For **Washington** (Clark and Cowlitz counties) **groups with 1–50** employees

MEDICAL PLANS OVERVIEW

For coverage effective on or after January 1, 2026

WASHINGTON 2026

WHY CHOOSE KAISER PERMANENTE

Convenience

Scheduled and no-appointment-needed 24/7 phone and video visits, e-visits, 24/7 advice, and the ability for employees to email their doctor nonurgent questions on **kp.org** are convenient alternatives that offer high-quality care, comparable with an in-person visit.[1] To find all the ways to obtain care, visit **kp.org/getcare**.

Choice

Your employees have access to more than 1,250 Kaiser Permanente providers across Oregon and Southwest Washington, plus a network of providers and specialists. Visit **kp.org/locations** for more information.

Value

Kaiser Permanente members can enjoy no-cost and discounted online apps, tools, classes, programs, and activities that can help keep your employees happy and healthy. Visit **kp.org/healthyliving** to learn more.

Quality

Kaiser Foundation Health Plan of the Northwest **ties for the highest-rated commercial plan** in Oregon and second-highest-rated in Washington according to the latest National Committee for Quality Assurance ratings.[2]

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

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

- Manage members by enrolling, terminating, and updating group membership.
- Make one-time premium payments, set up or manage recurring payments, and view payment history and transaction details.
- Manage email notification preferences for invoices and e-receipts.
- 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:

- Schedule, review, or cancel routine appointments
- Complete an e-visit, phone visit, or video visit
- Email their doctor
- Fill and refill most prescriptions
- View most test results and immunizations
- View their digital ID card
- Pay bills and see cost estimates

Give us a call or talk to your producer

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 **1-877-237-5548**

business.kp.org

[1,2]See page 28 for corresponding footnotes.

KAISER PERMANENTE®

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Plan options

METAL TIER	Traditional	Deductible	HSA-qualified high deductible	KP Plus™	Added Choice® point-of-service[1]	PPO Plus[1]
Platinum	KP WA Platinum 0	KP WA Platinum 250 KP WA Platinum 500		KP WA Platinum KP Plus 0	KP WA Platinum Added Choice 250	KP WA Platinum PPO Plus 250
Gold	KP WA Gold 0	KP WA Gold 1000 KP WA Gold 1500 KP WA Gold 2000	KP WA Gold HSA 1800	KP WA Gold KP Plus 1000	KP WA Gold Added Choice 500 KP WA Gold Added Choice 1000	KP WA Gold PPO Plus 1000
Silver		KP WA Silver 3000 KP WA Silver 4000 KP WA Silver 5000 KP WA Silver 6000	KP WA Silver HSA 3600	KP WA Silver KP Plus 3000	KP WA Silver Added Choice 3000 KP WA Silver Added Choice 4000	KP WA Silver PPO Plus 3000 KP WA Silver PPO Plus 4000
Bronze		KP WA Bronze 7000 KP WA Bronze 9200	KP WA Bronze HSA 7100	KP WA Bronze KP Plus 7000	KP WA Bronze Added Choice 7000	KP WA Bronze PPO Plus 7000

Buy-up option	Any of the above medical plans can be paired with the following vision coverage buy-up option: **Adult vision hardware and vision exam:** $250 hardware benefit allowance every 2-year period and primary care office visit cost share applies for exam, not subject to plan deductible.

[1]If you have employees who live or work outside our service area, they may be eligible for a PPO Plus plan. Rates and approval subject to underwriting.

PLAN NAME	KP WA Platinum 0	KP WA Gold 0
ANNUAL OUT-OF-POCKET MAXIMUM	$2,500 per individual; $5,000 per family	$8,500 per individual; $17,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$30
Urgent care	$40	$60
Specialty care	$30	$50
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$30	$50
Chiropractic services[2]	$30	$50
Naturopathic services	$20	$30
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$30	$50
OUTPATIENT THERAPIES[4]	$30	$50
OUTPATIENT SURGERY	$200	$300
LAB	$20	$30
X-RAY/DIAGNOSTIC TEST	$30	$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	$200	$500
OUTPATIENT PRESCRIPTION DRUGS	$5 generic; $15 preferred brand name; $50 non-preferred brand name; 50% specialty	$15 generic; $50 preferred brand name; 50% non-preferred brand name; 50% specialty
MATERNITY CARE Inpatient	$300 per day, $1,500 per admission	$500 per day, $2,500 per admission

[1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

DEDUCTIBLE PLANS

PLAN NAME	KP WA Platinum 250	KP WA Platinum 500	KP WA Gold 1000
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$250 per individual; $500 per family	$500 per individual; $1,000 per family	$1,000 per individual; $2,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$3,500 per individual; $7,000 per family	$3,200 per individual; $6,400 per family	$8,800 per individual; $17,600 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	$20	$25	$20
Urgent care	$40	$40	$50
Specialty care	$30	$35	$40
TELEHEALTH (PHONE/VIDEO)	$0	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$30	$35	$40
Chiropractic services[2]	$30	$35	$40
Naturopathic services	$20	$25	$20
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$30	$35	$40
OUTPATIENT THERAPIES[4]	$30	$35	$40
OUTPATIENT SURGERY	15%*	20%*	25%*
LAB	$20	$20	$20
X-RAY/DIAGNOSTIC TEST	$30	$30	$20
CT, MRI, AND PET SCANS	15%*	20%*	$300
INPATIENT HOSPITAL CARE	15%*	20%*	25%*
EMERGENCY DEPARTMENT VISIT	15%*	20%*	25%*
OUTPATIENT PRESCRIPTION DRUGS	$5 generic; $25 preferred brand name; $50 non-preferred brand name; 50% specialty	$10 generic; $25 preferred brand name; $50 non-preferred brand name; 50% specialty	$15 generic; $40 preferred brand name; 50% non-preferred brand name; 50% specialty
MATERNITY CARE Inpatient	15%*	20%*	25%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP WA Gold 1500	KP WA Gold 2000
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,500 per individual; $3,000 per family	$2,000 per individual; $4,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,500 per individual; $17,000 per family	$8,500 per individual; $17,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$35	$35
Urgent care	$55	$60
Specialty care	$55	$60
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$55	$60
Chiropractic services[2]	$55	$60
Naturopathic services	$35	$35
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$55	$60
OUTPATIENT THERAPIES[4]	$55	$60
OUTPATIENT SURGERY	30%*	30%*
LAB	$35	$35
X-RAY/DIAGNOSTIC TEST	$35	$35
CT, MRI, AND PET SCANS	$300	$300
INPATIENT HOSPITAL CARE	30%*	30%*
EMERGENCY DEPARTMENT VISIT	30%*	30%*
OUTPATIENT PRESCRIPTION DRUGS	$10 generic; $30 preferred brand name; $75 non-preferred brand name; 50% specialty	$10 generic; $30 preferred brand name; $65 non-preferred brand name; 50% specialty
MATERNITY CARE Inpatient	30%*	30%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

DEDUCTIBLE PLANS

PLAN NAME	KP WA Silver 3000	KP WA Silver 4000
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,000 per individual; $6,000 per family	$4,000 per individual; $8,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,900 per individual; $17,800 per family	$8,900 per individual; $17,800 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$40	$45
Urgent care	$65	$70
Specialty care	$60	$60
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$60	$60
Chiropractic services[2]	$60	$60
Naturopathic services	$40	$45
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$60	$60
OUTPATIENT THERAPIES[4]	$60	$60
OUTPATIENT SURGERY	40%*	40%*
LAB	$40	$45
X-RAY/DIAGNOSTIC TEST	$50	$50
CT, MRI, AND PET SCANS	40%*	40%*
INPATIENT HOSPITAL CARE	40%*	40%*
EMERGENCY DEPARTMENT VISIT	40%*	40%*
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $65 preferred brand name; 50% non-preferred brand name; 50%* specialty	$30 generic; $60 preferred brand name; 50%* non-preferred brand name; 50%* specialty
MATERNITY CARE Inpatient	40%*	40%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP WA Silver 5000	KP WA Silver 6000
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$5,000 per individual; $10,000 per family	$6,000 per individual; $12,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,900 per individual; $17,800 per family	$9,400 per individual; $18,800 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$50	$50
Urgent care	$75	40%*
Specialty care	$70	$70
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$70	$70
Chiropractic services[2]	$70	$70
Naturopathic services	$50	$50
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$70	$70
OUTPATIENT THERAPIES[4]	$70	$70
OUTPATIENT SURGERY	40%*	40%*
LAB	$50	40%*
X-RAY/DIAGNOSTIC TEST	40%*	40%*
CT, MRI, AND PET SCANS	40%*	40%*
INPATIENT HOSPITAL CARE	40%*	40%*
EMERGENCY DEPARTMENT VISIT	40%*	40%*
OUTPATIENT PRESCRIPTION DRUGS	$30 generic; $60 preferred brand name; 50%* non-preferred brand name; 50%* specialty	$30 generic; $75 preferred brand name; 50%* non-preferred brand name; 50%* specialty
MATERNITY CARE Inpatient	40%*	40%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

DEDUCTIBLE PLANS

PLAN NAME	KP WA Bronze 7000	KP WA Bronze 9200
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$9,200 per individual; $18,400 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,200 per individual; $18,400 per family	$9,200 per individual; $18,400 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$50	$40 for first 3 visits; then 0%*
Urgent care	40%*	0%*
Specialty care	$70*	0%*
TELEHEALTH (PHONE/VIDEO)	$0	$0
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$70*	0%*
Chiropractic services[2]	$70*	0%*
Naturopathic services	$50	0%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$70*	0%*
OUTPATIENT THERAPIES[4]	$70*	0%*
OUTPATIENT SURGERY	40%*	0%*
LAB	40%*	0%*
X-RAY/DIAGNOSTIC TEST	40%*	0%*
CT, MRI, AND PET SCANS	40%*	0%*
INPATIENT HOSPITAL CARE	40%*	0%*
EMERGENCY DEPARTMENT VISIT	40%*	0%*
OUTPATIENT PRESCRIPTION DRUGS	$35 generic; $60 preferred brand name; 50%* non-preferred brand name; 50%* specialty	$30 generic; $0* preferred brand name; $0* non-preferred brand name; $0* specialty
MATERNITY CARE Inpatient	40%*	$0*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP WA Gold HSA 1800	KP WA Silver HSA 3600	KP WA Bronze HSA 7100
ACCUMULATION TYPE	Aggregate deductible; embedded out-of-pocket maximum	Embedded	Embedded
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,800 per individual; $3,600 per family	$3,600 per individual; $7,200 per family	$7,100 per individual; $14,200 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$5,500 per individual; $11,000 per family	$7,500 per individual; $15,000 per family	$7,100 per individual; $14,200 per family
BENEFITS		Member pays	
OFFICE VISITS Preventive care	$0	$0	$0
Primary care	20%*	25%*	0%*
Urgent care	20%*	25%*	0%*
Specialty care	20%*	25%*	0%*
TELEHEALTH (PHONE/VIDEO)	0%*	0%*	0%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	20%*	25%*	0%*
Chiropractic services[2]	20%*	25%*	0%*
Naturopathic services	20%*	25%*	0%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	20%*	25%*	0%*
OUTPATIENT THERAPIES[4]	20%*	25%*	0%*
OUTPATIENT SURGERY	20%*	25%*	0%*
LAB	20%*	25%*	0%*
X-RAY/DIAGNOSTIC TEST	20%*	25%*	0%*
CT, MRI, AND PET SCANS	20%*	25%*	0%*
INPATIENT HOSPITAL CARE	20%*	25%*	0%*
EMERGENCY DEPARTMENT VISIT	20%*	25%*	0%*
OUTPATIENT PRESCRIPTION DRUGS	$20* generic; 20%* preferred brand name; 50%* non-preferred brand name; 50%* specialty	$20* generic; $50* preferred brand name; 30%* non-preferred brand name; 50%* specialty	0%* generic; 0%* preferred brand name; 0%* non-preferred brand name; 0%* specialty
MATERNITY CARE Inpatient	20%*	25%*	0%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

KP PLUS PLANS

PLAN NAME	KP WA Platinum KP Plus 0	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$0	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$2,500 per individual; $5,000 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$40
Urgent care	$40	Not covered, except for services received outside the service area[2,3]
Specialty care	$30	$50
TELEHEALTH (PHONE/VIDEO)	$0	$40
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$30[4]	$50
Chiropractic services	$30[5]	$50
Naturopathic services	$20	$40
PHYSICIAN-REFERRED ALTERNATIVE CARE	$30[6]	Not covered
OUTPATIENT THERAPIES	$30[7]	$50
OUTPATIENT SURGERY	$200	Not covered
LAB	$20	$40
X-RAY/DIAGNOSTIC TEST	$30	$50
CT, MRI, AND PET SCANS	$75	Not covered
INPATIENT HOSPITAL CARE	$300 per day, $1,500 per admission	Not covered
EMERGENCY DEPARTMENT VISIT	$200	Covered at the in-network cost share[2]
OUTPATIENT PRESCRIPTION DRUGS	**Kaiser Permanente pharmacies:** $5 generic; $15 preferred brand name; $50 non-preferred brand name; 50% specialty	**Out-of-network pharmacies:** $25 generic; $35 preferred brand name; $70 non-preferred brand name; 50% specialty (limited to 5 prescriptions fills per year)[2]
MATERNITY CARE Inpatient	$300 per day, $1,500 per admission	Not covered

[1]These plans include a dependent out-of-area (OOA) benefit, which provides 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 billed charges. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. [2]The 10 covered services limit does not apply. [3]If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating facility may be covered if the services are deemed necessary to prevent serious deterioration of health. [4]Limited to 12 visits per year. [5]Limited to 10 visits per year. [6]Referred chiropractic/acupuncture based upon medical criteria. [7]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP WA Gold KP Plus 1000	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,000 per individual; $2,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$8,800 per individual; $17,600 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$20	$40
Urgent care	$50	Not covered, except for services received outside the service area[2,3]
Specialty care	$40	$60
TELEHEALTH (PHONE/VIDEO)	$0	$40
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$40[4]	$60
Chiropractic services	$40[5]	$60
Naturopathic services	$20	$40
PHYSICIAN-REFERRED ALTERNATIVE CARE	$40[6]	Not covered
OUTPATIENT THERAPIES	$40[7]	$60
OUTPATIENT SURGERY	25%*	Not covered
LAB	$20	$40
X-RAY/DIAGNOSTIC TEST	$20	$40
CT, MRI, AND PET SCANS	$300	Not covered
INPATIENT HOSPITAL CARE	25%*	Not covered
EMERGENCY DEPARTMENT VISIT	25%*	Covered at the in-network cost share[2]
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: $15 generic; $40 preferred brand name; 50% non-preferred brand name; 50% specialty	Out-of-network pharmacies: $35 generic; $60 preferred brand name; 50% non-preferred brand name; 50% specialty (limited to 5 prescriptions fills per year)[2]
MATERNITY CARE Inpatient	25%*	Not covered

*Subject to annual medical deductible. [1]These plans include a dependent out-of-area (OOA) benefit, which provides 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 billed charges. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. [2]The 10 covered services limit does not apply. [3]If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating facility may be covered if the services are deemed necessary to prevent serious deterioration of health. [4]Limited to 12 visits per year. [5]Limited to 10 visits per year. [6]Referred chiropractic/acupuncture based upon medical criteria. [7]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

KP PLUS PLANS

PLAN NAME	KP WA Silver KP Plus 3000	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,000 per individual; $6,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$8,900 per individual; $17,800 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$40	$60
Urgent care	$65	Not covered, except for services received outside the service area[2,3]
Specialty care	$60	$80
TELEHEALTH (PHONE/VIDEO)	$0	$60
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$60[4]	$80
Chiropractic services	$60[5]	$80
Naturopathic services	$40	$60
PHYSICIAN-REFERRED ALTERNATIVE CARE	$60[6]	Not covered
OUTPATIENT THERAPIES	$60[7]	$80
OUTPATIENT SURGERY	40%*	Not covered
LAB	$40	$60
X-RAY/DIAGNOSTIC TEST	$50	$70
CT, MRI, AND PET SCANS	40%*	Not covered
INPATIENT HOSPITAL CARE	40%*	Not covered
EMERGENCY DEPARTMENT VISIT	40%*	Covered at the in-network cost share[2]
OUTPATIENT PRESCRIPTION DRUGS	**Kaiser Permanente pharmacies:** $30 generic; $65 preferred brand name; 50% non-preferred brand name; 50%* specialty	**Out-of-network pharmacies:** $50 generic; $85 preferred brand name; 50% non-preferred brand name; 50% specialty (limited to 5 prescriptions fills per year)[2]
MATERNITY CARE Inpatient	40%*	Not covered

*Subject to annual medical deductible. [1]These plans include a dependent out-of-area (OOA) benefit, which provides 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 billed charges. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. [2]The 10 covered services limit does not apply. [3]If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating facility may be covered if the services are deemed necessary to prevent serious deterioration of health. [4]Limited to 12 visits per year. [5]Limited to 10 visits per year. [6]Referred chiropractic/acupuncture based upon medical criteria. [7]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP WA Bronze KP Plus 7000	
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (IND/FAM)	$9,200 per individual; $18,400 per family	N/A
BENEFITS[1]	Member pays	
OFFICE VISITS Preventive care	$0	$0
Primary care	$50	$70
Urgent care	40%*	Not covered, except for services received outside the service area[2,3]
Specialty care	$70*	$90
TELEHEALTH (PHONE/VIDEO)	$0	$70
SELF-REFERRED ALTERNATIVE CARE Acupuncture services	$70*[4]	$90
Chiropractic services	$70*[5]	$90
Naturopathic services	$50	$70
PHYSICIAN-REFERRED ALTERNATIVE CARE	$70*[6]	Not covered
OUTPATIENT THERAPIES	$70*[7]	$90
OUTPATIENT SURGERY	40%*	Not covered
LAB	40%*	50%
X-RAY/DIAGNOSTIC TEST	40%*	50%
CT, MRI, AND PET SCANS	40%*	Not covered
INPATIENT HOSPITAL CARE	40%*	Not covered
EMERGENCY DEPARTMENT VISIT	40%*	Covered at the in-network cost share[2]
OUTPATIENT PRESCRIPTION DRUGS	**Kaiser Permanente pharmacies:** $35 generic; $60 preferred brand name; 50%* non-preferred brand name; 50%* specialty	**Out-of-network pharmacies:** $55 generic; $80 preferred brand name; 50% non-preferred brand name; 50% specialty (limited to 5 prescription fills per year)[2]
MATERNITY CARE Inpatient	40%*	Not covered

*Subject to annual medical deductible. [1]These plans include a dependent out-of-area (OOA) benefit, which provides 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 billed charges. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. [2]The 10 covered services limit does not apply. [3]If you are temporarily out of the service area, urgent care from a nonparticipating provider or nonparticipating facility may be covered if the services are deemed necessary to prevent serious deterioration of health. [4]Limited to 12 visits per year. [5]Limited to 10 visits per year. [6]Referred chiropractic/acupuncture based upon medical criteria. [7]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP WA Platinum Added Choice 250		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$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	$3,500 per individual; $7,000 per family	$5,000 per individual; $10,000 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%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	35%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$30	$40	35%*
Chiropractic services[2]	$30	$40	35%*
Naturopathic services	$20	$30	35%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$30	$40	35%*
OUTPATIENT THERAPIES[4]	$30	$40	35%*
OUTPATIENT SURGERY	15%*	25%*	35%*
LAB	$20	$30	35%*
X-RAY/DIAGNOSTIC TEST	$20	$30	35%*
CT, MRI, AND PET SCANS	15%*	25%*	35%*
INPATIENT HOSPITAL CARE	15%*	25%*	35%*
EMERGENCY DEPARTMENT VISIT	15%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: $10 generic; $25 preferred brand name; $50 non-preferred brand name; 50% specialty MedImpact network pharmacies: $15 generic; $35 preferred brand name; 50% non-preferred brand name; 50% specialty		
MATERNITY CARE Inpatient	15%*	25%*	35%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP WA Gold Added Choice 500		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$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	$6,000 per individual; $12,000 per family	$8,100 per individual; $16,200 per family	$9,800 per individual; $ 19,600 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%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$55	$80	50%*
Chiropractic services[2]	$55	$80	50%*
Naturopathic services	$35	$60	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$55	$80	50%*
OUTPATIENT THERAPIES[4]	$55	$80	50%*
OUTPATIENT SURGERY	30%*	50%*	50%*
LAB	$35	40%*	50%*
X-RAY/DIAGNOSTIC TEST	$45	40%*	50%*
CT, MRI, AND PET SCANS	30%*	50%*	50%*
INPATIENT HOSPITAL CARE	30%*	50%*	50%*
EMERGENCY DEPARTMENT VISIT	30%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: $10 generic; $25 preferred brand name; $50 non-preferred brand name; 50% specialty MedImpact network pharmacies: $25 generic; $75 preferred brand name; 50% non-preferred brand name; 50% specialty		
MATERNITY CARE Inpatient	30%*	50%*	50%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP WA Gold Added Choice 1000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$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	$6,900 per individual; $13,800 per family	$8,900 per individual; $17,800 per family	$10,500 per individual; $21,000 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%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$40	$60	50%*
Chiropractic services[2]	$40	$60	50%*
Naturopathic services	$20	$40	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$40	$60	50%*
OUTPATIENT THERAPIES[4]	$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%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: $15 generic; $50 preferred brand name; 50% non-preferred brand name; 50% specialty MedImpact network pharmacies: $30 generic; $75 preferred brand name; 50% non-preferred brand name; 50% specialty		
MATERNITY CARE Inpatient	25%*	40%*	50%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP WA Silver Added Choice 3000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,000 per individual; $6,000 per family	$5,000 per individual; $10,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,700 per individual; $17,400 per family	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$45	$60	50%*
Urgent care	$65	$80	50%*
Specialty care	$60	$75	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$60	$75	50%*
Chiropractic services[2]	$60	$75	50%*
Naturopathic services	$45	$60	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$60	$75	50%*
OUTPATIENT THERAPIES[4]	$60	$75	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	$35	45%*	50%*
X-RAY/DIAGNOSTIC TEST	$45	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: $30 generic; $65 preferred brand name; 50% non-preferred brand name; 50%* specialty MedImpact network pharmacies: $40 generic; $75 preferred brand name; 50%* non-preferred brand name; 50%* specialty		
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

ADDED CHOICE POINT-OF-SERVICE PLANS

PLAN NAME	KP WA Silver Added Choice 4000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$4,000 per individual; $8,000 per family	$6,000 per individual; $12,000 per family	$7,000 per individual; $14,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,900 per individual; $17,800 per family	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$45	$60	50%*
Urgent care	$70	$90	50%*
Specialty care	$60	$70	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$60	$70	50%*
Chiropractic services[2]	$60	$70	50%*
Naturopathic services	$45	$60	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$60	$70	50%*
OUTPATIENT THERAPIES[4]	$60	$70	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	$45	45%*	50%*
X-RAY/DIAGNOSTIC TEST	$45	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: $30 generic; $60 preferred brand name; 50%* non-preferred brand name; 50%* specialty MedImpact network pharmacies: $40 generic; $70 preferred brand name; 50%* non-preferred brand name; 50%* specialty		
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

PLAN NAME	KP WA Bronze Added Choice 7000		
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$8,500 per individual; $17,000 per family	$11,000 per individual; $22,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,200 per individual; $18,400 per family	$9,200 per individual; $18,400 per family	$15,000 per individual; $30,000 per family
BENEFITS	Member pays		
OFFICE VISITS Preventive care	$0	$0	50%*
Primary care	$50	$60	50%*
Urgent care	40%*	45%*	50%*
Specialty care	$70*	$85*	50%*
TELEHEALTH (PHONE/VIDEO)	$0	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$70*	$85*	50%*
Chiropractic services[2]	$70*	$85*	50%*
Naturopathic services	$50	$60	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$70*	$85*	50%*
OUTPATIENT THERAPIES[4]	$70*	$85*	50%*
OUTPATIENT SURGERY	40%*	45%*	50%*
LAB	40%*	45%*	50%*
X-RAY/DIAGNOSTIC TEST	40%*	45%*	50%*
CT, MRI, AND PET SCANS	40%*	45%*	50%*
INPATIENT HOSPITAL CARE	40%*	45%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*		
OUTPATIENT PRESCRIPTION DRUGS	Kaiser Permanente pharmacies: $30 generic; $60 preferred brand name; 50%* non-preferred brand name; 50%* specialty MedImpact network pharmacies: $40 generic; $80 preferred brand name; 50%* non-preferred brand name; 50%* specialty		
MATERNITY CARE Inpatient	40%*	45%*	50%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies.

PPO PLUS PLANS (OUT-OF-AREA MEMBERS ONLY)

PLAN NAME	KP WA Platinum PPO Plus 250	
NETWORK	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$250 per individual; $500 per family	$750 per individual; $1,500 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$3,500 per individual; $7,000 per family	$7,000 per individual; $14,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	35%*
Primary care	$20	35%*
Urgent care	$40	35%*
Specialty care	$30	35%*
TELEHEALTH (PHONE/VIDEO)	$0	35%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$30	35%*
Chiropractic services[2]	$30	35%*
Naturopathic services	$20	35%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$30	35%*
OUTPATIENT THERAPIES[4]	$30	35%*
OUTPATIENT SURGERY	15%*	35%*
LAB	$20	35%*
X-RAY/DIAGNOSTIC TEST	$20	35%*
CT, MRI, AND PET SCANS	15%*	35%*
INPATIENT HOSPITAL CARE	15%*	35%*
EMERGENCY DEPARTMENT VISIT	15%*	
OUTPATIENT PRESCRIPTION DRUGS[5]	Kaiser Permanente and MedImpact network pharmacies: $10 generic; $25 preferred brand name; $50 non-preferred brand name; 50% specialty	
MATERNITY CARE Inpatient	15%*	35%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies. [5]Using Kaiser Permanente owned and operated pharmacies or those part of the MedImpact Pharmacy network.

PLAN NAME	KP WA Gold PPO Plus 1000	
NETWORK	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$1,000 per individual; $2,000 per family	$3,000 per individual; $6,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$7,000 per individual; $14,000 per family	$10,500 per individual; $21,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	45%*
Primary care	$35	45%*
Urgent care	$65	45%*
Specialty care	$60	45%*
TELEHEALTH (PHONE/VIDEO)	$0	45%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$60	45%*
Chiropractic services[2]	$60	45%*
Naturopathic services	$35	45%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$60	45%*
OUTPATIENT THERAPIES[4]	$60	45%*
OUTPATIENT SURGERY	35%*	45%*
LAB	$35	45%*
X-RAY/DIAGNOSTIC TEST	$45	45%*
CT, MRI, AND PET SCANS	35%*	45%*
INPATIENT HOSPITAL CARE	35%*	45%*
EMERGENCY DEPARTMENT VISIT	35%*	
OUTPATIENT PRESCRIPTION DRUGS[5]	Kaiser Permanente and MedImpact network pharmacies: $15 generic; $50 preferred brand name; $75 non-preferred brand name; 50% specialty	
MATERNITY CARE Inpatient	35%*	45%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies. [5]Using Kaiser Permanente owned and operated pharmacies or those part of the MedImpact Pharmacy network.

PPO PLUS PLANS (OUT-OF-AREA MEMBERS ONLY)

PLAN NAME	KP WA Silver PPO Plus 3000	
NETWORK	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$3,000 per individual; $6,000 per family	$9,000 per individual; $18,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,700 per individual; $17,400 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	50%*
Primary care	$45	50%*
Urgent care	$65	50%*
Specialty care	$60	50%*
TELEHEALTH (PHONE/VIDEO)	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$60	50%*
Chiropractic services[2]	$60	50%*
Naturopathic services	$45	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$60	50%*
OUTPATIENT THERAPIES[4]	$60	50%*
OUTPATIENT SURGERY	40%*	50%*
LAB	$35	50%*
X-RAY/DIAGNOSTIC TEST	$45	50%*
CT, MRI, AND PET SCANS	40%*	50%*
INPATIENT HOSPITAL CARE	40%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*	
OUTPATIENT PRESCRIPTION DRUGS[5]	Kaiser Permanente and MedImpact network pharmacies: $30 generic; $65 preferred brand name; 50%* non-preferred brand name; 50%* specialty	
MATERNITY CARE Inpatient	40%*	50%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies. [5]Using Kaiser Permanente owned and operated pharmacies or those part of the MedImpact Pharmacy network.

PLAN NAME	KP WA Silver PPO Plus 4000	
NETWORK	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$4,000 per individual; $8,000 per family	$9,000 per individual; $18,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$8,900 per individual; $17,800 per family	$14,000 per individual; $28,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	50%*
Primary care	$45	50%*
Urgent care	$70	50%*
Specialty care	$60	50%*
TELEHEALTH (PHONE/VIDEO)	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$60	50%*
Chiropractic services[2]	$60	50%*
Naturopathic services	$45	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$60	50%*
OUTPATIENT THERAPIES[4]	$60	50%*
OUTPATIENT SURGERY	40%*	50%*
LAB	$45	50%*
X-RAY/DIAGNOSTIC TEST	$45	50%*
CT, MRI, AND PET SCANS	40%*	50%*
INPATIENT HOSPITAL CARE	40%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*	
OUTPATIENT PRESCRIPTION DRUGS[5]	Kaiser Permanente and MedImpact network pharmacies: $30 generic; $60 preferred brand name; 50%* non-preferred brand name; 50%* specialty	
MATERNITY CARE Inpatient	40%*	50%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies. [5]Using Kaiser Permanente owned and operated pharmacies or those part of the MedImpact Pharmacy network.

PPO PLUS PLANS (OUT-OF-AREA MEMBERS ONLY)

PLAN NAME	KP WA Bronze PPO Plus 7000	
Network	PPO Providers	Nonparticipating Providers
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$7,000 per individual; $14,000 per family	$11,000 per individual; $22,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$9,200 per individual; $18,400 per family	$15,000 per individual; $30,000 per family
BENEFITS	Member pays	
OFFICE VISITS Preventive care	$0	50%*
Primary care	$50	50%*
Urgent care	40%*	50%*
Specialty care	$70*	50%*
TELEHEALTH (PHONE/VIDEO)	$0	50%*
SELF-REFERRED ALTERNATIVE CARE Acupuncture services[1]	$70*	50%*
Chiropractic services[2]	$70*	50%*
Naturopathic services	$50	50%*
PHYSICIAN-REFERRED ALTERNATIVE CARE[3]	$70*	50%*
OUTPATIENT THERAPIES[4]	$70*	50%*
OUTPATIENT SURGERY	40%*	50%*
LAB	40%*	50%*
X-RAY/DIAGNOSTIC TEST	40%*	50%*
CT, MRI, AND PET SCANS	40%*	50%*
INPATIENT HOSPITAL CARE	40%*	50%*
EMERGENCY DEPARTMENT VISIT	40%*	
OUTPATIENT PRESCRIPTION DRUGS[5]	Kaiser Permanente and MedImpact network pharmacies: $30 generic; $60 preferred brand name; 50%* non-preferred brand name; 50%* specialty	
MATERNITY CARE Inpatient	40%*	50%*

*Subject to annual medical deductible. [1]Limited to 12 visits per year. [2]Limited to 10 visits per year. [3]Referred chiropractic/acupuncture based upon medical criteria. [4]Rehabilitative and habilitative therapies have limits of 25 visits each per year. Neurodevelopmental conditions have an additional 25 visits per year for both rehabilitative and habilitative therapies. [5]Using Kaiser Permanente owned and operated pharmacies or those part of the MedImpact Pharmacy network.

PLAN NAME	SENIOR ADVANTAGE
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	$0
ANNUAL OUT-OF-POCKET MAXIMUM	$1,000 per individual
BENEFITS	Member pays
OFFICE VISITS — PREVENTIVE CARE	$0
Primary care	$20
Urgent care	$25
TELEHEALTH (PHONE/VIDEO)	$0
OUTPATIENT THERAPIES	$20
LAB	$0
X-RAY/DIAGNOSTIC TEST	$0
CT, MRI, AND PET SCANS	$0
OUTPATIENT SURGERY	$50
INPATIENT HOSPITAL CARE	$200 per admission
EMERGENCY CARE	$50
SELF-REFERRED ALTERNATIVE CARE	$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	$20 generic; $40 brand name and specialty. $0 generic/brand name and specialty in the catastrophic coverage stage.*

Senior Advantage plans cannot be modified. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

*Catastrophic coverage begins when the member's annual out-of-pocket costs (how much the member and those paying on member's behalf) reach $2,100.

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. Learn more at **kp2020.org/nw**.

Dental coverage

Our unique medical-dental integration helps improve quality of care and patient safety while boosting member satisfaction. Choose from our cost-effective Traditional plans or flexible Choice PPO plans. We have a range of options with comprehensive coverage to meet the needs of your employees. Learn more at **kp.org/dental/nw**.

Pediatric dental (benefits included in all medical plans)

All pediatric benefit plans are included in Dental Choice (PPO) plans.

PREVENTIVE AND DIAGNOSTIC SERVICES (ORAL EXAM, X-RAYS, TEETH CLEANING, FLUORIDE TREATMENTS)	$0
BASIC RESTORATIVE SERVICES (ROUTINE FILLINGS, BASIC CROWNS, SIMPLE EXTRACTIONS)	50%*
MAJOR RESTORATIVE SERVICES (GOLD OR PORCELAIN CROWNS, INLAYS, BRIDGE ABUTMENTS, PONTICS)	50%*

Plan highlights

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

Pediatric vision and vision hardware benefits: All plans include pediatric vision exams at $0 and pediatric vision hardware at no charge for 1 pair of frames with lenses or conventional or disposable contact lenses in lieu of eyeglasses (limited to 1 pair per year for conventional lenses or a 12-month supply of disposable contact lenses per year); no charge for low vision aid or medically necessary contact lenses (does not apply to non-contracted provider networks).

HSA plans: Pediatric dental services are subject to the medical deductible, up to the maximum out of pocket, on HSA-qualified plans.

HSA plan accumulation types:
Our new high deductible health plan, KP OR Gold HSA 1800, uses aggregate accumulation for the deductible and embedded accumulation for the out-of-pocket maximum. All other high deductible health plans are designed with embedded accumulations.

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

- **Aggregate accumulation:** If you are a member in a family of 2 or more members, you meet the deductible/out-of-pocket maximum when your entire family meets the family deductible/out-of-pocket maximum amount. Every member in your family must pay charges during the year until the entire family meets the family deductible/out-of-pocket maximum.
- **Embedded accumulation:** If there is at least one other member in your family, then you must each meet the member deductible/out-of-pocket maximum, or your family must meet the family deductible/out-of-pocket maximum, whichever is less. For any member of the family who has satisfied their individual deductible/out-of-pocket maximum, no further member deductible/out-of-pocket maximum will be due for that family

*Pediatric dental services are subject to the annual medical deductible, up to the maximum out of pocket, on HSA-qualified plans.

member the remainder of the year. Each member deductible amount counts toward the family deductible/out-of-pocket maximum amount. Once the family deductible/out-of-pocket maximum is satisfied, no further member deductible/out-of-pocket maximum will be due for any family member for the remainder of the year.

Dependent out-of-area (OOA) benefit: Your dependent children have access to care beyond urgent and emergency care outside the Kaiser Permanente network. This benefit provides limited coverage for routine, continuing, and follow-up care for dependent children residing outside the service area. Services are limited to 10 office visits, a combination of 10 diagnostic X-rays (excluding specialty scans) and labs, and 10 prescription drug fills. For covered services the member pays 20% of the billed charges. (Does not apply to Added Choice, PPO Plus, or Senior Advantage plans.)

Outpatient prescription drugs

The Kaiser Permanente formulary applies to all plans. Members get up to a 30-day supply for each copay (up to a 90-day supply of eligible drugs for 2 copays when using our mail-order pharmacy). View our formulary at **kp.org/formulary**.

KP Plus outpatient prescription drugs
KP Plus members have access to 5 prescription fills per year at any licensed out-of-network pharmacy.

Additional prescription options for Added Choice and PPO Plus plans
Members on Added Choice or PPO Plus plans have the option of filling their prescriptions through MedImpact. When a member fills a prescription at a MedImpact pharmacy, the plan covers up to a 30-day supply of drugs. To locate a pharmacy, go to **kp.org/choiceproducts/nw**.

Alternative care (self-referred)

Visit **herayahealth.com** for a list of providers. If enrolled under Added Choice plans, these benefits may be used at CHP, PPO, and nonparticipating providers and facilities.

Members on our PPO Plus plans can access these benefits through PPO and nonparticipating providers and facilities.

Explanation of Added Choice benefits

Services under the first tier are provided by KP Select providers at Kaiser facilities. *The Evidence of Coverage (EOC)* provides a complete definition of KP Select providers and KP Select facilities and explains when KP Select provider services are provided by other providers and facilities.

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

Nonparticipating provider 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 KP Select providers and PPO providers. There is a separate deductible and out-of-pocket maximum amount for nonparticipating providers, which does not accumulate across any other provider networks.

Visit **kp.org/choiceproducts/nw** for more information.

Explanation of PPO Plus benefits

PPO Plus provides you with the opportunity to give your employees who live and work outside the service area the freedom to choose any doctor or hospital they want, anywhere in the country. Members can choose care from Kaiser Permanente providers, First Choice Health, First Health Network, and nonparticipating providers.

Visit **kp.org/choiceproducts/nw** for more information.

Explanation of KP Plus Benefits

KP Plus is an affordable option that gives your employees access to high-quality care from Kaiser Permanente and affiliated providers, plus the flexibility to receive certain types of care from out-of-network providers for a limited number of visits per year.

Visit **kp.org/choiceproducts/nw** for more information.

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

You can offer up to 3 medical plans in a bundle, with the limitation that there can only be 1 Added Choice plan per bundle. For groups that qualify, PPO Plus Out-of-Area plans are not counted toward the 3-plan limit. Once you select your plan offerings, employees choose the plan that best meets their needs.

Footnotes correspond with text on page 1:

[1]When appropriate and available. These features apply to care you get at Kaiser Permanente facilities. For high deductible health plan members, e-visits, phone visits, and video visits are subject to your plan's annual deductible. If you travel out of state, phone and video visits may not be available due to state laws that may prevent doctors from providing care across state lines. Laws differ by state. To have a video visit, members must be registered on kp.org and have a camera-equipped computer or mobile device. Applicable cost shares will apply for services or items ordered during an e-visit. For high deductible health plan members, e-visits, phone visits, and video visits are subject to your plan's annual deductible.

[2]National Committee for Quality Assurance, 2024-2025: Kaiser Foundation Health Plan of the Northwest – HMO (rated 4 out of 5)

Information in this document was accurate at the time of production. Details may have changed since publication.