2020 Kaiser Foundation Health Plan of Washington plans

Core Provider Network

KAISER PERMANENTE®

	HMO 200	HMO 500	HMO 750	HMO 1,000	HMO 2,000	HMO 3,000	HMO 5,000	HMO HSA 2,500	HMO HSA 4,500
Features	In Network	In-network	In-network	In-network	In-network	In-network	In-network	In-network	In-network
Plan type	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	HSA-qualified	HSA-qualified
Annual medical deductible (individual/family)	$200 / $400	$500 / $1,000	$750 / $1,500	$1,000 / $2,000	$2,000 / $4,000	$3,000 / $6,000	$5,000 / $10,000	$2,500 / $5,000*	$4,500 / $7,350*
Annual out-of-pocket maximum (individual/family) includes deductible	$2,500 / $5,000	$4,500 / $9,000	$5,500 / $11,000	$6,600 / $13,200	$7,900 / $15,800	$7,900 / $15,800	$7,900 / $15,800	$6,750 / $7,900†	$6,750 / $7,900†
Coinsurance	10%	20%	20%	20%	20%	20%	30%	10%	30%
Benefits									
Preventive care									
Routine physical exams, mammogram, etc.	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient services									
Primary care office visit	$15	$15	$15	$15	$15	$15	$15	10% after deductible	30% after deductible
Specialty care office visit	$30	$30	$30	$30	$30	$30	$30	10% after deductible	30% after deductible
Most X-rays	10% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	10% after deductible	30% after deductible
Most lab tests	10% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	10% after deductible	30% after deductible
MRI, CT, PET	10% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient surgery	10% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	10% after deductible	30% after deductible
Mental health visit	$15	$15	$15	$15	$15	$15	$15	10% after deductible	30% after deductible
Inpatient hospital care									
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	10% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	10% after deductible	30% after deductible
Maternity									
Routine prenatal care visits, first postpartum visit	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	10% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	10% after deductible	30% after deductible
Worldwide emergency and urgent care									
Emergency department visit	$50 ER copay, 10% after deductible	$50 ER copay, 20% after deductible	$50 ER copay, 20% after deductible	$50 ER copay, 20% after deductible	$50 ER copay, 20% after deductible	$50 ER copay, 20% after deductible	$50 ER copay, 30% after deductible	10% after deductible	30% after deductible
Urgent care visit	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	10% after deductible	30% after deductible
Prescription drugs (up to 30-day supply)									
Tier 1: Preferred generic	$10	$15	$15	$15	$15	$15	$15	10% after deductible	30% after deductible
Tier 2: Preferred brand	$20	$30	$30	$30	$30	$30	$30	10% after deductible	30% after deductible
Tier 3: Non-preferred generic and brand	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Tier 4: Preferred specialty	50% (up to $150)	50% (up to $150)	50% (up to $150)	50% (up to $150)	50% (up to $150)	50% (up to $150)	50% (up to $150)	10% after deductible	30% after deductible
Mail order	2X copay per 90 day supply	2X copay per 90 day supply	2X copay per 90 day supply	2X copay per 90 day supply	2X copay per 90 day supply	2X copay per 90 day supply	2X copay per 90 day supply	3X costshare per 90 day supply	3X costshare per 90 day supply
Alternative medicine									
10 chiropractor visits and 12 accupuncture visits	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	10% after deductible	30% after deductible
Optical (hardware not covered)									
Exam	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	No copay, deductible/coinsurance	No copay, deductible/coinsurance

This is a brief summary of the benefits. Please review your Evidence of Coverage for more details.

*Coverage begins after the annual deductible has been met. See your Evidence of Coverage for details.
†With an aggregate deductible, the health plan doesn't begin paying for the health expenses of anyone in the family until the entire family deductible is met or the individual has reached their out-of-pocket maximum.

2020 Kaiser Foundation Health Plan of Washington Options, Inc. plans

Access PPO Provider Network

KAISER PERMANENTE®

	PPO 200			PPO 500			PPO 750		
Features	**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)	$200 / $400		Shared with in-network	$500 / $1,000		Shared with in-network	$750 / $1,500		Shared with in-network
Annual out-of-pocket maximum (individual/family)	$2,500 / $5,000		Shared with in-network	$4,000 / $8,000		Shared with in-network	$5,000 / $10,000		Shared with in-network
Coinsurance	10%		50%	20%		50%	20%		50%
Benefits									
Preventive care									
Routine physical exams, mammogram, etc.	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible
Outpatient services									
Primary care office visit	$20	$30	50% after deductible	$20	$30	50% after deductible	$20	$30	50% after deductible
Specialty care office visit	$40	$60	50% after deductible	$40	$60	50% after deductible	$40	$60	50% after deductible
Most X-rays	10% after deductible	10% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible
Most lab tests	10% after deductible	10% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible
MRI, CT, PET	10% after deductible	10% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible
Outpatient surgery	10% after deductible	10% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible
Mental health visit	$20	$30	50% after deductible	$20	$30	50% after deductible	$20	$30	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	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	10% 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	$100 copay, 10% after deductible			$100 copay, 20% after deductible			$100 copay, 20% after deductible		
Urgent care visit	$20 copay	$30 copay	50% after deductible	$20 copay	$30 copay	50% after deductible	$20 copay	$30 copay	50% after deductible
Prescription drugs (up to 30-day supply)									
Tier 1: Preferred generic	$5	$15	Not covered	$5	$15	Not covered	$5	$15	Not covered
Tier 2: Preferred brand	$15	$25	Not covered	$15	$25	Not covered	$15	$25	Not covered
Tier 3: Non-preferred generic and brand	$35	$45	Not covered	$35	$45	Not covered	$35	$45	Not covered
Tier 4: Preferred specialty	50% up to $150	50% up to $150	Not covered	50% up to $150	50% up to $150	Not covered	50% up to $150	50% up to $150	Not covered
Mail order	2X copay per 90 day supply		Not covered	2X copay per 90 day supply		Not covered	2X copay per 90 day supply		Not covered
Alternative medicine									
15 chiropractor visits and 12 accupuncture visits	$30 copay		50% after deductible	$30 copay		50% after deductible	$30 copay		50% after deductible
Optical (hardware not covered)									
Exam	Covered in full			Covered in full			Covered in full		

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Features	PPO 1,000			PPO 2,000			PPO 3,000		
	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)	$1,000 / $2,000		Shared with in-network	$2,000 / $4,000		Shared with in-network	$3,000 / $6,000		Shared with in-network
Annual out-of-pocket maximum (individual/family)	$6,600 / $13,200		Shared with in-network	$7,900 / $15,800		Shared with in-network	$7,900 / $15,800		Shared with in-network
Coinsurance	20%		50%	20%		50%	20%		50%
Benefits									
Preventive care									
Routine physical exams, mammogram, etc.	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible
Outpatient services									
Primary care office visit	$20	$30	50% after deductible	$20	$30	50% after deductible	$20	$30	50% after deductible
Specialty care office visit	$40	$60	50% after deductible	$40	$60	50% after deductible	$40	$60	50% after deductible
Most X-rays	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible
Most lab tests	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible
MRI, CT, PET	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible
Mental health visit	$20	$30	50% after deductible	$20	$30	50% after deductible	$20	$30	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	$100 copay, 20% after deductible			$100 copay, 20% after deductible			$100 copay, 20% after deductible		
Urgent care visit	$30 copay	50% after deductible	50% after deductible	$30 copay	50% after deductible	50% after deductible	$30 copay	50% after deductible	50% after deductible
Prescription drugs (up to 30-day supply)									
Tier 1: Preferred generic	$5	$15	Not covered	$5	$15	Not covered	$5	$15	Not covered
Tier 2: Preferred brand	$15	$25	Not covered	$15	$25	Not covered	$15	$25	Not covered
Tier 3: Non-preferred generic and brand	$35	$45	Not covered	$35	$45	Not covered	$35	$45	Not covered
Tier 4: Preferred specialty	50% up to $150	50% up to $150	Not covered	50% up to $150	50% up to $150	Not covered	50% up to $150	50% up to $150	Not covered
Mail order	2X copay per 90 day supply		Not covered	2X copay per 90 day supply		Not covered	2X copay per 90 day supply		Not covered
Alternative medicine									
15 chiropractor visits and 12 accupuncture visits	$30 copay		50% after deductible	$30 copay		50% after deductible	$30 copay		50% after deductible
Optical (hardware not covered)									
Exam	Covered in full			Covered in full			Covered in full		

This is a brief summary of the benefits. Please review your Evidence of Coverage for more details.

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Access PPO Provider Network

KAISER PERMANENTE®

Features	PPO 5,000			PPO HSA 2,500			PPO HSA 4,500		
	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			HSA-qualified			HSA-qualified		
Annual medical deductible (individual/family)	$5,000 / $10,000		Shared with in-network	$2,500 / $5,000		Shared with in-network	$4,500 / $9,000		Shared with in-network
Annual out-of-pocket maximum (individual/family)	$7,900 / $15,800		Shared with in-network	$6,750 / $7,900		Shared with in-network	$6,750 / $7,900		Shared with in-network
Coinsurance	30%		50%	20% (10% enhanced)		50%	30%		50%
Benefits									
Preventive care									
Routine physical exams, mammogram, etc.	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible
Outpatient services									
Primary care office visit	$20	$30	50% after deductible	10% after deductible	20% after deductible	50% after deductible	20% after deductible	30% after deductible	50% after deductible
Specialty care office visit	$40	$60	50% after deductible	10% after deductible	20% after deductible	50% after deductible	20% after deductible	30% after deductible	50% after deductible
Most X-rays	30% after deductible	30% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Most lab tests	30% after deductible	30% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	30% after deductible	30% after deductible	50% after deductible
MRI, CT, PET	30% after deductible	30% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	30% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Mental health visit	$20	$30	50% after deductible	10% after deductible	20% after deductible	50% after deductible	20% after deductible	30% after deductible	50% after deductible
Inpatient hospital care									
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible		50% after deductible	20% after deductible	20% after deductible	50% after deductible	30% after deductible	30% 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	30% after deductible		50% after deductible	20% after deductible	20% after deductible	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Worldwide emergency and urgent care									
Emergency department visit	$100 copay, 30% after deductible			$0 copay, 20% after deductible			$0 copay, 30% after deductible		
Urgent care visit	$30 copay	50% after deductible	50% after deductible	10% after deductible	20% after deductible	50% after deductible	20% after deductible	30% after deductible	50% after deductible
Prescription drugs (up to 30-day supply)									
Tier 1: Preferred generic	$5	$15	Not covered	10% after deductible	20% after deductible	Not covered	20% after deductible	30% after deductible	Not covered
Tier 2: Preferred brand	$15	$25	Not covered	10% after deductible	20% after deductible	Not covered	20% after deductible	30% after deductible	Not covered
Tier 3: Non-preferred generic and brand	$35	$45	Not covered	10% after deductible	20% after deductible	Not covered	20% after deductible	30% after deductible	Not covered
Tier 4: Preferred specialty	50% up to $150	50% up to $150	Not covered	10% after deductible	20% after deductible	Not covered	20% after deductible	30% after deductible	Not covered
Mail order	2X copay per 90 day supply		Not covered	3X enhanced copay, per 90 day supply		Not covered	3X enhanced copay, per 90 day supply		Not covered
Alternative medicine									
15 chiropractor visits and 12 accupuncture visits	$30 copay		50% after deductible	20% after deductible	20% after deductible	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Optical (hardware not covered)									
Exam	Covered in full			Covered in full			Covered in full		

This is a brief summary of the benefits. Please review your Evidence of Coverage for more details.