2026 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.





Table of contents: Plan categories

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
Kaiser Permanente Plus™ plans	85
Kaiser Permanente Everyday Care plans	95
Supplemental benefits	98

OVERVIEW HMO VIRTUAL PLUS SUMMIT PPO ACCESS PPO KP PLUS EVERYDAY CARE

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 2026:

Kaiser Permanente Everyday Care Plans

With a Kaiser Permanente Everyday Care plan, your employees get convenient access to routine care at a \$0 or \$10 copay – depending on their plan – making it ideal for employees who value routine care and regularly stay on top of their health.

NEW! Plans Include:

Kaiser Permanente Everyday Care Plan \$0/\$4000

Kaiser Permanente Everyday Care Plan \$0/\$5000

Kaiser Permanente Everyday Care Plan \$0/\$6000

Kaiser Permanente Everyday Care Plan \$0/\$7000

Kaiser Permanente Everyday Care Plan \$10/\$2000

Kaiser Permanente Everyday Care Plan \$10/\$3000

Kaiser Permanente Everyday Care Plan \$10/\$4000

Kaiser Permanente Everyday Care Plan \$10/\$5000

Kaiser Permanente Everyday Care Plan \$10/\$6000



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, Access PPO, KP Plus, and Kaiser Permanente Everyday Care. 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 2026 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		НМО Сор	oay 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 days	
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 days	
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	1 per ear every 36 months				
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 order (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	3 11 31	4450	44.50	#450	
Preferred specialty drugs Non-preferred	\$150 30%	\$150 30%	\$150 30%	\$150 30%	
specialty drugs Drug list/formulary	5-tier in-network	5-tier in-network	5-tier in-network	5-tier in-network	
,	pharmacy benefit	pharmacy benefit	pharmacy benefit	pharmacy benefit	

^{*}PCY = Per calendar year.



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Reset		Compare plan	Plans selected:
Commission College and a name		HMO Waiver Plans: VisitsPlu	S
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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months
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 o	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 – 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 special tier in-network pharmacy benefi

^{*}PCY = Per calendar year.

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



Plans selected:	Compare plans		Reset
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Reset		Compare plan	Plans selected:
	ı	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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months
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 o	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 – specia	lty (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 benef

^{*}PCY = Per calendar year.



Reset		Compare plan	Plans selected:
	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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months
Prescription drugs – retail (up to a 30-day supply)	ı	1
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

Drug list/formulary

Preferred specialty drugs

Non-preferred specialty

drugs

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

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

50% up to \$150

Not covered

1 or 2-tier with additional specialty

tier in-network pharmacy benefit

50% up to \$150

Not covered

1 or 2-tier with additional specialty

tier in-network pharmacy benefit



50% up to \$150

Not covered

1 or 2-tier with additional specialty

tier in-network pharmacy benefit

^{*}PCY = Per calendar year.

Reset	Compare plans Plans selected:		
Complete Cuite actorium	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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months
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.

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



Plans selected:

Reset Compare plans

Reset		Compare plan	Flans selected:
Campleta Suita satagaga	HM	10 Waiver Plans: Lab/X-Ray P	lus
Complete Suite category	■ HMO 1000 L4	■ HMO 1500 L5	■ HMO 2000 L6
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: 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	\$25/\$35	\$25/\$35
Urgent care office visits (primary/specialty)	\$25/\$35	\$25/\$35	\$25/\$35
Lab and X-ray procedures (outpatient)	\$25	\$25	\$25
CT, MRI, and PET scans (outpatient)	\$100	\$100	\$100
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)	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	\$25	\$25	\$25
Acupuncture (12 visits, PCY)	\$25	\$25	\$25
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	\$25
Routine eye exam (1 exam every 12 months, primary/specialty)	\$25/\$35	\$25/\$35	\$25/\$35
Hearing hardware	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months
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.



Reset	Compare plans	Plans selected:

Reset		Compare plan	Plans selected:
Commission Cuito cotonomi	HM	IO 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 an 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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months
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 benef

^{*}PCY = Per calendar year.

OVERVIEW HMO VIRTUAL PLUS SUMMIT PPO ACCESS PPO KP PLUS EVERYDAY CARE

Reset

Compare plans

Plans selected:

Reset		Compare plan	Plans selected:
Complete Catherine		HMO Welcome Plans	
Complete Suite category	■ HMO 250 W1	■ HMO 500 W3	■ HMO 750 W5
Plan deductible, PCY ¹ (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: 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	\$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% coinsurance 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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months
Prescription drugs – retail (up to a 30-day supply)	I	I
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	50% up to \$150	\$150	50% up to \$150
Non-preferred specialty drugs	Not covered	30%	Not covered
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 specialty tier in-network pharmacy benefit

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





OVERVIEW HMO VIRTUAL PLUS SUMMIT PPO ACCESS PPO KP PLUS EVERYDAY CARE

Reset

Compare plans

Plans selected:

Reset		Compare plan	Plans selected:	
Consultate Calle and annual	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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months	
Prescription drugs – retail (up to a 30-day supply)	1	I	
Preferred generic drugs	\$15	\$15	\$15	
Preferred brand-name drugs	\$40	\$30	\$40	
Non-preferred generic and brand-name drugs	\$60	Not covered	\$60	
Prescription drugs – mail o	rder (up to a 90-day supply)			
Preferred generic drugs Preferred brand-name	\$30 \$80	\$30 \$60	\$30 \$80	
drugs Non-preferred generic	\$120	Not covered	\$120	
and brand-name drugs Prescription drugs – special				
Preferred specialty drugs	\$150	50% up to \$150	\$150	
Non-preferred specialty drugs	30%	Not covered	30%	
Drug list/formulary	5-tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit	5-tier in-network pharmacy benefi	

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

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





VIRTUAL PLUS **OVERVIEW** НМО **SUMMIT PPO** ACCESS PPO **KP PLUS EVERYDAY CARE**

Reset

Compare plans Plans selected:

Reset		Compare plan	Plans selected:	
Complete Suite setenam	HMO Welcome Plans			
Complete Suite category	■ HMO 2500 W12	■ HMO 3000 W13	■ HMO 5000 W14	
Plan deductible, PCY ¹ (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: 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, CI 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	\$30 copay, then 30% coinsurance after deductible ²	\$30 copay, then 30% coinsurance after deductible ²	\$40 copay, then 30% coinsurance after deductible ²	
Urgent care office visits	\$30 copay, then 30% coinsurance after deductible ²	\$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% coinsuranc 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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months	
Prescription drugs – retail (up to a 30-day supply)	I	I	
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				
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 specialt tier in-network pharmacy benefit	

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





Reset			Compare plans	Plans selected:
		HMO Dedu	ctible Plans	
Complete Suite category	■ HMO 1500	■ HMO 2500	■ HMO 3000	■ 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	1 per ear every 36 months			
Prescription drugs – retail (up to a 30-day supply)			
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 o	rder (up to a 90-day supply)			
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 – specia	3 11 3			
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.



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

Reset

Compare plans

Plans selected:

Complete Suite category	HMO HSA Plans			
	HMO 1700 (A) HSA	■ HMO 2500 (A) HSA	■ HMO 3500 (A) HSA	
Plan deductible, PCY* (individual/family)	\$1,700/\$3,400	\$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 covere in full	
Office visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
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 deductibl	
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 deductibl	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
Home health care (130 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
Manipulative therapy (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
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 deductibl	
Hearing hardware	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months	
Prescription drugs – retail (up to a 30-day supply)			
Preferred generic drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
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 deductibl	
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
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 plans

Plans selected:

Complete Suite category	HMO HSA Plans			
	■ HMO 3400 (E) HSA	■ HMO 3500 (E) HSA	HMO 4000 (E) HSA	
Plan deductible, PCY* (individual/family)	\$3,400/\$6,800	\$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 covere 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 deductibl	
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
Outpatient surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
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 deductibl	
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
Home health care (130 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
Manipulative therapy (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductibl	
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 deductibl	
Routine eye exam (1 exam every 12 months)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	
Hearing hardware	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months	
Prescription drugs – retail (up to a 30-day supply)		1	
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 deductibl	
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 deductibl	
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**.

Plans selected:

Reset Compare plans

Reset		Compare plan	Fights selected:	
Complete Suite category	HMO HSA Plans			
Complete Suite Category	HMO 4500 (E) HSA	■ HMO 5000 (E) 100% HSA	HMO 6000 (E) 100% HSA	
Plan deductible, PCY* (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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months	
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.



Reset

Compare plans Plans selected:

Reset		Compare plan	Plans selected:	
Consolida Collegado esta conso	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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months	
Prescription drugs – retail ((up to a 30-day supply)		I	
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	
Prescription drugs – mail o	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.

pharmacy benefit

pharmacy benefit

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



pharmacy benefit

Reset	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% coinsurance 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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months	
Prescription drugs – retail (up to a 30-day supply)			
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	
	rder (up to a 90-day supply)	A.F.	A.	
Preferred generic drugs Preferred brand-name	\$5	\$5	\$5	
drugs Non-preferred generic	\$70	\$70	\$80	
and brand-name drugs	Not covered	Not covered	Not covered	
Prescription drugs – specia			·	
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.



	_		
Reset		Compare plans	Plans selected:

Reset		Compare plan	Plans selected:	
Complete College	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% after 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 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 (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	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months	
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	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.



Reset		Compare plan	Plans 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	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	1 per ear every 36 months	1 per ear every 36 months	Not Covered		
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					
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**.

Reset		Compare plans	Plans selected:
	Summit	t PPO Plans	

	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)	\$3,000	\$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	1 per ear every 36 months	1 per ear every 36 months	Not Covered
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 or	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			
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.

Reset	Compare plans Plans select	ted:
	Summit PPO Plans	

	Summit PPO Plans		
Complete Suite category			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (individual/family)	\$500/9	\$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 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	1 per ear every 36 months	1 per ear every 36 months	Not Covered
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
	order (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		A	
Preferred specialty drugs Non-preferred specialty	\$150 30%	\$150 30%	Not covered Not covered
drugs			
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 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	1 per ear every 36 months	1 per ear every 36 months	Not Covered
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
	order (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	3 11 3		
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.

Reset		Compare plan	Plans selected:		
		Summit PPO Plans			
Complete Suite category	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	1 per ear every 36 months	1 per ear every 36 months	Not Covered		
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	3 11 3·				
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.

	Cummit DDO Blanc		
Reset	Compare plans	Plans selected:	

	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* (individual/family)	\$1,500/\$3,000		\$4,500/\$9,000		
Out-of-pocket maximum, PCY (individual/family)	\$5,000/	\$10,000	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)	\$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	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)	\$150 copay, then 10% coinsurance after deductible	\$150 copay, then 10% coinsurance after deductible	\$150 copay, then 10% coinsuranc 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)	\$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	20% 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	1 per ear every 36 months	1 per ear every 36 months	Not Covered		
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		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**.

		Summit PPO Plans		
Complete Suite category	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% coinsuranc 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)	\$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	1 per ear every 36 months	1 per ear every 36 months	Not Covered	
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 or				
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	2 11 2			
Preferred specialty drugs Non-preferred specialty	\$150	\$150	Not covered	
drugs	30%	30%	Not covered	

^{*}PCY = Per calendar year.



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

Reset		Compare plan	Fians selected.
	Summit PPO Plans		
Complete Suite category			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (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%
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	1 per ear every 36 months	1 per ear every 36 months	Not Covered
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
	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	

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	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/	\$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	1 per ear every 36 months	1 per ear every 36 months	Not Covered		
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 – 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			

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Reset	Compare plans	Plans selected:

Plant deductible, PCY* (infolfeductarianly) 10.001 of pocket maximum, PCY(infolfeductarianly) 10.001 of po		Summit PPO Plans			
Plan deductible, PCY (individual/family) 100 to fooder maximum, PCY (individu	Complete Suite category				
Individual/shamily Su,0000Sq,000 Unlimited		Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)	
PCV (Individual/Smilly) Coinsurance 20% 40% 50% coinsurance 20% No charge No coinsurance after deductible No coinsurance after		\$3,000	/\$6,000	\$9,000/\$18,000	
Preventive and well-child care Inchesiath No charge No consurance after dedu Urgent care office visits (primary/specialty) Lab and X-ray procedures (outpatient) Lab and X-ray procedures (outpatient) Lab and X-ray procedures (outpatient) Outpatient surgery 20% coinsurance 20% coinsurance 40% coinsurance 40% coinsurance 50% coinsurance after dedu Unique tare office visits (primary/specialty) Lab and X-ray procedures (outpatient) Outpatient surgery 20% coinsurance 20% coinsurance 40% coinsurance 40% coinsurance 50% coinsurance after dedu 50% coinsurance a		\$6,000/	\$12,000	Unlimited	
Telehealth No charge No charge SUS consurance after deductible (primary/specialty)	Coinsurance	20%	40%	50%	
Office visits (primary)specialty) Lab and Kary procedures (uotapatient) Lab and Kary procedures (uotapatient) Lab and Kary procedures (uotapatient) CT, MRI, and PET scans (uotapatient) CUptapatient surgery CT, MRI, and PET scans (uotapatient) Salva (solinsurance after deductible (40% coinsurance after deductible (solinsurance after deduct		No charge	No charge	50% coinsurance after deductible	
(primary/specially) Urgent care office visits (primary/specially) Lab and Xray procedures (outpatient) CLMRI, and PET scans (outpatient) CUtpatient surgery Continuation Cutpatient surgery Continuation Cutpatient surgery Continuation Continuation Cutpatient surgery Continuation	Telehealth	No charge	No charge	Not covered	
(primary/specalty) Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) CT, MRI, and PET scans (outpatient) CT, MRI, and PET scans (outpatient) 20% coinsurance 20% coinsurance 40% coinsurance after deductible 50% coinsurance after deductible 600 colorate 600 colo		\$20/\$40	\$40/\$80	50% coinsurance after deductible	
Coupatient Cou		\$20/\$40	\$40/\$80	50% coinsurance after deductible	
Coutpatient surgery 20% coinsurance after deductible 40% coinsurance after deductible 50% coinsurance after deductible 40% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 40% coinsurance after deduc		20% coinsurance	40% coinsurance	50% coinsurance after deductible	
Emergency care (copay waive dif admitted to inpatient) Inpatient) Inpatient) Inpatient) Inpatient 20% coinsurance after deductible Inpatient are (uniminited) Inpatient merapy (8 visits, PCY) Inpatient mental health and substance use disorder Inpatient mental health and substance use (1 visits, PCY) Inpatient mental hea		20% coinsurance	40% coinsurance	50% coinsurance after deductible	
waived if admitted to ingratient) Ingratient) Ingratient) Ingratient) Ingratient) Ingratient Ingratient) Ingratient Ingra		20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Hospital inpatient 20% coinsurance after deductible Skilled nursing facility (60 days, PCY) 20% coinsurance after deductible 20% coinsurance after deductible 40% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 820 \$40 \$40 \$50% coinsurance after deductible 40% coinsurance after deductible 50% coinsurance after deductible 820 \$40 \$50% coinsurance after deductible 830 \$40 \$50% coinsurance after deductible 840 \$50% coinsurance after deductible 840 \$50% coinsurance after deductible 850% coinsurance after d	waived if admitted to			\$200 copay, then 20% coinsuranc after deductible	
Home health care (unlimited) 20% coinsurance after deductible 40% coinsurance after deductible Manipulative therapy (8 visits, PCY; additional visits with prior authorization) 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) primary/specialty) Hearing hardware 1 per ear every 36 months 1 per ear every 36 months Not Covered Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$ 30 Not covered		20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
(unlimited) 20% coinsurance after deductible 40% 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 1 per ear every 36 months 1 per ear every 36 months Not Covered Prescription drugs – retail (up to a 30-day supply) \$15 \$25 Not covered Preferred generic drugs \$15 \$25 Not covered Preferred generic and brand-name drugs \$50 \$80 Not covered Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Non-preferred generic drugs \$30 Not covered Not covered Non-preferred generic drugs \$100 Not covered Not covered Non-preferred specialty drugs \$1		20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
Section Sect		20% coinsurance after deductible	40% 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 Outpatient mental health and substance use disorder Routine eye exam (1 exam every 12 months) primary/specialty) Hearing hardware 1 per ear every 36 months 1 per ear every 36 months Not Covered Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs \$15 \$25 Not covered Preferred brand-name drugs Non-preferred generic and brand-name drugs Prescription drugs – mail order (up to a 90-day supply) Preferred brand-name drugs Preferred brand-name drugs \$30 Not covered Not covered Not covered Non-preferred generic drugs \$30 Not covered Non-preferred generic drugs \$30 Not covered Non-preferred generic drugs \$30 Not covered	(8 visits, PCY; additional visits with prior	\$20	\$40	50% coinsurance after deductible	
and substance use disorder Outpatient mental health and substance use disorder Routine eye exam (1 exam every 12 months) primary/specialty) Hearing hardware 1 per ear every 36 months 1 per ear every 36 months 1 per ear every 36 months Not Covered Preferred generic drugs Non-preferred generic and brand-name drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs Prescription drugs – sail order (up to a 90-day supply) Preferred generic drugs – sail order (up to a 90-day supply) Preferred generic drugs – sail order (up to a 90-day supply) Preferred generic drugs – sail order (up to a 90-day supply) Preferred generic drugs – sail order (up to a 90-day supply) Preferred generic drugs – sail order (up to a 90-day supply) Preferred generic drugs – sail order (up to a 90-day supply) Preferred generic drugs – specialty (up to a 30-day supply) Preferred generic and brand-name drugs Non-preferred generic and brand-name drugs Non-preferred generic and brand-name drugs Signa – sail order (up to a 30-day supply) Preferred specialty drugs – specialty (up to a 30-day supply) Preferred specialty drugs – specialty (up to a 30-day supply) Preferred specialty drugs – specialty – spec		\$20	\$40	50% coinsurance after deductible	
health and substance use disorder Routine eye exam (1 exam every 12 months) primary/specialty) Hearing hardware 1 per ear every 36 months 1 per ear every 36 months Not Covered Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs \$15 \$25 Not covered Preferred brand-name drugs Non-preferred generic and brand-name drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Preferred brand-name drugs \$30 Not covered Not covered Not covered Preferred generic drugs \$30 Not covered Not covered Preferred brand-name drugs \$100 Not covered Not covered Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 \$150 Not covered Not covered Not covered Non-preferred specialty drugs \$150 \$150 Not covered Non-preferred specialty drugs Non-preferred specialty drugs Non-preferred specialty	and substance use	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	
(1 exam every 12 months) primary/specialty) Hearing hardware 1 per ear every 36 months 1 per ear every 36 months Not Covered Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs \$15 \$25 Not covered Preferred brand-name drugs Non-preferred generic and brand-name drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Preferred brand-name drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Not covered Not covered Preferred brand-name drugs \$100 Not covered Not covered Not covered Not covered Non-preferred generic and brand-name drugs \$100 Not covered Non-preferred generic and brand-name drugs \$100 Not covered Non-preferred specialty (up to a 30-day supply) Preferred specialty drugs \$150 Not covered Non-preferred specialty drugs \$150 Not covered	health and substance use	\$20	\$40	50% coinsurance after deductible	
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 order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Preferred brand-name drugs \$30 Not covered Not covered Preferred brand-name drugs \$40 Not covered Not covered Preferred brand-name frugs \$100 Not covered Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 \$150 Not covered Non-preferred specialty drugs \$150 Not covered	(1 exam every 12 months)	\$0/\$0	\$40/\$80	50% coinsurance after deductible	
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 order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Preferred brand-name drugs \$60 Not covered Not covered Preferred generic and brand-name drugs \$100 Not covered Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 \$150 Not covered Non-preferred specialty drugs \$150 \$150 Not covered	Hearing hardware	1 per ear every 36 months	1 per ear every 36 months	Not Covered	
Preferred brand-name drugs \$30 \$50 Not covered Non-preferred generic and brand-name drugs \$50 \$80 Not covered Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Preferred brand-name drugs \$60 Not covered Not covered Preferred generic and brand-name drugs \$100 Not covered Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 \$150 Not covered Not covered Non-preferred specialty drugs \$150 Not covered Non-preferred specialty 30% Not covered Non-preferred specialty	Prescription drugs – retail (up to a 30-day supply)			
Avoing the state of the state o	Preferred generic drugs	\$15	\$25	Not covered	
Prescription drugs — mail order (up to a 90-day supply) Preferred generic drugs \$30 Not covered Not covered Preferred brand-name drugs \$60 Not covered Not covered Preferred generic and brand-name drugs \$100 Not covered Not covered Prescription drugs — specialty (up to a 30-day supply) Preferred specialty drugs \$150 \$150 Not covered Not covered Not covered Not covered Not covered		\$30	\$50	Not covered	
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 Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 \$150 Not covered Non-preferred specialty 30% Not covered		\$50	\$80	Not covered	
Preferred brand-name drugs \$60 Not covered Not covered Not covered Non-preferred generic and brand-name drugs \$100 Not covered Not covered Prescription drugs – specialty (up to a 30-day supply) Preferred specialty drugs \$150 \$150 Not covered Non-preferred specialty 30% Not covered		7 11 2			
drugs		\$30	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	\$60	Not covered	Not covered	
Preferred specialty drugs \$150 \$150 Not covered Non-preferred specialty 30% Not covered	and brand-name drugs	·	Not covered	Not covered	
Non-preferred specialty 30% Not covered	, , ,				
NOT THE INDICTIVE IN THE INDICTIVE INTO THE IN	Non-preferred specialty				
drugs Drug list/formulary 5-tier in-network pharmacy benefit	drugs	J 0 /0		NOT COVERED	

^{*}PCY = Per calendar year.



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

Reset		Compare plan	Plans 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% coinsuranc 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	1 per ear every 36 months	1 per ear every 36 months	Not Covered	
Prescription drugs – retail (up to a 30-day supply)		l	
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	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	ty (up to a 30-day supply)			
Preferred specialty drugs Non-preferred specialty	\$150 30%	\$150 30%	Not covered Not covered	
drugs	3370		Trot 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

Reset 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, PCY1 \$250/\$500 \$750/\$1,500 (individual/family) Out-of-pocket maximum, \$2,500/\$5,000 Unlimited PCY (individual/family) 10% 30% 50% 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 Waiver: Welcome N/A 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 50% coinsurance after deductible No charge No charge care Telehealth No charge No charge Not covered Office visits \$10/\$20 copay, then \$20/\$40 copay, then 50% coinsurance after deductible (primary/specialty) 10% coinsurance after deductible² 30% coinsurance after deductible² \$10/\$20 copay, then Urgent care office visits \$20/\$40 copay, then 50% coinsurance after deductible (primary/specialty) 10% coinsurance after deductible² 30% coinsurance after deductible² 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 coinsurance² CT, MRI, and PET scans 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 coinsurance² 30% coinsurance after deductible 50% coinsurance after deductible **Outpatient surgery** 10% coinsurance after deductible **Emergency care** \$100 copay, then 10% coinsurance \$100 copay, then 10% coinsurance \$100 copay, then 10% coinsurance (copay waived if admitted after deductible after deductible after deductible to inpatient) 10% coinsurance after deductible Hospital inpatient 30% coinsurance after deductible 50% coinsurance after deductible Skilled nursing facility 10% coinsurance after deductible 30% coinsurance after deductible 50% coinsurance after deductible (60 days, PCY) Home health care 10% coinsurance after deductible 50% coinsurance after deductible 30% coinsurance after deductible (unlimited) Manipulative therapy (8 visits, PCY; additional \$10/\$20 copay, then \$20/\$40 copay, then 50% coinsurance after deductible visits with prior 10% coinsurance after deductible² 30% coinsurance after deductible² authorization) \$10/\$20 copay, then \$20/\$40 copay, then Acupuncture 50% coinsurance after deductible (12 visits, PCY) 10% coinsurance after deductible² 30% coinsurance after deductible² Inpatient mental health 10% coinsurance after deductible and substance use 30% coinsurance after deductible 50% coinsurance after deductible disorder **Outpatient mental** \$10/\$20 copay, then \$20/\$40 copay, then health and substance use 50% coinsurance after deductible 10% coinsurance after deductible² 30% coinsurance after deductible² disorder Routine eye exam (1 exam every 12 months) No charge \$20/\$402 50% coinsurance after deductible primary/specialty) Hearing hardware 1 per ear every 36 months 1 per ear every 36 months Not Covered Prescription drugs – retail (up to a 30-day supply) Preferred generic drugs \$5 \$15 Not covered Preferred brand-name \$30 \$50 Not covered drugs Non-preferred generic \$65 \$95 Not covered and brand-name drugs Prescription drugs – mail order (up to a 90-day supply) Preferred generic drugs \$10 Not covered Not covered Preferred brand-name \$60 Not covered Not covered drugs Non-preferred generic Not covered \$130 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

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



Drug list/formulary

^{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.

Reset		Compare plan	Plans selected:	
	Summit PPO Welcome Plans			
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	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)	\$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)	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			
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	1 per ear every 36 months	1 per ear every 36 months	Not Covered	
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 or				
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.
 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.

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



Reset		Compare plan	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)	\$1,000	/\$2,000	\$3,000/\$6,000	
Out-of-pocket maximum, PCY (individual/family)	\$4,000	/\$8,000	Unlimited	
Coinsurance	10%	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	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 ed in-network, in-network, or out-of-network.		
CT, MRI, and PET scans (outpatient)	No charge for first \$5	500 of combined lab, X-ray, CT, MRI, and red in-network, in-network, or out-of-network, o	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)	\$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/\$40 ²	50% coinsurance after deductible	
Hearing hardware	1 per ear every 36 months	1 per ear every 36 months	Not Covered	
Prescription drugs – retail (up to a 30-day supply)	I	I	
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 or	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		

PCY = Per calendar year.
 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.
 View the drug formulary at kp.org/wa/formulary.





Reset		Compare plan	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	0/\$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 (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 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/\$80²	50% coinsurance after deductible	
Hearing hardware	1 per ear every 36 months	1 per ear every 36 months	Not Covered	
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 order (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			

PCY = Per calendar year.
 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.



Reset		Compare plan	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)	\$3,000	/\$6,000	\$9,000/\$18,000	
Out-of-pocket maximum, PCY (individual/family)	\$6,000/	\$12,000	Unlimited	
Coinsurance	20%	40%	50%	
Waiver: Welcome		ole and coinsurance apply. No charge nostic lab, X-ray, CT, MRI and PET scan	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)		ioo of combined lab, X-ray, CT, MRI, and ed in-network, in-network, or out-of-net		
CT, MRI, and PET scans (outpatient)	No charge for first \$5	500 of combined lab, X-ray, CT, MRI, and ed in-network, in-network, or out-of-net	PET scan procedures,	
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	1 per ear every 36 months	1 per ear every 36 months	Not Covered	
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	
1 0	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				
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.
 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.
 View the drug formulary at kp.org/wa/formulary.



Reset		Compare plan	Plans selected:	
		Summit PPO Welcome Plans	;	
Complete Suite 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 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 (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/\$80²	50% coinsurance after deductible	
Hearing hardware	1 per ear every 36 months	1 per ear every 36 months	Not Covered	
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 – 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		

PCY = Per calendar year.
 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.

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



Compare plans

Plans selected:

ted:	

	Summit PPO HSA Plans				
Complete Suite category	Summit PPO HSA 1700 (A)				
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$1,700	/\$3,400	\$3,400/\$6,800		
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	1 per ear every 36 months	1 per ear every 36 months	Not Covered		
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			

^{*}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.



		Summit PPO HSA Plans	
Complete Suite category			
complete suite tategory	Preferred in-network (Tier I)	Summit PPO HSA 2500 (A) 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)	\$5,000	/\$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	1 per ear every 36 months	1 per ear every 36 months	Not Covered
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	der (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**.

	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	1 per ear every 36 months	1 per ear every 36 months	Not Covered		
Prescription drugs – retail (up to a 30-day supply)		I.		
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	lty (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**.

	Summit PPO HSA Plans				
Complete Suite category		Summit PPO HSA 3400 (E)			
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)		
Plan deductible, PCY* (individual/family)	\$3,400	/ \$6,800	\$6,800/\$13,600		
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	1 per ear every 36 months	1 per ear every 36 months	Not Covered		
Prescription drugs – retail (up to a 30-day supply)	I.	l.		
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.



Plans selected:

Compare plans

	Summit PPO HSA Plans				
Complete Suite category	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 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	1 per ear every 36 months	1 per ear every 36 months	Not Covered		
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	lty (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	I.		

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 Plans selected:

Reset		Compare plan	Plans selected:
	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	1 per ear every 36 months	1 per ear every 36 months	Not Covered
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 – specia	lty (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
D 1: 1/f			

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.

Reset	Compare plans	Plans selected:	

Reset		Compare plans Plans selected:
	Access P	PO 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 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	1 per ear every 36 months	Not covered
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.



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	\$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		
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	1 per ear every 36 months	Not covered		
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	5-tier in-network pharmacy benefit		

^{*}PCY = Per calendar year.



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	1 per ear every 36 months	Not covered	
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	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.



Reset		Compare plans	Plans selected:	
	Access PPO Plans			
Complete Suite category	Access	s PPO 5000 Out-of-network		
	In-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% coinsuran	ce after deductible	
Telehealth	No charge		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% coinsurance after deductible			
Hospital inpatient	30% coinsurance after deductible	50% coinsuran	ce 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% coinsuran	ce 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	1 per ear every 36 months	Not	covered	
Prescription drugs – retail (up to a 30-day supply)	<u>I</u>		
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	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

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



Compare plans

Plans selected:

Reset		Compare plans Flans selected:		
	Access PPO Waiver Plans: VisitsPlus			
Complete Suite category	Access F	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	1 per ear every 36 months	Not covered		
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.



Compare plans

Plans selected:

Reset		Compare plans Plans selected:		
	Access PPO Waiver Plans: VisitsPlus			
Complete Suite category	Access I	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	1 per ear every 36 months	Not covered		
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.



Plans selected:

Reset Compare plans

	Tidilo Sciected.			
	Access PPO Waiver 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% 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	1 per ear every 36 months	Not covered		
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.



Compare plans

Plans selected:

Reset		Compare plans Plans selected:		
	Access PPO Waiver Plans: VisitsPlus			
Complete Suite category	nplete Suite category Access PPO 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% 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)	\$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	1 per ear every 36 months	Not covered		
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 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 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.



Plans selected:

Reset Compare plans

Reset		Compare plans selected:		
	Access PPO Waiver 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	1 per ear every 36 months	Not covered		
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.

Compare plans

Plans selected:

Reset		Compare plans Frans selected:		
	Access PPO Waive	Access PPO Waiver 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	1 per ear every 36 months	Not covered		
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.



Compare plans

Plans selected:

Reset

Reset		Compare plans Frans Selected:	
	Access PPO Waiver Plans: VisitsPlus		
Complete Suite category	Access P	PO 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	1 per ear every 36 months	Not covered	
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.

Plans selected:

Reset Compare plans

Reset		Compare plans Plans selected:		
	Access PPO Waiver Plans: VisitsPlus			
Complete Suite category	Access P	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% 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	1 per ear every 36 months	Not covered		
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:	
	Access PPO Waive	r Plans: VisitsPlus		
Complete Suite category		PO 5000 V15		
Plan deductible, PCY*	In-network \$5,000/\$10,000	Out-of-network \$10,000/\$20,000		
(individual/family) Out-of-pocket maximum,			·	
PCY (individual/family) Coinsurance	\$9,000/\$18,000		limited 50%	
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to		N/A	
Preventive and well-child	office visits, including surgery			
care	No charge		ce after deductible	
Telehealth	No charge		ce after deductible line (e-visits): Not covered	
Office visits	\$50 copay	50% coinsuran	ce after deductible	
Urgent care office visits	\$50 copay	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% 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	1 per ear every 36 months	Not covered		
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 – 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	nharmacy henefit		

^{*}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: 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% coinsurance 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	1 per ear every 36 months	Not covered	
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	
	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	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:

Complete Suite category In-network 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. Diagnostic lab and X-ray are subject to plan coinsurance only. Preventive and well-child care Telehealth No charge Telehealth No charge Office visits \$30 copay Urgent care office visits \$30 copay Urgent care office visits \$30 copay CT, MR, and PET scans (outpatient) Outpatient surgery Emergency care (copay waived if admitted to inpatient) Hospital inpatient 20% coinsurance after deductible	<u> </u>	
In-network	Out-of-network \$1,000/\$3,000 Unlimited 50% N/A	
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. Diagnostic lab and X-ray are subject to plan coinsurance only. Preventive and well-child care Telehealth No charge Office visits \$30 copay Urgent care office visits \$30 copay Urgent care office visits \$20% coinsurance Outpatient) CT, MRI, and PET scans (outpatient) Outpatient surgery 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient)	\$1,000/\$3,000 Unlimited 50% N/A	
(individual/family) Out-of-pocket maximum, PCY (individual/family) Coinsurance 20% Maiver: 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. Preventive and well-child care Telehealth No charge Office visits \$30 copay Urgent care office visits \$30 copay Urgent care office visits \$30 copay CT, MRI, and PET scans (outpatient) CT, MRI, and PET scans (outpatient) Outpatient surgery 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) \$200 coinsurance office visits	Unlimited 50% N/A	
PCY (individual/family) Coinsurance 20% Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only. Preventive and well-child care Telehealth No charge Office visits \$30 copay Urgent care office visits \$30 copay CT, MRI, and PET scans (outpatient) Outpatient surgery 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) \$20% coinsurance after 20% coinsurance \$20% coinsurance after deductible	50% N/A	
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. Preventive and well-child Ro charge Telehealth No charge Office visits \$30 copay Urgent care office visits Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) Outpatient surgery 20% coinsurance 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) \$200 copay, then 20% coinsurance	N/A	
Waiver: Lab/X-Ray Plus office visits. Diagnostic lab and X-ray are subject to plan coinsurance only. No charge Telehealth No charge Office visits \$30 copay Urgent care office visits Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) Outpatient surgery 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) \$200 coinsurance 20% coinsurance \$200 copay, then 20% coinsurance (copay waived if admitted to inpatient)		
Telehealth No charge Office visits \$30 copay Urgent care office visits Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) Outpatient surgery 20% coinsurance 20% coinsurance 20% coinsurance \$20% coinsurance \$20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) \$200 copay, then 20% coinsurance to inpatient)	50% coinsurance after deductible	
Office visits \$30 copay Urgent care office visits \$30 copay Lab and X-ray procedures (outpatient) 20% coinsurance CT, MRI, and PET scans (outpatient) 20% coinsurance Outpatient surgery 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) \$200 copay, then 20% coinsurance to inpatient)		
Urgent care office visits \$30 copay Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) Outpatient surgery 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) \$200 copay, then 20% coinsurance to inpatient)	50% coinsurance after deductible Telephone services/online (e-visits): Not covered	
Lab and X-ray procedures (outpatient) CT, MRI, and PET scans (outpatient) Outpatient surgery Emergency care (copay waived if admitted to inpatient) 20% coinsurance after deductible \$200 copay, then 20% coins to inpatient)	50% coinsurance after deductible	
(outpatient) CT, MRI, and PET scans (outpatient) Outpatient surgery Emergency care (copay waived if admitted to inpatient) 20% coinsurance after deductible \$200 copay, then 20% coins to inpatient)	50% coinsurance after deductible	
(outpatient) Outpatient surgery 20% coinsurance after deductible Emergency care (copay waived if admitted to inpatient) \$200 copay, then 20% coins	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient) \$200 copay, then 20% coins	50% coinsurance after deductible	
(copay waived if admitted to inpatient) \$200 copay, then 20% coins	50% coinsurance after deductible	
Hospital inpatient 20% coinsurance after deductible	\$200 copay, then 20% coinsurance after deductible	
20% combutations	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 \$30 copay	50% coinsurance after deductible	
Inpatient mental health and substance use 20% coinsurance after deductible disorder	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 1 per ear every 36 months	Not covered	
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 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		
Prescription drugs – specialty (up to a 30-day supply)	Not covered	
Preferred specialty drugs \$150	Not covered	
Non-preferred specialty drugs 30%	Not covered Not covered	
Drug list/formulary 5-tier in-network ph		

^{*}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: Lab/X-Ray Plus	
Complete Suite category	Access PPO 750 L3		
	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: 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	1 per ear every 36 months	Not covered	
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	
	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.

Compare plans

Plans selected:

Reset		Compare plans Plans selected	1:	
	Access PPO Waiver Plans: Lab/X-Ray Plus			
Complete Suite category	Category 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 cov	ered	
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	1 per ear every 36 months	Not covered		
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 – 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 P	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% 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	1 per ear every 36 months	Not covered	
Prescription drugs – retail (up to a 30-day supply)	I	
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	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:

кезет		Trains selected.	
	Access PPO Waiver P	lans: Lab/X-Ray Plus	
Complete Suite category	Access PPO 2000 L6		
	In-network	In-networkOut-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% 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	1 per ear every 36 months	Not covered	
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.

Compare plans

Plans selected:

Reset		Trans selected.	
	Access PPO Waiver P	lans: Lab/X-Ray Plus	
Complete Suite category	Access PPO 2500 L7		
	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: 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% 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)	\$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	1 per ear every 36 months	Not covered	
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 – 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:

кезет		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	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	1 per ear every 36 months	Not covered	
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.

Compare plans

Plans selected:

Reset		Compare plans Plans selected:	
	Access PPO Waiver Plans: Lab/X-Ray Plus Complete Suite category Access PPO 5000 L9		
Complete Suite category			
	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% 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)	\$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	1 per ear every 36 months	Not covered	
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 – 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:

Reset		Compare plans Plans selected:	L
	Access PPO W	elcome Plans	
Complete Suite category	Access P	PO 250 W1	
	In-network	Out-of-network	
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 deductible Telephone services/online (e-visits): Not cover	ed
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	No charge for first \$500 of combined lab		
(outpatient)	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	ut-of-network deductible and coinsurance ²	
Outpatient surgery	10% coinsurance after deductible	50% coinsurance after deductible	
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 10% coinsurance 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	1 per ear every 36 months	Not covered	
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	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 Welcome Plans Access PPO 500 W2 In-network Out-of-network
In-network Out-of-network
In-network Plan deductible, PCY¹ (individual/family) Out-of-pocket maximum, PCY (individual/family) Coinsurance 20% 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
(individual/family) Out-of-pocket maximum, PCY (individual/family) Coinsurance 20% 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
PCY (individual/family) Coinsurance 20% 50% 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
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
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 deductible and coinsurance apply
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, then 20% coinsurance after deductible 50% coinsurance after deductible
Urgent care office visits \$30 copay, then 20% coinsurance after deductible 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, then subject to applicable in network or out of network deductible and seingurance?
(outpatient) then subject to applicable 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 in-network or out-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% 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) \$30 copay, then 20% coinsurance after deductible² 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 50% coinsurance after deductible
Routine eye exam (1 exam every 12 months) No charge
Hearing hardware 1 per ear every 36 months Not covered
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 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 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	elcome Plans
Complete Suite category	Access P	PO 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%
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 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% 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	1 per ear every 36 months	Not covered
Prescription drugs – retail (u	p 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 ord	ler (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 – specialty	y (up to a 30-day supply)	
Preferred specialty drugs	\$150	Not covered
Non-preferred specialty	·	Makananad
drugs	30%	Not covered

Drug list/formulary

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

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.





Compare plans Plans selected:

Reset		Compare plans Plans se	lected:
	Access PPO W	elcome Plans	
Complete Suite category	Access Pl	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 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		o, X-ray, CT, MRI, and PET scan procedures,	
(outpatient)	then subject to applicable in-network or or		<u> </u>
CT, MRI, and PET scans (outpatient)		o, X-ray, CT, MRI, and PET scan procedures, ut-of-network deductible and coinsurance ²	
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after dedu	ctible
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 dedu	ctible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	50% coinsurance after dedu	ctible
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	1 per ear every 36 months	Not covered	
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 – specialt	ty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty	30%	Not covered	
drugs			

^{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 P	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)		o, X-ray, CT, MRI, and PET scan procedures, ut-of-network deductible and coinsurance ²	
CT, MRI, and PET scans (outpatient)		o, 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	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)	\$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	1 per ear every 36 months	Not covered	
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 W	elcome Plans	
Complete Suite category	Access Pl	PO 2000 W7	
	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		o, X-ray, CT, MRI, and PET scan procedures,	
(outpatient)	then subject to applicable in-network or ou		
CT, MRI, and PET scans (outpatient)	, , , ,	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% 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)	\$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	1 per ear every 36 months	Not covered	
Prescription drugs – retail (u	ıp 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	der (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 – specialt	ty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
urugs			

^{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:	L
	Access PPO Welcome Plans		
Complete Suite category	Access Pl	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 covere	d
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	No charge for first \$500 of combined lab		
(outpatient)	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	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% 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)	\$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	1 per ear every 36 months	Not covered	
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 – specialt	ty (up to a 30-day supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
		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 PPO 3000 W10		
	In-network	Out-of-network	
Plan deductible, PCY ¹ (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: 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	\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Urgent care office visits	\$40 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 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	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)	\$40 copay, then 30% coinsurance after deductible ²	50% coinsurance after deductible	
Acupuncture (12 visits, PCY)	\$40 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	\$40 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	1 per ear every 36 months	Not covered	
Prescription drugs – retail (u	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	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	\$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:

Reset		Compare plans Plans selected:	
	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 covered	
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	, 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% 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)	\$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	
Routine eye exam (1 exam every 12 months)	No charge	No charge	
Hearing hardware	1 per ear every 36 months	Not covered	
Prescription drugs – retail (u	ıp 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	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	\$140	Not covered	
Prescription drugs – specialt	ty (up to a 30-dav supply)		
Preferred specialty drugs	\$150	Not covered	
Non-preferred specialty drugs	30%	Not covered	
Drug list/formulary	5-tier in-network	nharmacy honofit	

^{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 PPO HSA Plans Access PPO 1700 (A) HSA		
	In-network	Out-of-network	
Plan deductible, PCY* (individual/family)	\$1,700/\$3,400	\$3,400/\$6,800	
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% 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)	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	1 per ear every 36 months	Not covered	
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	
	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:

Vezet		Trains selected.	
	Access PPO HSA Plans		
Complete Suite category Access PPO 2500 (A) HSA) 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% 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)	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	1 per ear every 36 months	Not covered	
Prescription drugs – retail (up to a 30-day supply)	I	
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	

^{*}PCY = Per calendar year.

Specialty drugs are limited to a 30-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.

Compare plans

Plans selected:

Neset		Trans selected.
	Access PPO HSA Plans	
Complete Suite category	nplete Suite category Access PPO 3500 (A) 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)	\$6,000/\$,8500	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
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	1 per ear every 36 months	Not covered
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 or	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.

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

Compare plans

Plans selected:

	Access PPO HSA Plans		
Complete Suite category	Access PPO 3400 (E) HSA		
	In-network	Out-of-network	
Plan deductible, PCY* (individual/family)	\$3,400/\$6,800	\$6,800/\$13,600	
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 (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% 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)	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	1 per ear every 36 months	Not covered	
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		

^{*}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	Access PPO 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% 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)	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	1 per ear every 36 months	Not covered	
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	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.

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:

Vezet		Trains selected.
Access PPO HSA Plans		HSA Plans
Complete Suite category	Complete Suite category Access PPO 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% 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
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	1 per ear every 36 months	Not covered
Prescription drugs – retail (up to a 30-day supply)	I
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.



Compare plans

Plans selected:

	Access PPO HSA Plans		
Complete Suite category	Access PPO 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% 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	
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	1 per ear every 36 months	Not covered	
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	Prescription drugs – mail 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	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	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	
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	1 per ear every 36 months	Not covered	
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% coinsuranceafter 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.



Compare plans

Plans selected:

Vezer		Trans selected.	
	Access PPO HSA Plans		
Complete Suite category	tegory 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% 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	
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	1 per ear every 36 months	Not covered	
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	
	o act in notice, printingly policing		

^{*}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.

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

Reset		Compare plans Plans selected:	
	Kaiser Permanente Plus™ Plans		
Complete Suite category	■ KP PI	us 250 L1	
p	In-network	Out-of-network (limited to 10 covered services per year, combined)	
Plan deductible, PCY ¹ (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	r 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	1 per ear every 36 months	Not covered	
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	
	rder (up to a 90-day supply)	1	
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 – 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	
-	o 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:
	Kaiser Permanente Plus™ Plans		
Complete Suite category	olete Suite category KP Plus 500 V2		
complete care caregory	In-network	Out-of-network (limited to 10 covered services per year, comb	
Plan deductible, PCY ¹ (individual/family)	\$500/\$1,500	NA	
Out-of-pocket maximum, PCY (individual/family)	\$3,000/\$9,000		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	N	lo charge
Telehealth	No charge		\$40
Office visits	\$20		\$40
Urgent care office visits	\$20		\$40
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	30%	coinsurance
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	No	ot covered
Outpatient surgery	20% coinsurance after deductible	No	ot covered
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsurance	e after in-network deducti	ible ²
Hospital inpatient	20% coinsurance after deductible	No	ot covered
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	No	ot covered
Home health care (130 visits, PCY)	No charge	Not covered	
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	\$20		\$40
Acupuncture (12 visits, PCY)	\$20	\$40	
Inpatient mental health and substance use disorder	20% coinsurance after deductible	No	ot covered
Outpatient mental health and substance use disorder	\$20	\$40	
Routine eye exam (1 exam every 12 months)	\$20		\$40
Hearing hardware	1 per ear every 36 months	No	ot covered
Prescription drugs – retail (up to a 30-day supply)	Limited to 5 pres	scription fills per year
Preferred generic drugs	\$10	,	\$30
Preferred brand-name drugs	\$20		\$40
Non-preferred generic and brand-name drugs	Not covered	No	ot covered
Prescription drugs – mail o	rder (up to a 90-day supply)		
Preferred generic drugs	\$20	No	ot covered
Preferred brand-name drugs	\$40	No	ot covered
Non-preferred generic and brand-name drugs	Not covered	No	ot covered
Prescription drugs – specia	lty (up to a 30-day supply)		
Preferred specialty drugs	50% up to \$150	No	ot covered
Non-preferred specialty drugs	Not covered	No	ot covered
Drug list/formulary	1 or 2-tier with additional specialty	tier In-network pharmacy	v benefit

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



Compare plans Plans selected: Reset

Reset		Compare plans Plans s	selected:
	Kaiser Permanente Plus™ Plans		
Complete Suite category	■ KP PI	Plus 750 L3	
,	In-network	Out-of-network (limited to 10 covered services per year, combi	
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	\$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	20% coinsurance after deductible	Not covered	
Emergency care (copay waived if admitted to inpatient)	20% coinsurance afte	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	1 per ear every 36 months	Not covered	
Prescription drugs – retail ((up to a 30-day supply)	Limited to 5 prescription fill	s 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	Not 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%	Not covered	
Drug list/formulary	5-tier In-network	pharmacy benefit	
	o act an action production		

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



Reset		Compare plans	Plans selected:
	Kaiser Permanente Plus™ Plans wite category KP Plus 1000 V4		
Complete Suite category			
	In-network	Out-of-network (limited to 10 covered services per year, combin	
Plan deductible, PCY ¹ (individual/family)	\$1,000/\$3,000	NA	
Out-of-pocket maximum, PCY (individual/family)	\$4,000/\$12,000	NA	
Coinsurance	20%	١	NA
Waiver	Annual deductible and plan coinsurance do not apply to office visits, including surgery	1	NA
Preventive and well-child care	No charge	No c	harge
Telehealth	No charge	\$	45
Office visits	\$25	\$	45
Urgent care office visits	\$25	\$	45
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	30% coi	insurance
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	Not c	overed
Outpatient surgery	20% coinsurance after deductible	Not c	overed
Emergency care (copay waived if admitted to inpatient)	\$200 copay, then 20% coinsu	rance after in-network deduc	tible ²
Hospital inpatient	20% coinsurance after deductible	Not c	overed
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	Not c	overed
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	1 per ear every 36 months	Not c	overed
Prescription drugs – retail ((up to a 30-day supply)	Limited to 5 prescr	ription fills per year
Preferred generic drugs	\$15	•	35
Preferred brand-name drugs	\$30		50
Non-preferred generic and brand-name drugs	Not covered	Not c	overed
Prescription drugs – mail o	rder (up to a 90-day supply)		
Preferred generic drugs	\$30	Not c	overed
Preferred brand-name drugs	\$60	Not c	overed
Non-preferred generic and brand-name drugs	Not covered	Not c	overed
Prescription drugs – specia	lty (up to a 30-day supply)		
Preferred specialty drugs	50% up to \$150	Not c	overed
Non-preferred specialty drugs	Not covered	Not covered	
Drug list/formulary	1 or 2-tier with additional specialt	y tier In-network pharmacy be	enefit
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^{1.} PCY = Per calendar year. **2.** The limit of 10 covered services does not apply.



Compare plans Plans selected: Reset

Reset		Compare plans Plans selected:	
	Kaiser Permanente Plus™ Plans		
Complete Suite category	KP Plu	ıs 1500 L5	
p	In-network	Out-of-network (limited to 10 covered services 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	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	\$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	20% coinsurance after deductible	Not covered	
Emergency care (copay waived if admitted to inpatient)	20% coinsurance after i	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	1 per ear every 36 months	Not covered	
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 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	\$120	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	

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



Reset	Compare plans	Plans selected:	

Reset		Compare plans	selected:
	Kaiser Permanente Plus™ Plans		
Complete Suite category	KP Plus 2000 V6		
,	In-network	Out-of-network (limited to 10 covered services pe	
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% coinsurance)
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 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)	\$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	1 per ear every 36 months	Not covered	
Prescription drugs – retail (up to a 30-day supply)	Limited to 5 prescription fi	lls 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	Not 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%	Not covered	
Drug list/formulary	5-tier In-network	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:	
	Kaiser Permanente Plus™ Plans		
Complete Suite category	KP Plus 2500 V7		
Complete Suite category	-	Out-of-network	
	In-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	1 per ear every 36 months	Not covered	
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	\$100	Not covered	
Non-preferred generic and brand-name drugs	Not covered	Not covered	
Prescription drugs – specia	lty (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:	
	Kaiser Permanente Plus™ Plans			
Complete Suite category KP Plus 2500 L7				
	In-network	Out-of-network (limited to 10 covered services per year, combin		
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 o	charge	
Telehealth	No charge	\$4!	5/\$55	
Office visits	\$25/\$35	\$4!	5/\$55	
Urgent care office visits	\$25/\$35	\$4!	5/\$55	
Lab and X-ray procedures (outpatient)	\$25	\$	545	
CT, MRI, and PET scans (outpatient)	\$100	Not o	covered	
Outpatient surgery	30% coinsurance after deductible	Not o	covered	
Emergency care (copay waived if admitted to inpatient)	30% coinsurance after	in-network deductible ²		
Hospital inpatient	30% coinsurance after deductible	Not o	covered	
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	Not o	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	\$4:	5/\$55	
Hearing hardware	1 per ear every 36 months	Not o	covered	
Prescription drugs – retail (up to a 30-day supply)	Limited to 5 presci	ription fills per year	
Preferred generic drugs	\$15		535	
Preferred brand-name drugs	\$40		560	
Non-preferred generic and brand-name drugs	\$60	\$	\$80	
	rder (up to a 90-day supply)			
Preferred generic drugs	\$30	Not o	covered	
Preferred brand-name drugs	\$80	Not o	covered	
Non-preferred generic and brand-name drugs	\$120	Not o	covered	
Prescription drugs – specia	lty (up to a 30-day supply)			
Preferred specialty drugs	\$150	Not o	covered	
Non-preferred specialty drugs	30%	Not o	covered	
Drug list/formulary	5-tier In-network	c pharmacy benefit		
		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:	
	Kaiser Permanente Plus™ Plans		
Complete Suite category	■ KP Plu	s 3000 V8	
complete salice category	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	1 per ear every 36 months	Not covered	
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	\$100	Not covered	
Non-preferred generic and brand-name drugs	Not covered	Not covered	
Prescription drugs – specia	lty (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:	
	Kaiser Permanente Plus™ Plans		
Complete Suite category	■ KP Plu	is 5000 L9	
	In-network	Out-of-network (limited to 10 covered services per year, combined	
Plan deductible, PCY ¹ (individual/family)	\$5,000/\$10,000	NA	
Out-of-pocket maximum, PCY (individual/family)	\$9,000/\$18,000	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	\$50/\$60	
Office visits	\$30/\$40	\$50/\$60	
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 afte	r 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/\$40	\$50/\$60	
Hearing hardware	1 per ear every 36 months	Not covered	
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 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	\$120	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	

^{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 EVERYDAY CARE

Reset

Compare plans

Plans selected:

Complete	NEW Kaiser Permanente Everyday Care Plans		
Complete Suite category	Everyday \$0/\$4000	Everyday \$0/\$5000	\$0/\$6000
Plan deductible, PCY1 (individual/family)	\$4000/\$8000	\$5000/\$10000	\$6000/\$12000
Out-of-pocket maximum, PCY (individual/family)	\$4000/\$8000	\$5000/\$10000	\$6000/\$12000
Preventive and well-child care	No charge	No charge	No charge
Telehealth	No charge	No charge	No charge
Office visits	\$0	\$0	\$0
Urgent care office visits	\$0	\$0	\$0
Lab and X-ray procedures (outpatient)	Lab: \$0 X-Ray: \$50	Lab: \$0 X-Ray: \$50	Lab: \$0 X-Ray: \$50
CT, MRI, and PET scans (outpatient)	\$500	\$500	\$500
Outpatient Surgery	\$0 after deductible	\$0 after deductible	\$0 after deductible
Emergency care (copay waived if admitted to inpatient)	\$500	\$500	\$500
Inpatient Hospital (per admission)	\$0 after deductible	\$0 after deductible	\$0 after deductible
Skilled Nursing Facility (100 Days PCY)	\$0 after deductible	\$0 after deductible	\$0 after deductible
Home Health Care (130 Visits PCY)	\$0	\$0	\$0
Manipulative Therapy (20 Visit PCY)	\$0	\$0	\$0
Acupuncture (20 Visits PCY)	\$0	\$0	\$0
Inpatient Mental Health and Substance Use Disorder (per admission)	\$0 after deductible	\$0 after deductible	\$0 after deductible
Outpatient Mental Health and Substance Use Disorder	\$0	\$0	\$0
Routine Eye Exam (1 exam every 12 months) (Primary/Specialty)	\$0	\$0	\$0
Hearing Hardware	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months
Prescription drugs – retail (u	up to a 30-day supply)		
Preferred generic drugs	\$0	\$0	\$0
Preferred brand-name drugs	\$50	\$50	\$50
Non-preferred generic and brand-name drugs	\$125	\$125	\$125
Prescription Drugs- Mail-Orc	der (Up to a 90-day supply)		
Preferred generic drugs	\$0	\$0	\$0
Preferred brand-name drugs	\$100	\$100	\$100
Non-preferred generic and brand-name drugs	\$250	\$250	\$250
Prescription drugs – special	ty (up to a 30-day supply)		
Specialty drugs	\$250 per script	\$250 per script	\$250 per script
Drug List / Formulary	4-Tier In-Network Pharmacy Benefit	4-Tier In-Network Pharmacy Benefit	4-Tier In-Network Pharmacy Benef



OVERVIEW HMO VIRTUAL PLUS SUMMIT PPO ACCESS PPO KP PLUS EVERYDAY CARE

Reset

Compare plans

Plans selected:

	NEW Kaiser Permanente Everyday Care Plans						
Complete Suite category	Everyday \$0/\$7000	Everyday \$10/\$2000	Everyday \$10/\$3000				
Plan deductible, PCY1 (individual/family)	\$7000/\$14000	\$2000/\$4000	\$3000/\$6000				
Out-of-pocket maximum, PCY (individual/family)	\$7000/\$14000	\$2000/\$4000	\$3000/\$6000				
Preventive and well-child care	No charge	No charge	No charge				
Telehealth	No charge	No charge	No charge				
Office visits	\$0	\$10	\$10				
Urgent care office visits	\$0	\$10	\$10				
Lab and X-ray procedures (outpatient)	Lab: \$0 X-Ray: \$50	Lab: \$10 X-Ray: \$50	Lab: \$10 X-Ray: \$50				
CT, MRI, and PET scans outpatient)	\$500	\$500	\$500				
Outpatient Surgery	\$0 after deductible	\$0 after deductible	\$0 after deductible				
Emergency care (copay waived if admitted to inpatient)	\$500	\$500	\$500				
Inpatient Hospital (per admission)	\$0 after deductible	\$0 after deductible	\$0 after deductible				
Skilled Nursing Facility (100 Days PCY)	\$0 after deductible	\$0 after deductible	\$0 after deductible				
Home Health Care (130 Visits PCY)	\$0	\$0	\$0				
Manipulative Therapy (20 Visit PCY)	\$0	\$10	\$10				
Acupuncture (20 Visits PCY)	\$0	\$10	\$10				
Inpatient Mental Health and Substance Use Disorder (per admission)	\$0 after deductible	\$0 after deductible	\$0 after deductible				
Outpatient Mental Health and Substance Use Disorder	\$0	\$10	\$10				
Routine Eye Exam (1 exam every 12 months) (Primary/Specialty)	\$0	\$10	\$10				
Hearing Hardware	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months				
Prescription drugs – retail (up to a 30-day supply)						
Preferred generic drugs	\$0	\$10	\$10				
Preferred brand-name drugs	\$50	\$50	\$50				
Non-preferred generic and brand-name drugs	\$125	\$125	\$125				
Prescription Drugs- Mail-Or	der (Up to a 90-day supply)						
Preferred generic drugs	\$0	\$20	\$20				
Preferred brand-name drugs	\$100	\$100	\$100				
Non-preferred generic and brand-name drugs	\$250	\$250	\$250				
Prescription drugs – special	ty (up to a 30-day supply)						
Specialty drugs	\$250 per script	\$250 per script	\$250 per script				
Drug List / Formulary	4-Tier In-Network Pharmacy Benefit	4-Tier In-Network Pharmacy Benefit	4-Tier In-Network Pharmacy Benefit				

OVERVIEW НМО **VIRTUAL PLUS SUMMIT PPO** ACCESS PPO **KP PLUS EVERYDAY CARE**

Reset

Compare plans

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	NEW Kaiser Permanente Everyday Care Plans						
Complete Suite category	Everyday \$10/\$4000	Everyday \$10/\$5000	Everyday \$10/\$6000				
Plan deductible, PCY1 (individual/family)	\$4000/\$8000	\$5000/\$10000	\$6000/\$12000				
Out-of-pocket maximum, PCY (individual/family)	\$4000/\$8000	\$5000/\$10000	\$6000/\$12000				
Preventive and well-child care	No charge	No charge	No charge				
Telehealth	No charge	No charge	No charge				
Office visits	\$10	\$10	\$10				
Urgent care office visits	\$10	\$10	\$10				
Lab and X-ray procedures (outpatient)	Lab: \$10 X-Ray: \$50	Lab: \$10 X-Ray: \$50	Lab: \$10 X-Ray: \$50				
CT, MRI, and PET scans (outpatient)	\$500	\$500	\$500				
Outpatient Surgery	\$0 after deductible	\$0 after deductible	\$0 after deductible				
Emergency care (copay waived if admitted to inpatient)	\$500	\$500	\$500				
Inpatient Hospital (per admission)	\$0 after deductible	\$0 after deductible	\$0 after deductible				
Skilled Nursing Facility (100 Days PCY)	\$0 after deductible	\$0 after deductible	\$0 after deductible				
Home Health Care (130 Visits PCY)	\$0	\$0	\$0				
Manipulative Therapy (20 Visit PCY)	\$10	\$10	\$10				
Acupuncture (20 Visits PCY)	\$10	\$10	\$10				
Inpatient Mental Health and Substance Use Disorder (per admission)	\$0 after deductible	\$0 after deductible	\$0 after deductible				
Outpatient Mental Health and Substance Use Disorder	\$10	\$10	\$10				
Routine Eye Exam (1 exam every 12 months) (Primary/Specialty)	\$10	\$10	\$10				
Hearing Hardware	1 per ear every 36 months	1 per ear every 36 months	1 per ear every 36 months				
Prescription drugs – retail (1		30 11011113	30 11011113				
Preferred generic drugs	\$10	\$10	\$10				
Preferred brand-name drugs	\$50	\$50	\$50				
Non-preferred generic and brand-name drugs	\$125	\$125	\$125				
Prescription Drugs- Mail-Or	der (Up to a 90-day supply)						
Preferred generic drugs	\$20	\$20	\$20				
Preferred brand-name drugs	\$100	\$100	\$100				
Non-preferred generic and brand-name drugs	\$250	\$250	\$250				
Prescription drugs – specialty (up to a 30-day supply)							
Specialty drugs	\$250 per script	\$250 per script	\$250 per script				
Drug List / Formulary	4-Tier In-Network Pharmacy Benefit	4-Tier In-Network Pharmacy Benefit	4-Tier In-Network Pharmacy Benefit				



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 EVERYDAY CARE

Reset					Со	mpare 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							
Prescription drugs – retail (up to a 30-day supply)		I				1
Preferred generic drugs							
Preferred brand-name drugs							
Non-preferred generic and brand-name drugs							
Prescription drugs – mail o	rder (up to a 90-day sup	ply)	 	 			
Preferred generic drugs							
Preferred brand-name drugs							
Non-preferred generic and brand-name drugs							
Drug list/formulary							

*PCY = Per calendar year



