000 per individual; $10,000 per family	$6,000 per individual; $12,000 per family	$6,000 per individual; $12,000 per family
BENEFITS	Member pays		Member pays	
OFFICE VISITS Specialty care	$45	$45	$55	$55
OUTPATIENT THERAPIES	$45	$45	$55	$55
OUTPATIENT PRESCRIPTION DRUGS	$60 non-preferred brand-name	$60 non-preferred brand-name	$50 non-preferred brand-name	$50 non-preferred brand-name

*Subject to annual medical deductible.

YEAR	2020			2021		
PLAN NAME	KP OR Gold 1000/35 3T POS OOA			KP OR Gold 1000/35 3T POS OOA		
Tier	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL OUT-OF-POCKET MAXIMUM	$5,000 per individual; $10,000 per family	$5,000 per individual; $10,000 per family	$10,000 per individual; $20,000 per family	$6,000 per individual; $12,000 per family	$6,000 per individual; $12,000 per family	No change
BENEFITS	Member pays			Member pays		
OFFICE VISITS Specialty care	$45	$45	50%*	$55	$55	No change
OUTPATIENT THERAPIES	$45	$45	50%*	$55	$55	No change
OUTPATIENT SURGERY	30%*	30%*	50%*	35%*	35%*	No change
INPATIENT HOSPITAL CARE	30%*	30%*	50%*	35%*	35%*	No change
EMERGENCY DEPARTMENT VISIT	30%*			35%*		
AMBULANCE SERVICES	30%*			35%*		
MENTAL HEALTH SERVICES Inpatient psychiatric care	30%*	30%*	50%*	35%*	35%*	No change
Residential treatment	30%*	30%*	50%*	35%*	35%*	No change
DURABLE MEDICAL EQUIPMENT	30%*	30%*	50%*	35%*	35%*	No change
MATERNITY CARE Inpatient	30%*	30%*	50%*	35%*	35%*	No change

YEAR	2020		2021	
PLAN NAME	KP OR Silver 2500/45 3T POS OOA		KP OR Silver 2500/45 3T POS OOA	
Tier	Tier 1	Tier 2	Tier 1	Tier 2
ANNUAL OUT-OF-POCKET MAXIMUM	$8,150 per individual; $16,300 per family	$8,150 per individual; $16,300 per family	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family

*Subject to annual medical deductible.

2021 DENTAL PLAN CHANGES

	NEW 2021 DENTAL PLANS		
PLAN NAME	**KP OR Traditional 80 Pediatric Dental Plan**	**KP OR Traditional 100 Pediatric Dental Plan ($50 individual/$150 family)**	**KP OR Traditional 100 + Ortho Pediatric Dental Plan ($50 individual/$150 family)**
ANNUAL BENEFIT MAXIMUM	N/A	N/A	N/A
OUT-OF-POCKET MAXIMUM	$350 per child; $700 per family	$350 per child; $700 per family	$350 per child; $700 per family
BENEFITS	Member pays		
OFFICE VISIT COPAY	$0	$0	$0
PREVENTIVE AND DIAGNOSTIC SERVICES[1]	20%	0%	0%
BASIC RESTORATIVE SERVICES	75%	20%	20%
SIMPLE EXTRACTIONS	75%	20%	20%
ORAL SURGERY	75%	20%	20%
PERIODONTICS	75%	20%	20%
ENDODONTICS	75%	20%	20%
MAJOR RESTORATIVE SERVICES	75%	50%	50%
REMOVABLE PROSTHETIC SERVICES	75%	50%	50%
MEDICALLY NECESSARY ORTHODONTICS	50% medically necessary only	50% medically necessary only	50% medically necessary ortho 50% for cosmetic ortho, up to $1,500 benefit maximum[2]
NIGHT GUARDS[1]	10%	10%	10%
NITROUS OXIDE[1]	$25 - 13 and older $0 - 12 and under	$25 - 13 and older $0 - 12 and under	$25 - 13 and older $0 - 12 and under
EMERGENCY TREATMENT At Kaiser Permanente facilities	Member pays any copays or coinsurance that noramlly applies.		
EMERGENCY TREATMENT From other providers	Member pays any copay or coinsurance that normally applies, and all charges over $100.		

PEDIATRIC DENTAL PLAN REMINDER

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

[1]Preventive and diagnostic services, night guards, and nitrous oxide services do not apply to the deductible nor count toward the annual benefit maximum.

[2]The lifetime benefit maximum is $1,500. The member pays 50% of charges up to the orthodontic benefit maximum and then pays 100% thereafter.

NEW 2021 Optional Family Dental Coverage Options

Implant Coverage	
IMPLANT COVERAGE CAN BE ADDED TO ANY OF THE FOLLOWING PLANS:	KP OR Family Traditional 100 – $2500 Max + Implant
	KP OR Family Traditional 100 – $2000 Max + Implant
Implant lifetime maximum of 4 implants. The member pays 50% of charges up to the plan annual benefit maximum and then pays 100% thereafter.	

Cosmetic Orthodontia + Implant Coverage	
ORTHODONTIC AND IMPLANT COVERAGE CAN BE ADDED TO ANY OF THE FOLLOWING PLANS:	KP OR Family Traditional 100 – $2500 Max + Ortho + Implant
	KP OR Family Traditional 100 – $2000 Max + Ortho + Implant
Orthodontic lifetime benefit maximum is $1,500. The member pays 50% of charges up to the orthodontic benefit maximum and then pays 100% thereafter. Implant lifetime maximum of 4 implants. The member pays 50% of charges up to the plan annual benefit maximum and then pays 100% thereafter.	

2021 *GROUP AGREEMENT* AND *EVIDENCE OF COVERAGE* SUMMARY OF CHANGES AND CLARIFICATIONS FOR OREGON SMALL EMPLOYER GROUPS

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage (EOC),* benefit summary, and any applicable endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the previous pages in this Plan Updates document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your group renews in 2021. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

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

Changes to Kaiser Permanente Senior Advantage plans are explained at the end of this summary.

Benefit changes

- **Preventive Care Services.** Selected preventive care services to be covered without a deductible for individuals diagnosed with specific chronic conditions has been added to Deductible and High Deductible Health Plans, as allowed under the IRS and US Treasury Department Notice 2019-45.
- **Maternity and Newborn Care.** Newborn nurse home visiting services are covered as required per Oregon Senate Bill 526.
- **Outpatient Durable Medical Equipment (DME).** Home ultraviolet light therapy equipment for treatment of certain skin conditions has been added to the list of covered DME.
- **Outpatient Prescription Drugs and Supplies.** The cost share for insulin is not subject to Deductible and will not exceed $100 per 30-day supply.

Benefit clarifications

- **Post-Stabilization Care, Pediatric Vision Services, and Vision Hardware and Optical Services.** Modifications have been made to indicate that these benefit provisions apply to covered services from vendors, such as providers of Durable Medical Equipment (DME) and vision hardware.
- **External Prosthetic Devices and Orthotic Devices.** For Traditional, Deductible, and High Deductible Health Plans, language has been added to specify that services are covered subject to Utilization Review.
- **Mental Health Services.** Modifications have been made to the *EOC* and the Benefit Summary to clarify that partial hospitalization is a covered service.
- **Outpatient Durable Medical Equipment.** The *EOC* has been modified to clarify that both blood glucose monitors and continuous glucose monitors are covered.

- **Exclusions and Limitations.** The surrogacy limitation clarifies that it applies to both traditional and gestational surrogacy arrangements.

Administrative changes or clarifications

- ***Group Agreement.*** Modifications have been made to clarify that Company may terminate the *Group Agreement* if there are no members covered, regardless of whether members reside or work in the service area, as that is not a requirement of eligibility for all products.
- **Definitions.** The term Cost Share has been defined in the *EOC*. Throughout all documents, the defined term Cost Share replaces some, but not all, instances of Deductible, Copayments, or Coinsurance used for improved readability, accuracy, and administrative purposes.
- **Definitions.** The terms Non-Participating Vendor and Participating Vendor have been added to the Traditional, Deductible, and High Deductible Health Plan *EOC* for alignment across products.
- **Alternative Care Services.** The definition of Non-Participating Provider, specific to the "Alternative Care Services" section of the *EOC*, has been modified for accuracy to reflect that a Non-Participating Provider is an Alternative Care provider who is not a Participating Provider.
- **Definitions.** The definition of Spouse has been modified to clarify that the term includes a person who is validly registered as a domestic partner under the laws of another state.
- **Adding New Dependents to an Existing Account.** The time allowed to submit an enrollment application for a newborn, adopted child, or foster child has been changed from 30 days to 31 days.
- **Prior and Concurrent Authorization and Utilization Review.** For Traditional, Deductible, and High Deductible Health Plans prior authorization determination notices will be provided to both the member and the requesting provider within 2 business days of the request and to outline the timelines when additional information is required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for services submitted by a member are outlined in the "Grievances, Claims, and Appeals" section.
- **Injuries or Illnesses Alleged to be Caused by Third Parties.** This section of the *EOC* has been modified and retitled "Injuries or Illnesses Alleged to be Caused by Other Parties." Language has been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- **Injuries or Illnesses Alleged to be Caused by Third Parties.** This section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.
- **Surrogacy Arrangements.** This section of the *EOC* has been modified to clarify that the section applies to both traditional and gestational surrogacy arrangements.
- **Moving to Another Kaiser Foundation Health Plan Service Area.** Members may be eligible to enroll in a plan in the other Kaiser Foundation Health Plan Service Area, rather than transferring to another plan; however, they would still need to meet the eligibility requirements of the new plan.

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

Benefit changes

- **Services Subject to Prior Authorization Review under Tier 2 and Tier 3.** DME items covered under External Prosthetic Devices and Orthotic Devices and Outpatient Durable Medical Equipment (DME) will now require prior authorization in all tiers.
- **Failure to Satisfy Prior Authorization Review Requirements.** Tier 2 and Tier 3 Out-of-Pocket Maximum sections of the *EOC* have been modified to specify that if a Member does not obtain the required prior authorization for Services from a Non-Participating Provider, Non-Participating Vendor, or Non-Participating Facility, the claim will be denied and the Member will be responsible for the Charges.
- **Cost Share for Covered Drugs and Supplies.** There is a change in how the Member cost share is applied for drugs obtained from MedImpact Pharmacies when a generic equivalent is available, but the Member chooses a brand-name drug. Members will now only pay the Copayment or Coinsurance for the brand-name drug rather than paying the difference between the pharmacy's retail price for the brand-name drug and the generic drug, in addition to the applicable drug tier cost share.

Benefit clarifications

- **How to Obtain Services – General Information.** The language in the *EOC* noting Urgent Care as an exception to the Tier 1 requirements has been removed. Only Emergency Services received at a PPO Facility or Non-Participating Facility are covered under Tier 1. Urgent Care Services received at a PPO Facility or Non-Participating Facility are covered under Tier 2 or Tier 3, whichever applies.
- **Tier 2 and Tier 3 Urgent Care.** The *EOC* has been modified to clarify that we cover Urgent Care under Tier 2 or Tier 3. The language indicating that if a Member receives Urgent Care that is not covered under Tier 1 has been removed as Urgent Care is covered under Tier 1. We do not cover Services in Tier 2 or Tier 3 that are not covered under Tier 1.

Administrative changes or clarifications

- **Tier 1, Tier 2, and Tier 3 Prior Authorization Review Requirements** sections of the *EOC* have been updated to the **Prior and Concurrent Authorization and Utilization Review** section and have been modified to reflect that prior authorization determination notices will be provided to both the Member and the requesting provider within 2 business days of the request and to outline the timelines when additional information is required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, Appeals, and External Review" section.

Changes and clarifications that apply to dental plans

Benefit clarifications

- **Limitations.** A new limitation has been added to clarify that routine fillings are limited to amalgam or glass ionomer fillings on posterior teeth and composite fillings on anterior teeth. This limitation does not change how fillings are currently restored.

Administrative changes or clarifications

- ***Group Agreement.*** Modifications have been made to clarify that Company may terminate the *Group Agreement* if there are no members covered, regardless of whether members reside or work in the service area, as that is not a requirement of eligibility for all products.
- **Definitions.** The definition of Spouse has been modified to clarify that the term includes a person who is validly registered as a domestic partner under the laws of another state.
- **Adding New Dependents to an Existing Account.** The time allowed to submit an enrollment application for a newborn, adopted child, or foster child has been changed from 30 days to 31 days.
- **Participating or Non-Participating Provider.** The PPO *EOC*s have been revised to clarify that all care and Service must be directed by a Participating or Non-Participating Provider within the United States.
- **Injuries or Illnesses Alleged to be Caused by Third Parties.** This section of the *EOC* has been modified for accuracy and clarity. The section has been retitled "Injuries or Illnesses Alleged to be Caused by Other Parties" and references throughout the section to "third parties" have been changed. Language has also been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- **Injuries or Illnesses Alleged to be Caused by Third Parties.** Language in the "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.

Changes and clarifications that apply to all Senior Advantage plans

- **Outpatient Prescription Drugs.** True out-of-pocket cost for Part D covered drugs in a calendar year has increased from $6,350 to $6,550.

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