These medical plans are fully insured and underwritten by Kaiser Permanente. This is a summary only. Any errors or omissions are unintentional. Plan Handbooks are available by request.

DEDUCTIBLES AND CO-INSURANCE MAXIMUMS	COPAY B	DEDUCTIBLE A	DEDUCTIBLE B	HDHP-1
Deductible per Calendar Year	None	$250 Single $750 Family	$500 Single $1,500 Family	$1,700 Single $3,400 Family*
Maximum out-of-pocket per Calendar Year *(Includes deductible, cotnsurance, and prescription copays)*	$1,500 Single $3,000 Family	$2,000 Single $6,000 Family	$3,000 Single $9,000 Family	$3,400 Single $6,800 Family**
BENEFIT FEATURES				
Preventive Care Services	**Covered Person Pays**	**Covered Person Pays**		
Routine well-baby care, physical examinations, health screenings, and immunizations	No charge	No charge		
Professional Services	**Covered Person Pays**	**Covered Person Pays**		
Office visits for illness or injury, naturopathic services, mental/behavioral health or substance use disorder***	$5 visits 1- 3 , $20 per visit - primary $30 per visit - specialist	$5 visits 1- 3, $15 per visit - primary $25 per visit - specialist	$5 visits 1- 3, $20 per visit - primary, $30 per visit - specialist	After deductible $0 visits 1- 3, 20% for additional visits
Urgent Care	$40 per visit	$35 per visit	$40 per visit	20% after deductible
Outpatient laboratory, radiology, and diagnostic procedures	$20 per department visit	$15 per department visit	$0 for preventative procedures, $20 for non-preventative	$0 for preventative procedures, 20% after deductilbe for non-preventative
CT, MRI, PET scans	$50 per department visit	$15 per department visit	$50 per department visit	20% after deductible
Outpatient surgery	$50 copay	20% after deductible	20% after deductible	10% after deductible
Maternity care	No charge	No charge		
Therapeutic injections including allergy shots	$10 copay *($20 copay for office visit may apply)*	$10 per visit may apply *(no deductible)*		20% after deductible
Hospital/Facility Services	**Covered Person Pays**	**Covered Person Pays**		
Inpatient services	$200/day up to $1,000/admission	20% after deductible	20% after deductible	
Physical, speech and occupational therapies Inpatient Outpatient - 20 visits/therapy/Calendar Year	$200/day up to $1,000/admission $30 per visit	20% after deductible $25 per visit	20% after deductible $30 per visit	20% after deductible 20% after deductible
Mental/behavioral health & chemical dependency services Inpatient Outpatient	$200/day up to $1,000/admission $20 per visit	20% after deductible $15 per visit	20% after deductible $0 visits 1- 3, then $20 per visit	
Emergency room visit	$200 per visit *(waived if admitted)*	20% after deductible	20% after deductible	
Skilled Nursing Facility – *Up to 100 days/Calendar Year*	No charge	20% after deductible	20% after deductible	
OTHER SERVICES	**Covered Person Pays**	**Covered Person Pays**		
Ambulance (per transport)	$75 copay	20% after deductible	20% after deductible	
Home health care – 130 visits/Calendar Year	No charge	20% after deductible	20% after deductible	
Hospice	No charge	No charge		
Durable medical equipment and supplies	20% co-insurance	20% after deductible	20% after deductible	

****Co-insurance and copay amounts are subject to change based on Oregon legislation and rule making.*

**Embedded $1700 deductible per individual*
***Embedded $3400 out-of-pocket maximum per individual*

PRESCRIPTION MEDICATION BENEFIT	COPAY PLAN B	DEDUCTIBLE A	DEDUCTIBLE B	HDHP-1
Generic drugs	$10	$10	$10	20% after deductible
Preferred brand drugs	$20	$20	$20	
Non-Preferred brand drugs *(must meet formulary exception)*	$40	$20	$40	
Speciality Generic *(Kaiser Permanente formulary applies)*	$40	$20	$40	
Mail order *(31 to 90-day supply)*	2x copay	2x copay	2x copay	
Administered medications, including injections *(all outpatient settings)*	20% co-insurance	$0	20% after deductible	

OTHER SERVICES PROVIDED BY KAISER PERMANENTE

Bariatric Surgery: *Bariatric surgery may be covered to treat morbid obesity if the covered person meets specified medical criteria, subject to inpatient hospital cost share.*	Case and Disease Management: *Supports and educates members with serious illnesses, chronic conditions, or injuries.*
Healthy Lifestyle Programs: *Individualized online programs that provide encouragement and information about specific health conditions: back pain, chronic conditions, depression, insomnia, nutrition, smoking cessation, stress, and weight management.*	Appointment Alternatives • Advice Nurse Line available 24/7 • Virtual Care doctor appointment by computer or mobile device • Email Your Doctor by secure email
BeyondWell (Provided by Regence and offered to Regence and Kaiser members): *A comprehensive well-being solution for members that integrates wellness activities, goals, rewards, and challenges into a single location for a holistic wellness offering.*	Prenatal and Pregnancy Services

ADDITIONAL PLAN RIDERS

The following benefits can be added to all Kaiser Plans for an additional cost, unless otherwise noted. These riders are selected on the group level, not at the individual employee level.

ALTERNATIVE CARE RIDER
Must use Complimentary Healthcare Plan Providers and does not count towards out-of-pocket maximum

	COPAY & DEDUCTIBLE PLANS	HDHP-1
Acupuncture Services (up to 12 visits per year)	$20 copay per visit	After deductible, $20 copay per visit
Chiropractic Services (up to 20 visits per year)	$20 copay per visit	After deductible, $20 copay per visit
Massage Therapy (up to 12 visits per year)	$25 copay per visit	After deductible, $25 copay per visit

HEARING AID RIDER
For participants over the age of 18. State mandated coverage applies to children 18 years and younger. Hearing exam is included in medical plan benefit under office visit.

BENEFIT	COPAY PLAN B	DEDUCTIBLE A & B	HDHP-1
Hearing Examination	$30 copay	$25 copay	20% After Deductible
Hearing Aids Benefit	$1,500 allowance for each hearing aid per ear every 3 years.		

Note: The Hearing Aid Rider is not available for the HDHP-1 plan.

KAISER VISION RIDER
State mandated coverage applies to children 18 and younger.

BENEFIT	COPAY PLAN B	DEDUCTIBLE A	DEDUCTIBLE B	HDHP-1
Eye Exam	$20 copay	$15 copay	$20 copay	20% After Deductible
Lenses and Frames	$150 allowance to be applied to one prescription for lenses and frames per calendar year.			
Elective Contact Lenses	$150 allowance to be applied toward one prescription of contact lenses in lieu of lenses and frames per calendar year.			