2024 Kaiser Foundation Health Plan of Washington plans

Core provider network

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

	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)	$7,200/$14,400	$7,500/$15,000	$8,400/$16,800	$8,400/$16,800	$8,400/$16,800
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	
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	$30	$30
Tier 2: Preferred brand	50% after deductible	40% 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

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.

See page 25 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 22–24 for details, as well as information on optional dental coverage for adults and families.

2024 Kaiser Foundation Health Plan of Washington plans

Core provider network

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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	$15	$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

Pharmacy coverage

For plans featuring the **Connect** and **Summit PPO networks**: 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**).

See page 25 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 22–24 for details, as well as information on optional dental coverage for adults and families.

2024 Kaiser Foundation Health Plan of Washington plans

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Connect provider network

	Virtual Plus Silver			Virtual Plus Gold		
Features	**In-network**			**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)	$9,150/$18,300			$8,200/$16,400		
Coinsurance	35%			25%		
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	$30	35% after deductible	No charge	$15	25% after deductible
Specialty care office visit	No charge	$70	35% after deductible	No charge	$30	25% after deductible
Most X-rays	N/A	35% after deductible		N/A	25% after deductible	
Most lab tests	N/A	35% after deductible		N/A	25% after deductible	
MRI, CT, PET	N/A	35% after deductible		N/A	25% after deductible	
Outpatient surgery	N/A	35% after deductible		N/A	25% after deductible	
Mental health visit	No charge	$30	35% after deductible	No charge	$15	25% 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	25% 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	25% after deductible	
Worldwide emergency and urgent care						
Emergency department visit	35% after deductible			25% after deductible		
Network Urgent Care Center	N/A	$70	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	25% 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	$30 primary / $7 0 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		

Kaiser Permanente 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.

See page 25 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 22–24 for details, as well as information on optional dental coverage for adults and families.

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.

2024 Kaiser Foundation Health Plan of Washington Options, Inc. plans

Access PPO provider network

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

	Access PPO Bronze HSA		Access PPO Silver HSA		Access PPO VisitsPlus Silver HD	
Features	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**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)	$7,250 / $14,500	No limit	$7,200 / $14,400	No limit	$8,450/$16,900	No limit
Coinsurance	40%	50%	35%	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	40% after deductible	50% after deductible	35% after deductible	50% after deductible	$40	50% after deductible
Specialty care office visit	40% after deductible	50% after deductible	35% after deductible	50% after deductible	$65	50% after deductible
Most X-rays	40% after deductible	50% after deductible	35% after deductible	50% after deductible	40% after deductible	50% after deductible
Most lab tests	40% after deductible	50% after deductible	35% after deductible	50% after deductible	40% after deductible	50% after deductible
MRI, CT, PET	40% after deductible	50% after deductible	35% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient surgery	40% after deductible	50% after deductible	35% after deductible	50% after deductible	40% after deductible	50% after deductible
Mental health visit	40% after deductible	50% after deductible	35% after deductible	50% after deductible	$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	35% 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	35% after deductible	50% after deductible	40% after deductible	50% after deductible
Worldwide emergency and urgent care						
Emergency department visit	40% after deductible		35% after deductible		40% after deductible	50% after deductible
Urgent care visit	40% after deductible	50% after deductible	35% after deductible	50% after deductible	$65	50% after deductible
Retail prescription drugs (up to 30-day supply)	**In-network-Enhanced** / **In-network-Standard**		**In-network-Enhanced** / **In-network-Standard**		**In-network-Enhanced** / **In-network-Standard**	
Tier 1: Preferred generic	30% after deductible / 50% after deductible	Not covered	10% after deductible / 20% after deductible	Not covered	$25 / $35	Not covered
Tier 2: Preferred brand	30% after deductible / 50% after deductible	Not covered	20% after deductible / 30% after deductible	Not covered	$60 / $70	Not covered
Tier 3: Nonpreferred generic and brand	40% after deductible / 50% after deductible	Not covered	40% 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	40% after deductible	50% after deductible	35% after deductible	50% after deductible	$40 primary / $65 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	

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 22–24 for details, as well as information on optional dental coverage for adults and families.

2024 Kaiser Foundation Health Plan of Washington Options, Inc. plans

Access PPO provider network

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	Access PPO VisitsPlus Silver LD LX		Access PPO VisitsPlus Silver LX		Access PPO VisitsPlus Silver LX - EO	
Features	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Plan type	Deductible		Deductible		Deductible	
Annual medical deductible (individual/family)	$2,500/$5,000	$5,000/$10,000	$3,000/$6,000	$6,000/$12,000	$3,000/$6,000	$6,000/$12,000
Annual out-of-pocket maximum (individual/family)	$8,700/$17,400	No limit	$8,500/$17,000	No limit	$8,500/$17,000	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	$35	50% after deductible	$45	50% after deductible	$45	50% after deductible
Specialty care office visit	$65	50% after deductible	$65	50% after deductible	$65	50% after deductible
Most X-rays	$55	50% after deductible	$50	50% after deductible	$50	50% after deductible
Most lab tests	$55	50% after deductible	$50	50% after deductible	$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	$35	50% after deductible	$45	50% after deductible	$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	$65	50% after deductible	$65	50% after deductible	$65	50% after deductible
Retail prescription drugs (up to 30-day supply)	**In-network–Enhanced** / **In-network–Standard**		**In-network–Enhanced** / **In-network–Standard**		**In-network–Enhanced** / **In-network–Standard**	
Tier 1: Preferred generic	$20 / $40	Not covered	$20 / $30	Not covered	$20 / $30	Not covered
Tier 2: Preferred brand	$60 / $75	Not covered	$50 / $60	Not covered	$50 / $60	Not covered
Tier 3: Nonpreferred generic and brand	40% after deductible / 50% after deductible	Not covered	40% after deductible / 50% after deductible	Not covered	40% 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	$35 primary/$65 specialty	50% after deductible	$45 primary/$65 specialty	50% after deductible	$45 primary/$65 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	

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 22–24 for details, as well as information on optional dental coverage for adults and families.

2024 Kaiser Foundation Health Plan of Washington Options, Inc. plans

Access PPO provider network

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	Access PPO VisitsPlus Gold LX		Access PPO VisitsPlus Gold HD LX		Access PPO VisitsPlus Platinum HD LX	
Features	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**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	$500/$1,000	$1,000/$2,000
Annual out-of-pocket maximum (individual/family)	$5,500/$11,000	No limit	$6,000/$12,000	No limit	$2,700/$5,400	No limit
Coinsurance	20%	50%	20%	50%	20%	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	50% after deductible	$35	50% after deductible	$10	50% after deductible
Specialty care office visit	$50	50% after deductible	$55	50% after deductible	$25	50% after deductible
Most X-rays	$40	50% after deductible	$40	50% after deductible	$20	50% after deductible
Most lab tests	$40	50% after deductible	$40	50% after deductible	$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	$30	50% after deductible	$35	50% after deductible	$25	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	$50	50% after deductible	$55	50% after deductible	$25	50% after deductible
Retail prescription drugs (up to 30-day supply)	**In-network–Enhanced** / **In-network–Standard**		**In-network–Enhanced** / **In-network–Standard**		**In-network–Enhanced** / **In-network–Standard**	
Tier 1: Preferred generic	$15 / $25	Not covered	$10 / $25	Not covered	$5 / $10	Not covered
Tier 2: Preferred brand	$45 / $50	Not covered	$30 / $50	Not covered	$15 / $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	35% 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	$30 primary / $50 specialty	50% after deductible	$35 primary / $55 specialty	50% after deductible	$10 primary / $25 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	

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 22–24 for details, as well as information on optional dental coverage for adults and families.

2024 Kaiser Foundation Health Plan of Washington Options, Inc., plans

Access PPO provider network

Features	Access PPO VisitsPlus Platinum LX		
	In-network		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	$20		50% after deductible
Specialty care office visit	$35		50% after deductible
Most X-rays	$20		50% after deductible
Most lab tests	$20		50% after deductible
MRI, CT, PET	10% after deductible		50% after deductible
Outpatient surgery	10% after deductible		50% after deductible
Mental health visit	$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	$35		50% after deductible
Retail prescription drugs (up to 30-day supply)	In-network–Enhanced	In-network–Standard	
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	$20 primary / $35 specialty		50% after deductible
Optical hardware			
Pediatric (18 and younger)	Covered in full		
Adult (19 and older)	$100 allowance per calendar year		

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

2024 Kaiser Foundation Health Plan of Washington Options, Inc., plans

Summit PPO provider network

Features	Summit PPO Bronze HSA		
	Tier 1 – In-network	Tier 2 – In-network	Out-of-network
Plan type	HSA-qualified		
Annual medical deductible (individual/family)	$6,500/$13,000		$13,000/$26,000
Annual out-of-pocket maximum (individual/family)	$7,500/$15,000		No limit
Coinsurance	20%	40%	50%
Benefits			
Preventive care			
Routine physical exam, mammogram, etc.	No charge		50% after deductible
Outpatient services (per visit or procedure)			
Primary care office visit	20% after deductible	40% after deductible	50% after deductible
Specialty care office visit	20% after deductible	40% after deductible	50% after deductible
Most X-rays	20% after deductible	40% after deductible	50% after deductible
Most lab tests	20% after deductible	40% after deductible	50% after deductible
MRI, CT, PET	20% after deductible	40% after deductible	50% after deductible
Outpatient surgery	20% after deductible	40% after deductible	50% after deductible
Mental health visit	20% after deductible	40% after deductible	50% after deductible
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	40% after deductible	50% after deductible
Maternity			
Routine prenatal care visits, first postpartum visit	No charge		50% after deductible
Delivery and inpatient well-baby care	20% after deductible	40% after deductible	50% after deductible
Worldwide emergency and urgent care			
Emergency department visit	20% after deductible		
Urgent care visit	20% after deductible	40% after deductible	50% after deductible
Retail prescription drugs (up to 30-day supply)			
Tier 1: Preferred generic	20% after deductible	50% after deductible	Not covered
Tier 2: Preferred brand	20% after deductible	50% after deductible	Not covered
Tier 3: Nonpreferred generic and brand	40% after deductible	50% after deductible	Not covered
Tier 4: Specialty	50% after deductible	50% after deductible	Not covered
Alternative medicine			
10 chiropractic and 12 acupuncture visits	20% after deductible	40% after deductible	50% after deductible
Optical hardware			
Pediatric (18 and younger)	Covered in full		
Adult (19 and older)	$100 allowance per calendar year		

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

See pages 22–24 for details, as well as information on optional dental coverage for adults and families.

2024 Kaiser Foundation Health Plan of Washington Options, Inc., plans

Summit PPO provider network

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

	Summit PPO VisitsPlus Silver LX			Summit PPO VisitsPlus Gold LX			Summit PPO VisitsPlus Platinum LX		
Features	**Tier 1 – In-network**	**Tier 2 – In-network**	**Out-of-network**	**Tier 1 – In-network**	**Tier 2 – In-network**	**Out-of-network**	**Tier 1 – In-network**	**Tier 2 – In-network**	**Out-of-network**
Plan type	Deductible			Deductible			Deductible		
Annual medical deductible (individual/family)	$3,500/$7,000		$7,000/$14,000	$1,500/$3,000		$3,000/$6,000	$300/$600		$600/$1,200
Annual out-of-pocket maximum (individual/family)	$8,900/$17,800		No limit	$6,500/$13,000		No limit	$2,450/$4,900		No limit
Coinsurance	20%	40%	50%	10%	30%	50%	5%	25%	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)									
Primary care office visit	$25	$45	50% after deductible	$10	$30	50% after deductible	$5	$25	50% after deductible
Specialty care office visit	$45	$65	50% after deductible	$30	$50	50% after deductible	$25	$40	50% after deductible
Most X-rays	$30	$50	50% after deductible	$20	$40	50% after deductible	$5	$25	50% after deductible
Most lab tests	$30	$50	50% after deductible	$20	$40	50% after deductible	$5	$25	50% after deductible
MRI, CT, PET	20% after deductible	40% after deductible	50% after deductible	10% after deductible	30% after deductible	50% after deductible	5% after deductible	25% after deductible	50% after deductible
Outpatient surgery	20% after deductible	40% after deductible	50% after deductible	10% after deductible	30% after deductible	50% after deductible	5% after deductible	25% after deductible	50% after deductible
Mental health visit	$25	$45	50% after deductible	$10	$30	50% after deductible	$5	$25	50% after deductible
Inpatient hospital care									
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	40% after deductible	50% after deductible	10% after deductible	30% after deductible	50% after deductible	5% after deductible	25% 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	40% after deductible	50% after deductible	10% after deductible	30% after deductible	50% after deductible	5% after deductible	25% after deductible	50% after deductible
Worldwide emergency and urgent care									
Emergency department visit	20% after deductible			10% after deductible			5% after deductible		
Urgent care visit	$45	$65	50% after deductible	$30	$50	50% after deductible	$25	$40	50% after deductible
Retail prescription drugs (up to 30-day supply)									
Tier 1: Preferred generic	$20	$40	Not covered	$10	$20	Not covered	$5	$25	Not covered
Tier 2: Preferred brand	$50	$70	Not covered	$30	$50	Not covered	$10	$30	Not covered
Tier 3: Nonpreferred generic and brand	30% after deductible	50% after deductible	Not covered	25% after deductible	45% after deductible	Not covered	30% after deductible	50% after deductible	Not covered
Tier 4: Specialty	50% after deductible	50% after deductible	Not covered	45% after deductible	45% after deductible	Not covered	30% after deductible	30% after deductible	Not covered
Alternative medicine									
10 chiropractic and 12 acupuncture visits	$25 primary / $45 specialty	$45 primary / $65 specialty	50% after deductible	$10 primary / $30 specialty	$30 primary / $50 specialty	50% after deductible	$5 primary / $25 specialty	$25 primary / $40 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		

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.

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