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

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.

Reset | Compare plans | Plans selected:

Complete Suite category	HMO Copay Plans			
	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	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	$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 – specialty (up to a 30-day supply)				
Preferred specialty drugs	$150	$150	$150	$150
Non-preferred specialty drugs	30%	30%	30%	30%
Drug list/formulary	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit

*PCY = Per calendar year.

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

Reset | Compare plans | Plans selected:

Complete Suite category	HMO Waiver Plans: VisitsPlus		
	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 order (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 – specialty (up to a 30-day supply)			
Preferred specialty drugs	50% up to $150	50% up to $150	50% up to $150
Non-preferred specialty drugs	Not covered	Not covered	Not covered
Drug list/formulary	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit

*PCY = Per calendar year.

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

Reset | Compare plans | Plans selected:

Complete Suite category	HMO Waiver Plans: VisitsPlus		
	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 order (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 – specialty (up to a 30-day supply)			
Preferred specialty drugs	50% up to $150	50% up to $150	$150
Non-preferred specialty drugs	Not covered	Not covered	30%
Drug list/formulary	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit	5-tier in-network pharmacy benefit

*PCY = Per calendar year.

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

Reset | Compare plans | Plans selected:

Complete Suite category	HMO Waiver Plans: VisitsPlus		
	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)			
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 order (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 – specialty (up to a 30-day supply)			
Preferred specialty drugs	50% up to $150	50% up to $150	50% up to $150
Non-preferred specialty drugs	Not covered	Not covered	Not covered
Drug list/formulary	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit

*PCY = Per calendar year.

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

Reset | Compare plans | Plans selected:

Complete Suite category	HMO Waiver Plans: Lab/X-Ray Plus		
	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 order (up to a 90-day supply)			
Preferred generic drugs	$30	$30	$30
Preferred brand-name drugs	$80	$80	$80
Non-preferred generic and brand-name drugs	$120	$120	$120
Prescription drugs – specialty (up to a 30-day supply)			
Preferred specialty drugs	$150	$150	$150
Non-preferred specialty drugs	30%	30%	30%
Drug list/formulary	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit

*PCY = Per calendar year.

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

Reset | Compare plans | Plans selected:

Complete Suite category	HMO Waiver Plans: Lab/X-Ray Plus		
	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 order (up to a 90-day supply)			
Preferred generic drugs	$30	$30	$30
Preferred brand-name drugs	$80	$80	$80
Non-preferred generic and brand-name drugs	$120	$120	$120
Prescription drugs – specialty (up to a 30-day supply)			
Preferred specialty drugs	$150	$150	$150
Non-preferred specialty drugs	30%	30%	30%
Drug list/formulary	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit

*PCY = Per calendar year.

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

Reset | Compare plans | Plans selected:

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

*PCY = Per calendar year.

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

Reset

Compare plans

Plans selected:

Complete Suite category	HMO Welcome Plans		
	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)			
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 order (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 – specialty (up to a 30-day supply)			
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.

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

Reset

Compare plans

Plans selected:

Complete Suite category	HMO Welcome Plans		
	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)			
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 order (up to a 90-day supply)			
Preferred generic drugs	$30	$30	$30
Preferred brand-name drugs	$80	$60	$80
Non-preferred generic and brand-name drugs	$120	Not covered	$120
Prescription drugs – specialty (up to a 30-day supply)			
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 benefit

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

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

Reset

Compare plans

Plans selected:

Complete Suite category	HMO Welcome Plans		
	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, 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	$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% coinsurance after deductible
Hospital inpatient	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Home health care (130 visits, PCY)	No charge	No charge	No charge
Manipulative therapy (12 visits, PCY)	$30 copay, then 30% coinsurance after deductible[2]	$30 copay, then 30% coinsurance after deductible[2]	$40 copay, then 30% coinsurance after deductible[2]
Acupuncture (12 visits, PCY)	$30 copay, then 30% coinsurance after deductible[2]	$30 copay, then 30% coinsurance after deductible[2]	$40 copay, then 30% coinsurance after deductible[2]
Inpatient mental health and substance use disorder	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient mental health and substance use disorder	$30 copay, then 30% coinsurance after deductible[2]	$30 copay, then 30% coinsurance after deductible[2]	$40 copay, then 30% coinsurance after deductible[2]
Routine eye exam (1 exam every 12 months, primary/specialty)	$30	$30	$40
Hearing hardware	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	$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 order (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 – specialty (up to a 30-day supply)			
Preferred specialty drugs	50% up to $150	50% up to $150	50% up to $150
Non-preferred specialty drugs	Not covered	Not covered	Not covered
Drug list/formulary	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit	1 or 2-tier with additional specialty tier in-network pharmacy benefit

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	HMO Deductible Plans			
	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	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	$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 order (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 – specialty (up to a 30-day supply)				
Preferred specialty drugs	$150	$150	$150	$150
Non-preferred specialty drugs	30%	30%	30%	30%
Drug list/formulary	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit	5-tier in-network pharmacy benefit

*PCY = Per calendar year.

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 covered in full
Office visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Urgent care office visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency care	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hospital inpatient	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home health care (130 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Manipulative therapy (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hearing hardware	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 deductible
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Prescription drugs – mail order (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Drug list/formulary	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit

*PCY = Per calendar year.

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

Specialty drugs are limited to a 30-day supply.

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

Reset | Compare 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 covered in full
Office visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Urgent care office visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency care	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hospital inpatient	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home health care (130 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Manipulative therapy (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Acupuncture (12 visits, PCY)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient mental health and substance use disorder	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hearing hardware	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 deductible
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Prescription drugs – mail order (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Preferred brand-name drugs	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Drug list/formulary	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit	1 or 2-tier in-network pharmacy benefit

*PCY = Per calendar year.

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

Specialty drugs are limited to a 30-day supply.

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

Reset | Compare plans | Plans selected:

Complete Suite category	HMO HSA Plans		
	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 order (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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Virtual Plus® Plans		
	☐ 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)			
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 order (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 – specialty (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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Virtual Plus® Plans		
	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% after 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
Prescription drugs – mail order (up to a 90-day supply)			
Preferred generic drugs	$5	$5	$5
Preferred brand-name drugs	$70	$70	$80
Non-preferred generic and brand-name drugs	Not covered	Not covered	Not covered
Prescription drugs – specialty (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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Virtual Plus® Plans		
	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
Prescription drugs – mail order (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 – specialty (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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO Plans		
	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
Prescription drugs – mail 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 – specialty (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.

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:

Complete Suite category	Summit PPO Plans		
	☐ 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 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 – specialty (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.

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:

Complete Suite category	Summit PPO Plans		
	Summit PPO 500		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (individual/family)	$500/$1,000		$1,500/$3,000
Out-of-pocket maximum, PCY (individual/family)	$3,000/$6,000		Unlimited
Coinsurance	10%	30%	50%
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible
Telehealth	No charge	No charge	Not covered
Office visits (primary/specialty)	$10/$20	$20/$40	50% coinsurance after deductible
Urgent care office visits (primary/specialty)	$10/$20	$20/$40	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$100 copay, then 10% coinsurance after deductible	$100 copay, then 10% coinsurance after deductible	$100 copay, then 10% coinsurance after deductible
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after 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
Prescription drugs – mail 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 – specialty (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.

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:

Complete Suite category	Summit PPO Plans		
	☐ 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
Prescription drugs – mail 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 – specialty (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.

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:

Complete Suite category	Summit PPO Plans		
	☐ Summit PPO 1000		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (individual/family)	$1,000/$2,000		$3,000/$6,000
Out-of-pocket maximum, PCY (individual/family)	$4,000/$8,000		Unlimited
Coinsurance	10%	30%	50%
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible
Telehealth	No charge	No charge	Not covered
Office visits (primary/specialty)	$10/$20	$20/$40	50% coinsurance after deductible
Urgent care office visits (primary/specialty)	$10/$20	$20/$40	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$150 copay, then 10% coinsurance after deductible	$150 copay, then 10% coinsurance after deductible	$150 copay, then 10% coinsurance after deductible
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Home health care (unlimited)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	$10	$20	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	$10	$20	50% coinsurance after deductible
Inpatient mental health and substance use disorder	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	$10	$20	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months) primary/specialty)	$0/$0	$20/$40	50% coinsurance after deductible
Hearing hardware	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 – specialty (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.

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:

Complete Suite category	Summit PPO Plans		
	☐ 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% 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)	$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 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 – specialty (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.

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:

Complete Suite category	Summit PPO Plans		
	Summit PPO 1500		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (individual/family)	$1,500/$3,000		$4,500/$9,000
Out-of-pocket maximum, PCY (individual/family)	$5,000/$10,000		Unlimited
Coinsurance	10%	30%	50%
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible
Telehealth	No charge	No charge	Not covered
Office visits (primary/specialty)	$20/$40	$40/$80	50% coinsurance after deductible
Urgent care office visits (primary/specialty)	$20/$40	$40/$80	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	10% coinsurance	30% coinsurance	50% coinsurance after deductible
Outpatient surgery	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$150 copay, then 10% coinsurance after deductible	$150 copay, then 10% coinsurance after deductible	$150 copay, then 10% coinsurance after deductible
Hospital inpatient	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after 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 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 – specialty (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.

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**.

KAISER PERMANENTE®

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO Plans		
	☐ Summit PPO 2000		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (individual/family)	$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
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 – specialty (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.

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:

Complete Suite category	Summit PPO Plans		
	☐ 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
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
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 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:

Complete Suite category	Summit PPO Plans		
	■ Summit PPO 3000		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (individual/family)	$3,000/$6,000		$9,000/$18,000
Out-of-pocket maximum, PCY (individual/family)	$6,000/$12,000		Unlimited
Coinsurance	20%	40%	50%
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible
Telehealth	No charge	No charge	Not covered
Office visits (primary/specialty)	$20/$40	$40/$80	50% coinsurance after deductible
Urgent care office visits (primary/specialty)	$20/$40	$40/$80	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 20% coinsurance after deductible	$200 copay, then 20% coinsurance after deductible	$200 copay, then 20% coinsurance after deductible
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	$20	$40	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	$20	$40	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	$20	$40	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months) primary/specialty)	$0/$0	$40/$80	50% coinsurance after deductible
Hearing hardware	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
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
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 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:

Complete Suite category	Summit PPO Plans		
	■ Summit PPO 5000		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (individual/family)	$5,000/$10,000		$15,000/$30,000
Out-of-pocket maximum, PCY (individual/family)	$7,000/$14,000		Unlimited
Coinsurance	20%	40%	50%
Preventive and well-child care	No charge	No charge	50% coinsurance after deductible
Telehealth	No charge	No charge	Not covered
Office visits (primary/specialty)	$20/$40	$40/$80	50% coinsurance after deductible
Urgent care office visits (primary/specialty)	$20/$40	$40/$80	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance	40% coinsurance	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 20% coinsurance after deductible	$200 copay, then 20% coinsurance after deductible	$200 copay, then 20% coinsurance after deductible
Hospital inpatient	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Skilled nursing facility (60 days, PCY)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Home health care (unlimited)	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy (8 visits, PCY; additional visits with prior authorization)	$20	$40	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	$20	$40	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	$20	$40	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months) primary/specialty)	$0/$0	$40/$80	50% coinsurance after deductible
Hearing hardware	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
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
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 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:

Complete Suite category	Summit PPO Welcome Plans		
	☐ Summit PPO 250 W1		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY[1] (individual/family)	$250/$500		$750/$1,500
Out-of-pocket maximum, PCY (individual/family)	$2,500/$5,000		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)	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	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 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 – specialty (up to a 30-day supply)			
Preferred specialty drugs	$150	$150	Not covered
Non-preferred specialty drugs	30%	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit		

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

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO Welcome Plans		
	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/$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)	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	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 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 – specialty (up to a 30-day supply)			
Preferred specialty drugs	$150	$150	Not covered
Non-preferred specialty drugs	30%	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit		

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

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO Welcome Plans		
	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)	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)	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	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)			
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 – specialty (up to a 30-day supply)			
Preferred specialty drugs	$150	$150	Not covered
Non-preferred specialty drugs	30%	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit		

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

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

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

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

Reset | Compare plans | Plans selected:

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

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

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO Welcome Plans		
	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	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)	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)	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)	$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
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
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 drugs	30%	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit		

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

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO Welcome Plans		
	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	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)	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)	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)	$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
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
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 drugs	30%	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit		

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO HSA Plans		
	■ 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 order (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 – specialty (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**.

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO HSA Plans		
	Summit PPO HSA 2500 (A)		
	Preferred in-network (Tier I)	In-network (Tier 2)	Out-of-network (Tier 3)
Plan deductible, PCY* (individual/family)	$2,500/$5,000		$5,000/$10,000
Out-of-pocket maximum, PCY (individual/family)	$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 order (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 – specialty (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**.

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO HSA Plans		
	■ 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)			
Preferred generic drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered
Preferred brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered
Prescription drugs – mail order (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	Not covered	Not covered
Preferred brand-name drugs	20% coinsurance after deductible	Not covered	Not covered
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered	Not covered
Prescription drugs – specialty (up to a 30-day supply)			
Preferred specialty drugs	20% coinsurance after deductible	20% coinsurance after deductible	Not covered
Non-preferred specialty drugs	40% coinsurance after deductible	40% coinsurance after deductible	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit		

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO HSA Plans		
	■ 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)			
Preferred generic drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered
Preferred brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	40% coinsurance after deductible	Not covered
Prescription drugs – mail order (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	Not covered	Not covered
Preferred brand-name drugs	20% coinsurance after deductible	Not covered	Not covered
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered	Not covered
Prescription drugs – specialty (up to a 30-day supply)			
Preferred specialty drugs	20% coinsurance after deductible	20% coinsurance after deductible	Not covered
Non-preferred specialty drugs	40% coinsurance after deductible	40% coinsurance after deductible	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit		

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO HSA Plans		
	☐ 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 order (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	Not covered	Not covered
Preferred brand-name drugs	20% coinsurance after deductible	Not covered	Not covered
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered	Not covered
Prescription drugs – specialty (up to a 30-day supply)			
Preferred specialty drugs	20% coinsurance after deductible	20% coinsurance after deductible	Not covered
Non-preferred specialty drugs	40% coinsurance after deductible	40% coinsurance after deductible	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit		

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Summit PPO HSA Plans		
	☐ 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 order (up to a 90-day supply)			
Preferred generic drugs	20% coinsurance after deductible	Not covered	Not covered
Preferred brand-name drugs	20% coinsurance after deductible	Not covered	Not covered
Non-preferred generic and brand-name drugs	20% coinsurance after deductible	Not covered	Not covered
Prescription drugs – specialty (up to a 30-day supply)			
Preferred specialty drugs	20% coinsurance after deductible	20% coinsurance after deductible	Not covered
Non-preferred specialty drugs	40% coinsurance after deductible	40% coinsurance after deductible	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit		

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Plans	
	☐ 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% 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 ($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 order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Plans	
	☐ 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% 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 order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Plans	
	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% 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	$25 ($15 enhanced benefit)	Not covered
Preferred brand-name drugs	$60 ($40 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	$100 ($70 enhanced benefit)	Not covered
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$140	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Plans	
	Access PPO 5000	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$5,000/$10,000	$10,000/$20,000
Out-of-pocket maximum, PCY (individual/family)	$9,000/$18,000	Unlimited
Coinsurance	30%	50%
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	30% coinsurance after deductible	50% coinsurance after deductible
Urgent care office visits	30% coinsurance after deductible	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 30% 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	$25 ($15 enhanced benefit)	Not covered
Preferred brand-name drugs	$60 ($40 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	$100 ($70 enhanced benefit)	Not covered
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$140	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: VisitsPlus	
	☐ Access PPO 250 V1	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$250/$750	$500/$1,500
Out-of-pocket maximum, PCY (individual/family)	$3,000/$9,000	Unlimited
Coinsurance	10%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$30 copay	50% coinsurance after deductible
Urgent care office visits	$30 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	10% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	10% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 10% 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	$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	

*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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: VisitsPlus	
	☐ Access PPO 500 V2	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$500/$1,500	$1,000/$3,000
Out-of-pocket maximum, PCY (individual/family)	$3,000/$9,000	Unlimited
Coinsurance	20%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$30 copay	50% coinsurance after deductible
Urgent care office visits	$30 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 20% 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	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 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	

*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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: VisitsPlus	
	☐ 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 order (up to a 90-day supply)		
Preferred generic drugs	$10	Not covered
Preferred brand-name drugs	$60	Not covered
Non-preferred generic and brand-name drugs	$130	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: VisitsPlus	
	☐ 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% 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 order (up to a 90-day supply)		
Preferred generic drugs	$10	Not covered
Preferred brand-name drugs	$60	Not covered
Non-preferred generic and brand-name drugs	$130	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: VisitsPlus	
	☐ Access PPO 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% 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 order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: VisitsPlus	
	☐ Access PPO 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% 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 order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: VisitsPlus	
	☐ Access PPO 2500 V6	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$2,500/$5,000	$5,000/$10,000
Out-of-pocket maximum, PCY (individual/family)	$6,000/$12,000	Unlimited
Coinsurance	30%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$35 copay	50% coinsurance after deductible
Urgent care office visits	$35 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 30% 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
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: VisitsPlus	
	☐ Access PPO 3000 V7	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$3,000/$6,000	$6,000/$12,000
Out-of-pocket maximum, PCY (individual/family)	$7,500/$15,000	Unlimited
Coinsurance	30%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$40 copay	50% coinsurance after deductible
Urgent care office visits	$40 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 30% 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	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 order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$140	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: VisitsPlus	
	☐ Access PPO 5000 V15	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$5,000/$10,000	$10,000/$20,000
Out-of-pocket maximum, PCY (individual/family)	$9,000/$18,000	Unlimited
Coinsurance	30%	50%
Waiver: VisitsPlus	Annual deductible and plan coinsurance don't apply to office visits, including surgery	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$50 copay	50% coinsurance after deductible
Urgent care office visits	$50 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 30% 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	$25 ($15 enhanced benefit)	Not covered
Preferred brand-name drugs	$60 ($40 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	$100 ($70 enhanced benefit)	Not covered
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$140	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus	
	☐ 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
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$10	Not covered
Preferred brand-name drugs	$60	Not covered
Non-preferred generic and brand-name drugs	$130	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus	
	☐ Access PPO 500 L2	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$500/$1,500	$1,000/$3,000
Out-of-pocket maximum, PCY (individual/family)	$3,000/$9,000	Unlimited
Coinsurance	20%	50%
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$30 copay	50% coinsurance after deductible
Urgent care office visits	$30 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 20% 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	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 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	

*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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus	
	☐ 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
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	

*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.

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

Reset | Compare plans | Plans selected:

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

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus	
	☐ 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% 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 order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus	
	☐ 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 order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus	
	☐ Access PPO 2500 L7	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$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
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus	
	☐ 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% 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	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 order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Waiver Plans: Lab/X-Ray Plus	
	☐ Access PPO 5000 L9	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$5,000/$10,000	$10,000/$20,000
Out-of-pocket maximum, PCY (individual/family)	$9,000/$18,000	Unlimited
Coinsurance	30%	50%
Waiver: Lab/X-Ray Plus	Annual deductible and plan coinsurance don't apply to office visits. Diagnostic lab and X-ray are subject to plan coinsurance only.	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$50 copay	50% coinsurance after deductible
Urgent care office visits	$50 copay	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	30% coinsurance	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	30% coinsurance	50% coinsurance after deductible
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 30% 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
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	30%	Not covered
Drug list/formulary	5-tier in-network pharmacy benefit	

*PCY = Per calendar year.

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

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Welcome Plans	
	Access PPO 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 covered
Office visits	$30 copay, then 10% coinsurance after deductible[2]	50% coinsurance after deductible
Urgent care office visits	$30 copay, then 10% coinsurance after deductible[2]	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	No charge for first $500 of combined lab, X-ray, CT, MRI, and PET scan procedures, 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	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 (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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Welcome Plans	
	Access PPO 500 W2	
	In-network	Out-of-network
Plan deductible, PCY[1] (individual/family)	$500/$1,500	$1,000/$3,000
Out-of-pocket maximum, PCY (individual/family)	$3,000/$9,000	Unlimited
Coinsurance	20%	50%
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first $500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first $500, plan deductible and coinsurance apply	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$30 copay, then 20% coinsurance after deductible[2]	50% coinsurance after deductible
Urgent care office visits	$30 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, X-ray, CT, MRI, and PET scan procedures, 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 deductible[2]	50% coinsurance after deductible
Acupuncture (12 visits, PCY)	$30 copay, then 20% coinsurance after deductible[2]	50% coinsurance after deductible
Inpatient mental health and substance use disorder	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient mental health and substance use disorder	$30 copay, then 20% coinsurance after deductible[2]	50% coinsurance after deductible
Routine eye exam (1 exam every 12 months)	No charge	No charge
Hearing hardware	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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Welcome Plans	
	Access PPO 750 W3	
	In-network	Out-of-network
Plan deductible, PCY[1] (individual/family)	$750/$2,250	$1,500/$4,500
Out-of-pocket maximum, PCY (individual/family)	$3,500/$10,500	Unlimited
Coinsurance	20%	50%
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, X-ray, CT, MRI, and PET scan procedures, 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)	$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	$15 ($5 enhanced benefit)	Not covered
Preferred brand-name drugs	$50 ($30 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	$95 ($65 enhanced benefit)	Not covered
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$10	Not covered
Preferred brand-name drugs	$60	Not covered
Non-preferred generic and brand-name drugs	$130	Not covered
Prescription drugs – 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Welcome Plans	
	Access PPO 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 (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]	
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)	$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	$15 ($5 enhanced benefit)	Not covered
Preferred brand-name drugs	$50 ($30 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	$95 ($65 enhanced benefit)	Not covered
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$10	Not covered
Preferred brand-name drugs	$60	Not covered
Non-preferred generic and brand-name drugs	$130	Not covered
Prescription drugs – 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Welcome Plans	
	Access PPO 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)	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]	
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)	$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 order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – 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.

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

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Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Welcome Plans	
	Access PPO 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 (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]	
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)	$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 order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	$60	Not covered
Prescription drugs – 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Welcome Plans	
	☐ Access PPO 2500 W8	
	In-network	Out-of-network
Plan deductible, PCY[1] (individual/family)	$2,500/$5,000	$5,000/$10,000
Out-of-pocket maximum, PCY (individual/family)	$6,000/$12,000	Unlimited
Coinsurance	30%	50%
Waiver: Welcome	First 4 office visits are subject to copay only. After first 4 office visits, copays are waived and plan deductible and coinsurance apply. No charge for the first $500 of combined diagnostic lab, X-ray, CT, MRI and PET scan procedures. After the first $500, plan deductible and coinsurance apply.	N/A
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	No charge	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	$35 copay, then 30% coinsurance after deductible[2]	50% coinsurance after deductible
Urgent care office visits	$35 copay, then 30% coinsurance after deductible[2]	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	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]	
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	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 (up to a 30-day supply)		
Preferred generic drugs	$15 ($5 enhanced benefit)	Not covered
Preferred brand-name drugs	$50 ($30 enhanced benefit)	Not covered
Non-preferred generic and brand-name drugs	$95 ($65 enhanced benefit)	Not covered
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$10	Not covered
Preferred brand-name drugs	$60	Not covered
Non-preferred generic and brand-name drugs	$130	Not covered
Prescription drugs – 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Welcome Plans	
	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, X-ray, CT, MRI, and PET scan procedures, 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	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 (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 order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$140	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO Welcome Plans	
	Access PPO 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, X-ray, CT, MRI, and PET scan procedures, 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	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 (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 order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$140	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	$150	Not covered
Non-preferred specialty drugs	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.

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

Reset | Compare plans | Plans selected:

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
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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO HSA Plans	
	☐ Access PPO 2500 (A) HSA	
	In-network	Out-of-network
Plan deductible, PCY* (individual/family)	$2,500/$5,000	$5,000/$10,000
Out-of-pocket maximum, PCY (individual/family)	$5,000/$8,500	Unlimited
Coinsurance	20%	50%
Preventive and well-child care	No charge	50% coinsurance after deductible
Telehealth	Subject to deductible, then covered in full	50% coinsurance after deductible Telephone services/online (e-visits): Not covered
Office visits	20% coinsurance after deductible	50% coinsurance after deductible
Urgent care office visits	20% coinsurance after deductible	50% coinsurance after deductible
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery	20% coinsurance after deductible	50% coinsurance after deductible
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 20% 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 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO HSA Plans	
	☐ 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 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO HSA Plans	
	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 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO HSA Plans	
	☐ 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 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO HSA Plans	
	☐ 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)		
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 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO HSA Plans	
	☐ 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 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO HSA Plans	
	☐ 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 order (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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Access PPO HSA Plans	
	☐ 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 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.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	KP Plus 250 L1	
	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 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
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$120	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.** The limit of 10 covered services does not apply.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	KP Plus 500 V2	
	In-network	Out-of-network (limited to 10 covered services per year, combined)
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	No 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	Not covered
Outpatient surgery	20% coinsurance after deductible	Not covered
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 20% coinsurance after 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)	$20	$40
Acupuncture (12 visits, PCY)	$20	$40
Inpatient mental health and substance use disorder	20% coinsurance after deductible	Not 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	Not covered
Prescription drugs – retail (up to a 30-day supply)		Limited to 5 prescription fills per year
Preferred generic drugs	$10	$30
Preferred brand-name drugs	$20	$40
Non-preferred generic and brand-name drugs	Not covered	Not covered
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$20	Not covered
Preferred brand-name drugs	$40	Not covered
Non-preferred generic and brand-name drugs	Not covered	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	50% up to $150	Not covered
Non-preferred specialty drugs	Not covered	Not covered
Drug list/formulary	1 or 2-tier with additional specialty tier In-network pharmacy benefit	

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	☐ KP Plus 750 L3	
	In-network	Out-of-network (limited to 10 covered services per year, combined)
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 after 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 order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$120	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.** The limit of 10 covered services does not apply.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	☐ KP Plus 1000 V4	
	In-network	Out-of-network (limited to 10 covered services per year, combined)
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%	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	$45
Office visits	$25	$45
Urgent care office visits	$25	$45
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	30% coinsurance
CT, MRI, and PET scans (outpatient)	20% coinsurance after deductible	Not covered
Outpatient surgery	20% coinsurance after deductible	Not covered
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 20% coinsurance after 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	$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	$30	$50
Non-preferred generic and brand-name drugs	Not covered	Not covered
Prescription drugs – mail order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$60	Not covered
Non-preferred generic and brand-name drugs	Not covered	Not covered
Prescription drugs – specialty (up to a 30-day supply)		
Preferred specialty drugs	50% up to $150	Not covered
Non-preferred specialty drugs	Not covered	Not covered
Drug list/formulary	1 or 2-tier with additional specialty tier In-network pharmacy benefit	

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	☐ KP Plus 1500 L5	
	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 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 order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$120	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.** The limit of 10 covered services does not apply.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	☐ KP Plus 2000 V6	
	In-network	Out-of-network (limited to 10 covered services per year, combined)
Plan deductible, PCY[1] (individual/family)	$2,000/$4,000	NA
Out-of-pocket maximum, PCY (individual/family)	$5,500/$11,000	NA
Coinsurance	20%	NA
Waiver	Annual deductible and plan coinsurance do not apply to office visits including surgery	NA
Preventive and well-child care	No charge	No charge
Telehealth	No charge	$50
Office visits	$30	$50
Urgent care office visits	$30	$50
Lab and X-ray procedures (outpatient)	20% coinsurance after deductible	30% 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 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)	$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 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 order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$120	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.** The limit of 10 covered services does not apply.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	☐ KP Plus 2500 V7	
	In-network	Out-of-network (limited to 10 covered services per year, combined)
Plan deductible, PCY[1] (individual/family)	$2,500/$5,000	NA
Out-of-pocket maximum, PCY (individual/family)	$6,000/$12,000	NA
Coinsurance	30%	NA
Waiver	Annual deductible and plan coinsurance do not apply to office visits including surgery	NA
Preventive and well-child care	No charge	No charge
Telehealth	No charge	$50
Office visits	$30	$50
Urgent care office visits	$30	$50
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	40% coinsurance
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	Not covered
Outpatient surgery	30% coinsurance after deductible	Not covered
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 30% coinsurance after in-network deductible[2]	
Hospital inpatient	30% coinsurance after deductible	Not covered
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	Not covered
Home health care (130 visits, PCY)	No charge	Not covered
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	$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 order (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 – specialty (up to a 30-day supply)		
Preferred specialty drugs	50% up to $150	Not covered
Non-preferred specialty drugs	Not covered	Not covered
Drug list/formulary	1 or 2-tier with additional specialty tier In-network pharmacy benefit	

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	☐ KP Plus 2500 L7	
	In-network	Out-of-network (limited to 10 covered services per year, combined)
Plan deductible, PCY[1] (individual/family)	$2,500/$5,000	NA
Out-of-pocket maximum, PCY (individual/family)	$6,000/$12,000	NA
Coinsurance	30%	NA
Waiver	Annual deductible and plan coinsurance do not apply to office visits or to diagnostic laboratory and radiology services	NA
Preventive and well-child care	No charge	No charge
Telehealth	No charge	$45/$55
Office visits	$25/$35	$45/$55
Urgent care office visits	$25/$35	$45/$55
Lab and X-ray procedures (outpatient)	$25	$45
CT, MRI, and PET scans (outpatient)	$100	Not covered
Outpatient surgery	30% coinsurance after deductible	Not covered
Emergency care (copay waived if admitted to inpatient)	30% coinsurance after in-network deductible[2]	
Hospital inpatient	30% coinsurance after deductible	Not covered
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	Not covered
Home health care (130 visits, PCY)	No charge	Not covered
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	$25	$45
Acupuncture (12 visits, PCY)	$25	$45
Inpatient mental health and substance use disorder	30% coinsurance after deductible	Not covered
Outpatient mental health and substance use disorder	$25	$45
Routine eye exam (1 exam every 12 months)	$25/$35	$45/$55
Hearing hardware	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 order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$120	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.** The limit of 10 covered services does not apply.

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	☐ KP Plus 3000 V8	
	In-network	Out-of-network (limited to 10 covered services per year, combined)
Plan deductible, PCY[1] (individual/family)	$3,000/$6,000	NA
Out-of-pocket maximum, PCY (individual/family)	$7,500/$15,000	NA
Coinsurance	30%	NA
Waiver	Annual deductible and plan coinsurance do not apply to office visits including surgery	NA
Preventive and well-child care	No charge	No charge
Telehealth	No charge	$50
Office visits	$30	$50
Urgent care office visits	$30	$50
Lab and X-ray procedures (outpatient)	30% coinsurance after deductible	40% coinsurance
CT, MRI, and PET scans (outpatient)	30% coinsurance after deductible	Not covered
Outpatient surgery	30% coinsurance after deductible	Not covered
Emergency care (copay waived if admitted to inpatient)	$200 copay, then 30% coinsurance after in-network deductible[2]	
Hospital inpatient	30% coinsurance after deductible	Not covered
Skilled nursing facility (60 days, PCY)	30% coinsurance after deductible	Not covered
Home health care (130 visits, PCY)	No charge	Not covered
Manipulative therapy (12 visits, PCY; additional visits with prior authorization)	$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 order (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 – specialty (up to a 30-day supply)		
Preferred specialty drugs	50% up to $150	Not covered
Non-preferred specialty drugs	Not covered	Not covered
Drug list/formulary	1 or 2-tier with additional specialty tier In-network pharmacy benefit	

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

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

Reset | Compare plans | Plans selected:

Complete Suite category	Kaiser Permanente Plus™ Plans	
	☐ KP Plus 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 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/$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 order (up to a 90-day supply)		
Preferred generic drugs	$30	Not covered
Preferred brand-name drugs	$80	Not covered
Non-preferred generic and brand-name drugs	$120	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.** The limit of 10 covered services does not apply.

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

Reset | Compare plans | Plans selected:

Complete Suite category	NEW Kaiser Permanente Everyday Care Plans		
	☐ 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 (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-Order (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 – 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

Reset | Compare plans | Plans selected:

Complete Suite category	NEW Kaiser Permanente Everyday Care Plans		
	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-Order (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 – 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

Reset | Compare plans | Plans selected:

Complete Suite category	NEW Kaiser Permanente Everyday Care Plans		
	☐ 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 (up to a 30-day supply)			
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-Order (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.

Reset

Compare plans Plans selected:

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

*PCY = Per calendar year

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

Start over

KAISER PERMANENTE®