For **Oregon groups with 1–50** employees

MEDICAL PLANS OVERVIEW

For coverage effective on or after January 1, 2021

OREGON 2021

WHY CHOOSE KAISER PERMANENTE

Small businesses come with big growing pains. Finding a solid health plan shouldn't be one of them. Work smarter and healthier with affordable care and coverage from Kaiser Permanente.

Value

Your employees see doctors who are motivated by outcomes, not profits — so you get the most value for your health care dollars.

Our integrated care delivery model means built-in cost control. And stable rates help give you the freedom — and confidence — to grow your business.

Quality

Kaiser Foundation Health Plan of the Northwest commercial plans tied for the highest rating in Oregon and Washington, according to the 2019–2020 Health Insurance Plan ratings from the National Committee for Quality Assurance (NCQA).[1]

Choice

Your employees have access to more than 1,250 Kaiser Permanente doctors across Oregon and Southwest Washington, plus a network of providers and specialists, including The Portland Clinic.[2]

Convenience

In addition to in-person care, telehealth options like email, phone visits, and video visits can help employees get care when and where they need it, saving them — and you — valuable time and money.

[1]The NCQA's Health Insurance Plan Ratings are based on combined scores for health plans in HEDIS® (Healthcare Effectiveness Data and Information Set); CAHPS® (Consumer Assessment of Healthcare Providers and Systems); and NCQA Accreditation standards scores. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Last accessed May 2020. healthinsuranceratings.ncqa.org

[2]Some specialty care services are accessed through referral and prior authorization. The Portland Clinic is not available as an in-network provider to members on Medicaid, receiving full Medical Financial Assistance from Kaiser Permanente, or visiting from another Kaiser Permanente region.

Tools for employers: **account.kp.org**

With our online portal, account.kp.org, you have everything you need to take care of business in one place.

- View membership and eligibility, enroll or terminate subscribers, and update demographics.
- Order ID cards.
- View your bill and make payments.
- Download and save your group contracts online.

Tools for members: **kp.org and the Kaiser Permanente app**

Members have access to information and tools to better manage their health, so they can:

- View their digital ID card
- Access their health record
- Email their doctor
- Schedule routine and specialty appointments
- Fill and refill most prescriptions
- Check lab results
- Have phone or video visits

Give us a call or talk to your broker

We can answer your questions about medical coverage, eligibility, plan design, or renewal. Please contact us or your producer/broker if you would like a booklet with more details about our plans and options.

Toll free..... 1-800-813-2630
TTY..... 711
Language interpretation services.... 1-800-324-8010
Fax 503-813-4426

account.kp.org

KAISER PERMANENTE®

SMALL BUSINESS TAX CREDIT

Qualified small employers who wish to claim the small business health care tax credit through the Oregon Health Insurance Marketplace must select a plan without buy-up coverage. Additionally, our Choice products are not qualified plans for this tax credit. The IRS Small Business Health Care Tax Credit helps qualified small businesses lower the cost of offering health insurance to employees. Small businesses in Oregon must also meet the minimum criteria to qualify for the tax credit, available on **Oregon.gov**.

Plan options

METAL TIER	Traditional	Deductible	HSA-qualified high deductible	Added Choice® point-of-service[1]
Platinum	KP OR Platinum 0/20	KP OR Platinum 250/20 KP OR Platinum 500/20		KP OR Platinum 250/20 3T POS[2] KP OR Platinum 250/20 3T POS OOA[2]
Gold	KP OR Gold 0/30	KP Oregon Standard Gold Plan KP OR Gold 1000/20 KP OR Gold 1500/35 KP OR Gold 2000/40		KP OR Gold 500/35 3T POS[2] KP OR Gold 500/35 3T POS OOA[2] KP OR Gold 1000/20 3T POS[2] KP OR Gold 1000/35 3T POS OOA[2]
Silver		KP Oregon Standard Silver Plan KP OR Silver 2500/45 KP OR Silver 3500/40 KP OR Silver 4500/45 KP OR Silver 5500/50	KP OR Silver 2800/25% HSA	KP OR Silver 2500/45 3T POS[2] KP OR Silver 2500/45 3T POS OOA[2]
Bronze		KP Oregon Standard Bronze Plan KP OR Bronze 7000/50 KP OR Bronze 8550/40	KP OR Bronze 6900/0% HSA	

[1]If you have employees who live or work outside our service area, they may be eligible for an Added Choice out-of-area (OOA) plan. Rates and approval subject to underwriting.

[2]Added Choice OOA plans: Groups must meet underwriting requirements to purchase.

Buy-up options	Any of the above medical plans can be paired with a buy-up option listed below, with the exception of the Standard plans. **A. Adult vision hardware and vision exam:** Vision hardware allowance of $200/2-year period for ages 19 and older and vision exam covered at primary office visit cost share. Visit **kp2020.org** for more information. **B. Alternative Care:** $20 chiropractic and acupuncture, $25 massage therapy (limit 12 per year)/$1,000 max per enrolled member. Visit **chpgroup.com** for a list of alternative care providers. If purchased with Added Choice plans, these benefits may be used at CHP, PPO, and other nonparticipating providers and facilities. **C. Vision + Alternative Care:** Bundle of Options A and B above

PLAN NAME	TRADITIONAL PLANS	
	KP OR Platinum 0/20	**KP OR Gold 0/30**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$0 per individual; $0 per family	$0 per individual; $0 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$2,000 per individual; $4,000 per family	$7,500 per individual; $15,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$30
Urgent care	$40	$60
Specialty care	$30	$50
Prenatal care	$0	$0
OUTPATIENT THERAPIES[1]	$30	$50
OUTPATIENT SURGERY	$100	40%
LAB	$20	$30
X-RAY/DIAGNOSTIC TEST	$20	$30
CT, MRI, AND PET SCANS	$75	$300
INPATIENT HOSPITAL CARE	$300 per day, $1,500 per admission	$500 per day, $2,500 per admission
EMERGENCY DEPARTMENT VISIT	$150	$300
SELF-REFERRED NATUROPATHIC CARE[2]	$30	$50
OUTPATIENT PRESCRIPTION DRUGS	$5 generic; $15 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$15 generic; $40 preferred brand-name; $60 non-preferred brand-name; 50% specialty

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

[2]Limited to 6 visits per year.

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.

OREGON PLAN
COMPARISON

	DEDUCTIBLE PLANS	
PLAN NAME	**KP OR Platinum 250/20**	**KP OR Platinum 500/20**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$250 per individual; $500 per family	$500 per individual; $1,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$2,500 per individual; $5,000 per family	$4,000 per individual; $8,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$20
Urgent care	$40	$40
Specialty care	$30	$30
Prenatal care	$0	$0
OUTPATIENT THERAPIES[1]	$30	$30
OUTPATIENT SURGERY	10%*	20%*
LAB	$20	$20
X-RAY/DIAGNOSTIC TEST	$20	$20
CT, MRI, AND PET SCANS	10%*	20%*
INPATIENT HOSPITAL CARE	10%*	20%*
EMERGENCY DEPARTMENT VISIT	10%*	20%*
SELF-REFERRED NATUROPATHIC CARE[2]	$30	$30
OUTPATIENT PRESCRIPTION DRUGS	$5 generic; $15 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$5 generic; $15 preferred brand-name; $50 non-preferred brand-name; 50% specialty

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

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.

	DEDUCTIBLE PLANS		
PLAN NAME	**KP OR Gold 1000/20**	**KP OR Gold 1500/35**	**KP OR Gold 2000/40**
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	$2,000 per individual; $4,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$7,500 per individual; $15,000 per family	$7,000 per individual; $14,000 per family	$8,000 per individual; $16,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$20	$35	$40
Urgent care	$50	$55	$60
Specialty care	$40	$45	$50
Prenatal care	$0	$0	$0
OUTPATIENT THERAPIES[1]	$40	$45	$50
OUTPATIENT SURGERY	25%*	20%*	25%*
LAB	$20	$35	$40
X-RAY/DIAGNOSTIC TEST	$20	$35	$40
CT, MRI, AND PET SCANS	$300	$300	$300
INPATIENT HOSPITAL CARE	25%*	20%*	25%*
EMERGENCY DEPARTMENT VISIT	25%*	20%*	25%*
SELF-REFERRED NATUROPATHIC CARE[2]	$40	$45	$50
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% specialty	$10 generic; $20 preferred brand-name; $60 non-preferred brand-name; 50% specialty	$15 generic; $45 preferred brand-name; 50% non-preferred brand-name; 50% specialty

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

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COMPARISON

	DEDUCTIBLE PLANS		
PLAN NAME	**KP Oregon Standard Gold Plan[1]**	**KP OR Silver 2500/45**	**KP OR Silver 3500/40**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$1,500 per individual; $3,000 per family	$2,500 per individual; $5,000 per family	$3,500 per individual; $7,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$7,300 per individual; $14,600 per family	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$20	$45	$40
Urgent care	$60	$65	$70
Specialty care	$40	$55	$50
Prenatal care	20%*	$0	$0
OUTPATIENT THERAPIES[2]	$20	$55	$50
OUTPATIENT SURGERY	20%*	30%*	30%*
LAB	20%*	$45	$40
X-RAY/DIAGNOSTIC TEST	20%*	$45	$40
CT, MRI, AND PET SCANS	20%*	30%*	30%*
INPATIENT HOSPITAL CARE	20%*	30%*	30%*
EMERGENCY DEPARTMENT VISIT	20%*	30%*	30%*
SELF-REFERRED NATUROPATHIC CARE[3]	Not covered	$55	$50
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% specialty (up to $500 maximum)	$30 generic; $50 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$30 generic; $50 preferred brand-name; 30% non-preferred brand-name; 50%* specialty

*Subject to annual medical deductible.

[1]These plans may not be sold with additional coverage such as adult vision hardware and eye exam and alternative care. Only medically necessary eye exams are covered. These plans exclude the following benefits: Physician Referred Alternative Care, Dependent Out of Area, Infertility diagnosis.

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

[3]Limited to 6 visits per year.

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.

	DEDUCTIBLE PLANS		
PLAN NAME	**KP OR Silver 4500/45**	**KP OR Silver 5500/50**	**KP Oregon Standard Silver Plan[1]**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$4,500 per individual; $9,000 per family	$5,500 per individual; $11,000 per family	$3,650 per individual; $7,300 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$45	$50	$40
Urgent care	$75	35%*	$70
Specialty care	$55	$70	$80
Prenatal care	$0	$0	30%*
OUTPATIENT THERAPIES[2]	$55	$70	$40
OUTPATIENT SURGERY	30%*	35%*	30%*
LAB	$45	35%*	30%*
X-RAY/DIAGNOSTIC TEST	$45	35%*	30%*
CT, MRI, AND PET SCANS	30%*	35%*	30%*
INPATIENT HOSPITAL CARE	30%*	35%*	30%*
EMERGENCY DEPARTMENT VISIT	30%*	35%*	30%*
SELF-REFERRED NATUROPATHIC CARE[3]	$55	$70	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $50 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$30 generic; $50 preferred brand-name; 50%* non-preferred brand-name; 50%* specialty	$15 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50% specialty

*Subject to annual medical deductible.

[1]These plans may not be sold with additional coverage such as adult vision hardware and eye exam and alternative care. Only medically necessary eye exams are covered. These plans exclude the following benefits: Physician Referred Alternative Care, Dependent Out of Area, Infertility diagnosis.

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

[3]Limited to 6 visits per year.

OREGON PLAN
COMPARISON

	DEDUCTIBLE PLANS		
PLAN NAME	**KP OR Bronze 7000/50**	**KP OR Bronze 8550/40**	**KP Oregon Standard Bronze Plan[1]**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$7,000 per individual; $14,000 per family	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$50	$40 for 3 visits; then 0%*	$50
Urgent care	35%*	0%*	$100
Specialty care	$60*	0%*	$100
Prenatal care	$0	$0	0%*
OUTPATIENT THERAPIES[2]	$60*	0%*	$50
OUTPATIENT SURGERY	35%*	0%*	0%*
LAB	35%*	0%*	0%*
X-RAY/DIAGNOSTIC TEST	35%*	0%*	0%*
CT, MRI, AND PET SCANS	35%*	0%*	0%*
INPATIENT HOSPITAL CARE	35%*	0%*	0%*
EMERGENCY DEPARTMENT VISIT	35%*	0%*	0%*
SELF-REFERRED NATUROPATHIC CARE[3]	$60*	0%*	Not covered
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60[4] preferred brand-name; 50%[4] non-preferred brand-name; 50%[4] specialty	$30 generic; 0%* preferred brand-name; 0%* non-preferred brand-name; 0%* specialty	$20 generic; 0%* preferred brand-name; 0%* non-preferred brand-name; 0%* specialty

*Subject to annual medical deductible.

[1]These plans may not be sold with additional coverage such as adult vision hardware and eye exam and alternative care. Only medically necessary eye exams are covered. These plans exclude the following benefits: Physician Referred Alternative Care, Dependent Out of Area, Infertility diagnosis.

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

[3]Limited to 6 visits per year.

[4]Subject to $1,000 prescription drug 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.

	HIGH DEDUCTIBLE HEALTH PLANS	
PLAN NAME	**KP OR Silver 2800/25% HSA**	**KP OR Bronze 6900/0% HSA**
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$2,800 per individual; $5,600 per family	$6,900 per individual; $13,800 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$5,400 per individual; $10,800 per family	$6,900 per individual; $13,800 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	0%	0%
Primary care	25%*	0%*
Urgent care	25%*	0%*
Specialty care	25%*	0%*
Prenatal care	0%	0%
OUTPATIENT THERAPIES[1]	25%*	0%*
OUTPATIENT SURGERY	25%*	0%*
LAB	25%*	0%*
X-RAY/DIAGNOSTIC TEST	25%*	0%*
CT, MRI, AND PET SCANS	25%*	0%*
INPATIENT HOSPITAL CARE	25%*	0%*
EMERGENCY DEPARTMENT VISIT	25%*	0%*
SELF-REFERRED NATUROPATHIC CARE[2]	25%*	0%*
OUTPATIENT PRESCRIPTION DRUGS	$20* generic; $40* preferred brand-name; 30%* non-preferred brand-name; 50%* specialty	0%* generic; 0%* preferred brand-name; 0%* non-preferred brand-name; 0%* specialty

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

PLAN NAME	ADDED CHOICE® POINT-OF-SERVICE PLANS KP OR Platinum 250/20 3T POS		
Tier	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$250 per individual; $500 per family	$500 per individual; $1,000 per family	$750 per individual; $1,500 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$2,500 per individual; $5,000 per family	$3,500 per individual; $7,000 per family	$7,000 per individual; $14,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	35%*
Primary care	$20	$30	35%*
Urgent care	$40	$60	35%*
Specialty care	$30	$40	35%*
Prenatal care	$0	$0	35%*
OUTPATIENT THERAPIES[1]	$30	$40	35%*
OUTPATIENT SURGERY	10%*	25%*	35%*
LAB	$20	$30	35%*
X-RAY/DIAGNOSTIC TEST	$20	$30	35%*
CT, MRI, AND PET SCANS	10%*	25%*	35%*
INPATIENT HOSPITAL CARE	10%*	25%*	35%*
EMERGENCY DEPARTMENT VISIT	10%*		
SELF-REFERRED NATUROPATHIC CARE[2]	$30	$40	35%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$15 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% specialty	Not covered

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

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.

	ADDED CHOICE® POINT-OF-SERVICE PLANS		
PLAN NAME	KP OR Gold 500/35 3T POS		
Tier	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$500 per individual; $1,000 per family	$1,500 per individual; $3,000 per family	$4,500 per individual; $9,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$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		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$35	$60	50%*
Urgent care	$60	$80	50%*
Specialty care	$55	$80	50%*
Prenatal care	$0	$0	50%*
OUTPATIENT THERAPIES[1]	$55	$80	50%*
OUTPATIENT SURGERY	30%*	50%*	50%*
LAB	$35	40%*	50%*
X-RAY/DIAGNOSTIC TEST	$35	40%*	50%*
CT, MRI, AND PET SCANS	30%*	50%*	50%*
INPATIENT HOSPITAL CARE	30%*	50%*	50%*
EMERGENCY DEPARTMENT VISIT	30%*		
SELF-REFERRED NATUROPATHIC CARE[2]	$55	$80	50%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$25 generic; $75 preferred brand-name; 50% non-preferred brand-name; 50% specialty	Not covered

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

PLAN NAME	ADDED CHOICE® POINT-OF-SERVICE PLANS KP OR Gold 1000/20 3T POS		
Tier	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$1,000 per individual; $2,000 per family	$2,000 per individual; $4,000 per family	$6,000 per individual; $12,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$6,000 per individual; $12,000 per family	$8,000 per individual; $16,000 per family	$10,000 per individual; $20,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$20	$40	50%*
Urgent care	$50	$100	50%*
Specialty care	$40	$60	50%*
Prenatal care	$0	$0	50%*
OUTPATIENT THERAPIES[1]	$40	$60	50%*
OUTPATIENT SURGERY	25%*	40%*	50%*
LAB	$20	40%*	50%*
X-RAY/DIAGNOSTIC TEST	$20	40%*	50%*
CT, MRI, AND PET SCANS	$300	40%*	50%*
INPATIENT HOSPITAL CARE	25%*	40%*	50%*
EMERGENCY DEPARTMENT VISIT	25%*		
SELF-REFERRED NATUROPATHIC CARE[2]	$40	$60	50%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $30 preferred brand-name; 50% non-preferred brand-name; 50% specialty	$25 generic; $75 preferred brand-name; 50% non-preferred brand-name; 50% specialty	Not covered

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

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.

PLAN NAME	ADDED CHOICE® POINT-OF-SERVICE PLANS KP OR Silver 2500/45 3T POS		
Tier	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$2,500 per individual; $5,000 per family	$4,500 per individual; $9,000 per family	$6,500 per individual; $13,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family	$13,000 per individual; $26,000 per family
BENEFITS	**Member pays**		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$45	$60	50%*
Urgent care	$65	$80	50%*
Specialty care	$55	$70	50%*
Prenatal care	$0	$0	50%*
OUTPATIENT THERAPIES[1]	$55	$70	50%*
OUTPATIENT SURGERY	30%*	40%*	50%*
LAB	$45	40%*	50%*
X-RAY/DIAGNOSTIC TEST	$45	40%*	50%*
CT, MRI, AND PET SCANS	30%*	40%*	50%*
INPATIENT HOSPITAL CARE	30%*	40%*	50%*
EMERGENCY DEPARTMENT VISIT	30%*		
SELF-REFERRED NATUROPATHIC CARE[2]	$55	$70	50%*
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $40 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$40 generic; $60 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not covered

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

OREGON PLAN
COMPARISON

If you have employees who live or work outside our service area, they may be eligible for an Added Choice out-of-area (OOA) plan. Rates and approval subject to underwriting. Groups must meet underwriting requirements to purchase. These plans are only offered outside the Oregon Health Insurance Marketplace.

	ADDED CHOICE® POINT-OF-SERVICE OUT-OF-AREA PLANS		
PLAN NAME	KP OR Platinum 250/20 3T POS OOA		
Tier	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$250 per individual; $500 per family	$250 per individual; $500 per family	$750 per individual; $1,500 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$2,500 per individual; $5,000 per family	$2,500 per individual; $5,000 per family	$7,000 per individual; $14,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	35%*
Primary care	$20	$20	35%*
Urgent care	$40	$40	35%*
Specialty care	$30	$30	35%*
Prenatal care	$0	$0	35%*
OUTPATIENT THERAPIES[1]	$30	$30	35%*
OUTPATIENT SURGERY	10%*	10%*	35%*
LAB	$20	$20	35%*
X-RAY/DIAGNOSTIC TEST	$20	$20	35%*
CT, MRI, AND PET SCANS	$100	$100	35%*
INPATIENT HOSPITAL CARE	10%*	10%*	35%*
EMERGENCY DEPARTMENT VISIT	10%*		
SELF-REFERRED NATUROPATHIC CARE[2]	$30	$30	35%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	Not covered

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

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.

PLAN NAME	ADDED CHOICE® POINT-OF-SERVICE OUT-OF-AREA PLANS KP OR Gold 500/35 3T POS OOA		
Tier	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$500 per individual; $1,000 per family	$500 per individual; $1,000 per family	$4,500 per individual; $9,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$6,000 per individual; $12,000 per family	$6,000 per individual; $12,000 per family	$10,000 per individual; $20,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$35	$35	50%*
Urgent care	$60	$60	50%*
Specialty care	$55	$55	50%*
Prenatal care	$0	$0	50%*
OUTPATIENT THERAPIES[1]	$55	$55	50%*
OUTPATIENT SURGERY	35%*	35%*	50%*
LAB	$35	$35	50%*
X-RAY/DIAGNOSTIC TEST	$35	$35	50%*
CT, MRI, AND PET SCANS	$250*	$250*	50%*
INPATIENT HOSPITAL CARE	35%*	35%*	50%*
EMERGENCY DEPARTMENT VISIT	35%*		
SELF-REFERRED NATUROPATHIC CARE[2]	$55	$55	50%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	$10 generic; $20 preferred brand-name; $50 non-preferred brand-name; 50% specialty	Not covered

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

OREGON PLAN
COMPARISON

PLAN NAME	ADDED CHOICE® POINT-OF-SERVICE OUT-OF-AREA PLANS KP OR Gold 1000/35 3T POS OOA		
Tier	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$1,000 per individual; $2,000 per family	$1,000 per individual; $2,000 per family	$6,000 per individual; $12,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$6,000 per individual; $12,000 per family	$6,000 per individual; $12,000 per family	$10,000 per individual; $20,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$35	$35	50%*
Urgent care	$75	$75	50%*
Specialty care	$55	$55	50%*
Prenatal care	$0	$0	50%*
OUTPATIENT THERAPIES[1]	$55	$55	50%*
OUTPATIENT SURGERY	35%*	35%*	50%*
LAB	$35	$35	50%*
X-RAY/DIAGNOSTIC TEST	$35	$35	50%*
CT, MRI, AND PET SCANS	$300	$300	50%*
INPATIENT HOSPITAL CARE	35%*	35%*	50%*
EMERGENCY DEPARTMENT VISIT	35%*		
SELF-REFERRED NATUROPATHIC CARE[2]	$55	$55	50%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $20 preferred brand-name; $60 non-preferred brand-name; 50% specialty	$10 generic; $20 preferred brand-name; $60 non-preferred brand-name; 50% specialty	Not covered

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

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.

	ADDED CHOICE® POINT-OF-SERVICE OUT-OF-AREA PLANS		
PLAN NAME	KP OR Silver 2500/45 3T POS OOA		
Tier	Tier 1	Tier 2	Tier 3
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$2,500 per individual; $5,000 per family	$2,500 per individual; $5,000 per family	$6,500 per individual; $13,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,550 per individual; $17,100 per family	$8,550 per individual; $17,100 per family	$12,000 per individual; $24,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$45	$45	50%*
Urgent care	$65	$65	50%*
Specialty care	$55	$55	50%*
Prenatal care	$0	$0	50%*
OUTPATIENT THERAPIES[1]	$55	$55	50%*
OUTPATIENT SURGERY	40%*	40%*	50%*
LAB	$45	$45	50%*
X-RAY/DIAGNOSTIC TEST	$45	$45	50%*
CT, MRI, AND PET SCANS	40%*	40%*	50%*
INPATIENT HOSPITAL CARE	40%*	40%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
SELF-REFERRED NATUROPATHIC CARE[2]	$55	$55	50%*
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $40 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	$30 generic; $40 preferred brand-name; 50% non-preferred brand-name; 50%* specialty	Not covered

*Subject to annual medical deductible.

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

[2]Limited to 6 visits per year.

PLAN NAME	2021 SMALL GROUP SENIOR ADVANTAGE
ANNUAL MEDICAL DEDUCTIBLE Accumulates to out-of-pocket maximum	$0
ANNUAL OUT-OF-POCKET MAXIMUM	$1,000 per individual
BENEFITS	**Member pays**
OFFICE VISITS Preventive care	$0
Primary care	$20
Urgent care	$25
Specialty care	$20
Prenatal care	$0
OUTPATIENT THERAPIES	$20
OUTPATIENT SURGERY	$50
LAB	$0
X-RAY/DIAGNOSTIC TEST	$0
CT, MRI, AND PET SCANS	$0
INPATIENT HOSPITAL CARE	$200 per admission
EMERGENCY DEPARTMENT VISIT	$50
SELF-REFERRED ALTERNATIVE CARE[1]	$20 copay covers self-referred chiropractic, naturopathic, and acupuncture visits. $25 copay for massage therapy up to 12 visits per calendar year, $1,000 benefit max per calendar year for all services combined.
OUTPATIENT PRESCRIPTION DRUGS[2]	$20 generic; $40 preferred brand-name and specialty; $3 generic/$7 preferred brand-name after TrOOP ($6,550)

Senior Advantage Plans cannot be modified. Kaiser Permanente is a plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal. Benefits, premiums and/or copays/coinsurance may change on January 1 of each year and at other times in accord with your group's contract with us. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

[1]CHP network only.

[2]The Part D prescription drug gap begins when total drug costs (Kaiser Permanente share plus your copay or coinsurance) for the year to date total $4,020.

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.

Plan highlights

Out-of-pocket maximum: All benefits displayed accumulate to the out-of-pocket maximum.

Pediatric benefits: All plans include pediatric vision exams at $0 and pediatric vision hardware at no charge for 1 pair standard frames with lenses, 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); no charge for low vision aid from selected list or medically necessary contact lenses.

Pediatric dental coverage is required, and we offer a choice of 3 different plans (please see the dental brochure).

Standard plans: Standard plans are designed by the state of Oregon and cover only essential health benefits.* These plans have the same benefits from one company to the next so consumers can compare like plans across carriers that offer qualified health plans to small employers.

Explanation of Added Choice benefits

Tier 1 services, in most cases, are provided by select providers and select facilities. *The Evidence of Coverage (EOC)* provides a complete definition of select providers and select facilities and explains when Tier 1 services are provided by other providers and facilities.

Tier 2 services are provided by PPO providers and facilities. Refer to the *EOC* for a complete definition of PPO providers and facilities.

Tier 3 services are provided by nonparticipating providers and facilities. Refer to the *EOC* for a complete definition of nonparticipating providers and facilities.

Deductible and out-of-pocket maximum amounts cross-accumulate between Tiers 1 and 2. There is a separate deductible and out-of-pocket maximum amount in Tier 3, which does not accumulate across any other tiers.

Bundled plan options when you purchase coverage outside the health insurance exchange

You can offer 2 or 3 medical plans in a bundle, with the limitation that there can only be 1 Added Choice plan per bundle. Once you select your plan offerings, employees choose the plan that best meets their needs.

INTEGRATED EYE HEALTH

We treat eye health as a component of total health, not in isolation. When you choose the vision option, you're choosing the option that is more convenient and connected, which can help uncover major health issues and lead to better health outcomes.

DENTAL COVERAGE

Investing in dental health helps keep your employees happy, healthy, and productive. Our Traditional dental plans allow you to choose from a wide range of options including deductibles or office visit copays. If you would like more flexibility, the Dental Choice PPO plans are designed for choice — providing comprehensive coverage, while allowing members to see any dentist.

*These plans may not be sold with additional coverage such as adult vision hardware and eye exam and alternativecare. Only medically necessary eye exams are covered. These plans exclude the following benefits: Physician Referred Alternative Care, Dependent Out of Area, and Infertility diagnosis.

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