2025 PLANS AND PRODUCTS | WASHINGTON



Complete Suite plan comparison chart

Use this overview of our Complete Suite portfolio to easily explore a wide range of Kaiser Permanente plans. This interactive tool also enables you to get quick side-by-side comparisons of the different plans we have to offer.

НМО

HMO Copay plans	5
HMO Waiver plans	6
HMO Welcome plans	12
HMO Deductible plans	15
HMO HSA plans	16
Kaiser Permanente Virtual Plus® plans	19
Summit PPO plans	22
Summit PPO Welcome plans	33
Summit PPO HSA plans	39
Access PPO plans	45
Access PPO Waiver plans	49
Access PPO Welcome plans	67
Access PPO HSA plans	76
KP Plus plans	85
Supplemental benefits	95

OVERVIEW HMO VIRTUAL PLUS SUMMIT PPO ACCESS PPO KP PLUS

Compare. Select. Administer. It's that easy.

With Complete Suite, we've done the work for you. We've compiled our most popular standard midmarket plans in this interactive plan comparison chart, which allows you to easily compare plan benefits.

Complete Suite changes for 2025:

New! Kaiser Permanente Plus™ plans, offered by Kaiser Foundation Health Plan of Washington Options, Inc.

KP Plus offers employees an affordable health plan option to get high-quality care from Kaiser Permanente and affiliated doctors. They also get flexibility of covered care from out-of-network doctors for up to 10 outpatient medical services and 5 prescriptions fills or refills.

Availability in the following Washington counties: Benton, Columbia, Franklin, Island, King, Kitsap, Lewis, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, and Yakima

Plans include:

KP Plus 250 L1

KP Plus 750 L3

KP Plus 1500 L5

KP Plus 2500 L7

KP Plus 5000 L9

KP Plus 500 V2

KP Plus 1000 V4

KP Plus 2000 V6

KP Plus 2500 V7

KP Plus 3000 V8



OVERVIEW HMO VIRTUAL PLUS SUMMIT PPO ACCESS PPO KP PLUS

How to compare plans

With our Complete Suite interactive plan comparison chart, you can choose up to 3 plans at a time and get as many comparisons as you'd like.

To get a comparison:

- 1. Click the **Overview** tab at the top of the page.
- 2. Check the box next to each plan you'd like to compare, then click the **Compare plans** button at the top-right corner of the page.
- 3. To remove a plan from your comparison, click the checked box to clear it.

 To remove all plans selected, click the **Reset** button at the top left of the page.

You can also get more detailed information about each plan type by clicking the tabs at the top of the page –HMO, Virtual Plus, Summit PPO, and Access PPO. To go back to the plan comparison page at any time, simply click the **Overview** tab at the top-left corner of the page.



How to use this interactive PDF to compare plans:

- 1. Download the interactive PDF to your desktop.
- 2. Open the PDF with Adobe Reader.

The plan summary highlights the most frequently asked-about benefits and is for illustration purposes only. For a complete description, please refer to the appropriate *Evidence of Coverage* or contact your producer or Kaiser Permanente representative.

Information may have changed since date of publication.

Ready to connect?

Check out our 2025 plans and request a quote from your Kaiser Permanente representative today.

All HMO and Virtual Plus plans are offered and underwritten by Kaiser Foundation Health Plan of Washington. All PPO plans are offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.



Reset		Compare plans	Plans selected:	
Complete Suite category	HMO Co _l	pay Plans		

Reset			Compare plans	Plans selected:
		HMO Cop	pay Plans	
Complete Suite category	■ HMO Copay 2	■ HMO Copay 3	HMO Copay 5	■ HMO Copay 7
Plan deductible, PCY* (individual/family)	\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0
Out-of-pocket maximum, PCY (individual/family)	\$1,000/\$2,000	\$1,500/\$3,000	\$2,000/\$4,000	\$4,000/\$8,000
Preventive and well-child care	No charge	No charge	No charge	No charge
Telehealth	No charge	No charge	No charge	No charge
Office visits (primary/specialty)	\$10/\$20	\$20/\$30	\$20/\$30	\$30/\$40
Urgent care office visits (primary/specialty)	\$10/\$20	\$20/\$30	\$20/\$30	\$30/\$40
Lab and X-ray procedures (outpatient)	\$10	\$20	\$20	\$30
CT, MRI, and PET scans (outpatient)	\$50	\$50	\$50	\$100
Outpatient surgery	\$50	\$50	\$50	\$100
Emergency care (copay waived if admitted to inpatient)	\$100	\$100	\$200	\$200
Hospital inpatient (per admission)	\$100 per day up to 5 days	\$100 per day up to 5 days	\$200 per day up to 5 days	\$200 per day up to 5 day
Skilled nursing facility (60 days, PCY)	No charge	No charge	No charge	No charge
Home health care (130 visits, PCY)	No charge	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	\$10	\$20	\$20	\$30
Acupuncture (12 visits, PCY)	\$10	\$20	\$20	\$30
Inpatient mental health and substance use disorder (per admission)	\$100 per day up to 5 days	\$100 per day up to 5 days	\$200 per day up to 5 days	\$200 per day up to 5 day
Outpatient mental health and substance use disorder	\$10	\$20	\$20	\$30
Routine eye exam (1 exam every 12 months, primary/specialty)	\$10/\$20	\$20/\$30	\$20/\$30	\$30/\$40
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$15	\$15	\$15	\$15
Preferred brand-name drugs	\$40	\$40	\$40	\$40
Non-preferred generic and brand-name drugs	\$60	\$60	\$60	\$60
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$30	\$30	\$30	\$30
Preferred brand-name drugs	\$80	\$80	\$80	\$80
Non-preferred generic and brand-name drugs	\$120	\$120	\$120	\$120
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	\$150	\$150	\$150
Non-preferred specialty drugs	30%	30%	30%	30%
Drug list/formulary	5-tier in-network pharmacy benefit			

^{*}PCY = Per calendar year.



		_
Reset	Compare plans	Plans selected:

Reset		Compare plan	Plans selected:
Complete Suite seteman	mplete Suite category HMO Waiver Plans: VisitsPlus		
Complete Suite category	■ HMO 250 V1	■ HMO 500 V2	■ HMO 750 V3
Plan deductible, PCY* (individual/family)	\$250/\$750	\$500/\$1,500	\$750/\$2,250
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	\$3,000/\$9,000	\$3,500/\$10,500
Coinsurance	10%	20%	20%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	Annual deductible and plan coinsurance don't apply to office visits, including surgery	Annual deductible and plan coinsurance don't apply to office visits, including surgery
Preventive and well-child care	No charge	No charge	No charge
Telehealth	No charge	No charge	No charge
Office visits	\$20	\$20	\$25
Urgent care office visits	\$20	\$20	\$25
Lab and X-ray procedures (outpatient)	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 10% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible
Hospital inpatient	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home health care (130 visits, PCY)	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	\$20	\$20	\$25
Acupuncture (12 visits, PCY)	\$20	\$20	\$25
Inpatient mental health and substance use disorder	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient mental health and substance use disorder	\$20	\$20	\$25
Routine eye exam (1 exam every 12 months)	\$20	\$20	\$25
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$10	\$10	\$15
Preferred brand-name drugs	\$20	\$20	\$30
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Prescription drugs – mail or	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	\$20	\$30
Preferred brand-name drugs	\$40	\$40	\$60
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Prescription drugs – special	lty (up to a 30-day supply)		
Preferred specialty drugs	50% up to \$150	50% up to \$150	50% up to \$150
Non-preferred specialty drugs	Not covered	Not covered	Not covered
Drug list/formulary	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit

^{*}PCY = Per calendar year.

View the drug formulary at $\mbox{\bf kp.org/wa/formulary}.$



Reset Compare plans Plans selected:			
	Reset	Compare plans	Plans selected:

Reset		Compare plan	Plans selected:
	I	HMO Waiver Plans: VisitsPlu	S
Complete Suite category	■ HMO 1000 V4	■ HMO 1500 V5	■ HMO 2000 V6
Plan deductible, PCY* (individual/family)	\$1,000/\$3,000	\$1,500/\$4,500	\$2,000/\$4,000
Out-of-pocket maximum, PCY (individual/family)	\$4,000/\$12,000	\$5,000/\$15,000	\$5,500/\$11,000
Coinsurance	20%	20%	20%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	Annual deductible and plan coinsurance don't apply to office visits, including surgery	Annual deductible and plan coinsurance don't apply to office visits, including surgery
Preventive and well-child care	No charge	No charge	No charge
Telehealth	No charge	No charge	No charge
Office visits	\$25	\$25	\$30
Urgent care office visits	\$25	\$25	\$30
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible
Hospital inpatient	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home health care (130 visits, PCY)	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	\$25	\$25	\$30
Acupuncture (12 visits, PCY)	\$25	\$25	\$30
Inpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient mental health and substance use disorder	\$25	\$25	\$30
Routine eye exam (1 exam every 12 months)	\$25	\$25	\$30
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$15	\$15	\$15
Preferred brand-name drugs	\$30	\$30	\$40
Non-preferred generic and brand-name drugs	Not covered	Not covered	\$60
Prescription drugs – mail or	rder (up to a 90-day supply)		
Preferred generic drugs	\$30	\$30	\$30
Preferred brand-name drugs	\$60	\$60	\$80
Non-preferred generic and brand-name drugs	Not covered	Not covered	\$120
Prescription drugs – special	ty (up to a 30-day supply)		
Preferred specialty drugs	50% up to \$150	50% up to \$150	\$150
Non-preferred specialty drugs	Not covered	Not covered	30%
Drug list/formulary	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit	5-tier in-network pharmacy benefit

^{*}PCY = Per calendar year.



Reset	Compare plans	Plans selected:	
		ı	

Reset		Compare plan	Fians selected.
Complete Cuite setenam	ı	HMO Waiver Plans: VisitsPlu	S
Complete Suite category	■ HMO 2500 V7	■ HMO 3000 V8	■ HMO 5000 V9
Plan deductible, PCY* (individual/family)	\$2,500/\$5,000	\$3,000/\$6,000	\$5,000/\$10,000
Out-of-pocket maximum, PCY (individual/family)	\$6,000/\$12,000	\$7,500/\$15,000	\$9,000/\$18,000
Coinsurance	30%	30%	30%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	Annual deductible and plan coinsurance do not apply to office visits including surgery	Annual deductible and plan coinsurance do not apply to office visits including surgery
Preventive and well-child care	No charge	No charge	No charge
Telehealth	No charge	No charge	No charge
Office visits	\$30	\$30	\$40
Urgent care office visits	\$30	\$30	\$40
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient surgery	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coinsurance after deductible	\$200 copay, then 30% coinsurance after deductible	\$200 copay, then 30% coinsurance after deductible
Hospital inpatient	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Home health care (130 visits, PCY)	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	\$30	\$30	\$40
Acupuncture (12 visits, PCY)	\$30	\$30	\$40
Inpatient mental health and substance use disorder	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient mental health and substance use disorder	\$30	\$30	\$40
Routine eye exam (1 exam every 12 months)	\$30	\$30	\$40
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$25	\$25	\$25
Preferred brand-name drugs	\$50	\$50	\$50
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Prescription drugs – mail o	rder (up to a 90-day supply)		
Preferred generic drugs	\$50	\$50	\$50
Preferred brand-name drugs	\$100	\$100	\$100
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Prescription drugs – specia	lty (up to a 30-day supply)		
Preferred specialty drugs	50% up to \$150	50% up to \$150	50% up to \$150
Non-preferred specialty drugs	Not covered	Not covered	Not covered
Drug list/formulary	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit

^{*}PCY = Per calendar year.



Reset Compare plans

Neset			
Complete Suite category	HM	IO Waiver Plans: Lab/X-Ray P	lus
complete suite category	■ HMO 250 L1	■ HMO 500 L2	■ HMO 750 L3
Plan deductible, PCY* (individual/family)	\$250/\$750	\$500/\$1,500	\$750/\$2,250
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	\$3,000/\$9,000	\$3,500/\$10,500
Coinsurance	10%	20%	20%
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology services	Annual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology services	Annual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology services
Preventive and well-child care	No charge	No charge	No charge
Telehealth	No charge	No charge	No charge
Office visits (primary/ specialty)	\$15/\$25	\$20/\$30	\$25/\$35
Urgent care office visits (primary/specialty)	\$15/\$25	\$20/\$30	\$25/\$35
Lab and X-ray procedures (outpatient)	\$15	\$20	\$25
CT, MRI, and PET scans (outpatient)	\$100	\$100	\$100
Outpatient surgery	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency care	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hospital inpatient	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home health care (130 visits, PCY)	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	\$15	\$20	\$25
Acupuncture (12 visits, PCY)	\$15	\$20	\$25
Inpatient mental health and substance use disorder	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient mental health and substance use disorder	\$15	\$20	\$25
Routine eye exam (1 exam every 12 months, primary/specialty)	\$15/\$25	\$20/\$30	\$25/\$35
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge
Prescription drugs – retail (u	up to a 30-day supply)		
Preferred generic drugs	\$15	\$15	\$15
Preferred brand-name drugs	\$40	\$40	\$40
Non-preferred generic and brand-name drugs	\$60	\$60	\$60
Prescription drugs – mail or	der (up to a 90-day supply)		
Preferred generic drugs	\$30	\$30	\$30
Preferred brand-name drugs	\$80	\$80	\$80
Non-preferred generic and brand-name drugs	\$120	\$120	\$120
Prescription drugs – special	ty (up to a 30-day supply)		
Preferred specialty drugs	\$150	\$150	\$150
Non-preferred specialty drugs	30%	30%	30%
Drug list/formulary	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit

^{*}PCY = Per calendar year.

View the drug formulary at kp.org/wa/formulary.

Reset Compare plans

HMO Waiver Plans: Lab/X-Ray Plus ■ HMO 1000 L4 ■ HMO 1500 L5 ■ HMO 2000 L6 Plan deductible, PCY* (individual/family) Out-of-pocket maximum, PCY (individual/family) Coinsurance 20% Annual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology services Preventive and well-child care Preventive and well-child care No charge No charge Office visits (primary/ specialty) Urgent care office visits (primary/specialty) Lab and X-ray procedures (outpatient) HMO Waiver Plans: Lab/X-Ray Plus HMO 1000 L5 HMO 2000 L5 # HMO 2000 L5 # HMO 2000 L6 # HMO 1500 L5 # HMO 2000 L6 # HMO 1500 L5 # HMO 2000 L6 # Annual deductible, PCY* (individual/family) \$ 2,000/\$4,000 \$ \$2,000/	office
Preventive and well-child care Preventive visits or to diagnostic laboratory and radiology services Preventive visits or to diagnostic visit	office
(individual/family)\$1,000/\$3,000\$1,500/\$4,500\$2,000/\$4,000Out-of-pocket maximum, PCY (individual/family)\$4,000/\$12,000\$5,000/\$15,000\$5,500/\$11,000Coinsurance20%20%20%Waiver: Lab/X-Ray PlusAnnual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology servicesAnnual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology servicesAnnual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology servicesAnnual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology servicesPreventive and well-child careNo chargeNo chargeNo chargeTelehealthNo chargeNo chargeNo chargeOffice visits (primary/ specialty)\$25/\$35\$25/\$35\$25/\$35Urgent care office visits (primary/specialty)\$25/\$35\$25/\$35\$25/\$35Lab and X-ray procedures (outpatient)\$25\$25\$25	office
PCY (individual/family) Coinsurance 20% Annual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology services Preventive and well-child care No charge No charge No charge No charge Office visits (primary/ specialty) Urgent care office visits (primary/specialty) Lab and X-ray procedures (outpatient) \$4,000/\$12,000 \$35,000/\$11,000 \$35,000/\$11,000 \$35,000/\$11,000 \$4,000/\$12,000 \$20% Annual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology services No charge No charge No charge No charge \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35	office
Waiver: Lab/X-Ray PlusAnnual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology servicesAnnual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology servicesAnnual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology servicesPreventive and well-child careNo chargeNo chargeNo chargeTelehealthNo chargeNo chargeNo chargeOffice visits (primary/ specialty)\$25/\$35\$25/\$35\$25/\$35Urgent care office visits (primary/specialty)\$25/\$35\$25/\$35\$25/\$35Lab and X-ray procedures (outpatient)\$25\$25\$25	office
Waiver: Lab/X-Ray Pluscoinsurance don't apply to office visits or to diagnostic laboratory and radiology servicescoinsurance don't apply to office visits or to diagnostic laboratory and radiology servicescoinsurance don't apply to office visits or to diagnostic laboratory and radiology servicesPreventive and well-child careNo chargeNo chargeNo chargeTelehealthNo chargeNo chargeNo chargeOffice visits (primary/specialty)\$25/\$35\$25/\$35\$25/\$35Urgent care office visits (primary/specialty)\$25/\$35\$25/\$35\$25/\$35Lab and X-ray procedures (outpatient)\$25\$25\$25	office
Telehealth No charge No charge No charge Office visits (primary/ specialty) Urgent care office visits (primary/specialty) \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35	
Office visits (primary/ specialty) Urgent care office visits (primary/specialty) \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35 \$25/\$35	
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(primary/specialty) Lab and X-ray procedures (outpatient) \$25/\$33 \$25/\$33 \$25/\$33 \$25/\$33 \$25/\$33	
(outpatient) \$25	
CT, MRI, and PET scans (outpatient) \$100 \$100	
Outpatient surgery 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	ıctible
Emergency care 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	ıctible
Hospital inpatient 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	ıctible
Skilled nursing facility (60 days, PCY) 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	ıctible
Home health care (130 visits, PCY) No charge No charge	
Manipulative therapy (12 visits, PCY) \$25 \$25	
Acupuncture (12 visits, PCY) \$25 \$25	
Inpatient mental health and substance use disorder 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	ıctible
Outpatient mental health and substance \$25 \$25 \$25 use disorder	
Routine eye exam (1 exam every 12 months, primary/specialty) \$25/\$35 \$25/\$35 \$25/\$35	
Hearing hardware (\$3,000 per ear, every 36 months) No charge No charge No charge	
Prescription drugs – retail (up to a 30-day supply)	
Preferred generic drugs \$15 \$15 \$15	
Preferred brand-name drugs \$40 \$40 \$40	
Non-preferred generic and brand-name drugs \$60 \$60 \$60	
Prescription drugs – mail order (up to a 90-day supply)	
Preferred generic drugs \$30 \$30 \$30	
Preferred brand-name drugs \$80 \$80 \$80	
Non-preferred generic and brand-name drugs \$120 \$120	
Prescription drugs – specialty (up to a 30-day supply)	
Preferred specialty drugs \$150 \$150 \$150	
Non-preferred specialty drugs 30% 30%	
Drug list/formulary 5-tier in-network pharmacy benefit 5-tier in-network pharmacy benefit 5-tier in-network pharmacy	

^{*}PCY = Per calendar year.



Reset Compare plans

Reset		Compare plan	Flans selected:
Complete Soils and an arrange	HM	10 Waiver Plans: Lab/X-Ray F	Plus
Complete Suite category	■ HMO 2500 L7	■ HMO 3000 L8	■ HMO 5000 L9
Plan deductible, PCY* (individual/family)	\$2,500/\$5,000	\$3,000/\$6,000	\$5,000/\$10,000
Out-of-pocket maximum, PCY (individual/family)	\$6,000/\$12,000	\$7,500/\$15,000	\$9,000/\$18,000
Coinsurance	30%	30%	30%
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology services	Annual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology services	Annual deductible and plan coinsurance don't apply to office visits or to diagnostic laboratory and radiology services
Preventive and well-child care	No charge	No charge	No charge
Telehealth	No charge	No charge	No charge
Office visits (primary/ specialty)	\$25/\$35	\$30/\$40	\$30/\$40
Urgent care office visits (primary/specialty)	\$25/\$35	\$30/\$40	\$30/\$40
Lab and X-ray procedures (outpatient)	\$25	\$30	\$30
CT, MRI, and PET scans (outpatient)	\$100	\$100	\$100
Outpatient surgery	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Emergency care	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Hospital inpatient	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Home health care (130 visits, PCY)	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	\$25	\$30	\$30
Acupuncture (12 visits, PCY)	\$25	\$30	\$30
Inpatient mental health and substance use disorder	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient mental health and substance use disorder	\$25	\$30	\$30
Routine eye exam (1 exam every 12 months, primary/specialty)	\$25/\$35	\$30/\$40	\$30/\$40
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$15	\$15	\$15
Preferred brand-name drugs	\$40	\$40	\$40
Non-preferred generic and brand-name drugs	\$60	\$60	\$60
Prescription drugs – mail o	rder (up to a 90-day supply)		
Preferred generic drugs	\$30	\$30	\$30
Preferred brand-name drugs	\$80	\$80	\$80
Non-preferred generic and brand-name drugs	\$120	\$120	\$120
Prescription drugs – specia	lty (up to a 30-day supply)		
Preferred specialty drugs	\$150	\$150	\$150
Non-preferred specialty drugs	30%	30%	30%
Drug list/formulary	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit

^{*}PCY = Per calendar year.



Compare plans

Plans selected:

Reset		Compare plan	Plans selected:
Complete Suite setemen	HMO Welcome Plans		
Complete Suite category	■ HMO 250 W1	■ HMO 500 W3	■ HMO 750 W5
Plan deductible, PCY ¹	\$250/\$750	\$500/\$1,500	\$750/\$2,250
(individual/family) Out-of-pocket maximum,	\$3,000/\$9,000	\$3,000/\$9,000	\$3,500/\$10,500
PCY (individual/family) Coinsurance	10%	20%	20%
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	First 4 office visits are subject to copay only. After first 4 office visits, copays ar waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, C MRI and PET scan procedures. After the first \$500, plan deductib and coinsurance apply.
Preventive and well-child care	No charge	No charge	No charge
Telehealth	No charge	No charge	No charge
Office visits	\$20 copay, then 10% coinsurance after deductible ²	\$20 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsurance after deductible ²
Urgent care office visits	\$20 copay, then 10% coinsurance after deductible ²	\$20 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsurance after deductible ²
Lab and X-ray procedures (outpatient)	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 10% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 20% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures then subject to 20% coinsurance after deductible ²
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 10% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 20% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures then subject to 20% coinsurance after deductible ²
Outpatient surgery	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 10% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible
Hospital inpatient	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home health care (130 visits, PCY)	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	\$20 copay, then 10% coinsurance after deductible ²	\$20 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsuranc after deductible ²
Acupuncture (12 visits, PCY)	\$20 copay, then 10% coinsurance after deductible ²	\$20 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsurance after deductible ²
Inpatient mental health and substance use disorder	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient mental health and substance use disorder	\$20 copay, then 10% coinsurance after deductible ²	\$20 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsurance after deductible ²
Routine eye exam (1 exam every 12 months, primary/specialty)	\$20	\$20	\$25
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$10	\$15	\$15
Preferred brand-name drugs	\$20	\$40	\$30
Non-preferred generic and brand-name drugs	Not covered	\$60	Not covered
Prescription drugs – mail or	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	\$30	\$30
Preferred brand-name drugs	\$40	\$80	\$60
Non-preferred generic and brand-name drugs	Not covered	\$120	Not covered
Prescription drugs – special			
Preferred specialty drugs Non-preferred specialty	50% up to \$150	\$150 30%	50% up to \$150
drugs		3070	
Drug list/formulary	1 or 2-tier with additional specialty tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	1 or 2-tier with additional special tier in-network pharmacy benefi

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.





Compare plans

Plans selected:

Reset		Compare plan	Plans selected:		
Commisto Suito cotomoni	HMO Welcome Plans				
Complete Suite category	■ HMO 1000 W7	■ HMO 1500 W9	■ HMO 2000 W10		
Plan deductible, PCY ¹ (individual/family)	\$1,000/\$3,000	\$1,500/\$4,500	\$2,000/\$4,000		
Out-of-pocket maximum, PCY (individual/family)	\$4,000/\$12,000	\$5,000/\$15,000	\$5,500/\$11,000		
Coinsurance	20%	20%	20%		
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.		
Preventive and well-child care	No charge	No charge	No charge		
Telehealth	No charge	No charge	No charge		
Office visits	\$25 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsurance after deductible ²	\$30 copay, then 20% coinsurance after deductible ²		
Urgent care office visits	\$25 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsurance after deductible ²	\$30 copay, then 20% coinsurance after deductible ²		
Lab and X-ray procedures (outpatient)	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 20% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 20% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 20% coinsurance after deductible ²		
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 20% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 20% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 20% coinsurance after deductible ²		
Outpatient surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible		
Hospital inpatient	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Home health care (130 visits, PCY)	No charge	No charge	No charge		
Manipulative therapy (12 visits, PCY)	\$25 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsurance after deductible ²	\$30 copay, then 20% coinsurance after deductible ²		
Acupuncture (12 visits, PCY)	\$25 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsurance after deductible ²	\$30 copay, then 20% coinsurance after deductible ²		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$25 copay, then 20% coinsurance after deductible ²	\$25 copay, then 20% coinsurance after deductible ²	\$30 copay, then 20% coinsurance after deductible ²		
Routine eye exam (1 exam every 12 months, primary/specialty)	\$25	\$25	\$30		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	\$15	\$15	\$15		
Preferred brand-name drugs	\$40	\$30	\$40		
Non-preferred generic and brand-name drugs	\$60	Not covered	\$60		
1 3	rder (up to a 90-day supply)				
Preferred generic drugs Preferred brand-name	\$30 \$80	\$30 \$60	\$30 \$80		
drugs Non-preferred generic and brand-name drugs	\$120	Not covered	\$120		
Prescription drugs – specia	lty (up to a 30-day supply)				
	\$150	50% up to \$150	\$150		
Preferred specialty drugs	Ψ	σσ,σαριοφίου	Ų 100		
Preferred specialty drugs Non-preferred specialty drugs	30%	Not covered	30%		

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.

View the drug formulary at $\ensuremath{\text{kp.org/wa/formulary}}.$





Compare plans

Plans selected:

Complete Suite category Plan deductible, PCY¹ (individual/family) Out-of-pocket maximum, PCY (individual/family) Coinsurance Waiver: Welcome	\$2,500/\$5,000 \$6,000/\$12,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance after deductible² \$30 copay, then 30% coinsurance after deductible²	HMO Welcome Plans ### HMO 3000 W13 \$3,000/\$6,000 \$7,500/\$15,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance after deductible²	\$5,000/\$10,000 \$9,000/\$18,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$40 copay, then 30% coinsurance after deductible ²
Plan deductible, PCY¹ (individual/family) Out-of-pocket maximum, PCY (individual/family) Coinsurance	\$2,500/\$5,000 \$6,000/\$12,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance after deductible² \$30 copay, then 30% coinsurance	\$3,000/\$6,000 \$7,500/\$15,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance	\$5,000/\$10,000 \$9,000/\$18,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$40 copay, then 30% coinsurance
(individual/family) Out-of-pocket maximum, PCY (individual/family) Coinsurance	\$6,000/\$12,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance after deductible² \$30 copay, then 30% coinsurance	\$7,500/\$15,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance	\$9,000/\$18,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$40 copay, then 30% coinsurance
Out-of-pocket maximum, PCY (individual/family) Coinsurance	\$6,000/\$12,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance after deductible² \$30 copay, then 30% coinsurance	\$7,500/\$15,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance	\$9,000/\$18,000 30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$40 copay, then 30% coinsurance
PCY (individual/family) Coinsurance	30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance after deductible² \$30 copay, then 30% coinsurance	30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance	30% First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, Cl MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$40 copay, then 30% coinsurance
	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance after deductible² \$30 copay, then 30% coinsurance	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, C MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge
Waiver: Welcome	copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance after deductible² \$30 copay, then 30% coinsurance	copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply. No charge No charge \$30 copay, then 30% coinsurance	copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, C MRI and PET scan procedures. After the first \$500, plan deductibe and coinsurance apply. No charge No charge
	No charge \$30 copay, then 30% coinsurance after deductible ² \$30 copay, then 30% coinsurance	No charge \$30 copay, then 30% coinsurance	No charge \$40 copay, then 30% coinsurance
Preventive and well-child care	\$30 copay, then 30% coinsurance after deductible ² \$30 copay, then 30% coinsurance	\$30 copay, then 30% coinsurance	\$40 copay, then 30% coinsurance
Telehealth	\$30 copay, then 30% coinsurance after deductible ² \$30 copay, then 30% coinsurance	\$30 copay, then 30% coinsurance	\$40 copay, then 30% coinsurance
Office visits			
Urgent care office visits		\$30 copay, then 30% coinsurance after deductible ²	\$40 copay, then 30% coinsurance after deductible ²
Lab and X-ray procedures (outpatient)	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 30% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 30% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures then subject to 30% coinsurance after deductible ²
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 30% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to 30% coinsurance after deductible ²	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures then subject to 30% coinsurance after deductible ²
Outpatient surgery	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coinsurance after deductible	\$200 copay, then 30% coinsurance after deductible	\$200 copay, then 30% coinsurance after deductible
Hospital inpatient	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Home health care (130 visits, PCY)	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	\$30 copay, then 30% coinsurance after deductible ²	\$30 copay, then 30% coinsurance after deductible ²	\$40 copay, then 30% coinsurance after deductible ²
Acupuncture (12 visits, PCY)	\$30 copay, then 30% coinsurance after deductible ²	\$30 copay, then 30% coinsurance after deductible ²	\$40 copay, then 30% coinsurance after deductible ²
Inpatient mental health and substance use disorder	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient mental health and substance use disorder	\$30 copay, then 30% coinsurance after deductible ²	\$30 copay, then 30% coinsurance after deductible ²	\$40 copay, then 30% coinsurance after deductible ²
Routine eye exam (1 exam every 12 months, primary/specialty)	\$30	\$30	\$40
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge
Prescription drugs – retail (u	up to a 30-day supply)		
Preferred generic drugs	\$25	\$25	\$25
Preferred brand-name drugs	\$50	\$50	\$50
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Prescription drugs – mail or	7 11 2		
Preferred generic drugs	\$50	\$50	\$50
Preferred brand-name drugs	\$100	\$100	\$100
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Prescription drugs – specialt		F00/ . A450	F00/ . 4455
Preferred specialty drugs Non-preferred specialty	50% up to \$150 Not covered	50% up to \$150 Not covered	50% up to \$150 Not covered
drugs	1 or 2-tier with additional specialty	1 or 2-tier with additional specialty	1 or 2-tier with additional special
Drug list/formulary	tier in-network pharmacy benefit	tier in-network pharmacy benefit	tier in-network pharmacy benefi

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.





Reset			Compare plans	Plans selected:
Complete Suite estenam		HMO Dedu	ctible Plans	
Complete Suite category	■ NEW HMO 1500	■ NEW HMO 2500	■ NEW HMO 3000	■ NEW HMO 5000
Plan deductible, PCY* (individual/family)	\$1,500/\$4,500	\$2,500/\$5,000	\$3,000/\$6,000	\$5,000/\$10,000
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$15,000	\$6,000/\$12,000	\$7,500/\$15,000	\$9,000/18,000
Coinsurance	20%	30%	30%	30%
Preventive and well-child care	No charge	No charge	No charge	No charge
Telehealth	No charge	No charge	No charge	No charge
Office visits	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Urgent care office visits	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Emergency care	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Hospital inpatient	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Home health care (130 visits, PCY)	No charge	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient mental health and substance use disorder	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	No charge
Prescription drugs – retail (u		I	I	T
Preferred generic drugs	\$15	\$25	\$25	\$25
Preferred brand-name drugs	\$40	\$60	\$60	\$60
Non-preferred generic and brand-name drugs	\$60	\$100	\$100	\$100
Prescription drugs – mail or	2 11 2			
Preferred generic drugs	\$30	\$50	\$50	\$50
Preferred brand-name drugs	\$80	\$120	\$120	\$120
Non-preferred generic and brand-name drugs	\$120	\$200	\$200	\$200
Prescription drugs – special	ty (up to a 30-day supply)			
Preferred specialty drugs	\$150	\$150	\$150	\$150
Non-preferred specialty drugs	30%	30%	30%	30%
Drug list/formulary	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit

^{*}PCY = Per calendar year.



Compare plans

Plans selected:

Composite Coltanostanos	HMO HSA Plans			
Complete Suite category	■ HMO 1650 (A) HSA	■ HMO 2500 (A) HSA	NEW HMO 3500 (A) HSA	
Plan deductible, PCY* (individual/family)	\$1,650/\$3,300	\$2,500/\$5,000	\$3,500/\$7,000	
Out-of-pocket maximum, PCY (individual/family)	\$3,500/\$7,000	\$5,000/\$8,500	\$6,000/\$8,500	
Coinsurance	20%	20%	20%	
Preventive and well-child care	No charge	No charge	No charge	
Telehealth	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full	
Office visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Urgent care office visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Emergency care	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Manipulative therapy (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Outpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered	
Drug list/formulary	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit	

^{*}PCY = Per calendar year.



Prescription drugs filled through Kaiser Permanente's mail-order pharmacy will be subject to 2 times the prescription drug cost share for up to a 90-day supply.

Specialty drugs are limited to a 30-day supply.

View the drug formulary at kp.org/wa/formulary.

Reset		Compare plar	Plans selected:
Complete Suite category		HMO HSA Plans	
	HMO 3300 (E) HSA	HMO 3500 (E) HSA	NEW HMO 4000 (E) HSA

Complete Suite category	HMO HSA Plans			
Complete Suite talegory	■ HMO 3300 (E) HSA	■ HMO 3500 (E) HSA	NEW HMO 4000 (E) HSA	
Plan deductible, PCY* (individual/family)	\$3,300/\$6,600	\$3,500/\$7,000	\$4,000/\$8,000	
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$10,000	\$7,000/\$14,000	\$7,000/\$14,000	
Coinsurance	20%	20%	20%	
Preventive and well-child care	No charge	No charge	No charge	
Telehealth	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full	
Office visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Urgent care office visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Emergency care	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Manipulative therapy (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Outpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered	
Drug list/formulary	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit	

^{*}PCY = Per calendar year.

Prescription drugs filled through Kaiser Permanente's mail-order pharmacy will be subject to 2 times the prescription drug cost share for up to a 90-day supply.

Specialty drugs are limited to a 30-day supply.



Compare plans Reset

	LIMO USA Diana				
Complete Suite category	HMO HSA Plans				
Plan deductible, PCY*	HMO 4500 (E) HSA	HMO 5000 (E) 100% HSA	NEW HMO 6000 (E) 100% HSA		
(individual/family)	\$4,500/\$9,000	\$5,000/\$10,000	\$6,000/\$12,000		
Out-of-pocket maximum, PCY (individual/family)	\$7,000/\$14,000	\$5,000/\$10,000	\$6,000/\$12,000		
Coinsurance	30%	0%	0%		
Preventive and well-child care	No charge	No charge	No charge		
Telehealth	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Office visits	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Urgent care office visits	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Outpatient surgery	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Emergency care	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Hospital inpatient	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Home health care (130 visits, PCY)	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Manipulative therapy (12 visits, PCY)	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Acupuncture (12 visits, PCY)	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Inpatient mental health and substance use disorder	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Outpatient mental health and substance use disorder	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Routine eye exam (1 exam every 12 months)	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Preferred brand-name drugs	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)				
Preferred generic drugs	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Preferred brand-name drugs	30% coinsurance after deductible	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered		
Drug list/formulary	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit		

^{*}PCY = Per calendar year.

Prescription drugs filled through Kaiser Permanente's mail-order pharmacy will be subject to 2 times the prescription drug cost share for up to a 90-day supply.

Specialty drugs are limited to a 30-day supply.



Compare plans

Plans selected:

Reset		Compare plan	Plans selected:		
Complete Suite category	Virtual Plus Plans				
complete suite category	■ Virtual Plus 250	■ Virtual Plus 500	■ Virtual Plus 1000		
Plan deductible, PCY* (individual/family)	\$250/\$500	\$500/\$1,000	\$1,000/\$2,000		
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$6,000	\$3,000/\$6,000	\$4,000/\$8,000		
Coinsurance	10%	20%	20%		
Preventive and well-child care	No charge	No charge	No charge		
Virtual care/telehealth	No charge	No charge	No charge		
First primary care visit (nonpreventive)	No charge	No charge	No charge		
Office visits – referred (primary/specialty)	\$10/\$30	\$20/\$40	\$20/\$40		
Office visits – non-referred (primary/specialty)	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Urgent care office visits (primary/specialty)	In-person, authorized: \$10/\$30 In-person, self-directed: 10% after deductible	In-person, authorized: \$20/\$40 In-person, self-directed: 20% after deductible	In-person, authorized: \$20/\$40 In-person, self-directed: 20% after deductible		
Lab and X-ray procedures (outpatient)	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Outpatient surgery	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 10% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible		
Hospital inpatient	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Home health care (unlimited)	No charge	No charge	No charge		
Manipulative therapy (10 visits, PCY)	\$10	\$20	\$20		
Acupuncture (12 visits, PCY)	\$10	\$20	\$20		
Inpatient mental health and substance use disorder	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$10	\$20	\$20		
Routine eye exam (1 exam every 12 months) (primary/specialty)	\$10/\$30	\$20/\$40	\$20/\$40		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	\$10	\$15	\$15		
Preferred brand-name drugs	\$30	\$35	\$35		
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered		
	rder (up to a 90-day supply)				
Preferred generic drugs	\$5	\$5	\$5		
Preferred brand-name drugs	\$60	\$70	\$70		
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered		
Prescription drugs – specia	lty (up to a 30-day supply)				
Preferred specialty drugs	\$150	\$150	\$150		
Non-preferred specialty drugs	Not covered	Not covered	Not covered		
Drug list/formulary	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit		

^{*}PCY = Per calendar year.

Virtual Plus plans include the First Fill Maintenance Drug Program. The first time a prescription for a maintenance drug is filled, members are required to use either an in-network pharmacy or Kaiser Permanente's mail-order pharmacy. Members can fill up to a 30-day supply. Subsequent refills are required to be filled by using Kaiser Permanente's mail-order pharmacy. This doesn't apply to medication for sudden conditions or to drugs we can't mail. At any time, a member can request an emergency fill of a maintenance medication at any pharmacy in their network.



Compare plans Plans selected:

Reset		Compare plan	Plans selected:		
	Virtual Plus Plans				
Complete Suite category	■ Virtual Plus 1500	■ Virtual Plus 2000	■ Virtual Plus 2500		
Plan deductible, PCY* (individual/family)	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000		
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$10,000	\$5,500/\$11,000	\$6,000/\$12,000		
Coinsurance	20%	20%	30%		
Preventive and well-child care	No charge	No charge	No charge		
Virtual care/telehealth	No charge	No charge	No charge		
First primary care visit (nonpreventive)	No charge	No charge	No charge		
Office visits – referred (primary/specialty)	\$20/\$40	\$30/\$60	\$30/\$60		
Office visits – non-referred (primary/specialty)	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible		
Urgent care office visits (primary/specialty)	In-person, authorized: \$20/\$40 In-person, self-directed: 20% after deductible	In-person, authorized: \$30/\$60 In-person, self-directed: 30% after deductible	In-person, authorized: \$30/\$60 In-person, self-directed: 30% afte deductible		
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible		
Outpatient surgery	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 30% coinsuranc after deductible		
Hospital inpatient	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible		
Home health care (unlimited)	No charge	No charge	No charge		
Manipulative therapy (10 visits, PCY)	\$20	\$30	\$30		
Acupuncture (12 visits, PCY)	\$20	\$30	\$30		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$20	\$30	\$30		
Routine eye exam (1 exam every 12 months) (primary/specialty)	\$20/\$40	\$30/\$60	\$30/\$60		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs – retail ((up to a 30-day supply)	I			
Preferred generic drugs	\$15	\$15	\$20		
Preferred brand-name drugs	\$35	\$35	\$40		
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered		
	order (up to a 90-day supply)				
Preferred generic drugs	\$5	\$5	\$5		
Preferred brand-name drugs	\$70	\$70	\$80		
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered		
Prescription drugs – specia					
Preferred specialty drugs Non-preferred specialty	\$150 Not covered	\$150 Not covered	\$150 Not covered		
drugs Drug list/formulary	1 or 2-tier with additional specialty tier in-network	1 or 2-tier with additional specialty tier in-network	1 or 2-tier with additional specialty tier in-network		

^{*}PCY = Per calendar year.

Virtual Plus plans include the First Fill Maintenance Drug Program. The first time a prescription for a maintenance drug is filled, members are required to use either an in-network pharmacy or Kaiser Permanente's mail-order pharmacy. Members can fill up to a 30-day supply. Subsequent refills are required to be filled by using Kaiser Permanente's mail-order pharmacy. This doesn't apply to medication for sudden conditions or to drugs we can't mail. At any time, a member can request an emergency fill of a maintenance medication at any pharmacy in their network.

pharmacy benefit

pharmacy benefit

View the drug formulary at kp.org/wa/formulary.



pharmacy benefit

Compare plans Plans selected:

Reset		Compare plar	Plans selected:		
	Virtual Plus Plans				
Complete Suite category	■ Virtual Plus 3000	■ Virtual Plus 4000	■ Virtual Plus 5000		
Plan deductible, PCY* (individual/family)	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000		
Out-of-pocket maximum, PCY (individual/family)	\$7,000/\$14,000	\$7,000/\$14,000	\$9,000/\$18,000		
Coinsurance	30%	30%	30%		
Preventive and well-child care	No charge	No charge	No charge		
Virtual care/telehealth	No charge	No charge	No charge		
First primary care visit (nonpreventive)	No charge	No charge	No charge		
Office visits – referred (primary/specialty)	\$30/\$60	\$40/\$80	\$40/\$80		
Office visits – non-referred (primary/specialty)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible		
Urgent care office visits (primary/specialty)	In-person, authorized: \$30/\$60 In-person, self-directed: 30% after deductible	In-person, authorized: \$40/\$80 In-person, self-directed: 30% after deductible	In-person, authorized: \$40/\$80 In-person, self-directed: 30% afte deductible		
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible		
Outpatient surgery	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coinsurance after deductible	\$200 copay, then 30% coinsurance after deductible	\$200 copay, then 30% coinsurance		
Hospital inpatient	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible		
Home health care (unlimited)	No charge	No charge	No charge		
Manipulative therapy (10 visits, PCY)	\$30	\$40	\$40		
Acupuncture (12 visits, PCY)	\$30	\$40	\$40		
Inpatient mental health and substance use disorder	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$30	\$40	\$40		
Routine eye exam (1 exam every 12 months) (primary/specialty)	\$30/\$60	\$40/\$80	\$40/\$80		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs – retail ((up to a 30-day supply)				
Preferred generic drugs	\$20	\$20	\$20		
Preferred brand-name drugs	\$40	\$40	\$40		
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered		
	rder (up to a 90-day supply)				
Preferred generic drugs	\$5	\$5	\$5		
Preferred brand-name drugs	\$80	\$80	\$80		
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered		
Prescription drugs – specia					
Preferred specialty drugs Non-preferred specialty	\$150 Not covered	\$150 Not covered	\$150 Not covered		
drugs Drug list/formulary	1 or 2-tier with additional specialty tier in-network	1 or 2-tier with additional specialty tier in-network	1 or 2-tier with additional specialty tier in-network		

^{*}PCY = Per calendar year.

Virtual Plus plans include the First Fill Maintenance Drug Program. The first time a prescription for a maintenance drug is filled, members are required to use either an in-network pharmacy or Kaiser Permanente's mail-order pharmacy. Members can fill up to a 30-day supply. Subsequent refills are required to be filled by using Kaiser Permanente's mail-order pharmacy. This doesn't apply to medication for sudden conditions or to drugs we can't mail. At any time, a member can request an emergency fill of a maintenance medication at any pharmacy in their network.

pharmacy benefit

pharmacy benefit

View the drug formulary at kp.org/wa/formulary.



pharmacy benefit

Compare plans

Plans selected:

Reset		Compare plan	Fians selected.	
	Summit PPO Plans			
Complete Suite category	Summit PPO 250			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY* (individual/family)	\$250	/\$500	\$750/\$1,500	
Out-of-pocket maximum, PCY (individual/family)	\$2,500	/\$5,000	Unlimited	
Coinsurance	10%	30%	50%	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth Telehealth	No charge	No charge	Not covered	
Office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductibl	
Urgent care office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductibl	
Lab and X-ray procedures (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductibl	
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductibl	
Emergency care (copay waived if admitted to inpatient)	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurant after deductible	
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductibl	
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductibl	
Home health care unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductibl	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$10	\$20	50% coinsurance after deductibl	
Acupuncture (12 visits, PCY)	\$10	\$20	50% coinsurance after deductibl	
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$10	\$20	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$20/\$40	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$5	\$15	Not covered	
Preferred brand-name drugs	\$30	\$50	Not covered	
Non-preferred generic and brand-name drugs	\$65	\$95	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$10	Not covered	Not covered	
Preferred brand-name drugs	\$60	Not covered	Not covered	
Non-preferred generic and brand-name drugs	\$130	Not covered	Not covered	
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs Non-preferred specialty	\$150 30%	\$150 30%	Not covered	
drugs	SU76	5-tier in-network pharmacy benefit	NOT COVELED	
Drug list/formulary		5-tier in-network pharmacy benefit		

^{*}PCY = Per calendar year.

Services provided by out-of-network providers may be subject to balance billing.

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at kp.org/wa/formulary.

Reset Compare plans Plans selected:

Reset		Compare plan	Plans selected:		
	Summit PPO Plans				
Complete Suite category	Summit PPO 500 10%/20%				
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$500/	\$1,000	\$1,500/\$3,000		
Out-of-pocket maximum, PCY (individual/family)	·	/\$6,000	Unlimited		
Coinsurance	10%	20%	50%		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	No charge	No charge	Not covered		
Office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductible		
Urgent care office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	10% coinsurance	20% coinsurance	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	10% coinsurance	20% coinsurance	50% coinsurance after deductible		
Outpatient surgery	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible		
Hospital inpatient	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible		
Home health care (unlimited)	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$10	\$20	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$10	\$20	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$10	\$20	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$20/\$40	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	\$5	\$15	Not covered		
Preferred brand-name drugs	\$30	\$50	Not covered		
Non-preferred generic and brand-name drugs	\$65	\$95	Not covered		
	rder (up to a 90-day supply)				
Preferred generic drugs	\$10	Not covered	Not covered		
Preferred brand-name drugs	\$60	Not covered	Not covered		
Non-preferred generic and brand-name drugs	\$130	Not covered	Not covered		
Prescription drugs – special	3 11 3	\$450	N		
Preferred specialty drugs Non-preferred specialty	\$150 30%	\$150 30%	Not covered Not covered		
drugs Drug list/formulary		5-tier in-network pharmacy benefit			
Diag havioninalary		3-uer m-network pharmacy benefit			

^{*}PCY = Per calendar year.

Services provided by out-of-network providers may be subject to balance billing.

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at kp.org/wa/formulary.

Compare plans

Plans selected:

Keset		Compare pian	rians selected.		
	Summit PPO Plans				
Complete Suite category	Summit PPO 500				
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$500/	\$1,000	\$1,500/\$3,000		
Out-of-pocket maximum, PCY (individual/family)	\$3,000)/\$6,000	Unlimited		
Coinsurance	10%	30%	50%		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	No charge	No charge	Not covered		
Office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductible		
Urgent care office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible		
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible		
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductibl		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$10	\$20	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$10	\$20	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$10	\$20	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$20/\$40	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	\$5	\$15	Not covered		
Preferred brand-name drugs	\$30	\$50	Not covered		
Non-preferred generic and brand-name drugs	\$65	\$95	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)				
Preferred generic drugs	\$10	Not covered	Not covered		
Preferred brand-name drugs	\$60	Not covered	Not covered		
Non-preferred generic and brand-name drugs	\$130	Not covered	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)				
Preferred specialty drugs	\$150	\$150	Not covered		
Non-preferred specialty drugs	30%	30%	Not covered		
Drug list/formulary		5-tier in-network pharmacy benefit			

^{*}PCY = Per calendar year.

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Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at kp.org/wa/formulary.

Compare plans

Plans selected:

Reset		Compare plan	Plans selected:	
	Summit PPO Plans			
Complete Suite category	Summit PPO 750			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY* (individual/family)	\$750/	\$1,500	\$2,250/\$4,500	
Out-of-pocket maximum, PCY (individual/family)	\$4,000	/\$8,000	Unlimited	
Coinsurance	10%	30%	50%	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth	No charge	No charge	Not covered	
Office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductible	
Urgent care office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible	
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible	
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$10	\$20	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$10	\$20	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$10	\$20	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$20/\$40	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$5	\$15	Not covered	
Preferred brand-name drugs	\$30	\$50	Not covered	
Non-preferred generic and brand-name drugs	\$65	\$95	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$10	Not covered	Not covered	
Preferred brand-name drugs	\$60	Not covered	Not covered	
Non-preferred generic and brand-name drugs	\$130	Not covered	Not covered	
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	\$150	Not covered	
Non-preferred specialty drugs	30%	30%	Not covered	
Drug list/formulary		5-tier in-network pharmacy benefit		

5-tier in-network pharmacy benefit

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Compare plans

Plans selected:

Reset		Compare pian	Fidns selected.		
Complete Suite category	Summit PPO Plans				
		Summit PPO 1000			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$1,000)/\$2,000	\$3,000/\$6,000		
Out-of-pocket maximum, PCY (individual/family)	\$4,000)/\$8,000	Unlimited		
Coinsurance	10%	30%	50%		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	No charge	No charge	Not covered		
Office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductible		
Urgent care office visits (primary/specialty)	\$10/\$20	\$20/\$40	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible		
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$150 copay, then 10% coinsurance after deductible	\$150 copay, then 10% coinsurance after deductible	\$150 copay, then 10% coinsurance after deductible		
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$10	\$20	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$10	\$20	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$10	\$20	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$20/\$40	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	\$10	\$20	Not covered		
Preferred brand-name drugs	\$20	\$40	Not covered		
Non-preferred generic and brand-name drugs	\$30	\$60	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)				
Preferred generic drugs	\$20	Not covered	Not covered		
Preferred brand-name drugs	\$40	Not covered	Not covered		
Non-preferred generic and brand-name drugs	\$60	Not covered	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)				
Preferred specialty drugs	\$150	\$150	Not covered		
Non-preferred specialty drugs	30%	30%	Not covered		
Drug list/formulary		5-tier in-network pharmacy benefit			

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Reset Compare plans

Summit PPO Plans Complete Suite category Summit PPO 1500 10%/20% Preferred in-network (Tier I) In-network (Tier 2) Out-of-network (Tier 3) Plan deductible, PCY* \$1,500/\$3,000 \$4,500/\$9,000 (individual/family) Out-of-pocket maximum, \$5,000/\$10,000 Unlimited PCY (individual/family) 10% 20% 50% Coinsurance Preventive and well-child 50% coinsurance after deductible No charge No charge care Telehealth No charge No charge Not covered Office visits 50% coinsurance after deductible \$20/\$40 \$40/\$80 (primary/specialty) **Urgent care office visits** 50% coinsurance after deductible \$20/\$40 \$40/\$80 (primary/specialty) Lab and X-ray procedures 50% coinsurance after deductible 10% coinsurance 20% coinsurance (outpatient) CT, MRI, and PET scans 50% coinsurance after deductible 10% coinsurance 20% coinsurance (outpatient) 20% coinsurance after deductible 50% coinsurance after deductible **Outpatient surgery** 10% coinsurance after deductible Emergency care (copay \$150 copay, then 10% coinsurance \$150 copay, then 10% coinsurance \$150 copay, then 10% coinsurance waived if admitted to after deductible after deductible after deductible inpatient) 50% coinsurance after deductible **Hospital inpatient** 10% coinsurance after deductible 20% coinsurance after deductible Skilled nursing facility 10% coinsurance after deductible 20% coinsurance after deductible 50% coinsurance after deductible (60 days, PCY) Home health care 10% coinsurance after deductible 50% coinsurance after deductible 20% coinsurance after deductible (unlimited) Manipulative therapy (8 visits, PCY; additional \$20 \$40 50% coinsurance after deductible visits with prior authorization) Acupuncture \$20 \$40 50% coinsurance after deductible (12 visits, PCY) Inpatient mental health and substance use 10% coinsurance after deductible 20% coinsurance after deductible 50% coinsurance after deductible disorder **Outpatient mental** health and substance use \$20 \$40 50% coinsurance after deductible disorder Routine eye exam (1 exam every 12 months) 50% coinsurance after deductible \$0/\$0 \$40/\$80 primary/specialty) Hearing hardware (\$3,000 per ear, every No charge No charge No charge 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs \$10 \$20 Not covered Preferred brand-name \$20 \$40 Not covered drugs Non-preferred generic \$30 \$60 Not covered and brand-name drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$20 Not covered Not covered Preferred brand-name \$40 Not covered Not covered drugs Non-preferred generic \$60 Not covered Not covered and brand-name drugs Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 \$150 Not covered Non-preferred specialty 30% 30% Not covered drugs

5-tier in-network pharmacy benefit

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Compare plans

Plans selected:

Reset		Compare plan	Flans selected.		
Complete Suite category	Summit PPO Plans				
		Summit PPO 1500			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$1,500	/\$3,000	\$4,500/\$9,000		
Out-of-pocket maximum, PCY (individual/family)	\$5,000/	\$10,000	Unlimited		
Coinsurance	10%	30%	50%		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	No charge	No charge	Not covered		
Office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible		
Urgent care office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible		
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$150 copay, then 10% coinsurance after deductible	\$150 copay, then 10% coinsurance after deductible	\$150 copay, then 10% coinsurance after deductible		
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductibl		
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductibl		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$20	\$40	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$20	\$40	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$20	\$40	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$40/\$80	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs — retail (up to a 30-day supply)				
Preferred generic drugs	\$10	\$20	Not covered		
Preferred brand-name drugs	\$20	\$40	Not covered		
Non-preferred generic and brand-name drugs	\$30	\$60	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)				
Preferred generic drugs	\$20	Not covered	Not covered		
Preferred brand-name drugs	\$40	Not covered	Not covered		
Non-preferred generic and brand-name drugs	\$60	Not covered	Not covered		
Prescription drugs — special	ty (up to a 30-day supply)				
Preferred specialty drugs	\$150	\$150	Not covered		
Non-preferred specialty drugs	30%	30%	Not covered		
Drug list/formulary		5-tier in-network pharmacy benefit			

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Compare plans

Plans selected:

Noset		25 1		
Complete Suite category	Summit PPO Plans			
		Summit PPO 2000		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY* (individual/family)		/\$4,000	\$6,000/\$12,000	
Out-of-pocket maximum, PCY (individual/family)	\$5,000/	\$10,000	Unlimited	
Coinsurance	20%	40%	50%	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth	No charge	No charge	Not covered	
Office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible	
Urgent care office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$150 copay, then 20% coinsurance after deductible	\$150 copay, then 20% coinsurance after deductible	\$150 copay, then 20% coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$20	\$40	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$20	\$40	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$20	\$40	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$40/\$80	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$10	\$20	Not covered	
Preferred brand-name drugs	\$20	\$40	Not covered	
Non-preferred generic and brand-name drugs	\$30	\$60	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$20	Not covered	Not covered	
Preferred brand-name drugs	\$40	Not covered	Not covered	
Non-preferred generic and brand-name drugs	\$60	Not covered	Not covered	
Prescription drugs – specia				
Preferred specialty drugs	\$150	\$150	Not covered	
Non-preferred specialty drugs	30%	30%	Not covered	
Drug list/formulary		5-tier in-network pharmacy benefit		

5-tier in-network pharmacy benefit

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Compare plans

Plans selected:

Reset		Compare plan	Plans selected:	
	Summit PPO Plans			
Complete Suite category		Summit PPO 2500		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY* (individual/family)	\$2,500	/\$5,000	\$7,500/\$15,000	
Out-of-pocket maximum, PCY (individual/family)	\$6,000/	1 \$12,000	Unlimited	
Coinsurance	20%	40%	50%	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth	No charge	No charge	Not covered	
Office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible	
Urgent care office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$20	\$40	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$20	\$40	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$20	\$40	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$40/\$80	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$15	\$25	Not covered	
Preferred brand-name drugs	\$30	\$50	Not covered	
Non-preferred generic and brand-name drugs	\$50	\$80	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$30	Not covered	Not covered	
Preferred brand-name drugs	\$60	Not covered	Not covered	
Non-preferred generic and brand-name drugs	\$100	Not covered	Not covered	
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	\$150	Not covered	
Non-preferred specialty drugs	30%	30%	Not covered	
Drug list/formulary		5-tier in-network pharmacy benefit		

5-tier in-network pharmacy benefit

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Compare plans

Plans selected:

Reset		Compare pian	Fians selected.		
Complete Suite category	Summit PPO Plans				
	Summit PPO 3000				
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$3,000	/\$6,000	\$9,000/\$18,000		
Out-of-pocket maximum, PCY (individual/family)	\$6,000/	\$12,000	Unlimited		
Coinsurance	20%	40%	50%		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	No charge	No charge	Not covered		
Office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible		
Urgent care office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible		
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible		
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$20	\$40	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$20	\$40	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$20	\$40	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$40/\$80	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	\$15	\$25	Not covered		
Preferred brand-name drugs	\$30	\$50	Not covered		
Non-preferred generic and brand-name drugs	\$50	\$80	Not covered		
Prescription drugs – mail or	der (up to a 90-day supply)				
Preferred generic drugs	\$30	Not covered	Not covered		
Preferred brand-name drugs	\$60	Not covered	Not covered		
Non-preferred generic and brand-name drugs	\$100	Not covered	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)				
Preferred specialty drugs	\$150	\$150	Not covered		
Non-preferred specialty drugs	30%	30%	Not covered		
Drug list/formulary		5-tier in-network pharmacy benefit			

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Compare plans

Plans selected:

Reset		Compare plan	Fians selected.	
Complete Suite category	Summit PPO Plans			
	Summit PPO 5000			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY* (individual/family)	\$5,000/	\$10,000	\$15,000/\$30,000	
Out-of-pocket maximum, PCY (individual/family)	\$7,000/	\$14,000	Unlimited	
Coinsurance	20%	40%	50%	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth	No charge	No charge	Not covered	
Office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible	
Urgent care office visits (primary/specialty)	\$20/\$40	\$40/\$80	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$20	\$40	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$20	\$40	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$20	\$40	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	\$0/\$0	\$40/\$80	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$15	\$25	Not covered	
Preferred brand-name drugs	\$30	\$50	Not covered	
Non-preferred generic and brand-name drugs	\$50	\$80	Not covered	
	rder (up to a 90-day supply)			
Preferred generic drugs	\$30	Not covered	Not covered	
Preferred brand-name drugs	\$60	Not covered	Not covered	
Non-preferred generic and brand-name drugs	\$100	Not covered	Not covered	
Prescription drugs – special				
Preferred specialty drugs	\$150	\$150	Not covered	
Non-preferred specialty drugs	30%	30%	Not covered	
Drug list/formulary		5-tier in-network pharmacy benefit		

^{*}PCY = Per calendar year.



Services provided by out-of-network providers may be subject to balance billing.

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at kp.org/wa/formulary.

Compare plans

Plans selected:

Reset		Compare plar	Plans selected:	
		Summit PPO Welcome Plans		
Complete Suite category	Summit PPO 250 W1			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY ¹ (individual/family)	\$250/\$500		\$750/\$1,500	
Out-of-pocket maximum, PCY (individual/family)	\$2,50	0/\$5,000	Unlimited	
Coinsurance	10%	30%	50%	
Waiver: Welcome	copays are waived and plan deduct for the first \$500 of combined diag	copay only. After first 4 office visits, ible and coinsurance apply. No charge nostic lab, X-ray, CT, MRI and PET scan an deductible and coinsurance apply.	N/A	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth	No charge	No charge	Not covered	
Office visits (primary/specialty)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Urgent care office visits (primary/specialty)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)		500 of combined lab, X-ray, CT, MRI, and red in-network, in-network, or out-of-net		
CT, MRI, and PET scans (outpatient)	No charge for first \$	500 of combined lab, X-ray, CT, MRI, and red in-network, in-network, or out-of-net	PET scan procedures,	
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible	
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	No charge	\$20/\$40²	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$5	\$15	Not covered	
Preferred brand-name drugs	\$30	\$50	Not covered	
Non-preferred generic and brand-name drugs	\$65	\$95	Not covered	
1 3	rder (up to a 90-day supply)			
Preferred generic drugs	\$10	Not covered	Not covered	
Preferred brand-name drugs	\$60	Not covered	Not covered	
Non-preferred generic and brand-name drugs	\$130	Not covered	Not covered	
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	\$150	Not covered	
Non-preferred specialty drugs	30%	30%	Not covered	
Drug list/formulary		E tior in naturally pharmacy hanafit		

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver. Services provided by out-of-network providers may be subject to balance billing.

 $Specialty\ drugs\ are\ required\ to\ be\ filled\ through\ the\ Kaiser\ Permanente\ Specialty\ Pharmacy.$

5-tier in-network pharmacy benefit

View the drug formulary at **kp.org/wa/formulary**.



Compare plans Plans selected:

Reset		Compare plan	Plans selected:	
		Summit PPO Welcome Plans	5	
Complete Suite category	Summit PPO 500 W2			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY ¹ (individual/family)	\$500/	\$1,000	\$1,500/\$3,000	
Out-of-pocket maximum, PCY (individual/family)	\$3,000	0/\$6,000	Unlimited	
Coinsurance	10%	30%	50%	
Waiver: Welcome	copays are waived and plan deducti for the first \$500 of combined diag	copay only. After first 4 office visits, ble and coinsurance apply. No charge nostic lab, X-ray, CT, MRI and PET scan an deductible and coinsurance apply.	N/A	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth	No charge	No charge	Not covered	
Office visits (primary/specialty)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Urgent care office visits (primary/specialty)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)		500 of combined lab, X-ray, CT, MRI, and red in-network, in-network, or out-of-net		
CT, MRI, and PET scans (outpatient)		500 of combined lab, X-ray, CT, MRI, and red in-network, in-network, or out-of-net		
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible	\$100 copay, then 10% coinsurance after deductible	
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	No charge	\$20/\$40 ²	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$5	\$15	Not covered	
Preferred brand-name drugs	\$30	\$50	Not covered	
Non-preferred generic and brand-name drugs	\$65	\$95	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$10	Not covered	Not covered	
Preferred brand-name drugs	\$60	Not covered	Not covered	
Non-preferred generic and brand-name drugs	\$130	Not covered	Not covered	
Prescription drugs – specia	lty (up to a 30-day supply)	·		
Preferred specialty drugs	\$150	\$150	Not covered	
Non-preferred specialty drugs	30%	30%	Not covered	
Drug list/formulary	5-tier in-network pharmacy benefit			

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver. Services provided by out-of-network providers may be subject to balance billing.

 $Specialty\ drugs\ are\ required\ to\ be\ filled\ through\ the\ Kaiser\ Permanente\ Specialty\ Pharmacy.$

5-tier in-network pharmacy benefit

View the drug formulary at kp.org/wa/formulary.



Compare plans

Plans selected:

Reset		Compare plar	Plans selected:	
		Summit PPO Welcome Plans		
Complete Suite category	Summit PPO 1000 W3			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY ¹ (individual/family)		0/\$2,000	\$3,000/\$6,000	
Out-of-pocket maximum, PCY (individual/family)	\$4,000	0/\$8,000	Unlimited	
Coinsurance	10%	30%	50%	
Waiver: Welcome	copays are waived and plan deducti for the first \$500 of combined diag	copay only. After first 4 office visits, ible and coinsurance apply. No charge nostic lab, X-ray, CT, MRI and PET scan an deductible and coinsurance apply.	N/A	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth	No charge	No charge	Not covered	
Office visits (primary/specialty)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Urgent care office visits (primary/specialty)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Lab and X-ray procedures		500 of combined lab, X-ray, CT, MRI, and		
(outpatient)	, , , ,	red in-network, in-network, or out-of-net		
CT, MRI, and PET scans (outpatient)		500 of combined lab, X-ray, CT, MRI, and red in-network, in-network, or out-of-net		
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$150 copay, then 10% coinsurance after deductible	\$150 copay, then 10% coinsurance after deductible	\$150 copay, then 10% coinsurance after deductible	
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$10/\$20 copay, then 10% coinsurance after deductible ²	\$20/\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	No charge	\$20/\$402	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$10	\$20	Not covered	
Preferred brand-name drugs	\$20	\$40	Not covered	
Non-preferred generic and brand-name drugs	\$30	\$60	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$20	Not covered	Not covered	
Preferred brand-name drugs	\$40	Not covered	Not covered	
Non-preferred generic and brand-name drugs	\$60	Not covered	Not covered	
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	\$150	Not covered	
Non-preferred specialty drugs	30%	30%	Not covered	
Drug list/formulary		E tiar in naturally pharmacy hanafit		

^{1.} PCY = Per calendar year. 2. This service is eligible for the Welcome waiver.

Services provided by out-of-network providers may be subject to balance billing.

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

5-tier in-network pharmacy benefit

View the drug formulary at **kp.org/wa/formulary**.

Compare plans

Plans selected:

Reset		Compare plar	Plans selected:
		Summit PPO Welcome Plans	
Complete Suite category	Summit PPO 2000 W4		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY ¹ (individual/family)	\$2,000/\$4,000		\$6,000/\$12,000
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$10,000		Unlimited
Coinsurance	20%	40%	50%
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.		N/A
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible
Telehealth	No charge	No charge	Not covered
Office visits (primary/specialty)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible
Urgent care office visits (primary/specialty)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible
Lab and X-ray procedures	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures,		
(outpatient)	then subject to applicable preferred in-network, in-network, or out-of-network deductible and coinsurance ²		
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to applicable preferred in-network, in-network, or out-of-network deductible and coinsurance ²		
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$150 copay, then 20% coinsurance after deductible	\$150 copay, then 20% coinsurance after deductible	\$150 copay, then 20% coinsurance after deductible
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months) primary/specialty)	No charge	\$40/\$80 ²	50% coinsurance after deductible
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$10	\$20	Not covered
Preferred brand-name drugs	\$20	\$40	Not covered
Non-preferred generic and brand-name drugs	\$30	\$60	Not covered
Prescription drugs – mail o	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	Not covered	Not covered
Preferred brand-name drugs	\$40	Not covered	Not covered
Non-preferred generic and brand-name drugs	\$60	Not covered	Not covered
Prescription drugs – specia	lty (up to a 30-day supply)		1
Preferred specialty drugs	\$150	\$150	Not covered
Non-preferred specialty drugs	30%	30%	Not covered
Drug list/formulary		E tiar in naturally pharmagy hangfit	

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver. Services provided by out-of-network providers may be subject to balance billing.

 $Specialty\ drugs\ are\ required\ to\ be\ filled\ through\ the\ Kaiser\ Permanente\ Specialty\ Pharmacy.$

5-tier in-network pharmacy benefit

View the drug formulary at **kp.org/wa/formulary**.

Compare plans

Plans selected:

Reset		Compare plar	Plans selected:		
	Summit PPO Welcome Plans				
Complete Suite category	Summit PPO 3000 W5				
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY ¹ (individual/family)		0/\$6,000	\$9,000/\$18,000		
Out-of-pocket maximum, PCY (individual/family)	\$6,000	/\$12,000	Unlimited		
Coinsurance	20%	40%	50%		
Waiver: Welcome	copays are waived and plan deducti for the first \$500 of combined diag	copay only. After first 4 office visits, ble and coinsurance apply. No charge nostic lab, X-ray, CT, MRI and PET scan an deductible and coinsurance apply.	N/A		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	No charge	No charge	Not covered		
Office visits (primary/specialty)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible		
Urgent care office visits (primary/specialty)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible		
Lab and X-ray procedures		500 of combined lab, X-ray, CT, MRI, and			
(outpatient)	, , , ,	red in-network, in-network, or out-of-net			
CT, MRI, and PET scans (outpatient)		500 of combined lab, X-ray, CT, MRI, and red in-network, in-network, or out-of-net			
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible		
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	No charge	\$40/\$80²	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	\$15	\$25	Not covered		
Preferred brand-name drugs	\$30	\$50	Not covered		
Non-preferred generic and brand-name drugs	\$50	\$80	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)				
Preferred generic drugs	\$30	Not covered	Not covered		
Preferred brand-name drugs	\$60	Not covered	Not covered		
Non-preferred generic and brand-name drugs	\$100	Not covered	Not covered		
Prescription drugs – specia	lty (up to a 30-day supply)	'			
Preferred specialty drugs	\$150	\$150	Not covered		
Non-preferred specialty drugs	30%	30%	Not covered		
Drug list/formulary		E tiar in naturally pharmasy handfit			

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver. Services provided by out-of-network providers may be subject to balance billing.

 $Specialty\ drugs\ are\ required\ to\ be\ filled\ through\ the\ Kaiser\ Permanente\ Specialty\ Pharmacy.$

5-tier in-network pharmacy benefit

View the drug formulary at **kp.org/wa/formulary**.

Drug list/formulary

Compare plans Plans selected:

Reset		Compare plan	Plans selected:	
	Summit PPO Welcome Plans			
Complete Suite category	e category Summit PPO 5000 W6			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY ¹ (individual/family)	\$5,000/	\$10,000	\$15,000/\$30,000	
Out-of-pocket maximum, PCY (individual/family)	\$7,000/	\$14,000	Unlimited	
Coinsurance	20%	40%	50%	
Waiver: Welcome	copays are waived and plan deductil for the first \$500 of combined diagr	opay only. After first 4 office visits, ble and coinsurance apply. No charge nostic lab, X-ray, CT, MRI and PET scan n deductible and coinsurance apply.	N/A	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth	No charge	No charge	Not covered	
Office visits (primary/specialty)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible	
Urgent care office visits (primary/specialty)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)		500 of combined lab, X-ray, CT, MRI, and red in-network, in-network, or out-of-net		
CT, MRI, and PET scans (outpatient)		500 of combined lab, X-ray, CT, MRI, and red in-network, in-network, or out-of-net		
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$20/\$40 copay, then 20% coinsurance after deductible ²	\$40/\$80 copay, then 40% coinsurance after deductible ²	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	No charge	\$40/\$80 ²	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$15	\$25	Not covered	
Preferred brand-name drugs	\$30	\$50	Not covered	
Non-preferred generic and brand-name drugs	\$50	\$80	Not covered	
<u> </u>	rder (up to a 90-day supply)	I	I	
Preferred generic drugs	\$30	Not covered	Not covered	
Preferred brand-name drugs	\$60	Not covered	Not covered	
Non-preferred generic and brand-name drugs	\$100	Not covered	Not covered	
Prescription drugs – special	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	\$150	Not covered	
Non-preferred specialty drugs	30%	30%	Not covered	
Drug list/formulary		E tior in natural, pharmagy hanafit		

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver. Services provided by out-of-network providers may be subject to balance billing.

 $Specialty\ drugs\ are\ required\ to\ be\ filled\ through\ the\ Kaiser\ Permanente\ Specialty\ Pharmacy.$

5-tier in-network pharmacy benefit

View the drug formulary at kp.org/wa/formulary.



Drug list/formulary

Compare plans

Plans selected:

		Summit PPO HSA Plans			
Complete Suite category	Summit PPO HSA 1650 (A)				
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$1,650)/\$3,300	\$3,300/\$6,600		
Out-of-pocket maximum, PCY (individual/family)	\$3,500)/\$7,000	Unlimited		
Coinsurance	10%	30%	50%		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Not covered		
Office visits	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Urgent care office visits	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible		
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	10% coinsurance after deductible	30% coinsurance after deductible	Not covered		
Preferred brand-name drugs	10% coinsurance after deductible	30% coinsurance after deductible	Not covered		
Non-preferred generic and brand-name drugs	10% coinsurance after deductible	30% coinsurance after deductible	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)				
Preferred generic drugs	10% coinsurance after deductible	Not covered	Not covered		
Preferred brand-name drugs	10% coinsurance after deductible	Not covered	Not covered		
Non-preferred generic and brand-name drugs	10% coinsurance after deductible	Not covered	Not covered		
Prescription drugs – specia	lty (up to a 30-day supply)				
Preferred specialty drugs	10% coinsurance after deductible	10% coinsurance after deductible	Not covered		
Non-preferred specialty drugs	30% coinsurance after deductible	30% coinsurance after deductible	Not covered		
Drug list/formulary		5-tier in-network pharmacy benefit			

5-tier in-network pharmacy benefit

Drug list/formulary

^{*}PCY = Per calendar year.

Services provided by out-of-network providers may be subject to balance billing.

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at **kp.org/wa/formulary**.

Compare plans

		Summit PPO HSA Plans	
Complete Suite category			
Complete Suite Category	D (1) 1 (m) 1)	Summit PPO HSA 2500 (A)	0 (() (7) 0)
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (individual/family)	\$2,500	/\$5,000	\$5,000/\$10,000
Out-of-pocket maximum, PCY (individual/family)		/\$8,500	Unlimited
Coinsurance	10%	30%	50%
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible
Telehealth	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Not covered
Office visits	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Urgent care office visits	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months) primary/specialty)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	10% coinsurance after deductible	30% coinsurance after deductible	Not covered
Preferred brand-name drugs	10% coinsurance after deductible	30% coinsurance after deductible	Not covered
Non-preferred generic and brand-name drugs	10% coinsurance after deductible	30% coinsurance after deductible	Not covered
Prescription drugs – mail or	rder (up to a 90-day supply)		
Preferred generic drugs	10% coinsurance after deductible	Not covered	Not covered
Preferred brand-name drugs	10% coinsurance after deductible	Not covered	Not covered
Non-preferred generic and brand-name drugs	10% coinsurance after deductible	Not covered	Not covered
Prescription drugs – special	ty (up to a 30-day supply)		
Preferred specialty drugs	10% coinsurance after deductible	10% coinsurance after deductible	Not covered
Non-preferred specialty drugs	30% coinsurance after deductible	30% coinsurance after deductible	Not covered
Drug list/formulary		5-tier in-network pharmacy benefit	

^{*}PCY = Per calendar year.

Services provided by out-of-network providers may be subject to balance billing.

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at **kp.org/wa/formulary**.

Compare plans

	Summit PPO HSA Plans				
Complete Suite category	Summit PPO HSA 3500 (A)				
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$3,500	/\$7,000	\$7,000/\$14,000		
Out-of-pocket maximum, PCY (individual/family)	\$6,000	/\$8,500	Unlimited		
Coinsurance	20%	40%	50%		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Not covered		
Office visits	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Urgent care office visits	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Emergency care	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible		
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Preferred brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Prescription drugs – mail o	der (up to a 90-day supply)				
Preferred generic drugs	20% coinsurance after deductible	Not covered	Not covered		
Preferred brand-name drugs	20% coinsurance after deductible	Not covered	Not covered		
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)				
Preferred specialty drugs	20% coinsurance after deductible	20% coinsurance after deductible	Not covered		
Non-preferred specialty drugs	40% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Drug list/formulary		5-tier in-network pharmacy benefit			

^{*}PCY = Per calendar year.

Services provided by out-of-network providers may be subject to balance billing.

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at kp.org/wa/formulary.

Compare plans

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	Summit PPO HSA Plans				
Complete Suite category	Summit PPO HSA 3300 (E)				
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$3,300	/\$6,600	\$6,600/\$13,200		
Out-of-pocket maximum, PCY (individual/family)	\$6,000/	/ \$12,000	Unlimited		
Coinsurance	20%	40%	50%		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Not covered		
Office visits	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Urgent care office visits	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Emergency care	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible		
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Preferred brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)				
Preferred generic drugs	20% coinsurance after deductible	Not covered	Not covered		
Preferred brand-name drugs	20% coinsurance after deductible	Not covered	Not covered		
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)				
Preferred specialty drugs	20% coinsurance after deductible	20% coinsurance after deductible	Not covered		
Non-preferred specialty drugs	40% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Drug list/formulary		5-tier in-network pharmacy benefit			

^{*}PCY = Per calendar year.

Services provided by out-of-network providers may be subject to balance billing.

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at kp.org/wa/formulary.

Compare plans

	Summit PPO HSA Plans				
Complete Suite category	NEW Summit PPO HSA 4000 (E)				
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$4,000)/\$8,000	\$8,000/\$16,000		
Out-of-pocket maximum, PCY (individual/family)	\$6,000	/\$12,000	Unlimited		
Coinsurance	20%	40%	50%		
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible		
Telehealth	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Not covered		
Office visits	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Urgent care office visits	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductibl		
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductibl		
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Emergency care	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductibl		
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductibl		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductibl		
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductibl		
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductibl		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductibl		
Outpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months) primary/specialty)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible		
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Preferred brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Prescription drugs – mail or	rder (up to a 90-day supply)				
Preferred generic drugs	20% coinsurance after deductible	Not covered	Not covered		
Preferred brand-name drugs	20% coinsurance after deductible	Not covered	Not covered		
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)				
Preferred specialty drugs	20% coinsurance after deductible	20% coinsurance after deductible	Not covered		
Non-preferred specialty drugs	40% coinsurance after deductible	40% coinsurance after deductible	Not covered		
Drug list/formulary		5-tier in-network pharmacy benefit			

^{*}PCY = Per calendar year.

 $Services\ provided\ by\ out-of-network\ providers\ may\ be\ subject\ to\ balance\ billing.$

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at **kp.org/wa/formulary**.

Compare plans

	Summit PPO HSA Plans			
Complete Suite category	Summit PPO HSA 5000 (E)			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
Plan deductible, PCY* (individual/family)	\$5,000/	\$10,000	\$10,000/\$20,000	
Out-of-pocket maximum, PCY (individual/family)	\$6,000/	\$12,000	Unlimited	
Coinsurance	20%	40%	50%	
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible	
Telehealth	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Not covered	
Office visits	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Urgent care office visits	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Emergency care	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months) primary/specialty)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then covered in full	
Prescription drugs – retail (u	up to a 30-day supply)			
Preferred generic drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered	
Preferred brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered	
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered	
Prescription drugs – mail order (up to a 90-day supply)				
Preferred generic drugs	20% coinsurance after deductible	Not covered	Not covered	
Preferred brand-name drugs	20% coinsurance after deductible	Not covered	Not covered	
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered	Not covered	
Prescription drugs – special	ty (up to a 30-day supply)			
Preferred specialty drugs	20% coinsurance after deductible	20% coinsurance after deductible	Not covered	
Non-preferred specialty drugs	40% coinsurance after deductible	40% coinsurance after deductible	Not covered	
Drug list/formulary		5-tier in-network pharmacy benefit		

^{*}PCY = Per calendar year.

 $Services\ provided\ by\ out-of-network\ providers\ may\ be\ subject\ to\ balance\ billing.$

Specialty drugs are required to be filled through the Kaiser Permanente Specialty Pharmacy.

View the drug formulary at kp.org/wa/formulary.

Reset	Compare plans	Plans selected:	

Reset		Compare plans Plans selected:			
	Access PPO Plans				
Complete Suite category	Access PPO 1500				
	In-network	Out-of-network			
Plan deductible, PCY* (individual/family)	\$1,500/\$3,000	\$3,000/\$6,000			
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$10,000	Unlimited			
Coinsurance	20%	50%			
Preventive and well-child care	No charge	50% coinsurance after deductible			
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered			
Office visits	20% coinsurance after deductible	50% coinsurance after deductible			
Urgent care office visits	20% coinsurance after deductible	50% coinsurance after deductible			
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible			
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible			
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible			
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% co	insurance after deductible			
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible			
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible			
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible			
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	20% coinsurance after deductible	50% coinsurance after deductible			
Acupuncture (12 visits, PCY)	20% coinsurance after deductible 50% coinsurance after dedu				
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible			
Outpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible			
Routine eye exam (1 exam every 12 months)	No charge	No charge			
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge			
Prescription drugs – retail (up to a 30-day supply)				
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered			
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered			
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered			
Prescription drugs – mail or	Prescription drugs – mail order (up to a 90-day supply)				
Preferred generic drugs	\$20	Not covered			
Preferred brand-name drugs	\$40	Not covered			
Non-preferred generic and brand-name drugs	\$60	Not covered			
Prescription drugs – special	lty (up to a 30-day supply)				
Preferred specialty drugs	\$150	Not covered			
Non-preferred specialty drugs	30%	Not covered			
Drug list/formulary	5-tier in-network	pharmacy benefit			

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset	Compare plans	Plans selected:	

Reset		Compare plans Plans selected:		
	Access PPO Plans			
Complete Suite category	Access PPO 2500			
	In-network	Out-of-network		
Plan deductible, PCY* (individual/family)	\$2,500/\$5,000	\$5,000/\$10,000		
Out-of-pocket maximum, PCY (individual/family)	\$6,000/\$12,000	Unlimited		
Coinsurance	30%	50%		
Preventive and well-child care	No charge	50% coinsurance after deductible		
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered		
Office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Urgent care office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% co	insurance after deductible		
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	30% coinsurance after deductible	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered		
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered		
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$20	Not covered		
Preferred brand-name drugs	\$40	Not covered		
Non-preferred generic and brand-name drugs	\$60	Not covered		
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered		
Non-preferred specialty drugs	30%	Not covered		
Drug list/formulary	5-tier in-network	pharmacy benefit		

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset	Compare plans	Plans selected:	

Reset		Compare plans Plans selected:		
	Access PPO Plans			
Complete Suite category	Access PPO 3000			
	In-network	Out-of-network		
Plan deductible, PCY* (individual/family)	\$3,000/\$6,000	\$6,000/\$12,000		
Out-of-pocket maximum, PCY (individual/family)	\$7,500/\$15,000	Unlimited		
Coinsurance	30%	50%		
Preventive and well-child care	No charge	50% coinsurance after deductible		
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered		
Office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Urgent care office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% co	insurance after deductible		
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	30% coinsurance after deductible	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$25 (\$15 enhanced benefit)	Not covered		
Preferred brand-name drugs	\$60 (\$40 enhanced benefit)	Not covered		
Non-preferred generic and brand-name drugs	\$100 (\$70 enhanced benefit)	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$30	Not covered		
Preferred brand-name drugs	\$80	Not covered		
Non-preferred generic and brand-name drugs	\$140	Not covered		
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered		
Non-preferred specialty drugs	30%	Not covered		
Drug list/formulary	5-tier in-network pharmacy benefit			

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset	Compare plans	Plans selected:	

Reset		Compare plans Plans selected:		
	Access P	PO Plans		
Complete Suite category	Access PPO 5000			
	In-network	Out-of-network		
Plan deductible, PCY* (individual/family)	\$5,000/\$10,000	\$10,000/\$20,000		
Out-of-pocket maximum, PCY (individual/family)	\$9,000/\$18,000	Unlimited		
Coinsurance	30%	50%		
Preventive and well-child care	No charge	50% coinsurance after deductible		
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered		
Office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Urgent care office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% co	insurance after deductible		
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	30% coinsurance after deductible	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$25 (\$15 enhanced benefit)	Not covered		
Preferred brand-name drugs	\$60 (\$40 enhanced benefit)	Not covered		
Non-preferred generic and brand-name drugs	\$100 (\$70 enhanced benefit)	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$30	Not covered		
Preferred brand-name drugs	\$80	Not covered		
Non-preferred generic and brand-name drugs	\$140	Not covered		
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered		
Non-preferred specialty drugs	30%	Not covered		
Drug list/formulary	5-tier in-network pharmacy benefit			

^{*}PCY = Per calendar year

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset Compare plans

Reset		Compare plans Plans selected:		
	Access PPO Waive	r Plans: VisitsPlus		
Complete Suite category	Access PPO 250 V1			
	In-network	Out-of-network		
Plan deductible, PCY* (individual/family)	\$250/\$750	\$500/\$1,500		
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	Unlimited		
Coinsurance	10%	50%		
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A		
Preventive and well-child care	No charge	50% coinsurance after deductible		
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered		
Office visits	\$30 copay	50% coinsurance after deductible		
Urgent care office visits	\$30 copay	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	10% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	10% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	10% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 10% coi	insurance after deductible		
Hospital inpatient	10% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	50% coinsurance after deductible		
Home health care (130 visits, PCY)	10% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$30 copay	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$30 copay	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	10% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$30 copay	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered		
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered		
Non-preferred generic and brand-name drugs	\$70 (\$40 enhanced benefit)	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$10	Not covered		
Preferred brand-name drugs	\$40	Not covered		
Non-preferred generic and brand-name drugs	\$80	Not covered		
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered		
Non-preferred specialty drugs	30%	Not covered		
Drug list/formulary	5-tier in-network	pharmacy benefit		

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset Compare plans

Reset		Compare plans Plans selected:		
	Access PPO Waiver Plans: VisitsPlus			
Complete Suite category	Access PPO 500 V2			
	In-network	Out-of-network		
Plan deductible, PCY* (individual/family)	\$500/\$1,500	\$1,000/\$3,000		
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	Unlimited		
Coinsurance	20%	50%		
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A		
Preventive and well-child care	No charge	50% coinsurance after deductible		
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered		
Office visits	\$30 copay	50% coinsurance after deductible		
Urgent care office visits	\$30 copay	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	insurance after deductible		
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible		
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$30 copay	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$30 copay	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$30 copay	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered		
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered		
Non-preferred generic and brand-name drugs	\$70 (\$40 enhanced benefit)	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$10	Not covered		
Preferred brand-name drugs	\$40	Not covered		
Non-preferred generic and brand-name drugs	\$80	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered		
Non-preferred specialty drugs	30%	Not covered		
Drug list/formulary	5-tier in-network	pharmacy benefit		

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset Compare plans

Reset		Compare plans Plans selected:		
	Access PPO Waive	r Plans: VisitsPlus		
Complete Suite category	Access PPO 750 V3			
	In-network	Out-of-network		
Plan deductible, PCY* (individual/family)	\$750/\$2,250	\$1,500/\$4,500		
Out-of-pocket maximum, PCY (individual/family)	\$3,500/\$10,500	Unlimited		
Coinsurance	20%	50%		
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A		
Preventive and well-child care	No charge	50% coinsurance after deductible		
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered		
Office visits	\$35 copay	50% coinsurance after deductible		
Urgent care office visits	\$35 copay	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	insurance after deductible		
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible		
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered		
Preferred brand-name drugs	\$50 (\$30 enhanced benefit)	Not covered		
Non-preferred generic and brand-name drugs	\$95 (\$65 enhanced benefit)	Not covered		
Prescription drugs – mail order (up to a 90-day supply)				
Preferred generic drugs	\$10	Not covered		
Preferred brand-name drugs	\$60	Not covered		
Non-preferred generic and brand-name drugs	\$130	Not covered		
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered		
Non-preferred specialty drugs	30%	Not covered		
Drug list/formulary	5-tier in-network	pharmacy benefit		

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset Compare plans

Reset		Compare plans Flans Selected:
	Access PPO Waive	r Plans: VisitsPlus
Complete Suite category	Access P	PO 1000 V4
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$1,000/\$3,000	\$2,000/\$6,000
Out-of-pocket maximum, PCY (individual/family)	\$4,000/\$12,000	Unlimited
Coinsurance	20%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	\$35 copay	50% coinsurance after deductible
Urgent care office visits	\$35 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% co	insurance after deductible
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)	
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered
Preferred brand-name drugs	\$50 (\$30 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	\$95 (\$65 enhanced benefit)	Not covered
Prescription drugs – mail or	rder (up to a 90-day supply)	
Preferred generic drugs	\$10	Not covered
Preferred brand-name drugs	\$60	Not covered
Non-preferred generic and brand-name drugs	\$130	Not covered
Prescription drugs – special	ty (up to a 30-day supply)	
Preferred specialty drugs	\$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network	pharmacy benefit

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset Compare plans

Reset		Compare plans Plans selected:
	Access PPO Waive	r Plans: VisitsPlus
Complete Suite category	Access P	PO 1500 V5
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$1,500/\$4,500	\$3,000/\$9,000
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$15,000	Unlimited
Coinsurance	20%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	\$35 copay	50% coinsurance after deductible
Urgent care office visits	\$35 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% co	insurance after deductible
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)	
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered
Prescription drugs – mail or	rder (up to a 90-day supply)	
Preferred generic drugs	\$20	Not covered
Preferred brand-name drugs	\$40	Not covered
Non-preferred generic and brand-name drugs	\$60	Not covered
Prescription drugs – special	lty (up to a 30-day supply)	
Preferred specialty drugs	\$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network	pharmacy benefit

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset Compare plans

Reset		Compare plans Plans selected:
	Access PPO Waive	r Plans: VisitsPlus
Complete Suite category	Access PF	PO 2000 V17
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$2,000/\$4,000	\$4,000/\$8,000
Out-of-pocket maximum, PCY (individual/family)	\$5,500/\$11,000	Unlimited
Coinsurance	20%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	\$35 copay	50% coinsurance after deductible
Urgent care office visits	\$35 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	insurance after deductible
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)	
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered
Prescription drugs – mail or	rder (up to a 90-day supply)	
Preferred generic drugs	\$20	Not covered
Preferred brand-name drugs	\$40	Not covered
Non-preferred generic and brand-name drugs	\$60	Not covered
Prescription drugs – special	lty (up to a 30-day supply)	
Preferred specialty drugs	\$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network	pharmacy benefit

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset		Compare plans Plans selected:
	Access PPO Waive	r Plans: VisitsPlus
Complete Suite category	Access PPO 2500 V6	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$2,500/\$5,000	\$5,000/\$10,000
Out-of-pocket maximum, PCY (individual/family)	\$6,000/\$12,000	Unlimited
Coinsurance	30%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	\$35 copay	50% coinsurance after deductible
Urgent care office visits	\$35 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coi	insurance after deductible
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)	
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered
	rder (up to a 90-day supply)	
Preferred generic drugs	\$20	Not covered
Preferred brand-name drugs	\$40	Not covered
Non-preferred generic and brand-name drugs	\$60	Not covered
Prescription drugs – special		
Preferred specialty drugs Non-preferred specialty	\$150 30%	Not covered Not covered
drugs Drug list/formulary		
Drug list/formulary	5-tier in-network pharmacy benefit	

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset Compare plans

Reset		Compare plans Plans selected:	
	Access PPO Waiver Plans: VisitsPlus		
Complete Suite category	Access PPO 3000 V7		
	In-network	Out-of-network	
Plan deductible, PCY* (individual/family)	\$3,000/\$6,000	\$6,000/\$12,000	
Out-of-pocket maximum, PCY (individual/family)	\$7,500/\$15,000	Unlimited	
Coinsurance	30%	50%	
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Office visits	\$40 copay	50% coinsurance after deductible	
Urgent care office visits	\$40 copay	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% co	insurance after deductible	
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$40 copay	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$40 copay	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$40 copay	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$25 (\$15 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$60 (\$40 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$100 (\$70 enhanced benefit)	Not covered	
	rder (up to a 90-day supply)		
Preferred generic drugs	\$30	Not covered	
Preferred brand-name drugs	\$80	Not covered	
Non-preferred generic and brand-name drugs	\$140	Not covered	
Prescription drugs – specia	lty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network	pharmacy benefit	

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Reset Compare plans

Reset		Compare plans Plans selected:
	Access PPO Waive	r Plans: VisitsPlus
Complete Suite category	Access PF	PO 5000 V15
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$5,000/\$10,000	\$10,000/\$20,000
Out-of-pocket maximum, PCY (individual/family)	\$9,000/\$18,000	Unlimited
Coinsurance	30%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	\$50 copay	50% coinsurance after deductible
Urgent care office visits	\$50 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% co	insurance after deductible
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$50 copay	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	\$50 copay	50% coinsurance after deductible
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	\$50 copay	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)	
Preferred generic drugs	\$25 (\$15 enhanced benefit)	Not covered
Preferred brand-name drugs	\$60 (\$40 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	\$100 (\$70 enhanced benefit)	Not covered
Prescription drugs – mail or	rder (up to a 90-day supply)	
Preferred generic drugs	\$30	Not covered
Preferred brand-name drugs	\$80	Not covered
Non-preferred generic and brand-name drugs	\$140	Not covered
Prescription drugs – special	lty (up to a 30-day supply)	
Preferred specialty drugs	\$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network	pharmacy benefit

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans

Plans selected:

	Access PPO Waiver Plans: Lab/X-Ray Plus		
Complete Suite category	Access	PPO 250 L1	
	In-network	Out-of-network	
Plan deductible, PCY* (individual/family)	\$250/\$750	\$500/\$1,500	
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	Unlimited	
Coinsurance	10%	50%	
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Office visits	\$30 copay	50% coinsurance after deductible	
Urgent care office visits	\$30 copay	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	10% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	10% coinsurance	50% coinsurance after deductible	
Outpatient surgery	10% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 10% co	insurance after deductible	
Hospital inpatient	10% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	10% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$30 copay	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$30 copay	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	10% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$30 copay	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (1	up to a 30-day supply)		
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$50 (\$30 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$95 (\$65 enhanced benefit)	Not covered	
	der (up to a 90-day supply)		
Preferred generic drugs	\$10	Not covered	
Preferred brand-name drugs	\$60	Not covered	
Non-preferred generic and brand-name drugs	\$130	Not covered	
Prescription drugs – special			
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network	pharmacy benefit	

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans

Plans selected:

	Access PPO Waiver P	lans: Lab/X-Ray Plus
Complete Suite category	Access F	PPO 500 L2
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$500/\$1,500	\$1,000/\$3,000
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	Unlimited
Coinsurance	20%	50%
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	\$30 copay	50% coinsurance after deductible
Urgent care office visits	\$30 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	insurance after deductible
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility 60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$30 copay	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	\$30 copay	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	\$30 copay	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)	
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	\$70 (\$40 enhanced benefit)	Not covered
Prescription drugs – mail o	rder (up to a 90-day supply)	
Preferred generic drugs	\$10	Not covered
Preferred brand-name drugs	\$40	Not covered
Non-preferred generic and brand-name drugs	\$80	Not covered
Prescription drugs — specia	ty (up to a 30-day supply)	
Preferred specialty drugs	\$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network	pharmacy benefit

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans

Plans selected:

Innetwork		Access PPO Waiver P	Plans: Lab/X-Ray Plus	
Innetwork Innetwork Proceedings St. 500/\$10,500 Unlimited	Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus		
Plan deductible PCY individualizationly) Chromosoma				
The control of the co	Plan deductible, PCY*			
Consumance 20% Annual deductible and plan coincurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coincurance and reductible coincurance and reductible and plan coincurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coincurance after deductible coincurance and reductible coincurance and reductible coincurance and reductible coincurance and reductible software and well-child No charge S0% coincurance after deductible leilaphone senticestonline levisits; Not covered office visits S33 copay S0% coincurance after deductible levisits; Not covered office visits S33 copay S0% coincurance after deductible software processing and PET Caras COURDINATE and PE	-			
Annual deductible and plan coinsurance don't apply to office wists. Diagnostic bal and X-ray are subject to plan coinsurance after deductible coinsurance after deductible and plan coinsurance after desuctible and X-ray are subject to plan coinsurance after deductible and plan coinsurance after desuctible and X-ray are subject to plan coinsurance after deductible and plan coinsurance after desuctible and X-ray procedures and X	PCY (individual/family)			
Malver, LabX-Ray Plus office visits. Diagnostic lab and X-ray are subject to plan consumer only. No charge 50% coinsurance after deductible lefelphone services/online (e-visits). Not covered Office visits 535 copay 50% coinsurance after deductible lefelphone services/online (e-visits). Not covered Office visits 535 copay 50% coinsurance after deductible lefelphone services/online (e-visits). Not covered Office visits 20% coinsurance after deductible 30% coinsurance after deductible 3	Coinsurance	***	50%	
Telehealth No charge 50% coinsurance after deductible lelephone servicesonline (evistis). Not covered Pelehealth No charge 50% coinsurance after deductible lelephone servicesonline (evistis). Not covered Pelefered generic drugs 50% coinsurance after deductible 10 stan and X-rey procedures cortipation 50% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 30% coinsurance	Waiver: Lab/X-Ray Plus	office visits. Diagnostic lab and X-ray are subject to plan	N/A	
Telephone services/online (e wists): Not covered Office visits	Preventive and well-child care	No charge	50% coinsurance after deductible	
Urgent care office visits 1835 copay 50% coinsurance after deductible 2.0% coinsurance 2.0% coinsurance after deductible 50% coinsurance 50% coinsurance 50% coinsura	Telehealth	No charge		
Lab and X-ray procedures outpatient) 20% coinsurance 20% coinsurance 50% coinsurance after deductible COMPATION AND AND PET Scars Outpatient) 20% coinsurance after deductible 50% coinsurance after deductible Emergency care (copay waived if admitted or inpatient) 120% coinsurance after deductible 5200 copay, then 20% coinsurance after deductible 50% coinsurance after d	Office visits	\$35 copay	50% coinsurance after deductible	
Compatient 20% coinsurance 20% coinsurance 50% coinsurance after deductible 20% coinsurance after deductible 50% coinsurance after deductible 20% coinsurance after deductible 50% coinsurance after deductible 20% coinsurance after deductible 50% coinsurance after deductible	Urgent care office visits	\$35 copay	50% coinsurance after deductible	
Outpatient surgery 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) 12% coinsurance after deductible Solva coinsura	Lab and X-ray procedures (outpatient)	20% coinsurance	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient) Ausylated in damitted to inpatient) 20% coinsurance after deductible 50% coinsurance after deductible 60 days, PCY) Manipulative therapy (12 visits, PCY) S35 copay 50% coinsurance after deductible authorization) Acupuncture (12 visits, PCY) \$35 copay \$50% coinsurance after deductible inpatient mental health and substance use disorder Outpatient mental health and substance use disorder Outpatient mental health and substance use disorder No charge S15 (55 enhanced benefit) Not covered Prescription drugs — retail (up to a 30-day supply) Preferred generic drugs Prescription drugs — anil order (up to a 90-day supply) Preferred generic drugs Prescription drugs — mail order (up to a 90-day supply) Preferred generic drugs \$10 Not covered Not covered Not covered Non-preferred generic and hand-name drugs Prescription drugs — specialty (up to a 30-day supply) Preferred generic drugs — \$40 Non-preferred generic and hand-name drugs Prescription drugs — specialty (up to a 30-day supply) Preferred specialty drugs Non-preferred specialty drugs Not covered Not covered Not covered Not covered	CT, MRI, and PET scans (outpatient)	20% coinsurance	50% coinsurance after deductible	
Copay waived if admitted to in patient	Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY) Home health care (130 wists, PCY) Manipulative therapy (12 vists, PCY) S35 copay (12 vists, PCY) S35 copay (12 vists, PCY) S35 copay (13 vists, PCY) Impatient mental health and substance use disorder (13 vists, PCY) Outpatient mental health and substance use (13 vists, PCY) No charge (14 vists, PCY) No charge (15 vists, PCY) No charge (16 vists) No charge (17 vists, PCY) No charge (18 vists) No charge (1	Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	insurance after deductible	
Actionstrainter after deductible Sow coinsurance after deductible Sow coinsuranc	Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible	
130 visits, PCY 20% coinsurance after deductible S0% coinsurance after deductible	Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
12 vists, PCY; additional visits with prior authorization \$35 copay 50% coinsurance after deductible authorization \$35 copay 50% coinsurance after deductible Inpatient mental health and substance use disorder \$35 copay 50% coinsurance after deductible \$50% coinsur	Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Inpatient mental health and substance use disorder Outpatient mental health and substance use disorder Outpatient mental health and substance use disorder No charge No char	Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible	
and substance use disorder 20% coinsurance after deductible disorder Outpatient mental health and substance use disorder Routine eye exam (1 exam every 12 months) Hearing hardware (\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred brand-name drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$10	Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible	
health and substance use disorder Routine eye exam (1 exam every 12 months) No charge No covered Not covered Not covered Not covered Not covered Non-preferred specialty drugs	Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible	
Charge No charge No charge No charge No charge No charge S3,000 per ear, every 36 months Prescription drugs – retail (up to a 30-day supply)	Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible	
(\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs \$15 (\$5 enhanced benefit) Preferred brand-name drugs \$40 (\$20 enhanced benefit) Not covered Non-preferred generic and brand-name drugs \$70 (\$40 enhanced benefit) Not covered Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$10 Not covered Preferred brand-name drugs \$40 Not covered Preferred brand-name drugs \$10 Not covered Preferred brand-name drugs Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs Not covered	Routine eye exam (1 exam every 12 months)	No charge	No charge	
Preferred generic drugs \$15 (\$5 enhanced benefit) Not covered Preferred brand-name drugs \$40 (\$20 enhanced benefit) Not covered Non-preferred generic and brand-name drugs \$70 (\$40 enhanced benefit) Not covered Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$10 Not covered Preferred brand-name drugs \$40 Not covered Preferred generic and brand-name drugs \$80 Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered	Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Preferred brand-name drugs \$40 (\$20 enhanced benefit) Not covered Non-preferred generic and brand-name drugs \$70 (\$40 enhanced benefit) Not covered Prescription drugs — mail order (up to a 90-day supply) Preferred generic drugs \$10 Not covered Preferred brand-name drugs \$40 Not covered Non-preferred generic and brand-name drugs \$80 Not covered Prescription drugs — specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered	Prescription drugs – retail (up to a 30-day supply)		
Avoing the state of the state o	Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered	
Prescription drugs — mail order (up to a 90-day supply) Preferred generic drugs \$10	Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered	
Preferred generic drugs \$10 Not covered Preferred brand-name drugs \$40 Not covered Non-preferred generic and brand-name drugs \$80 Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$30% Not covered	Non-preferred generic and brand-name drugs	·	Not covered	
Preferred brand-name drugs \$40 Not covered Non-preferred generic and brand-name drugs \$80 Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs 30% Not covered				
Arugs \$40 Not covered Non-preferred generic and brand-name drugs \$80 Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs 30% Not covered		\$10	Not covered	
Prescription drugs — specialty (up to a 30-day supply) Preferred specialty drugs \$150	drugs	\$40	Not covered	
Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs 30% Not covered	and brand-name drugs	· ·	Not covered	
Non-preferred specialty drugs Not covered	1 3 1	3 11 3		
arugs	Non-preferred specialty			
	drugs Drug list/formulary			

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans

Plans selected:

Reset		Compare plans Plans selected:	
	Access PPO Waiver Plans: Lab/X-Ray Plus		
Complete Suite category	Ory Access PPO 1000 L4		
	In-network	Out-of-network	
Plan deductible, PCY* (individual/family)	\$1,000/\$3,000	\$2,000/\$6,000	
Out-of-pocket maximum, PCY (individual/family)	\$4,000/\$12,000	Unlimited	
Coinsurance	20%	50%	
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Office visits	\$35 copay	50% coinsurance after deductible	
Urgent care office visits	\$35 copay	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	20% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	20% coinsurance	50% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible		
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered	
Prescription drugs – mail or	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	Not covered	
Preferred brand-name drugs	\$40	Not covered	
Non-preferred generic and brand-name drugs	\$60	Not covered	
Prescription drugs – specialty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network	pharmacy benefit	

^{*}PCY = Per calendar year.



Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.

Compare plans

Plans selected:

	Access PPO Waiver Plans: Lab/X-Ray Plus		
Complete Suite category	Access PPO 1500 L5		
	In-network	Out-of-network	
Plan deductible, PCY* (individual/family)	\$1,500/\$4,500	\$3,000/\$9,000	
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$15,000	Unlimited	
Coinsurance	20%	50%	
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Office visits	\$35 copay	50% coinsurance after deductible	
Urgent care office visits	\$35 copay	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	20% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	20% coinsurance	50% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% co	insurance after deductible	
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered	
	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	Not covered	
Preferred brand-name drugs	\$40	Not covered	
Non-preferred generic and brand-name drugs	\$60	Not covered	
Prescription drugs – specia	2 11 2		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network pharmacy benefit		

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans

Plans selected:

	Access PPO Waiver Plans: Lab/X-Ray Plus ■ Access PPO 2000 L6	
Complete Suite category		
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$2,000/\$4,000	\$4,000/\$8,000
Out-of-pocket maximum, PCY (individual/family)	\$5,500/\$11,000	Unlimited
Coinsurance	20%	50%
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	\$35 copay	50% coinsurance after deductible
Urgent care office visits	\$35 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	insurance after deductible
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge
Prescription drugs – retail (
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered
	rder (up to a 90-day supply)	
Preferred generic drugs	\$20	Not covered
Preferred brand-name drugs	\$40	Not covered
Non-preferred generic and brand-name drugs	\$60	Not covered
Prescription drugs – specia	3 11 3	
Preferred specialty drugs	\$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans

Plans selected:

	Access PPO Waiver P	Plans: Lah/X-Ray Plus	
Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus Access PPO 2500 L7		
	In-network	Out-of-network	
Plan deductible, PCY*			
(individual/family) Out-of-pocket maximum,	\$2,500/\$5,000	\$5,000/\$10,000	
PCY (individual/family)	\$6,000/\$12,000	Unlimited	
Coinsurance	30%	50%	
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Office visits	\$35 copay	50% coinsurance after deductible	
Urgent care office visits	\$35 copay	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	30% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	30% coinsurance	50% coinsurance after deductible	
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coi	insurance after deductible	
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$35 copay	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$35 copay	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered	
	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	Not covered	
Preferred brand-name drugs	\$40	Not covered	
Non-preferred generic and brand-name drugs	\$60	Not covered	
Prescription drugs – special	3 · 1 · 3 · 11 3 ·	N .	
Preferred specialty drugs Non-preferred specialty	\$150 30%	Not covered Not covered	
drugs Drug list/formulary		pharmacy benefit	

^{*}PCY = Per calendar year.



Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.

Compare plans

Plans selected:

Reset		Trains selected.	
	Access PPO Waiver P	lans: Lab/X-Ray Plus	
Complete Suite category	Access PPO 3000 L8		
	In-network	Out-of-network	
Plan deductible, PCY* (individual/family)	\$3,000/\$6,000	\$6,000/\$12,000	
Out-of-pocket maximum, PCY (individual/family)	\$7,500/\$15,000	Unlimited	
Coinsurance	30%	50%	
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Office visits	\$40 copay	50% coinsurance after deductible	
Urgent care office visits	\$40 copay	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	30% coinsurance	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	30% coinsurance	50% coinsurance after deductible	
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coi	nsurance after deductible	
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$40 copay	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$40 copay	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$40 copay	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	Not covered	
Preferred brand-name drugs	\$40	Not covered	
Non-preferred generic and brand-name drugs	\$60	Not covered	
Prescription drugs – special	lty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network pharmacy benefit		

^{*}PCY = Per calendar year.



Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.

Compare plans

Plans selected:

Reset		Compare plans Plans selected:		
	Access PPO Waiver P	Plans: Lab/X-Ray Plus		
Complete Suite category	Access PPO 5000 L9			
	In-network	Out-of-network		
Plan deductible, PCY* (individual/family)	\$5,000/\$10,000	\$10,000/\$20,000		
Out-of-pocket maximum, PCY (individual/family)	\$9,000/\$18,000	Unlimited		
Coinsurance	30%	50%		
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A		
Preventive and well-child care	No charge	50% coinsurance after deductible		
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered		
Office visits	\$50 copay	50% coinsurance after deductible		
Urgent care office visits	\$50 copay	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	30% coinsurance	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	30% coinsurance	50% coinsurance after deductible		
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coi	insurance after deductible		
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$50 copay	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$50 copay	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$50 copay	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered		
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered		
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered		
Prescription drugs – mail or	rder (up to a 90-day supply)			
Preferred generic drugs	\$20	Not covered		
Preferred brand-name drugs	\$40	Not covered		
Non-preferred generic and brand-name drugs	\$60	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered		
Non-preferred specialty drugs	30%	Not covered		
Drug list/formulary	5-tier in-network pharmacy benefit			

^{*}PCY = Per calendar year.



Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.

Compare plans Plans selected:

Reset		Compare plans Plan	s selected:	
	Access PPO W	elcome Plans		
Complete Suite category	Access PPO 250 W1			
	In-network	Out-of-netwo	′k	
Plan deductible, PCY ¹ (individual/family)	\$250/\$750	\$500/\$1,500		
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	Unlimited		
Coinsurance	10%	50%		
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	N/A		
Preventive and well-child care	No charge	50% coinsurance after	deductible	
Telehealth	No charge	50% coinsurance after of Telephone services/online (e-v		
Office visits	\$30 copay, then 10% coinsurance after deductible ²	50% coinsurance after	deductible	
Urgent care office visits	\$30 copay, then 10% coinsurance after deductible ²	50% coinsurance after	deductible	
Lab and X-ray procedures (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or o			
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or o			
Outpatient surgery	10% coinsurance after deductible	50% coinsurance after	deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 10% co	oinsurance after deductible		
Hospital inpatient	10% coinsurance after deductible	50% coinsurance after	deductible	
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	50% coinsurance after	deductible	
Home health care (130 visits, PCY)	10% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$30 copay, then 10% coinsurance after deductible ²	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$30 copay, then 10% coinsurance after deductible ²	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	10% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$30 copay, then 10% coinsurance after deductible ²	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered		
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered		
Non-preferred generic and brand-name drugs	\$70 (\$40 enhanced benefit)	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$10	Not covered		
Preferred brand-name drugs	\$40	Not covered		
Non-preferred generic and brand-name drugs	\$80	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered		
Non-preferred specialty drugs	30%	Not covered		
Drug list/formulary	5-tier in-network	etwork pharmacy benefit		

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans Plans selected:

Reset		Compare plans Plans select	ted:
	Access PPO W	elcome Plans	
omplete Suite category Access PPO 500 W2		PO 500 W2	
	In-network	Out-of-network	
Plan deductible, PCY ¹ (individual/family)	\$500/\$1,500	\$1,000/\$3,000	
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	Unlimited	
Coinsurance	20%	50%	
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	9
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not	
Office visits	\$30 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	е
Urgent care office visits	$\$30$ copay, then 20% coinsurance after deductible 2	50% coinsurance after deductible	е
Lab and X-ray procedures (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or or		
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or or		
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible	е
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance after deductible		
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible	e
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$30 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$30 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$30 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (u	up to a 30-day supply)		
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$70 (\$40 enhanced benefit)	Not covered	
Prescription drugs – mail or	der (up to a 90-day supply)		
Preferred generic drugs	\$10	Not covered	
Preferred brand-name drugs	\$40	Not covered	
Non-preferred generic and brand-name drugs	\$80	Not covered	
Prescription drugs – special	ty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network	c pharmacy benefit	

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans Plans selected:

Reset		Compare plans	Plans selected:	
	Access PPO W	elcome Plans		
Complete Suite category	Access PPO 750 W3			
	In-network	Out-of-	network	
Plan deductible, PCY ¹ (individual/family)	\$750/\$2,250	\$1,500/\$4,500		
Out-of-pocket maximum, PCY (individual/family)	\$3,500/\$10,500	Unlimited		
Coinsurance	20%	50	0%	
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	N/A		
Preventive and well-child care	No charge	50% coinsurance	e after deductible	
Telehealth	No charge		e after deductible ne (e-visits): Not covered	
Office visits	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance	e after deductible	
Urgent care office visits	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance	e after deductible	
Lab and X-ray procedures (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or o			
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or o			
Outpatient surgery	20% coinsurance after deductible	50% coinsurance	e after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% co	oinsurance after deductible		
Hospital inpatient	20% coinsurance after deductible	50% coinsurance	e after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance	e after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered		
Preferred brand-name drugs	\$50 (\$30 enhanced benefit)	Not co	overed	
Non-preferred generic and brand-name drugs	\$95 (\$65 enhanced benefit)	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$10	Not covered		
Preferred brand-name drugs	\$60	Not covered		
Non-preferred generic and brand-name drugs	\$130	Not covered		
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not co	overed	
Non-preferred specialty drugs	30%	Not co	overed	
Drug list/formulary	5-tier in-network	etwork pharmacy benefit		

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.



Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.

Compare plans Plans selected:

Reset		Compare plans Plans selected	d:
	Access PPO W	elcome Plans	
Complete Suite category Access PPO 1000 W4		PO 1000 W4	
	In-network	Out-of-network	
Plan deductible, PCY ¹ (individual/family)	\$1,000/\$3,000	\$2,000/\$6,000	
Out-of-pocket maximum, PCY (individual/family)	\$4,000/\$12,000	Unlimited	
Coinsurance	20%	50%	
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not cov	vered
Office visits	$\$35$ copay, then 20% coinsurance after deductible 2	50% coinsurance after deductible	
Urgent care office visits	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or or		
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or or		
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	\$200 copay, then 20% coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (u	ıp to a 30-day supply)		
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$50 (\$30 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$95 (\$65 enhanced benefit)	Not covered	
Prescription drugs – mail or	der (up to a 90-day supply)		
Preferred generic drugs	\$10	Not covered	
Preferred brand-name drugs	\$60	Not covered	
Non-preferred generic and brand-name drugs	\$130	Not covered	
Prescription drugs – special	ty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network	s pharmacy benefit	

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans Plans selected:

Reset		Compare plans Plans selected:	
Access PPO Welcome Plans		elcome Plans	
Complete Suite category Access PPO 1500 W5		PO 1500 W5	
	In-network	Out-of-network	
Plan deductible, PCY ¹ (individual/family)	\$1,500/\$4,500	\$3,000/\$9,000	
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$15,000	Unlimited	
Coinsurance	20%	50%	
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Office visits	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Urgent care office visits	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)		, X-ray, CT, MRI, and PET scan procedures, ut-of-network deductible and coinsurance ²	
CT, MRI, and PET scans (outpatient)		, X-ray, CT, MRI, and PET scan procedures, ut-of-network deductible and coinsurance ²	
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% co	coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	Not covered	
Preferred brand-name drugs	\$40	Not covered	
Non-preferred generic and brand-name drugs	\$60	Not covered	
Prescription drugs – special	lty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network	pharmacy benefit	

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans Plans selected:

Reset		Compare plans Plans selected:	
Access PPO Welcome Plans		elcome Plans	
Complete Suite category			
	In-network	Out-of-network	
Plan deductible, PCY ¹ (individual/family)	\$2,000/\$4,000	\$4,000/\$8,000	
Out-of-pocket maximum, PCY (individual/family)	\$5,500/\$11,000	Unlimited	
Coinsurance	20%	50%	
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Office visits	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Urgent care office visits	$\$35$ copay, then 20% coinsurance after deductible 2	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or ou		
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or or		
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	coinsurance after deductible	
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$35 copay, then 20% coinsurance after deductible ²	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	\$20 (\$10 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$40 (\$20 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$60 (\$30 enhanced benefit)	Not covered	
Prescription drugs – mail or	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	Not covered	
Preferred brand-name drugs	\$40	Not covered	
Non-preferred generic and brand-name drugs	\$60	Not covered	
Prescription drugs – special	ty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network	pharmacy benefit	

^{1.} PCY = Per calendar year. 2. This service is eligible for the Welcome waiver.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans

Plans selected:

Reset		Compare plans Plans selected:
	Access PPO Welcome Plans	
Complete Suite category	Access P	PO 2500 W8
	In-network	Out-of-network
Plan deductible, PCY ¹ (individual/family)	\$2,500/\$5,000	\$5,000/\$10,000
Out-of-pocket maximum, PCY (individual/family)	\$6,000/\$12,000	Unlimited
Coinsurance	30%	50%
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$\$35$ copay, then 30% coinsurance after deductible 2	50% coinsurance after deductible
Urgent care office visits	\$35 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)		o, x-ray, CT, MRI and PET scan procedures, ut-of-network deductible and coinsurance ²
CT, MRI, and PET scans (outpatient)		, X-ray, CT, MRI, and PET scan procedures, ut-of-network deductible and coinsurance ²
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% co	nsurance after deductible
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$35 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	\$35 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	\$35 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge
Prescription drugs – retail (up to a 30-day supply)	
Preferred generic drugs	\$15 (\$5 enhanced benefit)	Not covered
Preferred brand-name drugs	\$50 (\$30 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	\$95 (\$65 enhanced benefit)	Not covered
Prescription drugs – mail or	rder (up to a 90-day supply)	
Preferred generic drugs	\$10	Not covered
Preferred brand-name drugs	\$60	Not covered
Non-preferred generic and brand-name drugs	\$130	Not covered
Prescription drugs – special	ty (up to a 30-day supply)	
Preferred specialty drugs	\$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.



Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.

Compare plans

Plans selected:

Institution St.	Reset		Compare plans Plans selected:	
Innetwork		Access PPO Welcome Plans		
Plant deductible, PCI' intrivioualization S. 3,00015,000 S. 6,000112,000 Unlimited Unlimited Unlimited Unlimited Unlimited Unlimited Colissuance First of effits which are subject to page perly 50% 50% 1	Complete Suite category	Access PF	0 3000 W10	
Section Sect		In-network	Out-of-network	
Performance 30% 50% First 4 office visits are subject to copay only. Alter first 4 office visits copays are viewed and plant debuttles and consumer early five that \$500 plan debuttles are consumer early. No charge for the first \$500 of combined diagnoses tab, X-apy CI, KBN and PET stars procedures. Nat he in this \$500, plan debuttles and consumers early. No charge Telehealth No charge Telehealth No charge 50% coinsurance after deductable Telephone servicesconline (e-wisits) Not covered Office visits \$40 capay, then 30% coinsurance after deductable? Some consumers are after deductable and coinsurance after deductable and coinsurance after deductable. The phone servicesconline (e-wisits) Not covered Office visits \$40 capay, then 30% coinsurance after deductable? Some consumers are after deductable and coinsurance after deductable. The phone servicesconline (e-wisits) Not covered Office visits \$40 capay, then 30% coinsurance after deductable? Some companient of the subject to applicable in network or out-of-network deductable and coinsurance? CI, MRN, and PET scans procedures, (outpatient) Quaptatient supery 30% coinsurance after deductable 50% coinsurance af		\$3,000/\$6,000	\$6,000/\$12,000	
Waiver: Welcome First 4 office visits copys are whose to the control of the visits of the visits (copys are whose the first 4 office visits, copys are whose the first 4 Sol of combined delapsessis in the X-500, the danger for the first 4 Sol of combined dispensation in the No Sol Opin and PET scan procedures. Plane the Inst 5500, plan of Bettier the Inst 5500 of Commission and after deductible in Deptier to Police visits. Sol Occupation and Inst 5500 and Inst 5500 of Commission and Inst Inst 5500 of Commission and Inst Inst Inst Inst Inst Inst Inst Inst	Out-of-pocket maximum, PCY (individual/family)	\$7,500/\$15,000	Unlimited	
Maiver: Welcome After first 4 office wists, copea's an event of the first 500 of combined diagnostic lall, X-ray, CJ, MRI and PEI scan procedures. After the first 500 plant deductible and consurance apply. Preventive and well-child care No charge Telehealth No charge S40 capay, then 30% coinsurance after deductible in Telephones services/online (e-wisits). Not covered flower and X-ray procedures. S40 capay, then 30% coinsurance after deductible in Telephones services/online (e-wisits). Not covered flower in the first 500 of combined lab. X-ray, CL MRI, and PEI scan procedures, then subject to applicable in network or out-of-inviewed identicible and consurance (coups after). S40 capay, then 30% coinsurance after deductible in network or out-of-inviewed identicible and consurance (coups after). S40 capay the service of the subject to applicable in network or out-of-inviewed identicible and consurance (coups after). S400 of combined in network or out-of-inviewed identicible and consurance (coups after). S400 capay, then 30% coinsurance after deductible in network or out-of-inviewed identicible and consurance (coups after). S400 capay, then 30% coinsurance after deductible in network or out-of-inviewed identicible and consurance (coups after). S400 capay, then 30% coinsurance after deductible in network or out-of-inviewed identicible and consurance coups and coups after deductible in network or out-of-inviewed identicible and consurance of coups after deductible in network or out-of-inviewed identicible and consurance after deductible in network or out-of-inviewed identicible and consurance after deductible in network or out-of-inviewed identicible and consurance after deductible in network or out-of-inviewed identicible and consurance after deductible in network or out-of-inviewed identicible and consurance after deductible in network or out-of-inviewed identicible and consurance after deductible in network or out-of-inviewed identicible and consurance after deductible in network or out-of-inviewed inviewed	Coinsurance	30%	50%	
Teleheaith No charge 50% coinsurance after deductible 160% coinsurance after deductible 250% coinsurance 250	Waiver: Welcome	After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan	N/A	
Telephone servicesonline (e-visis): Not covered Office visits	Preventive and well-child care	No charge	50% coinsurance after deductible	
Urgent care office visits \$40 copey, then 30% coinsurance after deductible No charge for first \$500 of combined lbb, X-ray, CT, MRI, and PET scan procedures, then subject to applicable in network or out-of-network deductible and coinsurance? CT, MRI, and PET scans (outpatient) No charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to applicable in network or out-of-network deductible and coinsurance? Outpatient surgery The surge of first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to applicable in-network or out-of-network deductible and coinsurance? Outpatient surgery The surge of the surgery and color of the surgery and sur	Telehealth	No charge		
Lab and X-ray procedures (outpatient) In charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to applicable in network or out-of-network deductible and coinsurance (outpatient) In charge for first \$500 of combined lab, X-ray, CT, MRI, and PET scan procedures, then subject to applicable in-network or out-of-network deductible and coinsurance with the subject to applicable in-network or out-of-network deductible and coinsurance in the subject to applicable in-network or out-of-network deductible to inpatient and the subject of applicable in-network or out-of-network deductible to inpatient and interest in the subject to applicable in-network or out-of-network deductible to inpatient and interest in the subject of applicable in-network or out-of-network deductible to inpatient and interest in the subject of applicable in-network or out-of-network deductible to inpatient and interest in the subject of applicable in-network or out-of-network deductible to insurance after deductible to inpatient material and interest in the subject of applicable in-network or out-of-network deductible to insurance after deductible to inpatient material and interest in the subject of applicable in-network or out-of-network deductible to insurance after deductible and coinsurance after deductible and interest in the subject of applicable in-network or out-of-network deductible and coinsurance after deductible and interest in the subject of applicable in-network or out-of-network deductible and coinsurance after deductible and interest in the subject of applicable in-network or out-of-network deductible and coinsurance after deductible and and substance use disorder. No charge in the subject in	Office visits	\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Clubpatient Tensor subject to applicable in network or out of network deductible and coinsurance?	Urgent care office visits	\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
T., MRI, and PET scans (outpatient) The subject to applicable in network or out-of-network deductible and coinsurance? Outpatient surgery The subject to applicable in network or out-of-network deductible and coinsurance? Outpatient surgery The surgency care (copay waived if admitted to inpatient) Hospital inpatient Solo coinsurance after deductible The surface after deductible Solo coinsurance after deductible Solo coinsur				
Coupatient surgery 30% coinsurance after deductible 50% coinsurance after deductible	•	, 11		
Emergency care (copay waived if admitted to inpatient) Hospital inpatient Sow coinsurance after deductible Skilled nursing facility 60 days, PCY) Home health care (130 visits, PCY) Manipulative therapy (12 visits, PCY) Manipulative therapy (13 visits possible deductible (13 visits possible deducti	(outpatient)	then subject to applicable in-network or o	ut-of-network deductible and coinsurance ²	
Copaign waived if admitted to inpatient 30% coinsurance after deductible 50% coi		30% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY) Home health care (130 visits, PCY) Manipulative therapy (12 visits, PCY) Acquanterial health and substance use disorder Outpatient mental health and substance use disorder Outpatient mental health health and substance use disorder No charge	Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% co	nsurance after deductible	
Some consultance after deductible Some consultance after deduc	Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 wists, PCV) 30% coinsurance after deductible 2 50% coinsurance after deductible 2 state price with prior authorization) 400 copay, then 30% coinsurance after deductible 2 50% coinsurance after deductible 2 10% sits, PCV) \$40 copay, then 30% coinsurance after deductible 2 50% coinsurance after deductible 30% coinsurance after deductible	Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
12 visits, PCY; additional visits with prior authorization \$40 copay, then 30% coinsurance after deductible 50% coinsurance after deductible 12 visits, PCY \$40 copay, then 30% coinsurance after deductible 50% coinsurance after deductible 12 visits, PCY \$40 copay, then 30% coinsurance after deductible 50% coinsurance after deductible 30% coinsurance after dedu	Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
Inpatient mental health and substance use disorder Outpatient mental health and substance use disorder Outpatient mental health and substance use disorder Routine eye exam (1 exam every 12 months) Hearing hardware (\$3,000 per ear, every 36 months) Preferred generic drugs No charge No charge No coinsurance after deductible disorder No charge	Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
and substance use disorder Outpatient mental health and substance use disorder Routine eye exam (1 exam every 12 months) Hearing hardware (53,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs No (\$70 enhanced benefit) Not covered Non-preferred generic and brand-name drugs Sa0 Not covered Non-preferred generic and brand-name drugs Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs San Not covered Non-preferred specialty drugs	Acupuncture (12 visits, PCY)	\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
health and substance use disorder Routine eye exam (1 exam every 12 months) No charge No covered Preferred generic drugs S25 (\$15 enhanced benefit) Not covered Not covered Prescription drugs — mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Non-preferred generic and brand-name drugs Prescription drugs — specialty (up to a 30-day supply) Preferred specialty drugs Non-preferred specialty drugs	Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible	
Contraining	Outpatient mental health and substance use disorder	\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
(\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs \$25 (\$15 enhanced benefit) Preferred brand-name drugs \$60 (\$40 enhanced benefit) Non-preferred generic and brand-name drugs \$100 (\$70 enhanced benefit) Not covered Preferred generic drugs — sail order (up to a 90-day supply) Preferred generic drugs — \$30 — Not covered Preferred brand-name drugs \$80 — Not covered Non-preferred generic and brand-name drugs Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs — \$150 — Not covered Non-preferred specialty drugs — \$150 — Not covered	Routine eye exam (1 exam every 12 months)	No charge	No charge	
Preferred generic drugs \$25 (\$15 enhanced benefit) Not covered Preferred brand-name drugs \$60 (\$40 enhanced benefit) Not covered Non-preferred generic and brand-name drugs \$100 (\$70 enhanced benefit) Not covered Prescription drugs — mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Preferred brand-name drugs \$80 Not covered Non-preferred generic and brand-name drugs \$140 Not covered Prescription drugs — specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered	Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Preferred brand-name drugs \$100 (\$70 enhanced benefit) Not covered Non-preferred generic and brand-name drugs \$100 (\$70 enhanced benefit) Not covered Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Preferred brand-name drugs \$80 Not covered Non-preferred generic and brand-name drugs \$140 Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered	, ,			
Avorages \$60 (\$40 enhanced benefit) Not covered Non-preferred generic and brand-name drugs \$100 (\$70 enhanced benefit) Not covered Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Preferred brand-name drugs \$80 Not covered Non-preferred generic and brand-name drugs \$140 Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered	Preferred generic drugs	\$25 (\$15 enhanced benefit)	Not covered	
And brand-name drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs Preferred brand-name drugs Not covered Non-preferred generic and brand-name drugs Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs Non-preferred specialty drugs	Preferred brand-name drugs	\$60 (\$40 enhanced benefit)	Not covered	
Preferred generic drugs \$30 Not covered Preferred brand-name drugs \$80 Not covered Non-preferred generic and brand-name drugs \$140 Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$30% Not covered	Non-preferred generic and brand-name drugs	\$100 (\$70 enhanced benefit)	Not covered	
Preferred brand-name drugs \$80 Not covered Non-preferred generic and brand-name drugs \$140 Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs 30% Not covered	Prescription drugs – mail or	rder (up to a 90-day supply)	to a 90-day supply)	
Non-preferred generic and brand-name drugs \$140 Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs 30% Not covered	Preferred generic drugs	\$30	Not covered	
And brand-name drugs Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs Not covered Non-preferred specialty drugs 30% Not covered	Preferred brand-name drugs	\$80	Not covered	
Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs 30% Not covered	Non-preferred generic and brand-name drugs	\$140	Not covered	
Non-preferred specialty drugs Not covered	Prescription drugs – special	lty (up to a 30-day supply)		
drugs Not covered	Preferred specialty drugs	\$150	Not covered	
Drug list/formulary 5-tier in-network pharmacy benefit	Non-preferred specialty drugs	30%	Not covered	
	Drug list/formulary	5-tier in-network	pharmacy benefit	

^{1.} PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans Plans selected:

Reset		Compare plans Plans selected:	
	Access PPO W	Access PPO Welcome Plans	
Complete Suite category	Access PP	0 5000 W11	
	In-network Out-of-network		
Plan deductible, PCY ¹ (individual/family)	\$5,000/\$10,000	\$10,000/\$20,000	
Out-of-pocket maximum, PCY (individual/family)	\$9,000/\$18,000	Unlimited	
Coinsurance	30%	50%	
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first \$500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first \$500, plan deductible and coinsurance apply.	N/A	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covere	d
Office visits	\$50 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Urgent care office visits	$$50\ copay$, then $30\%\ coinsurance\ after\ deductible^2$	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or or		
CT, MRI, and PET scans (outpatient)	No charge for first \$500 of combined lab then subject to applicable in-network or or		
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coi	nsurance after deductible	
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$50 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$50 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	\$50 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	ble
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	\$25 (\$15 enhanced benefit)	Not covered	
Preferred brand-name drugs	\$60 (\$40 enhanced benefit)	Not covered	
Non-preferred generic and brand-name drugs	\$100 (\$70 enhanced benefit)	Not covered	
Prescription drugs – mail or	rescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	\$30	Not covered	
Preferred brand-name drugs	\$80	Not covered	
Non-preferred generic and brand-name drugs	\$140	Not covered	
Prescription drugs – special	ty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network	pharmacy benefit	

1. PCY = Per calendar year. **2.** This service is eligible for the Welcome waiver. Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy. Services provided by out-of-network providers may be subject to balance billing.



Compare plans

Plans selected:

	Access PPO HSA Plans	
Complete Suite category	Access PPC) 1650 (A) HSA
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$1,650/\$3,300	\$3,300/\$6,600
Out-of-pocket maximum, PCY (individual/family)	\$3,500/\$7,000	Unlimited
Coinsurance	20%	50%
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	Subject to deductible, then covered in full	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	20% coinsurance after deductible	50% coinsurance after deductible
Urgent care office visits	20% coinsurance after deductible	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	nsurance after deductible
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	20% coinsurance after deductible	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full
Prescription drugs – retail (up to a 30-day supply)	
Preferred generic drugs	20% coinsurance (10% enhanced benefit) after deductible	Not covered
Preferred brand-name drugs	20% coinsurance (10% enhanced benefit) after deductible	Not covered
Non-preferred generic and brand-name drugs	20% coinsurance (10% enhanced benefit) after deductible	Not covered
Prescription drugs – mail o	rder (up to a 90-day supply)	
Preferred generic drugs	10% coinsurance after deductible	Not covered
Preferred brand-name drugs	10% coinsurance after deductible	Not covered
Non-preferred generic and brand-name drugs	10% coinsurance after deductible	Not covered
Drug list/formulary 3-tier in-network pharmacy benefit		pharmacy benefit

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy.

Prescription drugs filled through the Kaiser Permanente mail-order pharmacy will be subject to 2 times the enhanced benefit prescription drug cost share for up to a 90-day supply.

Specialty drugs are limited to a 30-day supply.



Compare plans

Plans selected

d:	

Vezet		Trains selected.	
	Access PPO HSA Plans		
Complete Suite category	Access PPO) 2500 (A) HSA	
	In-network	Out-of-network	
Plan deductible, PCY* (individual/family)	\$2,500/\$5,000	\$5,000/\$10,000	
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$8,500	Unlimited	
Coinsurance	20%	50%	
Preventive and well-child care	No charge	50% coinsurance after deductible	
Telehealth	Subject to deductible, then covered in full	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Office visits	20% coinsurance after deductible	50% coinsurance after deductible	
Urgent care office visits	20% coinsurance after deductible	50% coinsurance after deductible	
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible	
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coi	insurance after deductible	
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	20% coinsurance after deductible	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible	
Outpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	20% coinsurance (10% enhanced benefit) after deductible	e Not covered	
Preferred brand-name drugs	20% coinsurance (10% enhanced benefit) after deductible	Not covered	
Non-preferred generic and brand-name drugs	20% coinsurance (10% enhanced benefit) after deductible	Not covered	
Prescription drugs – mail o	rder (up to a 90-day supply)		
Preferred generic drugs	10% coinsurance after deductible	Not covered	
Preferred brand-name drugs	10% coinsurance after deductible	Not covered	
Non-preferred generic and brand-name drugs	10% coinsurance after deductible	Not covered	
Drug list/formulary	3-tier in-network	pharmacy benefit	

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy.

Prescription drugs filled through the Kaiser Permanente mail-order pharmacy will be subject to 2 times the enhanced benefit prescription drug cost share for up to a 90-day supply.

Specialty drugs are limited to a 30-day supply.



Compare plans Plans selected:

Reset		Compare plans	Plans selected:
	Access PPO HSA Plans ategory Access PPO 3500 (A) HSA		
Complete Suite category			
	In-network	Out-o	f-network
Plan deductible, PCY* (individual/family)	\$3,500/\$7,000	\$7,000/\$14,000	
Out-of-pocket maximum, PCY (individual/family)	\$6,000/\$,8500	Unlimited	
Coinsurance	30%	Į.	50%
Preventive and well-child care	No charge	50% coinsuran	ce after deductible
Telehealth	Subject to deductible, then covered in full		ce after deductible line (e-visits): Not covered
Office visits	30% coinsurance after deductible	50% coinsuran	ce after deductible
Urgent care office visits	30% coinsurance after deductible	50% coinsuran	ce after deductible
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsuran	ce after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsuran	ce after deductible
Outpatient surgery	30% coinsurance after deductible	50% coinsuran	ce after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coi	nsurance after deductible	
Hospital inpatient	30% coinsurance after deductible	50% coinsuran	ce after deductible
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsuran	ce after deductible
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsuran	ce after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	30% coinsurance after deductible	50% coinsuran	ce after deductible
Acupuncture (12 visits, PCY)	30% coinsurance after deductible	50% coinsuran	ce after deductible
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsuran	ce after deductible
Outpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsuran	ce after deductible
Routine eye exam (1 exam every 12 months)	No charge	No	charge
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductib	ole, then covered in full
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	30% coinsurance (20% enhanced benefit) after deductible	Not	covered
Preferred brand-name drugs	30% coinsurance (20% enhanced benefit) after deductible	Not	covered
Non-preferred generic and brand-name drugs	30% coinsurance (20% enhanced benefit) after deductible	Not	covered
Prescription drugs – mail o	rder (up to a 90-day supply)		
Preferred generic drugs	20% coinsurance after deductible	Not	covered
Preferred brand-name drugs	20% coinsurance after deductible	Not	covered
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not	covered
Drug list/formulary	Stormulary 2 tior in natural, pharmacy hanafit		

^{*}PCY = Per calendar year.

Drug list/formulary

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy.

Prescription drugs filled through the Kaiser Permanente mail-order pharmacy will be subject to 2 times the enhanced benefit prescription drug cost share for up to a 90-day supply.

3-tier in-network pharmacy benefit

Specialty drugs are limited to a 30-day supply.



Reset		Compare plans Plans selected:
	Access PPO HSA Plans	
Complete Suite category	Access PP	O 3300 (E) HSA
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$3,300/\$6,600	\$6,600/\$13,200
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$10,000	Unlimited
Coinsurance	20%	50%
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	Subject to deductible, then covered in full	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	20% coinsurance after deductible	50% coinsurance after deductible
Urgent care office visits	20% coinsurance after deductible	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans	20% coinsurance after deductible	50% coinsurance after deductible

\$200 copay, then 20% coinsurance after deductible

No charge

Subject to deductible, then covered in full

20% coinsurance (10% enhanced benefit) after deductible

20% coinsurance (10% enhanced benefit) after deductible

20% coinsurance (10% enhanced benefit) after deductible

10% coinsurance after deductible

10% coinsurance after deductible

10% coinsurance after deductible

(outpatient)

Outpatient surgery

(copay waived if admitted

Emergency care

Hospital inpatient

(60 days, PCY)

Home health care

(130 visits, PCY)

visits with prior authorization)

Acupuncture

(12 visits, PCY)

disorder

disorder

Inpatient mental health and substance use

Outpatient mental health and substance use

Routine eye exam

Hearing hardware (\$3,000 per ear, every

36 months)

drugs

drugs

(1 exam every 12 months)

Preferred generic drugs

Preferred brand-name

Non-preferred generic

and brand-name drugs

Preferred generic drugs

Preferred brand-name

Non-preferred generic

and brand-name drugs

Drug list/formulary

Prescription drugs – retail (up to a 30-day supply)

Prescription drugs – mail order (up to a 90-day supply)

Skilled nursing facility

Manipulative therapy (12 visits, PCY; additional

to inpatient)

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy.

Prescription drugs filled through the Kaiser Permanente mail-order pharmacy will be subject to 2 times the enhanced benefit prescription drug cost share for up to a 90-day supply.

3-tier in-network pharmacy benefit

Specialty drugs are limited to a 30-day supply.

View the drug formulary at kp.org/wa/formulary.



50% coinsurance after deductible

No charge

Subject to deductible, then covered in full

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

^{*}PCY = Per calendar year.

Reset		Compare plans Plans selected:
	Access PPO HSA Plans	
Complete Suite category	Access PPC	O 3500 (E) HSA
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$3,500/\$7,000	\$7,000/\$14,000
Out-of-pocket maximum, PCY (individual/family)	\$5,500/\$11,000	Unlimited
Coinsurance	20%	50%
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	Subject to deductible, then covered in full	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	20% coinsurance after deductible	50% coinsurance after deductible
Urgent care office visits	20% coinsurance after deductible	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% co	insurance after deductible
Hospital inpatient	20% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	20% coinsurance after deductible	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge

Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs

Preferred generic drugs	20% coinsurance (10% enhanced benefit) after deductible	Not covered
Preferred brand-name drugs	20% coinsurance (10% enhanced benefit) after deductible	Not covered
Non-preferred generic	20% sainsurance (10% anhanced banefit) after deductible	Not covered

20% coinsurance (10% enhanced benefit) after deductible

Subject to deductible, then covered in full

and brand-name drugs Prescription drugs – mail order (up to a 90-day supply)

Preferred generic drugs	10% coinsurance after deductible	Not covered
Preferred brand-name drugs	10% coinsurance after deductible	Not covered
Non-preferred generic and brand-name drugs	10% coinsurance after deductible	Not covered
Drug list/formulary	3-tier in-network	pharmacy benefit

^{*}PCY = Per calendar year.

Hearing hardware (\$3,000 per ear, every

36 months)

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy.

Prescription drugs filled through the Kaiser Permanente mail-order pharmacy will be subject to 2 times the enhanced benefit prescription drug cost share for up to a 90-day supply.

Specialty drugs are limited to a 30-day supply.

View the drug formulary at kp.org/wa/formulary.



Subject to deductible, then covered in full

Not covered

Compare plans

Plans selected:

	Access PPO HSA Plans	
Complete Suite category) 4000 (E) HSA
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	\$4,000/\$8,000	\$8,000/\$16,000
Out-of-pocket maximum, PCY (individual/family)	\$5,500/\$11,000	Unlimited
Coinsurance	30%	50%
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	Subject to deductible, then covered in full	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	30% coinsurance after deductible	50% coinsurance after deductible
Urgent care office visits	30% coinsurance after deductible	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coi	insurance after deductible
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	30% coinsurance after deductible	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full
Prescription drugs – retail (up to a 30-day supply)		
Preferred generic drugs	30% coinsurance (20% enhanced benefit) after deductible	Not covered
Preferred brand-name drugs	30% coinsurance (20% enhanced benefit) after deductible	Not covered
Non-preferred generic and brand-name drugs	30% coinsurance (20% enhanced benefit) after deductible	Not covered
Prescription drugs – mail o	order (up to a 90-day supply)	
Preferred generic drugs	20% coinsurance after deductible	Not covered
Preferred brand-name drugs	20% coinsurance after deductible	Not covered
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered
Drug list/formulary	ug list/formulary 3-tier in-network pharmacy benefit	

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy.

 $Prescription\ drugs\ filled\ through\ the\ Kaiser\ Permanente\ mail-order\ pharmacy\ will\ be\ subject\ to\ 2\ times\ the\ enhanced\ benefit\ prescription\ drug\ cost\ share\ for\ up\ to\ a\ 90-day\ supply.$

Specialty drugs are limited to a 30-day supply.



Compare plans

Plans selected:

	Access PPO	HSA Plans		
Complete Suite category) 4500 (E) HSA		
	In-network	Out-of-network		
Plan deductible, PCY* (individual/family)	\$4,500/\$9,000	\$9,000/\$18,000		
Out-of-pocket maximum, PCY (individual/family)	\$7,000/\$14,000	Unlimited		
Coinsurance	30%	50%		
Preventive and well-child care	No charge	50% coinsurance after deductible		
Telehealth	Subject to deductible, then covered in full	50% coinsurance after deductible Telephone services/online (e-visits): Not covered		
Office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Urgent care office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coi	insurance after deductible		
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	30% coinsurance after deductible	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	30% coinsurance (20% enhanced benefit) after deductible	Not covered		
Preferred brand-name drugs	30% coinsurance (20% enhanced benefit) after deductible	Not covered		
Non-preferred generic and brand-name drugs	30% coinsurance (20% enhanced benefit) after deductible	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	Not covered		
Preferred brand-name drugs	20% coinsurance after deductible	Not covered		
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered		
Drug list/formulary	3-tier in-network	pharmacy benefit		

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy.

Prescription drugs filled through the Kaiser Permanente mail-order pharmacy will be subject to 2 times the enhanced benefit prescription drug cost share for up to a 90-day supply.

Specialty drugs are limited to a 30-day supply.



Reset		Compare plans Plans selected:			
	Access PF	Access PPO HSA Plans			
Complete Suite category	Suite category Access PPO 5000 (E) HSA				
	In-network	Out-of-network			
Plan deductible, PCY* (individual/family)	\$5,000/\$10,000	\$10,000/\$20,000			
Out-of-pocket maximum, PCY (individual/family)	\$7,000/\$14,000	Unlimited			
Coinsurance	30%	50%			
Preventive and well-child care	No charge	50% coinsurance after deductible			
Telehealth	Subject to deductible, then covered in full	50% coinsurance after deductible Telephone services/online (e-visits): Not covered			
Office visits	30% coinsurance after deductible	50% coinsurance after deductible			
Urgent care office visits	30% coinsurance after deductible	50% coinsurance after deductible			
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible			
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible			
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible			
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30%	coinsurance after deductible			
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible			
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible			
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible			
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	30% coinsurance after deductible	50% coinsurance after deductible			
•					

30% coinsurance after deductible

30% coinsurance after deductible

30% coinsurance after deductible

No charge

Subject to deductible, then covered in full

30% coinsurance (20% enhanced benefit) after deductible

30% coinsurance (20% enhanced benefit) after deductible

30% coinsurance (20% enhanced benefit) after deductible

20% coinsuranceafter deductible

20% coinsurance after deductible

20% coinsurance after deductible

*PCY	= Per	cale	ndar	vear

Drug list/formulary

Acupuncture

disorder

disorder

(12 visits, PCY)

Inpatient mental health

and substance use

Outpatient mental health and substance use

Routine eye exam

Hearing hardware (\$3,000 per ear, every

36 months)

drugs

drugs

(1 exam every 12 months)

Preferred generic drugs

Preferred brand-name

Non-preferred generic

and brand-name drugs

Preferred generic drugs

Preferred brand-name

Non-preferred generic

and brand-name drugs

Prescription drugs – retail (up to a 30-day supply)

Prescription drugs - mail order (up to a 90-day supply)

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy.

Prescription drugs filled through the Kaiser Permanente mail-order pharmacy will be subject to 2 times the enhanced benefit prescription drug cost share for up to a 90-day supply.

3-tier in-network pharmacy benefit

Specialty drugs are limited to a 30-day supply.

View the drug formulary at **kp.org/wa/formulary**.



50% coinsurance after deductible

50% coinsurance after deductible

50% coinsurance after deductible

No charge

Subject to deductible, then covered in full

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Reset		Compare plans	Plans selected:	
	Access PPC	HSA Plans		
Complete Suite category	Access PPC	O 6000 (E) HSA		
	In-network	Out-	of-network	
51 1 1 11 500			·	

	Access PPO HSA Plans			
Complete Suite category	Access PPO 6000 (E) HSA			
	In-network	Out-of-network		
Plan deductible, PCY* (individual/family)	\$6,000/\$12,000	\$12,000/\$24,000		
Out-of-pocket maximum, PCY (individual/family)	\$7,500/\$15,000	Unlimited		
Coinsurance	30%	50%		
Preventive and well-child care	No charge	50% coinsurance after deductible		
Telehealth	Subject to deductible, then covered in full	50% coinsurance after deductible Telephone services/online (e-visits): Not covered		
Office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Urgent care office visits	30% coinsurance after deductible	50% coinsurance after deductible		
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible		
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coi	oinsurance after deductible		
Hospital inpatient	30% coinsurance after deductible	50% coinsurance after deductible		
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Home health care (130 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	30% coinsurance after deductible	50% coinsurance after deductible		
Acupuncture (12 visits, PCY)	30% coinsurance after deductible	50% coinsurance after deductible		
Inpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Outpatient mental health and substance use disorder	30% coinsurance after deductible	50% coinsurance after deductible		
Routine eye exam (1 exam every 12 months)	No charge	No charge		
Hearing hardware (\$3,000 per ear, every 36 months)	Subject to deductible, then covered in full	Subject to deductible, then covered in full		
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	30% coinsurance (20% enhanced benefit) after deductible	Not covered		
Preferred brand-name drugs	30% coinsurance (20% enhanced benefit) after deductible	Not covered		
Non-preferred generic and brand-name drugs	30% coinsurance (20% enhanced benefit) after deductible	Not covered		
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	Not covered		
Preferred brand-name drugs	20% coinsurance after deductible	Not covered		
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered		
Drug list/formulary	3-tier in-network	pharmacy benefit		
OCV. Bereiterleiner				

^{*}PCY = Per calendar year.

Enhanced in-network benefits apply when services are provided by a Kaiser Permanente Pharmacy or other designated pharmacy.

 $Prescription\ drugs\ filled\ through\ the\ Kaiser\ Permanente\ mail-order\ pharmacy\ will\ be\ subject\ to\ 2\ times\ the\ enhanced\ benefit\ prescription\ drug\ cost$ share for up to a 90-day supply.

Specialty drugs are limited to a 30-day supply.



Reset	Compare plans	Plans selected:	

Reset		Compare plans Plans se	lected:
	NEW Kaiser Perma	nente Plus™ Plans	
Complete Suite category	KP Plu	s 250 L1	
, ,	In-network	Out-of-network (limited to 10 covered services per year, con	
Plan deductible, PCY¹ (individual/family)	\$250/\$750	NA	
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	NA	
Coinsurance	10%	NA	
Waiver	Annual deductible and plan coinsurance do not apply to office visits or to diagnostic laboratory and radiology services	NA	
Preventive and well-child care	No charge	No charge	
Telehealth	No charge	\$35/\$45	
Office visits	\$15/\$25	\$35/\$45	
Urgent care office visits	\$15/\$25	\$35/\$45	
Lab and X-ray procedures (outpatient)	\$15	\$35	
CT, MRI, and PET scans (outpatient)	\$100	Not covered	
Outpatient surgery	10% coinsurance after deductible	Not covered	
Emergency care (copay waived if admitted to inpatient)	10% coinsurance after	er in-network deductible ²	
Hospital inpatient	10% coinsurance after deductible	Not covered	
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	Not covered	
Home health care (130 visits, PCY)	No charge	Not covered	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$15	\$35	
Acupuncture (12 visits, PCY)	\$15	\$35	
Inpatient mental health and substance use disorder	10% coinsurance after deductible	Not covered	
Outpatient mental health and substance use disorder	\$15	\$35	
Routine eye exam (1 exam every 12 months)	\$15/\$25	\$35/\$45	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge	
Prescription drugs – retail (u	ıp to a 30-day supply)	Limited to 5 prescription fills p	er year
Preferred generic drugs	\$15	\$35	
Preferred brand-name drugs	\$40	\$60	
Non-preferred generic and brand-name drugs	\$60	\$80	
Prescription drugs – mail or	der (up to a 90-day supply)		
Preferred generic drugs	\$30	Not covered	
Preferred brand-name drugs	\$80	Not covered	
Non-preferred generic and brand-name drugs	\$120	Not covered	
Prescription drugs – specialt	ty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5 tior In natural	pharmacy benefit	

^{1.} PCY = Per calendar year. 2. The limit of 10 covered services does not apply.



Reset Compare plans Plans selected:

Out-of-packet maximum, \$3,000/\$9,000 NA PCY (Individualisariii) Consumance 20% NA Annual deductible and plan consumance do not apply to office wist including aurgery Preventive and well-child care Telehealth No charge No charge 540 Office visits \$20 \$40 Ungent can office visits \$20 \$540 Ungentering 71, MRI), and PET Scarca (outpatient) 20% coinsurance after deductible Not covered Undepatient surgery Emergency care (outpatient meant and the care (130 visits, PCY) Home health care (130 visits, PCY) Home health care (130 visits, PCY) Home health care (120 visits, PCY) Inquitiont mental health and substance use disorder Undpatient mental health and substance use disorder Undpatient mental health and substance use disorder Extra care care care No charge No covered No c	Reset		Compare plans Plans selected:		
Inselvent Inse		NEW Kaiser Permanente Plus™ Plans			
Plan deductible, PCY' (Individual/Amily) Plan deductible, PCY' (Individual/Amily) Vol. of pocket maximum, PCY (Individual/Amily) Colinsurance 20% Annual deductible and plan consurance do not apply to office visits including surgery Preventive and well-child care Include and X-ray procedures Include and X-ray pr	Complete Suite category				
Plan deductible, PCY' (intividual/family) S500(\$1,500) NA Out-6 gooket maximum, PCY (individual/family) S3,000(\$9,000) NA Annual ideductible and plan coinsurance do not apply to outle outlet be dist including surgery Na Annual ideductible and plan coinsurance do not apply to outlet exists including surgery Na Charge Rocharge	Complete Suite Category				
Individuals/anily) SSUM31,300 NA Out-of-pocket maximum, PCY (individual/anily) Colinsurance Annual deductible and plan cinourance do not apply to office visits including surgery No charge Itelehealth S20 S40 Urgent care office visits S20 S40 S40 S40 S40 S40 S40 S40 S40 S40 S4		III-network	(limited to 10 covered services per year, combi	ned)	
Per Criminarior Socionissa (1905) Coinsurance 200% NA Makiver Annual deductible and plan coinsurance do not apply to office wists including surgery Preventive and well child Roc charge 1540 Preventive and well child Roc charge 1540 Preventive and well child Roc charge 1540 Office wists 1520 1540 Ligant care office wists 1520 1540 Loughailent surgery 20% coinsurance after deductible Roc covered Couppaient on the preferency care (scopy washed if admitted to impetent) Loughailent surgery 20% coinsurance after deductible Roc covered Stelled musting facility (60 days, PCY) Loughailent pacifity (100 days, PCY) Loughailent mental health and (110 wists, PCY) Loughailent mental health and substance use disorder Couppaient mental health and substance use disorder Rocation (100 mission pacific wists with prior authorization) Loughailent mental health and substance use disorder Rocation (100 mission pacific wists PCY) Loughailent mental health and substance use disorder Rocation (100 mission pacific wists PCY) Loughailent mental health and substance use disorder Rocation (100 mission pacific wists PCY) Loughailent mental health and substance use disorder Rocation (100 mission pacific wists PCY) Loughailent mental health and substance use disorder Rocation (100 mission pacific wists PCY) Loughailent mental health and substance use disorder Rocation (100 mission pacific wists PCY) Loughailent mental health and substance use disorder	Plan deductible, PCY ¹ (individual/family)	\$500/\$1,500	NA		
Maker Annual deductible and plan coinsurance do not apply to office visits including surgery Preventive and well child care No charge No charge 1 August	Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000	NA		
Preventive and well-child care No charge Telehealth No charge S40 Office visits S20 S40 Urgent care office visits S20 S40 Not covered Outpatient Outpatient surgery S20% coinsurance after deductible Not covered Not covered Not covered Not patient) S20% coinsurance after deductible Not covered	Coinsurance	20%	NA		
care No Grage No Grage S40 Tolehealth No charge S40 Office visits \$20 S40 Urgent care office visits \$20 Consurance after deductible S40 Scoinsurance office of coups with a second of coupside of the coups with a second of coupside of the cou	Waiver		NA		
Office visits \$20 \$40 Urgent care office visits \$200 \$40 Urgent care office visits \$20 \$40 Urgent care o	Preventive and well-child care	No charge	No charge		
Urgent care office visits \$ 20 \$ \$40 \$ 1ab and X-ray procedures (outpatient) \$ 20% coinsurance after deductible 30% coinsurance (outpatient) \$ 20% coinsurance after deductible Not covered Outpatient surgery 20% coinsurance after deductible Not covered Outpatient surgery 20% coinsurance after deductible Not covered Outpatient surgery 20% coinsurance after deductible Not covered Emergency care (copay waived if admitted to in patient) 20% coinsurance after deductible Not covered Stilled nursing facility (60 days, PCV) 20% coinsurance after deductible Not covered Home health care (130 visits, PCY) No charge Not covered Home health care (130 visits, PCY) S20 S40 Manipulative therapy (12 visits, PCY) S20 S40 Manipulative therapy (12 visits, PCY) S20 S40 Manipulative mental health and substance use disorder 20% coinsurance after deductible Not covered Mot covered S40 S40 S40 Mot covered S40 S40 S40 Mot covered S40 S40 S40 Mot covered S40 S40 S40 S40 S40 S40 Mot covered S40	Telehealth	No charge	\$40		
Lab and X-ray procedures (outpatient) 20% coinsurance after deductible 20% coinsurance after deductible Not covered Cutpatient surgery Emergency care (copps wrived if admitted to inpatient) 20% coinsurance after deductible \$200 copps, then 20% coinsurance after in-network deductible ² Not covered **Prefered generic drugs **Prefered generic and brand-name drugs **Preferered specialty drugs Not covered **Not c	Office visits	\$20	\$40		
Courts C	Urgent care office visits	\$20	\$40		
Outpatient surgery Emergency care (copps) waived if admitted to inpatient Skilled nursing facility (60 days, PCY) Home health care (130 wists, PCY) Home health care (130 wists, PCY) Home health care (12 wists, PCY) Home health care (13 wists with prior unthonization) Acupuncture (12 wists, PCY) Lipatient mental health Home substance use disorder Coutpatient mental health Home substance use disorder Routine eye exam (1 wam every 12 months) Hearing hardware (S3,000 per ear, every Ano charge No charge Preferred generic drugs Preferred peneric and brand-name drugs Preferred generic drugs Preferred peneric and brand-name drugs Non-preferred generic And trovered Not covered Not covered Not covered Preferred brand-name Routine error of the peneric and brand-name drugs Preferred peneric and brand-name drugs Not covered	Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	30% coinsurance		
Emergency care (copay waived if admitted to inpatient) Inspital inpatient Lospital inpati	CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	Not covered		
(copay waved if admitted to inpatient) Hospital inpatient Skilled nursing facility (60 days, PCY) Home health care (130 visits, PCY) Manipulative therapy (12 visits, PCY, daditional visits with prior authorization) Acupuncture (12 visits, PCY, daditional visits with prior authorization) Acupuncture (12 visits, PCY) Inpatient mental health and substance use disorder Outpatient mental health and substance use disorder (1 acum every 12 months) Hearing hardware (3 acum every 12 months) Hearing hardware (3 acum every 12 months) Perscription drugs – retail up to a 30-day supply) Preferred generic drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs Preferred generic drugs Preferred generic drugs Non preferred generic and home preferred generic and brand-name drugs Non preferred generic and home preferred generic and brand-name drugs Non preferred specialty (up to a 30-day supply) Preferred specialty drugs Non preferred specialty (up to a 30-day supply) Preferred specialty drugs Non preferred specialty Not covered	Outpatient surgery	20% coinsurance after deductible	Not covered		
Skilled nursing facility (60 days, PCY) Home health care (130 wists, PCY) Manipulative therapy (12 vists, PCY) S20 \$40 S40 Inpatient mental health and substance use disorder Outpatient mental health and substance use disorder Outpatient mental health and substance use disorder Not covered disorder No charge S0 \$40 S40 S40 S40 S40 S40 S40 S	Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance			
Accounted by Comment Accounted by Counted by Counter Accounted by Counted by Counte	Hospital inpatient	20% coinsurance after deductible	Not covered		
Manipulative therapy (172 wists, PCY) No charge \$20 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$4	Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	Not covered		
\$20 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$4	Home health care (130 visits, PCY)	No charge	Not covered		
Inpatient mental health and substance use disorder Outpatient mental health and substance use disorder Outpatient mental health and substance use disorder Routine eye exam (1 exam every 12 months) Hearing hardware (\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs Not covered Non-preferred generic drugs \$20 Not covered Not covered Not covered Not covered Not covered Non-preferred generic drugs \$20 Not covered Not covered Not covered Not covered Not covered Not covered Non-preferred generic drugs \$20 Not covered Not covered Not covered Not covered Non-preferred generic drugs Soo Not covered Not covered Non-preferred generic drugs Non-preferred generic drugs Non-preferred generic and brand-name drugs Non-preferred generic soluty (up to a 30-day supply) Preferred specialty (up to a 30-day supply) Preferred specialty drugs Non-preferred specialty drugs Non-preferred specialty drugs Not covered Non-preferred specialty drugs Not covered	Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$20	\$40		
and substance use disorder Outpatient mental health and substance use disorder Routine eye exam (1 exam every 12 months) Hearing hardware (\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs Not covered Non-preferred specialty drugs Sow up to \$150 Not covered Non-preferred specialty drugs	Acupuncture (12 visits, PCY)	\$20	\$40		
health and substance use disorder Routine eye exam (1 exam every 12 months) Rearing hardware (\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs Preferred brand-name drugs Not covered Not covered Not covered Preferred brand-name drugs Preferred generic drugs Not covered Not covered Not covered Not covered Preferred generic drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs Prescription drugs – Mot covered Not covered Not covered Preferred generic drugs Preferred generic drugs Prescription drugs – specialty (up to a 30-day supply) Preferred brand-name drugs Not covered	Inpatient mental health and substance use disorder	20% coinsurance after deductible	Not covered		
Comparison of the second of	Outpatient mental health and substance use disorder	\$20	\$40		
(\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Limited to 5 prescription fills per year Preferred generic drugs \$10 \$30 Preferred brand-name drugs Not covered Not covered Not covered Preferred generic drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$20 Not covered Not covered Not covered Preferred brand-name drugs \$40 Not covered Not covered Not covered Preferred generic drugs \$40 Not covered Not covered Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$50% up to \$150 Not covered	Routine eye exam (1 exam every 12 months)	\$20	\$40		
Preferred generic drugs \$10 \$30 Preferred brand-name drugs \$20 \$40 Non-preferred generic and brand-name drugs Not covered Not covered Not covered Prescription drugs — mail order (up to a 90-day supply) Preferred generic drugs \$20 Not covered Preferred brand-name drugs \$40 Not covered Not covered Not covered Preferred brand-name drugs Not covered Not covered Preferred speneric and brand-name drugs Sow up to \$150 Not covered Not covered Not covered Preferred specialty drugs Sow up to \$150 Not covered Not covered Not covered Non-preferred specialty drugs Sow up to \$150 Not covered Not c	Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Preferred brand-name drugs Not covered Not covered Not covered Not covered Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$20 Not covered Not covered Preferred brand-name drugs \$40 Not covered Non-preferred generic and brand-name drugs Non-preferred generic and brand-name drugs Non-preferred generic and brand-name drugs Not covered Not covered Not covered Not covered Not covered Non-preferred specialty (up to a 30-day supply) Preferred specialty drugs Non-preferred specialty drugs Not covered Not covered Not covered Not covered	Prescription drugs – retail (up to a 30-day supply)	Limited to 5 prescription fills per year		
S20	Preferred generic drugs	\$10	\$30		
Prescription drugs — mail order (up to a 90-day supply) Preferred generic drugs \$20 Not covered Preferred brand-name drugs \$40 Not covered Non-preferred generic and brand-name drugs Not covered Not covered Prescription drugs — specialty (up to a 30-day supply) Preferred specialty drugs 50% up to \$150 Not covered Non-preferred specialty drugs Not covered Not covered	Preferred brand-name drugs	\$20	\$40		
Preferred generic drugs \$20 Not covered Preferred brand-name drugs \$40 Not covered Non-preferred generic and brand-name drugs Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs 50% up to \$150 Not covered Non-preferred specialty drugs Not covered	Non-preferred generic and brand-name drugs	Not covered	Not covered		
Preferred brand-name drugs Not covered Not covered Not covered Not covered Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs Sow up to \$150 Not covered Not covered Not covered Not covered	Prescription drugs – mail o	rder (up to a 90-day supply)			
And brand-name drugs Not covered	Preferred generic drugs	\$20	Not covered		
Non-preferred generic and brand-name drugs Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs Sow up to \$150 Not covered Non-preferred specialty drugs Not covered Not covered	Preferred brand-name drugs	\$40	Not covered		
Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs 50% up to \$150 Not covered Non-preferred specialty drugs Not covered	Non-preferred generic and brand-name drugs	Not covered	Not covered		
Non-preferred specialty drugs Not covered Not covered	Prescription drugs – specia	lty (up to a 30-day supply)			
Non-preferred specialty drugs Not covered Not covered	Preferred specialty drugs	50% up to \$150	Not covered		
	Non-preferred specialty drugs	Not covered	Not covered		
	Drug list/formulary	1 or 2-tier with additional specialty	r tier In-network pharmacy benefit		

^{1.} PCY = Per calendar year. 2. The limit of 10 covered services does not apply.

Reset Compare plans Plans selected:

Reset		Compare plans	Plans selected:	
	NEW Kaiser Perma	anente Plus™ Plans		
Complete Suite category	KP Plu	lus 750 L3 Out-of-network (limited to 10 covered services per year, combined)		
-	In-network			
Plan deductible, PCY ¹ (individual/family)	\$750/\$2,250	NA		
Out-of-pocket maximum, PCY (individual/family)	\$3,500/\$10,500		NA	
Coinsurance	20%		NA	
Waiver	Annual deductible and plan coinsurance do not apply to office visits or to diagnostic laboratory and radiology services		NA	
Preventive and well-child care	No charge	No	charge	
Telehealth	No charge	\$4	15/\$55	
Office visits	\$25/\$35	\$4	15/\$55	
Urgent care office visits	\$25/\$35	\$4	15/\$55	
Lab and X-ray procedures (outpatient)	\$25		\$45	
CT, MRI, and PET scans (outpatient)	\$100	Not	covered	
Outpatient surgery	20% coinsurance after deductible	Not	covered	
Emergency care (copay waived if admitted to inpatient)	20% coinsurance afte	ter in-network deductible ²		
Hospital inpatient	20% coinsurance after deductible	Not covered		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	Not covered		
Home health care (130 visits, PCY)	No charge	Not covered		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$25	\$45		
Acupuncture (12 visits, PCY)	\$25	\$45		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	Not covered		
Outpatient mental health and substance use disorder	\$25	\$45		
Routine eye exam (1 exam every 12 months)	\$25/\$35	\$4	15/\$55	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No	charge	
Prescription drugs – retail (up to a 30-day supply)	Limited to 5 pre	scription fills per year	
Preferred generic drugs	\$15		\$35	
Preferred brand-name drugs	\$40		\$60	
Non-preferred generic and brand-name drugs	\$60		\$80	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs	\$30	Not	covered	
Preferred brand-name drugs	\$80		covered	
Non-preferred generic and brand-name drugs	\$120	Not	covered	
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not	covered	
Non-preferred specialty drugs	30%		covered	
Drug list/formulary	5-tier In-network	pharmacy benefit		
,	o dor in notwork pharmacy benefit			

^{1.} PCY = Per calendar year. **2.** The limit of 10 covered services does not apply.



Reset Compare plans Plans selected:

NEW Kaiser Permanente Plus™ Plans The plus 1000 V4 The network T		
Complete Suite category		
In-network Out-of-network (limited to 10 covered services per year, combined to 10 covered services per year,		
Plan deductible, PCY¹ (individual/family) Out-of-pocket maximum, PCY (individual/family) Coinsurance 20% Annual deductible and plan coinsurance do not apply to office visits, including surgery Preventive and well-child care Telehealth No charge Telehealth No charge Telentate of 10 tovered services per year, combound in the control of the c		
(individual/family) Out-of-pocket maximum, PCY (individual/family) Coinsurance 20% NA Waiver Annual deductible and plan coinsurance do not apply to office visits, including surgery Preventive and well-child care No charge Telehealth No charge Telehealth No charge \$45 Office visits \$25 \$45 Urgent care office visits \$25 \$45 Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) 20% coinsurance after deductible Not covered	ined)	
PCY (individual/family) Coinsurance 20% NA Waiver Annual deductible and plan coinsurance do not apply to office visits, including surgery Preventive and well-child care Telehealth No charge No charge Telehealth No charge \$45 Office visits \$25 \$45 Urgent care office visits \$25 \$45 Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) 20% coinsurance after deductible No covered		
WaiverAnnual deductible and plan coinsurance do not apply to office visits, including surgeryNAPreventive and well-child careNo chargeNo chargeTelehealthNo charge\$45Office visits\$25\$45Urgent care office visits\$25\$45Lab and X-ray procedures (outpatient)20% coinsurance after deductible30% coinsuranceCT, MRI, and PET scans (outpatient)20% coinsurance after deductibleNot covered		
Preventive and well-child care No charge No charge Telehealth No charge \$45 Office visits \$25 \$45 Urgent care office visits \$25 \$45 Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) 20% coinsurance after deductible No charge \$45 \$45 \$45 No charge \$45 \$45 No charge \$45 \$45 \$45 No charge \$45 \$45 No charge \$45 \$45 No charge		
Telehealth No charge S45 Office visits Urgent care office visits \$25 \$45 Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) 20% coinsurance after deductible (outpatient) No charge \$45 \$45 \$45 CT, MRI, and PET scans (outpatient) Not covered		
Office visits \$25 \$45 Urgent care office visits \$25 \$45 Lab and X-ray procedures (outpatient) 20% coinsurance after deductible 30% coinsurance (outpatient) 20% coinsurance after deductible Not covered		
Urgent care office visits \$25 \$45 Lab and X-ray procedures (outpatient) 20% coinsurance after deductible 30% coinsurance CT, MRI, and PET scans (outpatient) 20% coinsurance after deductible Not covered		
Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) 20% coinsurance after deductible Not covered		
(outpatient) CT, MRI, and PET scans (outpatient) 20% coinsurance after deductible Not covered		
(outpatient)		
Outpatient surgery 20% coinsurance after deductible Not covered		
Emergency care (copay waived if admitted \$200 copay, then 20% coinsurance after in-network deductible² to inpatient)		
Hospital inpatient 20% coinsurance after deductible Not covered		
Skilled nursing facility (60 days, PCY) 20% coinsurance after deductible Not covered		
Home health care (130 visits, PCY) No charge Not covered		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization) \$25 \$45		
Acupuncture (12 visits, PCY) \$25 \$45		
Inpatient mental health and substance use disorder 20% coinsurance after deductible Not covered		
Outpatient mental health and substance use disorder \$25 \$45		
Routine eye exam (1 exam every 12 months) \$25 \$45		
Hearing hardware (\$3,000 per ear, every 36 months) No charge No charge		
Prescription drugs – retail (up to a 30-day supply) Limited to 5 prescription fills per year		
Preferred generic drugs \$15 \$35		
Preferred brand-name drugs \$30 \$50		
Non-preferred generic and brand-name drugs Not covered Not covered		
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs \$30 Not covered		
Preferred brand-name drugs \$60 Not covered		
Non-preferred generic and brand-name drugs Not covered Not covered		
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs 50% up to \$150 Not covered		
Non-preferred specialty drugs Not covered Not covered		
Drug list/formulary 1 or 2-tier with additional specialty tier In-network pharmacy benefit		

^{1.} PCY = Per calendar year. **2.** The limit of 10 covered services does not apply.



Reset	Compare plans	Plans selected:	

Reset		Compare plans	Plans selected:	
	NEW Kaiser Perma	nente Plus™ Plans		
Complete Suite category	KP Plu	s 1500 L5		
	In-network		network rvices per year, combined)	
Plan deductible, PCY ¹ (individual/family)	\$1,500/\$4,500	NA		
Out-of-pocket maximum, PCY (individual/family)	\$5,000/\$15,000	ľ	NA	
Coinsurance	20%	ľ	NA	
Waiver	Annual deductible and plan coinsurance do not apply to office visits or to diagnostic laboratory and radiology services	١	NA	
Preventive and well-child care	No charge	No charge		
Telehealth	No charge	\$45	5/\$55	
Office visits	\$25/\$35	\$45	/\$55	
Urgent care office visits	\$25/\$35	\$45	/\$55	
Lab and X-ray procedures (outpatient)	\$25	\$	45	
CT, MRI, and PET scans (outpatient)	\$100	Not covered		
Outpatient surgery	20% coinsurance after deductible	Not c	overed	
Emergency care (copay waived if admitted to inpatient)	20% coinsurance after i	r in-network deductible ²		
Hospital inpatient	20% coinsurance after deductible	Not covered		
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	Not covered		
Home health care (130 visits, PCY)	No charge	Not covered		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$25	\$45		
Acupuncture (12 visits, PCY)	\$25	\$45		
Inpatient mental health and substance use disorder	20% coinsurance after deductible	Not covered		
Outpatient mental health and substance use disorder	\$25	\$45		
Routine eye exam (1 exam every 12 months)	\$25/\$35	\$45	/\$55	
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No c	harge	
Prescription drugs – retail (u	up to a 30-day supply)	Limited to 5 presc	ription fills per year	
Preferred generic drugs	\$15	\$	35	
Preferred brand-name drugs	\$40	\$	60	
Non-preferred generic and brand-name drugs	\$60	\$	80	
Prescription drugs – mail or	der (up to a 90-day supply)			
Preferred generic drugs	\$30	Not covered		
Preferred brand-name drugs	\$80	Not covered		
Non-preferred generic and brand-name drugs	\$120	Not covered		
Prescription drugs – special	ty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not c	overed	
Non-preferred specialty drugs	30%	Not c	Not covered	
		pharmacy benefit		

^{1.} PCY = Per calendar year. **2.** The limit of 10 covered services does not apply.

Reset	Compare plans	Plans selected:	

Reset	Plans selected:					
	NEW Kaiser Perma	nente Plus™ Plans	nente Plus™ Plans			
Complete Suite category	■ KP Plus 2000 V6					
, , ,	In-network	Out-of-network (limited to 10 covered services per year, combined)				
Plan deductible, PCY ¹ (individual/family)	\$2,000/\$4,000		NA			
Out-of-pocket maximum, PCY (individual/family)	\$5,500/\$11,000		NA			
Coinsurance	20%		NA			
Waiver	Annual deductible and plan coinsurance do not apply to office visits including surgery		NA			
Preventive and well-child care	No charge	No	charge			
Telehealth	No charge	\$50				
Office visits	\$30		\$50			
Urgent care office visits	\$30		\$50			
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	30% co	oinsurance			
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	Not	covered			
Outpatient surgery	20% coinsurance after deductible	Not	covered			
Emergency care (copay waived if admitted to inpatient)	20% coinsurance after i	n-network deductible²				
Hospital inpatient	20% coinsurance after deductible	Not	covered			
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	Not	covered			
Home health care (130 visits, PCY)	No charge	Not covered				
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$30	\$50				
Acupuncture (12 visits, PCY)	\$30	\$50				
Inpatient mental health and substance use disorder	20% coinsurance after deductible	Not	covered			
Outpatient mental health and substance use disorder	\$30		\$50			
Routine eye exam (1 exam every 12 months)	\$30		\$50			
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No	charge			
Prescription drugs – retail (up to a 30-day supply)	Limited to 5 pres	scription fills per year			
Preferred generic drugs	\$15		\$35			
Preferred brand-name drugs	\$40		\$60			
Non-preferred generic and brand-name drugs	\$60		\$80			
Prescription drugs – mail o	ail order (up to a 90-day supply)					
Preferred generic drugs	\$30	Not covered				
Preferred brand-name drugs			covered			
Non-preferred generic and brand-name drugs	\$120	Not covered				
Prescription drugs – specia	ription drugs – specialty (up to a 30-day supply)					
Preferred specialty drugs	Preferred specialty drugs \$150 Not covered		covered			
Non-preferred specialty drugs	30%	Not	covered			
Drug list/formulary	5-tier In-network	oharmacy benefit				
	3 der in network pharmacy benefit					

^{1.} PCY = Per calendar year. **2.** The limit of 10 covered services does not apply.



Reset		Compare plans Plans selected:				
	NEW Kaiser Perma	nente Plus™ Plans				
Complete Suite category	■ KP Plus 2500 V7					
, , , , ,	In-network	Out-of-network (limited to 10 covered services per year, combined)				
Plan deductible, PCY ¹ (individual/family)	\$2,500/\$5,000	NA				
Out-of-pocket maximum, PCY (individual/family)	\$6,000/\$12,000	NA				
Coinsurance	30%	NA				
Waiver	Annual deductible and plan coinsurance do not apply to office visits including surgery	NA				
Preventive and well-child care	No charge	No charge				
Telehealth	No charge	\$50				
Office visits	\$30	\$50				
Urgent care office visits	\$30	\$50				
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	40% coinsurance				
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	Not covered				
Outpatient surgery	30% coinsurance after deductible	Not covered				
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coinsura	nce after in-network deductible ²				
Hospital inpatient	30% coinsurance after deductible	Not covered				
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	Not covered				
Home health care (130 visits, PCY)	No charge	Not covered				
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$30	\$50				
Acupuncture (12 visits, PCY)	\$30	\$50				
Inpatient mental health and substance use disorder	30% coinsurance after deductible	Not covered				
Outpatient mental health and substance use disorder	\$30	\$50				
Routine eye exam (1 exam every 12 months)	\$30	\$50				
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge				
Prescription drugs – retail (up to a 30-day supply)	Limited to 5 prescription fills per year				
Preferred generic drugs	\$25	\$45				
Preferred brand-name drugs	\$50	\$70				
Non-preferred generic and brand-name drugs	Not covered	Not covered				
Prescription drugs – mail o	rder (up to a 90-day supply)					
Preferred generic drugs	\$50	Not covered				
Preferred brand-name drugs	referred generic Not covered					
Non-preferred generic and brand-name drugs						
Prescription drugs – specia	ty (up to a 30-day supply)					
Preferred specialty drugs 50% up to \$150		Not covered				
Non-preferred specialty drugs	Not covered	Not covered				
Drug list/formulary	1 or 2-tier with additional specialty	y tier In-network pharmacy benefit				

^{1.} PCY = Per calendar year. **2.** The limit of 10 covered services does not apply.



Reset	Compare plans	Plans selected:	

Reset		Compare plans Plans selected:		
	NEW Kaiser Perma	nente Plus™ Plans		
Complete Suite category	KP Plu	is 2500 L7		
,	In-network	Out-of-network (limited to 10 covered services per year, combined)		
Plan deductible, PCY ¹ (individual/family)	\$2,500/\$5,000	NA		
Out-of-pocket maximum, PCY (individual/family)	\$6,000/\$12,000	NA		
Coinsurance	30%	NA		
Waiver	Annual deductible and plan coinsurance do not apply to office visits or to diagnostic laboratory and radiology services	NA		
Preventive and well-child care	No charge	No charge		
Telehealth	No charge	\$45/\$55		
Office visits	\$25/\$35	\$45/\$55		
Urgent care office visits	\$25/\$35	\$45/\$55		
Lab and X-ray procedures (outpatient)	\$25	\$45		
CT, MRI, and PET scans (outpatient)	\$100	Not covered		
Outpatient surgery	30% coinsurance after deductible	Not covered		
Emergency care (copay waived if admitted to inpatient)	30% coinsurance after	in-network deductible ²		
Hospital inpatient	30% coinsurance after deductible	Not covered		
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	Not covered		
Home health care (130 visits, PCY)	No charge	Not covered		
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$25	\$45		
Acupuncture (12 visits, PCY)	\$25	\$45		
Inpatient mental health and substance use disorder	30% coinsurance after deductible	Not covered		
Outpatient mental health and substance use disorder	\$25	\$45		
Routine eye exam (1 exam every 12 months)	\$25/\$35	\$45/\$55		
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge		
Prescription drugs – retail (up to a 30-day supply)	Limited to 5 prescription fills per year		
Preferred generic drugs	\$15	\$35		
Preferred brand-name drugs	\$40	\$60		
Non-preferred generic and brand-name drugs	\$60	\$80		
Prescription drugs – mail or	der (up to a 90-day supply)			
Preferred generic drugs	\$30	Not covered		
Preferred brand-name drugs	\$80	Not covered		
Non-preferred generic and brand-name drugs				
Prescription drugs – special	ty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not covered		
Non-preferred specialty drugs	30%	Not covered		
Drug list/formulary	5-tier In-network	pharmacy benefit		

^{1.} PCY = Per calendar year. **2.** The limit of 10 covered services does not apply.

Reset	Compare plans	Plans selected:	
		•	

Reset		Compare plans Plans selected:			
	NEW Kaiser Perma	nanente Plus™ Plans			
Complete Suite category	KP Plu	s 3000 V8			
, , ,	In-network	Out-of-network (limited to 10 covered services per year, combined)			
Plan deductible, PCY ¹ (individual/family)	\$3,000/\$6,000	NA			
Out-of-pocket maximum, PCY (individual/family)	\$7,500/\$15,000	NA			
Coinsurance	30%	NA			
Waiver	Annual deductible and plan coinsurance do not apply to office visits including surgery	NA			
Preventive and well-child care	No charge	No charge			
Telehealth	No charge	\$50			
Office visits	\$30	\$50			
Urgent care office visits	\$30	\$50			
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	40% coinsurance			
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	Not covered			
Outpatient surgery	30% coinsurance after deductible	Not covered			
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 30% coinsu	rance after in-network deductible ²			
Hospital inpatient	30% coinsurance after deductible	Not covered			
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	Not covered			
Home health care (130 visits, PCY)	No charge	Not covered			
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$30	\$50			
Acupuncture (12 visits, PCY)	\$30	\$50			
Inpatient mental health and substance use disorder	30% coinsurance after deductible	Not covered			
Outpatient mental health and substance use disorder	\$30	\$50			
Routine eye exam (1 exam every 12 months)	\$30	\$50			
Hearing hardware (\$3,000 per ear, every 36 months)	No charge	No charge			
Prescription drugs – retail (up to a 30-day supply)	Limited to 5 prescription fills per year			
Preferred generic drugs	\$25	\$45			
Preferred brand-name drugs	\$50	\$70			
Non-preferred generic and brand-name drugs	Not covered	Not covered			
Prescription drugs – mail o	rder (up to a 90-day supply)				
Preferred generic drugs	\$50	Not covered			
Preferred brand-name drugs	ed generic Not covered Not covered				
Non-preferred generic and brand-name drugs					
Prescription drugs – specialty (up to a 30-day supply)					
Preferred specialty drugs	50% up to \$150	Not covered			
Non-preferred specialty drugs Not covered Not covered		Not covered			
Drug list/formulary	1 or 2-tier with additional specialty	tier In-network pharmacy benefit			

^{1.} PCY = Per calendar year. **2.** The limit of 10 covered services does not apply.

Compare plans Plans selected: Reset

NEW Kaiser Permanente Plus** Plans Complete Suite category	Reset		Compare plans Plans selected:				
In-network In-network Itimited to 10 covered services per year, combined		NEW Kaiser Perma	nente Plus™ Plans				
Initiativo Initiatia Initiativo Initiativo Initiativo Initiativo Initiati	Complete Suite category	■ KP Plus 5000 L9					
Out-of-pocket maximum, PCY (Individualifamily) Out-of-pocket maximum, PCY (Individualifamily) Coinsurance 30% Maiver Annual deductible and plant coinsurance do not apply to office visits or to diagnostic laboratory and radiology services Preventive and well-child care Preventive and prevent		In-network	Out-of-network (limited to 10 covered services per year, combined)				
Pervinidudual/family) Coinsurance 30% Maiver Annual deductible and plan coinsurance do not apply to office visits or to dispressic laboratory and natiology services Preventive and well-child care Telehealth No charge Telehealth No charge S50/560 Office visits S30/540 Urgent care office visits S30/540 S50/560 Urgent care office visits S30/540 S50/560 CI, MRI, and PET scans (outpatient) Cutpatient surgery 30% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) Hospital inpatient 30% coinsurance after deductible Not covered Skilled nursing facility (60 days, PCY) Manipulative therapy (12 visits, PCY) Manipulative therapy (13 visits) S50 S50 S50 S50 S50 S50 S50 S5		\$5,000/\$10,000	NA				
Waiver Annual deductible and plan coinsurance do not apply to office visits or to diagnostic laboratory and radiology services Preventive and well-child care Telehealth No charge \$50\footnote{So0}\$ Office visits \$30\footnote{So0}\$ Urgent care office visits \$30\footnote{So0}\$ Not covered Not covered Outpatient surgery \$30\footnote{So0}\$ Sootnote office visits of visits \$30\footnote{So0}\$ Urgent care office visits \$30\footnote{So0}\$ Not covered Outpatient mental health and substance use disorder \$30\footnote{So0}\$ Urgent care office visits \$30\footnote{So0}\$ Not covered Not covered Not covered Sootnote office visits \$30\footnote{So0}\$ Not covered Sootnote office visits \$30\footnote{So0}\$ Not covered Not covered Sootnote office visits \$30\footnote{So0}\$ Not covered Not covered Sootnote office visits \$30\footnote{So0}\$ Not covered Not covered Not covered Sootnote office visits \$30\footnote{So0}\$ Sootnote office visits of \$30\footnote{So0}\$ Not covered Sootnote office visits of \$30\footnote{So0}\$ Not covered Not c		\$9,000/\$18,000	NA				
Preventive and well-child care Care No charge No charge No charge No charge No charge Telehealth No charge S30/\$40 Urgent care office visits \$30/\$40 \$50/\$60 Urgent care office visits \$30/\$40 \$50/\$60 Urgent care office visits \$30 \$50 CI, MRI, and PET scans (outpatient) Outpatient surgery 30% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) Hospital impatient 30% coinsurance after deductible Not covered Skilled nursing facility (od days, PCV) Home health care (130 visits, PCV) Home health care (130 visits, PCV) Manipulative therapy (12 visits, PCV) Acupuncture (12 visits, PCV) Outpatient mental health and substance use disorder Routine eye exam (1 exam every 12 months) Routine eye exam (1 exam every 12 months) Routine eye exam (1 exam every 12 months) Preferred generic drugs Preferred generic and solutions and charge of the prescription fills per year end brand-name drugs Solo Discovered of the prescription fills per year end brand-name drugs Solo Discovered of the prescription fills per year end brand-name drugs Solo Discovered of the prescription fills per year end brand-name drugs Solo Discovered of the prescription fills per year end brand-name drugs Solo Discovered denotes of the prescription fills per year end brand-name drugs Solo Discovered denotes of the prescription fills per year end brand-name drugs Solo Discovered denotes of the prescription fills per year end trugs Preferred generic drugs Preferred generic drugs Solo Discovered denotes of the prescription fills per year end trugs Solo Discovered denotes of the prescription fills per year end trugs Solo Discovered denotes of the prescription fills per year end trugs Solo Discovered denotes of the prescription fills per year end trugs Solo Discovered denotes of the prescription fills per year end trugs Solo Discovered denotes of the prescription	Coinsurance	30%	NA				
Telehealth No charge \$50/\$60 Office visits \$30/\$40 \$50/\$60 Urgent care office visits \$30 \$50 CT, MRI, and PET scans (outpatient) Outpatient surgery 30% coinsurance after deductible Not covered Emergency care (copay waived if admitted to inpatient) Hospital inpatient 30% coinsurance after deductible Not covered Skilled nursing facility (60 days, PCY) No charge Not covered Manipulative therapy (12 visits, PC/\$2 additional visits with prior authorization) Acupuncture (12 visits, PCY) Inpatient mental health and substance use disorder Outpatient mental health and substance use disorder Outpatient mental health and substance use disorder Routine eye exam Solvation (1 exam every 12 months) Hearing hardware (53,000 per ear, every 36 months) Prescription drugs — retail (up to a 30-day supply) Limited to 5 prescription fills per year Preferred generic drugs \$15 \$35 Preferred de generic drugs Selo Solvation Solv	Waiver		NA				
Office visits \$30/\$40 \$50/\$60 Urgent care office visits \$30/\$40 \$50/\$60 Lab and X-ray procedures (outpatient) \$30 \$50 CJ, MRI, and PET scans (outpatient) \$100 Not covered CUpatient surgery 30% coinsurance after deductible Not covered Emergency care (copay waived if admitted to inpatient) 30% coinsurance after deductible Not covered Hospital inpatient 30% coinsurance after deductible Not covered Skilled nursing facility (60 days, PCV) 30% coinsurance after deductible Not covered Home health care (130 visits, PCV) No charge Not covered Manipulative therapy (12 visits, PCV) additional visits with prior authorization) \$50 \$50 Acupuncture (12 visits, PCV) additional visits with prior authorization \$50 \$50 Inpatient mental health and substance use disorder 30% coinsurance after deductible Not covered Outpatient mental health and substance use disorder \$30 \$50 Routine eye exam (1 casm every 12 months) \$30/\$40 \$50/\$60 Hearing hardware (\$3,000 per ear, every 35 months) \$30/\$40 \$50/\$60		No charge	No charge				
Urgent care office visits \$30/\$40 \$50/\$60 Lab and X-ray procedures (outpatient) \$30 \$50 CT, MRI, and PET scans (outpatient) \$100 Not covered Outpatient surgery 30% coinsurance after deductible Not covered Emergency care (copay waived if admitted to inpatient) 30% coinsurance after deductible Not covered Hospital inpatient 30% coinsurance after deductible Not covered Skilled nursing facility (60 days, PCY) No charge Not covered Manipulative therapy (12 wists, PCY, additional visits with prior authorization) \$30 \$50 Acupuncture (12 wists, PCY, additional visits with prior authorization) \$30 \$50 Inpatient mental health and substance use disorder \$30 \$50 disorder \$30 \$50 Routine eye exam (1 exam every 12 months) \$30/\$40 \$50/\$60 Hearing hardware (\$3,000 per ear, every 3 months) No charge No charge Preferred generic drugs \$15 \$35 Preferred brand-name drugs \$40 \$60 Non-preferred generic and brand-name drugs \$60 \$80	Telehealth	No charge	\$50/\$60				
Lab and X-ray procedures (outpatient) \$30 \$50 CT, MRI, and PET scans (outpatient) \$100 Not covered Outpatient surgery 30% coinsurance after deductible Not covered Emergency care (copay waived if admitted to inpatient) 30% coinsurance after deductible Not covered Hospital inpatient 30% coinsurance after deductible Not covered Skilled nursing facility (60 days, PCY) 30% coinsurance after deductible Not covered Home health care (130 visits, PCY) No charge Not covered Manipulative therapy (12 visits, PCY) \$30 \$50 Vizits with prior vauthorization) \$30 \$50 Acupuncture (12 visits, PCY) \$30 \$50 Inpatient mental health and substance use disorder \$30% coinsurance after deductible Not covered Outpatient mental health and substance use disorder \$30 \$50 Routine eye exam (1 exam every 12 months) \$30 \$50 Hearing hardware (\$3,000 per ear, every 3 months) No charge No charge Preferred generic drugs \$15 \$35 Preferred brand-name drugs \$40 \$60 Non-preferred bgeneric drugs \$40	Office visits	\$30/\$40	\$50/\$60				
(outpatient) \$300 Not covered CT, MRI, and PET scans (outpatient) \$100 Not covered Outpatient surgery 30% coinsurance after deductible Not covered Emergency care (copay waived if admitted to inpatient) 30% coinsurance after deductible Not covered Skilled nursing facility (60 days, PCY) 30% coinsurance after deductible Not covered Skilled nursing facility (60 days, PCY) 30% coinsurance after deductible Not covered Home health care (130 visits, PCY) No charge Not covered Manipulative therapy (12 visits, PCY) additional visits with prior authorization) \$30 \$50 Acupuncture (12 visits, PCY) \$30 \$50 Inpatient mental health and substance use disorder 30% coinsurance after deductible Not covered Outpatient mental health and substance use disorder \$30 \$50 Routine eye exam (1 exam every 12 months) \$30 \$50 Rearing hardware (1 exam every 12 months) \$30/\$40 \$50/\$50 Prescription drugs – retail (up to a 30-day supply) Limited to 5 prescription fills per year Preferred generic drugs \$15 \$35 Preferred brand-name drugs \$40 \$60 Non-preferred generic and brand-name drugs \$60 \$80	Urgent care office visits	\$30/\$40	\$50/\$60				
(outpatient) Stool Not covered Emergency care (copay waived if admitted to inpatient) 30% coinsurance after deductible Not covered Hospital inpatient 30% coinsurance after deductible Not covered Skilled nursing facility (60 days, PCY) 30% coinsurance after deductible Not covered Home health care (130 visits, PCY) No charge Not covered Manipulative therapy (12 visits, PCY) \$30 \$50 Usitists, PCY) \$30 \$50 Inpatient mental health and substance use disorder 30% coinsurance after deductible Not covered Outpatient mental health and substance use disorder \$30 \$50 Outpatient mental health and substance use disorder \$30 \$50 Routine eye exam (1 exam every 12 months) \$30/\$40 \$50/\$60 Hearing hardware (\$3,000 per ear, every 36 months) No charge No charge 86 months) \$15 \$35 Prescription drugs - retail (up to a 30-day supply) Limited to 5 prescription fills per year Preferred generic drugs \$40 \$60 Non-preferred generic drugs \$60 \$80		\$30	\$50				
Emergency care (copay waived if admitted to inpatient) Hospital inpatient Hospital inpatient Manipulative therapy (12 visits, PCY) Manipulative therapy (12 visits, PCY) Acupuncture (130 visits, PCY) Inpatient mental health and substance use disorder Routine eye exam (1 example) Routine eye exam (1		\$100	Not covered				
(copay waived if admitted to inpatient) 30% coinsurance after innetwork deductible² Hospital inpatient 30% coinsurance after deductible Not covered (killed nursing facility (kod days, PCY) 30% coinsurance after deductible Not covered Home health care (130 visits, PCY) No charge Not covered Manipulative therapy (12 visits, PCY; additional visits with prior authorization) \$30 \$50 Acupuncture (12 visits, PCY) \$30 \$50 Inpatient mental health and substance use disorder 30% coinsurance after deductible Not covered Outpatient mental health and substance use disorder \$30 \$50 Routine eye exam (1 exam every 12 months) \$30/\$40 \$50/\$60 Hearing hardware (\$3,000 per ear, every 36 months) No charge No charge Prescription drugs – retail vot a 30-day supply) Limited to 5 prescription fills per year Preferred generic drugs \$15 \$35 Preferred generic drugs \$40 \$60 Non-preferred generic drugs \$60 \$80	Outpatient surgery	30% coinsurance after deductible	Not covered				
Skilled nursing facility (60 days, PCY) 30% coinsurance after deductible Not covered Home health care (130 visits, PCY) No charge Not covered Manipulative therapy (12 visits, PCY; additional visits with prior authorization) \$30 \$50 Accupuncture (12 visits, PCY) \$30 \$50 Inpatient mental health and substance use disorder 30% coinsurance after deductible Not covered Outpatient mental health and substance use disorder \$30 \$50 Routine eye exam (1 exam every 12 months) \$30/\$40 \$50/\$60 Hearing hardware (53,000 per ear, every 36 months) No charge No charge Prescription drugs – retail (up to a 30-day supply) Limited to 5 prescription fills per year Preferred generic drugs \$15 \$35 Preferred brand-name drugs \$40 \$60 Non-preferred generic and brand-name drugs \$60 \$80	(copay waived if admitted	30% coinsurance afte	r in-network deductible ²				
Home health care (130 visits, PCY) No charge Not covered	Hospital inpatient	30% coinsurance after deductible	Not covered				
(130 visits, PCY)No chargeNot coveredManipulative therapy (12 visits, PCY, additional visits with prior authorization)\$30\$50Accupuncture 		30% coinsurance after deductible	Not covered				
(12 visits, PCY; additional visits with prior authorization)\$30\$50Acupuncture (12 visits, PCY)\$30\$50Inpatient mental health and substance use disorder30% coinsurance after deductibleNot coveredOutpatient mental health and substance use disorder\$30\$50Routine eye exam (1 exam every 12 months)\$30/\$40\$50/\$60Hearing hardware (\$3,000 per ear, every 36 months)No chargeNo chargePrescription drugs – retail up to a 30-day supply)Limited to 5 prescription fills per yearPreferred generic drugs\$15\$35Preferred brand-name drugs\$40\$60Non-preferred generic and brand-name drugs\$60\$80		No charge	Not covered				
(12 visits, PCY)\$30\$30Inpatient mental health and substance use disorder30% coinsurance after deductibleNot coveredOutpatient mental health and substance use disorder\$30\$50Routine eye exam (1 exam every 12 months)\$30/\$40\$50/\$60Hearing hardware (\$3,000 per ear, every 36 months)No chargeNo chargePrescription drugs - retail (up to a 30-day supply)Limited to 5 prescription fills per yearPreferred generic drugs\$15\$35Preferred brand-name drugs\$40\$60Non-preferred generic and brand-name drugs\$60\$80	(12 visits, PCY; additional visits with prior	\$30	\$50				
and substance use disorder Outpatient mental health and substance use disorder Routine eye exam (1 exam every 12 months) Hearing hardware (\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs Preferred brand-name drugs Non-preferred generic and brand-name drugs \$60 Solve to the deductible of the constraint		\$30	\$50				
health and substance use disorder Routine eye exam (1 exam every 12 months) Hearing hardware (\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs Preferred brand-name drugs No charge \$15 \$35 \$36 \$40 \$60 \$80	and substance use	30% coinsurance after deductible	Not covered				
(1 exam every 12 months) Hearing hardware (\$3,000 per ear, every 36 months) Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs Preferred brand-name drugs No charge No charge No charge State of the state of	health and substance use	\$30	\$50				
No charge No charge No charge No charge		\$30/\$40	\$50/\$60				
Preferred generic drugs \$15 \$35 Preferred brand-name drugs \$40 \$60 Non-preferred generic and brand-name drugs \$60	(\$3,000 per ear, every	No charge	No charge				
Preferred brand-name drugs \$40 \$60 Non-preferred generic and brand-name drugs \$60	Prescription drugs – retail (up to a 30-day supply)	Limited to 5 prescription fills per year				
drugs \$40 \$60 Non-preferred generic and brand-name drugs \$60 \$80	Preferred generic drugs	\$15	\$35				
and brand-name drugs		\$40	\$60				
Prescription drugs – mail order (up to a 90-day supply)		\$60	\$80				
1 3 11 1177	Prescription drugs – mail o	rder (up to a 90-day supply)					
Preferred generic drugs \$30 Not covered	Preferred generic drugs	\$30	Not covered				
Preferred brand-name drugs \$80 Not covered		\$80	Not covered				
Non-preferred generic and brand-name drugs \$120 Not covered							
Prescription drugs – specialty (up to a 30-day supply)	Prescription drugs – specia	ty (up to a 30-day supply)					
Preferred specialty drugs \$150 Not covered	Preferred specialty drugs	\$150	Not covered				
Non-preferred specialty drugs Not covered		30%	Not covered				
Drug list/formulary 5-tier in-network pharmacy benefit	Drug list/formulary	5-tier in-network	pharmacy benefit				



^{1.} PCY = Per calendar year. **2.** The limit of 10 covered services does not apply.

OVERVIEW HMO VIRTUAL PLUS SUMMIT PPO ACCESS PPO KP PLUS

SUPPLEMENTAL BENEFITS

First Fill Maintenance Drug Program

Optionally, for our HMO, Access PPO, and Summit PPO suite of plans, you can choose to include our convenient and cost-effective First Fill Maintenance Drug Program. The first time you fill a prescription for a maintenance drug, 1 you may use either an in-network pharmacy or Kaiser Permanente's mail-order pharmacy. For subsequent refills, you are required to use Kaiser Permanente's mail-order or a Kaiser Permanente clinic pharmacy for your refills. Transferring your prescription into our mail-order pharmacy is simple – and delivery is no cost, safe, and fast. Most maintenance drugs refilled at non–Kaiser Permanente clinic pharmacies will not be covered. This does not apply to medication for sudden conditions or to drugs we can't mail.2 At any time, a member can request an emergency fill of a maintenance medication at any pharmacy in their network. Please contact your Kaiser Permanente representative for more information.

Vision hardware

Eye exams are included and covered under the medical benefits of all plans included in this brochure. Eye exam cost shares vary by plan. Please see the highlights within this brochure for more details. Optionally you can choose to add the following vision hardware benefit, that includes a flat dollar allowance. The vision hardware benefit can be used towards the purchase of prescription eyeglasses – including frames, prescription lenses and lens options such as tinting – or prescription contact lenses, contact lens exams, and fitting. When you offer a vision hardware benefit, the benefit also includes a specific pediatric vision hardware benefit for members under age 19.

Members age 19 and over:	Members under age 19:
Member pays nothing, limited to \$150 every 12 months. The benefit period begins on the date services are first obtained.	Frames and lenses (in lieu of contact lenses): No charge; member pays nothing for up to 1 pair per calendar year. Contact lenses (in lieu of eyeglasses): Member pays 50% coinsurance. The benefit period begins on January 1 and continues through the end of the calendar year.
Additional benefit details:	Additional benefit details:
Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations, and examinations associated with their fitting. The benefit period begins on the date services are first obtained. The Allowance may be used toward the following in any combination: • Eyeglass frames • Eyeglass lenses (any type) including tinting and coating • Corrective industrial (safety) lenses • Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity • Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations • Replacement frames, for any reason, including loss or breakage • Replacement contact lenses • Replacement eyeglass lenses	Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations, and examinations associated with their fitting. The benefit period begins on January 1 and continues through the end of the calendar year. The benefit may be used toward contact lenses (in lieu of eyeglasses) or 1 eyeglass frame and pair of lenses. • Eyeglass frames • Eyeglass lenses (any type) including tinting and coating • Corrective industrial (safety) lenses • Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations

^{1.} Maintenance drugs are used on a continuing basis for the treatment of ongoing conditions, such as diabetes. The maintenance drug list is available at wa.kaiserpermanente.org/static/pdf/public/pharmacy/maintenance-drugs.pdf. 2. Members may continue to pick up medication, that can't be sent through mail, at a network pharmacy. Types of medications that can't be mailed include Schedule 2 controlled substances, liquid antibiotics, oral typhoid, clozapine, isotretinoin, and over-the-counter drugs without a prescription.



OVERVIEW HMO VIRTUAL PLUS SUMMIT PPO ACCESS PPO KP PLUS

Reset								Compare plans	Plans selected:
Complete Suite category									
Plan deductible, PCY* (individual/family)									
Out-of-pocket maximum, PCY (individual/family)									
Coinsurance									
Preventive and well-child care									
Telehealth									
Office visits									
Urgent care office visits									
Lab and X-ray procedures (outpatient)									
CT, MRI, and PET scans (outpatient)									
Outpatient surgery									
Emergency care (copay waived if admitted to inpatient)									
Hospital inpatient									
Skilled nursing facility (60 days, PCY)									
Home health care									
Manipulative therapy									
Acupuncture (12 visits, PCY)									
Inpatient mental health and substance use disorder									
Outpatient mental health and substance use disorder									
Routine eye exam (1 exam every 12 months)									
Hearing hardware (\$3,000 per ear, every 36 months)									
Prescription drugs – retail ((up to a 30-day supply)								
Preferred generic drugs									
Preferred brand-name drugs									
Non-preferred generic and brand-name drugs									
	Prescription drugs – mail order (up to a 90-day supply)								
Preferred generic drugs									
Preferred brand-name drugs									
Non-preferred generic and brand-name drugs									
Drug list/formulary									

*PCY = Per calendar year

View the drug formulary at $\ensuremath{\text{kp.org/wa/formulary}}$



