2023 Kaiser Foundation Health Plan of Washington plans

Core provider network

	Bronze HSA	Silver HSA	Silver	Core VisitsPlus Silver LX	Core VisitsPlus Silver LX - EO
Features	**In-network**	**In-network**	**In-network**	**In-network**	**In-network**
Plan type	HSA-qualified	HSA-qualified	Deductible	Deductible	Deductible
Annual medical deductible (individual/family)	$6,000/$12,000	$3,500/$7,000	$1,800/$3,600	$2,900/$5,800	$2,900/$5,800
Annual out-of-pocket maximum (individual/family)	$6,950/$13,900	$6,900/$13,800	$8,400/$16,800	$8,900/$17,800	$8,900/$17,800
Coinsurance	40%	20%	30%	30%	30%
Benefits					
Preventive care					
Routine physical exam, mammogram, etc.	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				Upfront office visits prior to deductible	Upfront office visits prior to deductible
Primary care office visit	40% after deductible	20% after deductible	$30 after deductible	$35	$35
Specialty care office visit	40% after deductible	20% after deductible	$60 after deductible	$65	$65
Most X-rays	40% after deductible	20% after deductible	30% after deductible	$55	$55
Most lab tests	40% after deductible	20% after deductible	30% after deductible	$55	$55
MRI, CT, PET	40% after deductible	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient surgery	40% after deductible	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Mental health visit	40% after deductible	20% after deductible	$30 after deductible	$35	$35
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Maternity					
Routine prenatal care visits, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Worldwide emergency and urgent care					
Emergency department visit	40% after deductible	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Urgent care visit	40% after deductible	20% after deductible	$60	$65	$65
Retail prescription drugs (up to 30-day supply)					
Tier 1: Preferred generic	50% after deductible	20% after deductible	$30	$35	$35
Tier 2: Preferred brand	50% after deductible	30% after deductible	$60	$65	$65
Tier 3: Nonpreferred generic and brand	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Tier 4: Specialty	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Alternative medicine					
10 chiropractic visits and 12 acupuncture visits	40% after deductible	20% after deductible	$30 after deductible	$35	$35
Optical hardware					
Pediatric (18 and younger)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Adult (19 and older)	$100 allowance per calendar year	$100 allowance per calendar year	$100 allowance per calendar year	$100 allowance per calendar year	$100 allowance per calendar year

EO = Employee only HD = High deductible LD = Low deductible LX = Lab and X-ray

See page 19 for primary and specialty care descriptions. Rates and plans are subject to Office of the Insurance Commissioner (OIC) approval.

Plan and benefit details

Lab & X-ray (LX) plans

These plans include lab tests and basic X-ray for only a copay, not subject to the deductible.

VisitsPlus plans

These include office visits for only a copay, not subject to the deductible.

Care under one roof

At most Kaiser Permanente facilities, your employees can see their doctor, get a lab test or X-ray, and pick up prescriptions – all in a single trip.

Dental coverage is required for those 18 and younger and accompanies all Kaiser Permanente medical plans.

See pages 20–22 for details, as well as information on optional dental coverage for adults and families.

2023 Kaiser Foundation Health Plan of Washington plans

Core provider network

Features	Core VisitsPlus Gold HD LX In-network	Core VisitsPlus Gold LX In-network	Core VisitsPlus Gold LX - EO In-network	Core VisitsPlus Platinum LX In-network
Plan type	Deductible	Deductible	Deductible	Deductible
Annual medical deductible (individual/family)	$1,500/$3,000	$600/$1,200	$600/$1,200	$250/$500
Annual out-of-pocket maximum (individual/family)	$7,900/$15,800	$7,900/$15,800	$7,900/$15,800	$2,500/$5,000
Coinsurance	30%	25%	25%	10%
Benefits				
Preventive care				
Routine physical exam, mammogram, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)	Upfront office visits prior to deductible	Upfront office visits prior to deductible	Upfront office visits prior to deductible	Upfront office visits prior to deductible
Primary care office visit	$25	$15	$15	$5
Specialty care office visit	$60	$35	$35	$20
Most X-rays	$20	$25	$25	$10
Most lab tests	$20	$25	$25	$10
MRI, CT, PET	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Outpatient surgery	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Mental health visit	$25	$15	$15	$5
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Maternity				
Routine prenatal care visits, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Worldwide emergency and urgent care				
Emergency department visit	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Urgent care visit	$60	$35	$35	$20
Retail prescription drugs (up to 30-day supply)				
Tier 1: Preferred generic	$20	$15	$15	$5
Tier 2: Preferred brand	$45	$45	$45	$20
Tier 3: Nonpreferred generic and brand	40% after deductible	40% after deductible	40% after deductible	40% after deductible
Tier 4: Specialty	40% after deductible	40% after deductible	40% after deductible	40% after deductible
Alternative medicine				
10 chiropractic visits and 12 acupuncture visits	$25	$15	$15	$5
Optical hardware				
Pediatric (18 and younger)	Covered in full	Covered in full	Covered in full	Covered in full
Adult (19 and older)	$100 allowance per calendar year	$100 allowance per calendar year	$100 allowance per calendar year	$100 allowance per calendar year

EO = Employee only HD = High deductible LD = Low deductible LX = Lab and X-ray

See page 19 for primary and specialty care descriptions. Rates and plans are subject to Office of the Insurance Commissioner (OIC) approval.

Pharmacy coverage

For plans featuring the **Core** or **Connect network**: Members can fill the first prescription for a new medication at an in-network pharmacy or through our mail-order service. Then most refills and maintenance medications are filled through mail order.

Mail-order pharmacy

It's easy to transfer prescriptions and take advantage of the Kaiser Permanente Washington mail-order pharmacy. Once prescriptions are transferred, refills can be ordered using these methods.

- Sign in to **kp.org/wa** or the Kaiser Permanente Washington mobile app. Select "**Medications**," then select "**My Prescriptions**."
- Prescriptions may also be ordered by calling **1-800-245-7979** (TTY **711**).

Dental coverage is required for those 18 and younger and accompanies all Kaiser Permanente medical plans.

See pages 20–22 for details, as well as information on optional dental coverage for adults and families.

2023 Kaiser Foundation Health Plan of Washington plans

Connect provider network

Available in King, Kitsap, Pierce, Snohomish, Spokane, and Thurston counties

Features	Virtual Plus Silver In-network			Virtual Plus Gold In-network		
Plan type	Deductible			Deductible		
Annual medical deductible (individual/family)	$ 3,000/$6,000			$600/$1,200		
Annual out-of-pocket maximum (individual/family)	$8,900/$17,800			$8,200/$16,400		
Coinsurance	35%			20%		
Benefits	**Virtual**	**In person with referral**	**In person without referral**	**Virtual**	**In person with referral**	**In person without referral**
Preventive care						
Routine physical exam, mammogram, etc.	No charge			No charge		
Outpatient services (per visit or procedure)						
Primary care office visit	No charge	$25	35% after deductible	No charge	$15	20% after deductible
Specialty care office visit	No charge	$50	35% after deductible	No charge	$30	20% after deductible
Most X-rays	N/A	35% after deductible		N/A	20% after deductible	
Most lab tests	N/A	35% after deductible		N/A	20% after deductible	
MRI, CT, PET	N/A	35% after deductible		N/A	20% after deductible	
Outpatient surgery	N/A	35% after deductible		N/A	20% after deductible	
Mental health visit	No charge	$25	35% after deductible	No charge	$15	20% after deductible
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	N/A	35% after deductible		N/A	20% after deductible	
Maternity						
Routine prenatal care visits, first postpartum visit	No charge			No charge		
Delivery and inpatient well-baby care	N/A	35% after deductible		N/A	20% after deductible	
Worldwide emergency and urgent care						
Emergency department visit	35% after deductible			20% after deductible		
Network Urgent Care Center	N/A	$50	N/A	N/A	$30	N/A
Urgent care outside Kaiser Permanente of WA service area[1]	N/A	35% after deductible	N/A	N/A	20% after deductible	N/A
Retail prescriptions: One 30-day maintenance drug allowed at any network pharmacy. Subsequent maintenance fills (including maintenance fills at Kaiser Permanente pharmacies) must be filled via mail order.						
Tier 1: Preferred generic	$30 for a 30-day supply			$25 for a 30-day supply		
Tier 2: Preferred brand	$70 for a 30-day supply			$50 for a 30-day supply		
Tier 3: Nonpreferred generic and brand	50% after deductible for a 30-day supply			50% after deductible for a 30-day supply		
Tier 4: Specialty	50% after deductible for a 30-day supply			50% after deductible for a 30-day supply		
Alternative medicine						
10 chiropractic visits and 12 acupuncture visits	N/A	$25 primary/$50 specialty	N/A	N/A	$15 primary/$30 specialty	N/A
Optical hardware						
Pediatric (18 and younger)	Covered in full			Covered in full		
Adult (19 and older)	$100 allowance per calendar year			$100 allowance per calendar year		

EO = Employee only HD = High deductible LD = Low deductible LX = Lab and X-ray

[1] If you travel out of state, virtual care could be limited due to state laws that may prevent doctors from providing care across state lines. Laws differ by state.

[2] Virtual care is offered when appropriate and available.

See page 19 for primary and specialty care descriptions. Rates and plans are subject to Office of the Insurance Commissioner (OIC) approval.

Virtual Plus plans start with virtual care

Our Virtual Plus plans offer your employees convenient and affordable ways to get care virtually – when and where they want it – and in-person care when they need it.[1]

Virtual Plus highlights

- Low monthly premiums.
- No charge and no referral needed for virtual care, first in-person primary care visit, and all preventive care.
- Most care, including care from a specialist, starts with a virtual visit.[2]
- Virtual care options include 24/7 Care Chat, 24/7 advice line, and video and phone visits available 24/7 with no appointment needed or by scheduled appointment. Members can also choose an email for nonurgent issues or an e-visit.[2]
- Virtual visits are with Kaiser Permanente doctors and clinicians – the same ones you'd find in our medical facilities.
- When your employees get a referral for in-person care, their cost will be lower than if they start in-person care on their own.

Dental coverage is required for those 18 and younger and accompanies all Kaiser Permanente medical plans.

See pages 20–22 for details, as well as information on optional dental coverage for adults and families.

2023 Kaiser Foundation Health Plan of Washington Options, Inc., plans

Access PPO provider network

Access PPO enhanced benefit offers lower copays or coinsurance for office visits from a select group of providers and for some drugs.

Features	Access PPO Bronze HSA			Access PPO Silver HSA			Access PPO VisitsPlus Silver HD		
	In-network - Enhanced	In-network - Standard	Out-of-network	In-network - Enhanced	In-network - Standard	Out-of-network	In-network - Enhanced	In-network - Standard	Out-of-network
Plan type	HSA-qualified			HSA-qualified			Deductible		
Annual medical deductible (individual/family)	$6,000/$12,000		$12,000/$24,000	$3,500/$7,000		$7,000/$14,000	$6,000/$12,000		$12,000/$24,000
Annual out-of-pocket maximum (individual/family)	$6,950/$13,900		No limit	$6,900/$13,800		No limit	$8,450/$16,900		No limit
Coinsurance	40%		50%	30%		50%	40%		50%
Benefits									
Preventive care									
Routine physical exam, mammogram, etc.	No charge		50% after deductible	No charge		50% after deductible	No charge		50% after deductible
Outpatient services (per visit or procedure)							Upfront office visits prior to deductible		
Primary care office visit	30% after deductible	40% after deductible	50% after deductible	20% after deductible	30% after deductible	50% after deductible	$30	$40	50% after deductible
Specialty care office visit	30% after deductible	40% after deductible	50% after deductible	20% after deductible	30% after deductible	50% after deductible	$55	$65	50% after deductible
Most X-rays	40% after deductible		50% after deductible	30% after deductible		50% after deductible	30% after deductible	40% after deductible	50% after deductible
Most lab tests	40% after deductible		50% after deductible	30% after deductible		50% after deductible	30% after deductible	40% after deductible	50% after deductible
MRI, CT, PET	40% after deductible		50% after deductible	30% after deductible		50% after deductible	40% after deductible		50% after deductible
Outpatient surgery	40% after deductible		50% after deductible	30% after deductible		50% after deductible	40% after deductible		50% after deductible
Mental health visit	30% after deductible	40% after deductible	50% after deductible	20% after deductible	30% after deductible	50% after deductible	$30	$40	50% after deductible
Inpatient hospital care									
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible		50% after deductible	30% after deductible		50% after deductible	40% after deductible		50% after deductible
Maternity									
Routine prenatal care visits, first postpartum visit	No charge		50% after deductible	No charge		50% after deductible	No charge		50% after deductible
Delivery and inpatient well-baby care	40% after deductible		50% after deductible	30% after deductible		50% after deductible	40% after deductible		50% after deductible
Worldwide emergency and urgent care									
Emergency department visit	40% after deductible			30% after deductible			40% after deductible		50% after deductible
Urgent care visit	30% after deductible	40% after deductible	50% after deductible	20% after deductible	30% after deductible	50% after deductible	$55	$65	50% after deductible
Retail prescription drugs (up to 30-day supply)									
Tier 1: Preferred generic	45% after deductible	50% after deductible	Not covered	15% after deductible	20% after deductible	Not covered	$25	$35	Not covered
Tier 2: Preferred brand	45% after deductible	50% after deductible	Not covered	25% after deductible	30% after deductible	Not covered	$60	$70	Not covered
Tier 3: Nonpreferred generic and brand	45% after deductible	50% after deductible	Not covered	45% after deductible	50% after deductible	Not covered	45% after deductible	50% after deductible	Not covered
Tier 4: Specialty	50% after deductible		Not covered	50% after deductible		Not covered	50% after deductible		Not covered
Alternative medicine									
10 chiropractic and 12 acupuncture visits	30% after deductible		50% after deductible	20% after deductible		50% after deductible	$30 primary/$55 specialty		50% after deductible
Optical hardware									
Pediatric (18 and younger)	Covered in full			Covered in full			Covered in full		
Adult (19 and older)	$100 allowance per calendar year			$100 allowance per calendar year			$100 allowance per calendar year		

EO = Employee only HD = High deductible LD = Low deductible LX = Lab and X-ray
NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

See page 19 for primary and specialty care descriptions. Rates and plans are subject to Office of the Insurance Commissioner (OIC) approval.

Dental coverage is required for those 18 and younger and accompanies all Kaiser Permanente medical plans.

See pages 20–22 for details, as well as information on optional dental coverage for adults and families.

2023 Kaiser Foundation Health Plan of Washington Options, Inc., plans

Access PPO provider network

Access PPO enhanced benefit offers lower copays or coinsurance for office visits from a select group of providers and for some drugs.

Features	Access PPO VisitsPlus Silver LD LX			Access PPO VisitsPlus Silver LX			Access PPO VisitsPlus Silver LX - EO		
	In-network - Enhanced	In-network - Standard	Out-of-network	In-network - Enhanced	In-network - Standard	Out-of-network	In-network - Enhanced	In-network - Standard	Out-of-network
Plan type	Deductible			Deductible			Deductible		
Annual medical deductible (individual/family)	$2,600/$5,200		$5,200/$10,400	$3,000/$6,000		$6,000/$12,000	$3,000/$6,000		$6,000/$12,000
Annual out-of-pocket maximum (individual/family)	$8,900/$17,800		No limit	$8,900/$17,800		No limit	$8,900/$17,800		No limit
Coinsurance	35%		50%	35%		50%	35%		50%
Benefits									
Preventive care									
Routine physical exam, mammogram, etc.	No charge		50% after deductible	No charge		50% after deductible	No charge		50% after deductible
Outpatient services (per visit or procedure)	Upfront office visits prior to deductible			Upfront office visits prior to deductible			Upfront office visits prior to deductible		
Primary care office visit	$30	$45	50% after deductible	$25	$45	50% after deductible	$25	$45	50% after deductible
Specialty care office visit	$55	$65	50% after deductible	$45	$65	50% after deductible	$45	$65	50% after deductible
Most X-rays	$40	$55	50% after deductible	$35	$50	50% after deductible	$35	$50	50% after deductible
Most lab tests	$40	$55	50% after deductible	$35	$50	50% after deductible	$35	$50	50% after deductible
MRI, CT, PET	35% after deductible		50% after deductible	35% after deductible		50% after deductible	35% after deductible		50% after deductible
Outpatient surgery	35% after deductible		50% after deductible	35% after deductible		50% after deductible	35% after deductible		50% after deductible
Mental health visit	$30	$45	50% after deductible	$25	$45	50% after deductible	$25	$45	50% after deductible
Inpatient hospital care									
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible		50% after deductible	35% after deductible		50% after deductible	35% after deductible		50% after deductible
Maternity									
Routine prenatal care visits, first postpartum visit	No charge		50% after deductible	No charge		50% after deductible	No charge		50% after deductible
Delivery and inpatient well-baby care	35% after deductible		50% after deductible	35% after deductible		50% after deductible	35% after deductible		50% after deductible
Worldwide emergency and urgent care									
Emergency department visit	35% after deductible			35% after deductible			35% after deductible		
Urgent care visit	$55	$65	50% after deductible	$45	$65	50% after deductible	$45	$65	50% after deductible
Retail prescription drugs (up to 30-day supply)									
Tier 1: Preferred generic	$25	$40	Not covered	$25	$40	Not covered	$25	$40	Not covered
Tier 2: Preferred brand	$60	$75	Not covered	$55	$75	Not covered	$55	$75	Not covered
Tier 3: Nonpreferred generic and brand	45% after deductible	50% after deductible	Not covered	45% after deductible	50% after deductible	Not covered	45% after deductible	50% after deductible	Not covered
Tier 4: Specialty	50% after deductible		Not covered	50% after deductible		Not covered	50% after deductible		Not covered
Alternative medicine									
10 chiropractic and 12 acupuncture visits	$30 primary/$55 specialty		50% after deductible	$25 primary/$45 specialty		50% after deductible	$25 primary/$45 specialty		50% after deductible
Optical hardware									
Pediatric (18 and younger)	Covered in full			Covered in full			Covered in full		
Adult (19 and older)	$100 allowance per calendar year			$100 allowance per calendar year			$100 allowance per calendar year		

EO = Employee only HD = High deductible LD = Low deductible LX = Lab and X-ray

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

See page 19 for primary and specialty care descriptions. Rates and plans are subject to Office of the Insurance Commissioner (OIC) approval.

Dental coverage is required for those 18 and younger and accompanies all Kaiser Permanente medical plans.

See pages 20–22 for details, as well as information on optional dental coverage for adults and families.

2023 Kaiser Foundation Health Plan of Washington Options, Inc., plans

Access PPO provider network

Access PPO enhanced benefit offers lower copays or coinsurance for office visits from a select group of providers and for some drugs.

Features	Access PPO VisitsPlus Gold LX			Access PPO VisitsPlus Gold HD LX			Access PPO VisitsPlus Platinum HD LX		
	In-network - Enhanced	In-network - Standard	Out-of-network	In-network - Enhanced	In-network - Standard	Out-of-network	In-network - Enhanced	In-network - Standard	Out-of-network
Plan type	Deductible			Deductible			Deductible		
Annual medical deductible (individual/family)	$600/$1,200		$1,200/$2,400	$1,500/$3,000		$3,000/$6,000	$400/$800		$800/$1,600
Annual out-of-pocket maximum (individual/family)	$6,500/$13,000		No limit	$8,000/$16,000		No limit	$3,000/$6,000		No limit
Coinsurance	20%		50%	20%		50%	20%		50%
Benefits									
Preventive care									
Routine physical exam, mammogram, etc.	No charge	No charge	50% after deductible	No charge		50% after deductible	No charge		50% after deductible
Outpatient services (per visit or procedure)	Upfront office visits prior to deductible			Upfront office visits prior to deductible			Upfront office visits prior to deductible		
Primary care office visit	$10	$30	50% after deductible	$20	$35	50% after deductible	$5	$15	50% after deductible
Specialty care office visit	$30	$50	50% after deductible	$40	$55	50% after deductible	$10	$25	50% after deductible
Most X-rays	$20	$40	50% after deductible	$20	$40	50% after deductible	$5	$20	50% after deductible
Most lab tests	$20	$40	50% after deductible	$20	$40	50% after deductible	$5	$20	50% after deductible
MRI, CT, PET	20% after deductible		50% after deductible	20% after deductible		50% after deductible	20% after deductible		50% after deductible
Outpatient surgery	20% after deductible		50% after deductible	20% after deductible		50% after deductible	20% after deductible		50% after deductible
Mental health visit	$10	$30	50% after deductible	$20	$35	50% after deductible	$5	$15	50% after deductible
Inpatient hospital care									
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible		50% after deductible	20% after deductible		50% after deductible	20% after deductible		50% after deductible
Maternity									
Routine prenatal care visits, first postpartum visit	No charge		50% after deductible	No charge		50% after deductible	No charge		50% after deductible
Delivery and inpatient well-baby care	20% after deductible		50% after deductible	20% after deductible		50% after deductible	20% after deductible		50% after deductible
Worldwide emergency and urgent care									
Emergency department visit	20% after deductible			20% after deductible			20% after deductible		
Urgent care visit	$30	$50	50% after deductible	$40	$55	50% after deductible	$10	$25	50% after deductible
Retail prescription drugs (up to 30-day supply)									
Tier 1: Preferred generic	$15	$25	Not covered	$15	$20	Not covered	$5	$10	Not covered
Tier 2: Preferred brand	$45	$50	Not covered	$25	$50	Not covered	$10	$20	Not covered
Tier 3: Nonpreferred generic and brand	35% after deductible	40% after deductible	Not covered	30% after deductible	40% after deductible	Not covered	30% after deductible	40% after deductible	Not covered
Tier 4: Specialty	40% after deductible		Not covered	40% after deductible		Not covered	40% after deductible		Not covered
Alternative medicine									
10 chiropractic and 12 acupuncture visits	$10 primary/$30 specialty		50% after deductible	$20 primary/$40 specialty		50% after deductible	$5 primary/$10 specialty		50% after deductible
Optical hardware									
Pediatric (18 and younger)	Covered in full			Covered in full			Covered in full		
Adult (19 and older)	$100 allowance per calendar year			$100 allowance per calendar year			$100 allowance per calendar year		

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2023 Kaiser Foundation Health Plan of Washington Options, Inc., plans

Access PPO provider network

Access PPO enhanced benefit offers lower copays or coinsurance for office visits from a select group of providers and for some drugs.

Features	Access PPO VisitsPlus Platinum LX		
	In-network - Enhanced	In-network - Standard	Out-of-network
Plan type	Deductible		
Annual medical deductible (individual/family)	$250/$500		$500/$1,000
Annual out-of-pocket maximum (individual/family)	$2,500/$5,000		No limit
Coinsurance	10%		50%
Benefits			
Preventive care			
Routine physical exam, mammogram, etc.	No charge		50% after deductible
Outpatient services (per visit or procedure)	Upfront office visits prior to deductible		
Primary care office visit	$5	$20	50% after deductible
Specialty care office visit	$20	$35	50% after deductible
Most X-rays	$5	$20	50% after deductible
Most lab tests	$5	$20	50% after deductible
MRI, CT, PET	10% after deductible		50% after deductible
Outpatient surgery	10% after deductible		50% after deductible
Mental health visit	$5	$20	50% after deductible
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	10% after deductible		50% after deductible
Maternity			
Routine prenatal care visits, first postpartum visit	No charge		50% after deductible
Delivery and inpatient well-baby care	10% after deductible		50% after deductible
Worldwide emergency and urgent care			
Emergency department visit	10% after deductible		
Urgent care visit	$20	$35	50% after deductible
Retail prescription drugs (up to 30-day supply)			
Tier 1: Preferred generic	$5	$10	Not covered
Tier 2: Preferred brand	$15	$20	Not covered
Tier 3: Nonpreferred generic and brand	35% after deductible	40% after deductible	Not covered
Tier 4: Specialty	40% after deductible		Not covered
Alternative medicine			
10 chiropractic and 12 acupuncture visits	$5 primary/$20 specialty		50% after deductible
Optical hardware			
Pediatric (18 and younger)	Covered in full		
Adult (19 and older)	$100 allowance per calendar year		

EO = Employee only HD = High deductible LD = Low deductible LX = Lab and X-ray
NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

See page 19 for primary and specialty care descriptions. Rates and plans are subject to Office of the Insurance Commissioner (OIC) approval.

Appendix

PRIMARY CARE includes:

- Acupuncture
- Chemical Dependency/ Substance Abuse
- Chiropractic
- Emergency Medicine (where ER copay doesn't apply)
- Family Planning
- Family Practice
- General Practice
- Gerontology/Geriatrics
- Internal Medicine
- Mental Health
- Midwifery
- Naturopathy
- Obstetrics and Gynecology
- Optometry
- Osteopathy
- Pediatrics
- Pharmacist
- Urgent Care
- Women's Health Care (nonpreventive)

SPECIALTY CARE includes:

- Allergy and Immunology
- Anesthesiology
- Audiology
- Cardiology (pediatric and cardiovascular disease)
- Critical Care Medicine
- Dentistry
- Dermatology
- Endocrinology
- Enterostomal Therapy
- Gastroenterology
- Genetics
- Hepatology
- Infectious Disease
- Massage Therapy
- Neonatal-Perinatal Medicine
- Nephrology
- Neurology
- Hematology/Oncology
- Nutrition (nonpreventive)
- Occupational Medicine
- Occupational Therapy
- Oncology Pharmacist
- Ophthalmology
- Orthopedics
- ENT/Otolaryngology
- Pain Management
- Pathology
- Physiatry (Physical Medicine)
- Physical Therapy
- Podiatry
- Pulmonary Medicine/Disease
- Radiology (Nuclear Medicine, Radiation Therapy)
- Respiratory Therapy
- Rheumatology
- Speech Therapy
- Sports Medicine
- General Surgery (all specific surgeries)
- Urology

Please refer to your Evidence of Coverage for details.

Dental coverage is required for those 18 and younger and accompanies all Kaiser Permanente medical plans.

See pages 20–22 for details, as well as information on optional dental coverage for adults and families.

2023 Adult and pediatric dental coverage

When you select a 2023 Kaiser Permanente medical plan, you can choose to add dental coverage offered through Delta Dental of Washington. Adult coverage is for members and their dependents 19 and older; mandated pediatric coverage is for members or their dependents 18 and younger.

If you purchase the Delta Dental Basic Family or Standard Family plan, both of which include pediatric and adult coverage, you fulfill the federal mandate to provide pediatric dental coverage. However, if you do not purchase a family dental plan, the medical plan will automatically be paired with a pediatric-only dental plan offered by Delta Dental to fulfill the federal mandate. Here is a summary of benefits for the dental plans.

Summary of dental benefits

	BASIC FAMILY PLAN Maximum allowed amount paid by Delta Dental of Washington			
	PEDIATRIC 18 and younger		ADULT 19 and older	
	Delta Dental participating dentist	Nonparticipating dentist	Delta Dental participating dentist	Nonparticipating dentist
Maximum benefit	No annual maximum		$1,000 annual plan maximum $1,000 lifetime adult ortho maximum $1,000 annual TMJ[1] maximum $5,000 lifetime TMJ[1] maximum	
Annual deductible Deductible is waived for diagnostic, preventive, and medically necessary orthodontia	$50 per child per year		$50 per adult per year	
Annual out-of-pocket maximum	$350 per child per year $700 per year for families with 2 or more children	Not applicable	Not applicable	
Diagnostic and preventive Deductible is waived for exams, prophylaxis, fluoride, X-rays, sealants	100%	100%	100%	100%
Restorative Restorations (includes posterior composites), endodontics, periodontics, oral surgery	80%	80%	50%	50%
Major Crowns, dentures, partials, and bridges. Implants and TMJ[1] are for adults 19 and older.	50%	50%	50%	50%
Orthodontia Coinsurance Lifetime maximum Deductible is waived for medically necessary orthodontia	50% Unlimited Medically necessary[2]		50% $1,000 lifetime adult ortho maximum	

Pediatric Benefits: Only fees paid to a Delta Dental PPO Plus Premier™ dentist accrue to the annual out-of-pocket maximum.
Dental premiums will be assessed and billed separately from the medical premiums.
[1] TMJ = Temporomandibular joint [2] Requires preauthorization

	STANDARD FAMILY PLAN Maximum allowed amount paid by Delta Dental of Washington			
	PEDIATRIC 18 and younger		ADULT 19 and older	
	Delta Dental participating dentist	Nonparticipating dentist	Delta Dental participating dentist	Nonparticipating dentist
Maximum benefit	No annual maximum		$1,500 annual plan maximum $1,000 lifetime adult ortho maximum $1,000 annual TMJ[1] maximum $5,000 lifetime TMJ[1] maximum	
Annual deductible Deductible is waived for diagnostic, preventive, and medically necessary orthodontia	$50 per child per year		$50 per adult per year	
Annual out-of-pocket maximum	$350 per child per year $700 per year for families with 2 or more children	Not applicable	Not applicable	
Diagnostic and preventive Deductible is waived for exams, prophylaxis, fluoride, X-rays, sealants	100%	100%	100%	100%
Restorative Restorations (includes posterior composites), endodontics, periodontics, oral surgery	80%	80%	80%	80%
Major Crowns, dentures, partials, and bridges. Implants and TMJ[1] are for adults 19 and older.	50%	50%	50%	50%
Orthodontia Coinsurance Lifetime maximum Deductible is waived for medically necessary orthodontia	50% Unlimited Medically necessary[2]		50% $1,000 lifetime adult ortho maximum	

This is a brief summary of benefits and does not constitute a contract. For complete plan information, please refer to your Delta Dental of Washington benefits booklet.

Extra dental benefit for members with qualifying conditions

Regular preventive care is especially important for people with certain health conditions. To help reduce the risk of potential problems, our adult plans include a special dental benefit for members 19 and older who are pregnant, managing heart disease, or living with diabetes. Members with these qualifying conditions can receive an extra dental cleaning and exam with a Delta Dental PPO Plus Premier™ provider each year, at no additional charge.

Delta Dental of Washington will notify those who qualify for this extra benefit. Importantly, the member's specific diagnosis will remain confidential. This extra cleaning and exam doesn't apply to the annual maximum benefit, or the dental plan's cleaning and exam limitations.

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Visit a participating Delta Dental network dentist

We encourage your employees to see a participating dentist. These dentists contract with Delta Dental to provide services at discounted fees and file all claims for their patients. Dentists who are part of Delta Dental's networks will not charge more than their approved fees and cost less than an out-of-network dentist.

Your employees may select any licensed dentist to provide services under this plan. However, if they go to an out-of-network dentist, Delta Dental has no control over their fees. Employees will be responsible for submitting their claims and paying any difference in the charges. This is called balance billing.

Finding a Delta Dental network dentist

Your employees can visit **DeltaDentalWA.com** and use the Find a Dentist tool. Just remind them to select the Delta Dental PPO Plus Premier™ network. The online directory is easy to use anytime, on a computer or on a smartphone. Employees can search based on preferences that matter to them, including dentist name, specialty, location, and language. They can even see endorsements from other Delta Dental patients for categories including "extended office hours," "friendly staff," kid-friendly," and if they make extra efforts to help ease anxiety. Your employees can also call Delta Dental at **1-800-554-1907** for assistance in finding a network dentist.

2023 Pediatric dental coverage

Although coverage for adults 19 and older is optional, the federal government requires dental coverage for any person 18 and younger. This coverage is referred to as pediatric dental coverage. When you select a 2023 Kaiser Permanente medical plan, it will be paired with the pediatric dental plan that is offered by Delta Dental of Washington unless you select one of the 2 Delta Dental family plans that include this coverage. Here is a summary of Delta Dental's pediatric dental plan benefits.

Summary of dental benefits	**PEDIATRIC PLAN** – 18 and younger Maximum allowed amount paid by Delta Dental of Washington	
	Delta Dental participating dentist	**Nonparticipating dentist**
Maximum benefit	No annual maximum	
Annual deductible Deductible is waived for diagnostic, preventive, and medically necessary orthodontia	$50 per child per year	
Annual out-of-pocket maximum Does not apply to services performed by nonparticipating dentists	$350 per child per year $700 per year for families with 2 or more children	Not applicable
Diagnostic and preventive Deductible is waived for exams, prophylaxis, fluoride, X-rays, sealants	100%	100%
Restorative Restorations (includes posterior composites), endodontics, periodontics, oral surgery	80%	80%
Major Crowns, dentures, partials, bridges	50%	50%
Medically necessary orthodontia* Coinsurance Lifetime maximum Deductible is waived for medically necessary orthodontia	50% Unlimited	

Only fees paid to a Delta Dental PPO Plus Premier™ dentist accrue to the annual out-of-pocket maximum.
$700 per family maximum out-of-pocket limit only applies to members 18 and younger.
*Requires preauthorization

This is a brief summary of benefits and does not constitute a contract. For complete plan information, please refer to your Delta Dental of Washington benefits booklet.

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