

2021-2022 Kaiser Foundation Health Plan of Washington plans

Core Network



| | HMO 200 | HMO 500 | HMO 750 | HMO 1,000 |
|---|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Features | In-network | In-network | In-network | In-network |
| Plan type | Deductible | Deductible | Deductible | Deductible |
| Annual medical deductible (individual/family) | \$200 / \$400 | \$500 / \$1,000 | \$750 / \$1,500 | \$1,000 / \$2,000 |
| 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 |
| Coinsurance | 10% | 20% | 20% | 20% |
| Benefits | | | | |
| Preventive care | | | | |
| Routine physical exams, mammogram, etc. | No charge | No charge | No charge | No charge |
| Outpatient services | | | | |
| Primary care office visit | \$15 | \$15 | \$15 | \$15 |
| Specialty care office visit | \$30 | \$30 | \$30 | \$30 |
| Most X-rays | 10% after deductible | 20% after deductible | 20% after deductible | 20% after deductible |
| Most lab tests | 10% after deductible | 20% after deductible | 20% after deductible | 20% after deductible |
| MRI, CT, PET | 10% after deductible | 20% after deductible | 20% after deductible | 20% after deductible |
| Outpatient surgery | 10% after deductible | 20% after deductible | 20% after deductible | 20% after deductible |
| Mental health visit | \$15 | \$15 | \$15 | \$15 |
| 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 |
| Maternity | | | | |
| Routine prenatal care visits, first postpartum visit | 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 |
| 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 |
| Urgent care visit | \$15 copay | \$15 copay | \$15 copay | \$15 copay |
| Prescription drugs (up to 30-day supply) | | | | |
| Tier 1: Preferred generic | \$10 | \$15 | \$15 | \$15 |
| Tier 2: Preferred brand | \$20 | \$30 | \$30 | \$30 |
| Tier 3: Non-preferred generic and brand | 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) |
| 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 |
| Alternative medicine | | | | |
| 10 chiropractor visits and 12 acupuncture visits | \$15 copay | \$15 copay | \$15 copay | \$15 copay |
| Optical (hardware not covered) | | | | |
| Exam | \$15 copay | \$15 copay | \$15 copay | \$15 copay |

This is a brief summary of the benefits. Please review your Evidence of Coverage for more details. Plans are effective 1/1/21.
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| | 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 |
| Plan type | Deductible | Deductible | Deductible | HSA-qualified | HSA-qualified |
| Annual medical deductible (individual/family) | \$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 | \$7,900 / \$15,800 | \$7,900 / \$15,800 | \$7,900 / \$15,800 | \$6,750 / \$7,900* | \$6,750 / \$7,900* |
| Coinsurance | 20% | 20% | 30% | 10% | 30% |
| Benefits | | | | | |
| Preventive care | | | | | |
| Routine physical exams, mammogram, etc. | No charge | No charge | No charge | No charge | No charge |
| Outpatient services | | | | | |
| Primary care office visit | \$15 | \$15 | \$15 | 10% after deductible | 30% after deductible |
| Specialty care office visit | \$30 | \$30 | \$30 | 10% after deductible | 30% after deductible |
| Most X-rays | 20% after deductible | 20% after deductible | 30% after deductible | 10% after deductible | 30% after deductible |
| Most lab tests | 20% after deductible | 20% after deductible | 30% after deductible | 10% after deductible | 30% after deductible |
| MRI, CT, PET | 20% after deductible | 20% after deductible | 30% after deductible | 10% after deductible | 30% after deductible |
| Outpatient surgery | 20% after deductible | 20% after deductible | 30% after deductible | 10% after deductible | 30% after deductible |
| Mental health visit | \$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 | 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 |
| Delivery and inpatient well-baby care | 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, 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 | 10% after deductible | 30% after deductible |
| Prescription drugs (up to 30-day supply) | | | | | |
| Tier 1: Preferred generic | \$15 | \$15 | \$15 | 10% after deductible | 30% after deductible |
| Tier 2: Preferred brand | \$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 |
| Tier 4: Preferred specialty | 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 | 3X cost share per 90-day supply | 3X cost share per 90-day supply |
| Alternative medicine | | | | | |
| 10 chiropractor visits and 12 acupuncture visits | \$15 copay | \$15 copay | \$15 copay | 10% after deductible | 30% after deductible |
| Optical (hardware not covered) | | | | | |
| Exam | \$15 copay | \$15 copay | \$15 copay | No copay, deductible and coinsurance apply | No copay, deductible and coinsurance apply |

*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. If enrolled on the family plan you must meet the family out-of-pocket limit. See your Evidence of Coverage for details.

2021-2022 Kaiser Foundation Health Plan of Washington plans

Connect Network - Virtual Plus

Network includes providers at Kaiser Permanente facilities and some preferred providers and hospitals. Available in King, Kitsap, Pierce, Snohomish, Spokane, and Thurston counties.

| | VP 500 / 3000 / 20% | VP 1000 / 3000 / 20% |
|--|--|--|
| Features | | |
| Plan type | Virtual Plus | Virtual Plus |
| Annual medical deductible (individual/family) | \$500 / \$1,000 | \$1,000 / \$2,000 |
| Annual out-of-pocket maximum (individual/family) <i>All out-of-pocket expenses for covered services are included in the out-of-pocket limit.</i> | \$3,000 / \$6,000 | \$3,000 / \$6,000 |
| Coinsurance | 20% | 20% |
| Benefits | | |
| Preventive care | | |
| Routine physical exams, mammogram, etc. | Covered in full | Covered in full |
| Outpatient services | | |
| Primary care office visit | \$20 copay* | \$20 copay* |
| Specialty care office visit | \$40 copay* | \$40 copay* |
| Most X-rays | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Most lab tests | Deductible and coinsurance apply | Deductible and coinsurance apply |
| MRI, CT, PET | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Outpatient surgery | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Mental health visit <i>Inpatient: Deductible and coinsurance apply</i> <i>Outpatient: Deductible and coinsurance do not apply</i> | Outpatient: \$20 copay* | Outpatient: \$20 copay* |
| Inpatient hospital care | | |
| Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Maternity | | |
| Routine prenatal care visits, first postpartum visit <i>Inpatient: Deductible and coinsurance apply</i> <i>Outpatient: Deductible and coinsurance do not apply</i> <i>Routine care not subject to outpatient services copay</i> | \$20 copay* | \$20 copay* |
| Delivery and inpatient well-baby care | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Worldwide emergency and urgent care | | |
| Emergency department visit | \$200 copay at a designated facility \$200 copay at a non-designated facility Deductible and coinsurance apply | \$200 copay at a designated facility \$200 copay at a non-designated facility Deductible and coinsurance apply |
| Urgent care visit | \$20 copay primary / \$40 copay specialty | \$20 copay primary / \$40 copay specialty |
| Prescription drugs (up to 30-day supply) <i>After first fill, maintenance drugs must be filled through Kaiser Permanente's mail order service</i> | | |
| Tier 1: Preferred generic | \$15 | \$15 |
| Tier 2: Preferred brand | \$35 | \$35 |
| Tier 3: Non-preferred generic and brand | NA | NA |
| Tier 4: Preferred specialty | \$150 up to 30-day supply | \$150 up to 30-day supply |
| Mail order | \$5 per 90 days for generics 2X retail cost share per 90 days for brand | \$5 per 90 days for generics 2X retail cost share per 90 days for brand |
| Alternative medicine | | |
| 10 chiropractor visits and 12 acupuncture visits | \$20 copay, deductible and coinsurance do not apply | \$20 copay, deductible and coinsurance do not apply |
| Optical (hardware not covered) | | |
| Exam | \$20 copay, deductible and coinsurance waived | \$20 copay, deductible and coinsurance waived |

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Virtual Plus plans focus on virtual care

Our new Virtual Plus plans offer members convenient and affordable ways to get care virtually – when and where they want it – and in-person care when they need it.

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.
- Virtual care provided through 24/7 Care Chat online messaging or nurse phone line, scheduled video visits and phone appointments, e-visits, or email for nonurgent questions.¹
- 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
- Fill the prescription for a new medication at an in-network pharmacy or mail order. Get most refills and maintenance medications through mail order. Delivery is free and usually takes 1 to 2 days.

¹ When appropriate and available. This feature is available when your employees get care from Kaiser Permanente doctors and care teams.

| | VP 3000 / 6000 / 30% | VP 5000 / 8150 / 30% |
|--|---|---|
| Features | | |
| Plan type | Virtual Plus | Virtual Plus |
| Annual medical deductible (individual/family) | \$3,000 / \$6,000 | \$5,000 / \$10,000 |
| Annual out-of-pocket maximum (individual/family) | \$6,000 / \$12,000 | \$8,150 / \$16,300 |
| Coinsurance | 30% | 30% |
| Benefits | | |
| Preventive care | | |
| Routine physical exams, mammogram, etc. | Covered in full | Covered in full |
| Outpatient services | | |
| Primary care office visit | \$30 copay* | \$40 copay* |
| Specialty care office visit | \$60 copay* | \$80 copay* |
| Most X-rays | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Most lab tests | Deductible and coinsurance apply | Deductible and coinsurance apply |
| MRI, CT, PET | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Outpatient surgery | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Mental health visit <i>Inpatient: Deductible and coinsurance apply</i> <i>Outpatient: Deductible and coinsurance do not apply</i> | Outpatient: \$30 copay* | Outpatient: \$40 copay* |
| Inpatient hospital care | | |
| Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Maternity | | |
| Routine prenatal care visits, first postpartum visit <i>Inpatient: Deductible and coinsurance apply</i> <i>Outpatient: Deductible and coinsurance do not apply</i> <i>Routine care not subject to outpatient services copay</i> | \$30 copay* | \$40 copay* |
| Delivery and inpatient well-baby care | Deductible and coinsurance apply | Deductible and coinsurance apply |
| Worldwide emergency and urgent care | | |
| Emergency department visit | \$200 copay at a designated facility, \$200 copay at a non-designated facility Deductible and coinsurance apply | \$200 copay at a designated facility, \$200 copay at a non-designated facility Deductible and coinsurance apply |
| Urgent care visit | \$30 copay primary / \$60 copay specialty | \$40 copay primary / \$80 copay specialty |
| Prescription drugs (up to 30-day supply) <i>After first fill, maintenance drugs must be filled through Kaiser Permanente's mail order service</i> | | |
| Tier 1: Preferred generic | \$20 | \$20 |
| Tier 2: Preferred brand | \$40 | \$40 |
| Tier 3: Non-preferred generic and brand | NA | NA |
| Tier 4: Preferred specialty | \$150 up to 30-day supply | \$150 up to 30-day supply |
| Mail order | \$5 per 90 days for generics 2X retail cost share per 90 days for brand | \$5 per 90 days for generics 2X retail cost share per 90 days for brand |
| Alternative medicine | | |
| 10 chiropractor visits and 12 acupuncture visits | \$30 copay, deductible and coinsurance do not apply | \$40 copay, deductible and coinsurance do not apply |
| Optical (hardware not covered) | | |
| Exam | \$30 copay, deductible and coinsurance waived | \$40 copay, deductible and coinsurance waived |

*Virtual visits and the first non-preventive primary care office visit are covered in full. Deductible and coinsurance do not apply to authorized outpatient visits. Deductible and coinsurance do apply to non-authorized outpatient services, including all surgical services, but copays are waived.

2021-2022 Kaiser Foundation Health Plan of Washington Options, Inc. plans
Access PPO Network



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

| PPO 500 | | | PPO 750 | | |
|---|-----------------------|------------------------|-----------------------------------|-----------------------|------------------------|
| In Network - Enhanced | In Network - Standard | Out of Network | In Network - Enhanced | In Network - Standard | Out of Network |
| Deductible | | | Deductible | | |
| \$500 / \$1,000 | | Shared with in-network | \$750 / \$1,500 | | Shared with in-network |
| \$4,000 / \$8,000 | | Shared with in-network | \$5,000 / \$10,000 | | Shared with in-network |
| 20% | | 50% | 20% | | 50% |
| Benefits | | | | | |
| Preventive care | | | | | |
| No charge | No charge | 50% after deductible | No charge | No charge | 50% after deductible |
| Outpatient services | | | | | |
| \$20 | \$30 | 50% after deductible | \$20 | \$30 | 50% after deductible |
| \$40 | \$60 | 50% after deductible | \$40 | \$60 | 50% after deductible |
| 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 | 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 |
| 20% after deductible | 20% after deductible | 50% after deductible | 20% after deductible | 20% after deductible | 50% after deductible |
| \$20 | \$30 | 50% after deductible | \$20 | \$30 | 50% after deductible |
| Inpatient hospital care | | | | | |
| 20% after deductible | | 50% after deductible | 20% after deductible | | 50% after deductible |
| Maternity | | | | | |
| No charge | | 50% after deductible | No charge | | 50% after deductible |
| 20% after deductible | | 50% after deductible | 20% after deductible | | 50% after deductible |
| Worldwide emergency and urgent care | | | | | |
| \$100 copay, 20% after deductible | | | \$100 copay, 20% after deductible | | |
| \$20 copay | \$30 copay | 50% after deductible | \$20 copay | \$30 copay | 50% after deductible |
| Prescription drugs (up to 30-day supply) | | | | | |
| \$5 | \$15 | Not covered | \$5 | \$15 | Not covered |
| \$15 | \$25 | Not covered | \$15 | \$25 | Not covered |
| \$35 | \$45 | Not covered | \$35 | \$45 | Not covered |
| 50% up to \$150 | 50% up to \$150 | Not covered | 50% up to \$150 | 50% up to \$150 | Not covered |
| 2X copay per 90-day supply | | Not covered | 2X copay per 90-day supply | | Not covered |
| Alternative medicine | | | | | |
| \$30 copay | | 50% after deductible | \$30 copay | | 50% after deductible |
| Optical (hardware not covered) | | | | | |
| Covered in full | | | Covered in full | | |

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2021-2022 Kaiser Foundation Health Plan of Washington Options, Inc. plans
Access PPO Network



| Features | PPO 1,000 | | |
|---|-----------------------------------|-----------------------|------------------------|
| | In Network - Enhanced | In Network - Standard | Out of Network |
| Plan type | Deductible | | |
| Annual medical deductible (individual/family) | \$1,000 / \$2,000 | | Shared with in-network |
| Annual out-of-pocket maximum (individual/family) | \$6,600 / \$13,200 | | Shared with in-network |
| Coinsurance | 20% | | 50% |
| Benefits | | | |
| Preventive care | | | |
| Routine physical exams, mammogram, etc. | No charge | No charge | 50% after deductible |
| Outpatient services | | | |
| Primary care office visit | \$20 | \$30 | 50% after deductible |
| Specialty care office visit | \$40 | \$60 | 50% after deductible |
| Most X-rays | 20% after deductible | 20% after deductible | 50% after deductible |
| Most lab tests | 20% after deductible | 20% after deductible | 50% after deductible |
| MRI, CT, PET | 20% after deductible | 20% after deductible | 50% after deductible |
| Outpatient surgery | 20% after deductible | 20% after deductible | 50% after deductible |
| Mental health visit | \$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 |
| Maternity | | | |
| Routine prenatal care visits, first postpartum visit | No charge | | 50% after deductible |
| Delivery and inpatient well-baby care | 20% after deductible | | 50% after deductible |
| Worldwide emergency and urgent care | | | |
| Emergency department visit | \$100 copay, 20% after deductible | | |
| Urgent care visit | \$30 copay | 50% after deductible | 50% after deductible |
| Prescription drugs (up to 30-day supply) | | | |
| Tier 1: Preferred generic | \$5 | \$15 | Not covered |
| Tier 2: Preferred brand | \$15 | \$25 | Not covered |
| Tier 3: Non-preferred generic and brand | \$35 | \$45 | Not covered |
| Tier 4: Preferred specialty | 50% up to \$150 | 50% up to \$150 | Not covered |
| Mail order | 2X copay per 90-day supply | | Not covered |
| Alternative medicine | | | |
| 15 chiropractor visits and 12 acupuncture visits | \$30 copay | | 50% after deductible |
| Optical (hardware not covered) | | | |
| Exam | Covered in full | | |

| PPO 2,000 | | | PPO 3,000 | | |
|---|-----------------------|------------------------|-----------------------------------|-----------------------|------------------------|
| In Network - Enhanced | In Network - Standard | Out of Network | In Network - Enhanced | In Network - Standard | Out of Network |
| Deductible | | | Deductible | | |
| \$2,000 / \$4,000 | | Shared with in-network | \$3,000 / \$6,000 | | Shared with in-network |
| \$7,900 / \$15,800 | | Shared with in-network | \$7,900 / \$15,800 | | Shared with in-network |
| 20% | | 50% | 20% | | 50% |
| Benefits | | | | | |
| Preventive care | | | | | |
| No charge | No charge | 50% after deductible | No charge | No charge | 50% after deductible |
| Outpatient services | | | | | |
| \$20 | \$30 | 50% after deductible | \$20 | \$30 | 50% after deductible |
| \$40 | \$60 | 50% after deductible | \$40 | \$60 | 50% after deductible |
| 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 | 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 |
| 20% after deductible | 20% after deductible | 50% after deductible | 20% after deductible | 20% after deductible | 50% after deductible |
| \$20 | \$30 | 50% after deductible | \$20 | \$30 | 50% after deductible |
| Inpatient hospital care | | | | | |
| 20% after deductible | | 50% after deductible | 20% after deductible | | 50% after deductible |
| Maternity | | | | | |
| No charge | | 50% after deductible | No charge | | 50% after deductible |
| 20% after deductible | | 50% after deductible | 20% after deductible | | 50% after deductible |
| Worldwide emergency and urgent care | | | | | |
| \$100 copay, 20% after deductible | | | \$100 copay, 20% 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) | | | | | |
| \$5 | \$15 | Not covered | \$5 | \$15 | Not covered |
| \$15 | \$25 | Not covered | \$15 | \$25 | Not covered |
| \$35 | \$45 | Not covered | \$35 | \$45 | Not covered |
| 50% up to \$150 | 50% up to \$150 | Not covered | 50% up to \$150 | 50% up to \$150 | Not covered |
| 2X copay per 90-day supply | | Not covered | 2X copay per 90-day supply | | Not covered |
| Alternative medicine | | | | | |
| \$30 copay | | 50% after deductible | \$30 copay | | 50% after deductible |
| Optical (hardware not covered) | | | | | |
| Covered in full | | | Covered in full | | |

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Access PPO Network



| Features | PPO 5,000 | | |
|---|-----------------------------------|-----------------------|------------------------|
| | In Network - Enhanced | In Network - Standard | Out of Network |
| Plan type | Deductible | | |
| Annual medical deductible (individual/family) | \$5,000 / \$10,000 | | Shared with in-network |
| Annual out-of-pocket maximum (individual/family) | \$7,900 / \$15,800 | | Shared with in-network |
| Coinsurance | 30% | | 50% |
| Benefits | | | |
| Preventive care | | | |
| Routine physical exams, mammogram, etc. | No charge | No charge | 50% after deductible |
| Outpatient services | | | |
| Primary care office visit | \$20 | \$30 | 50% after deductible |
| Specialty care office visit | \$40 | \$60 | 50% after deductible |
| Most X-rays | 30% after deductible | 30% after deductible | 50% after deductible |
| Most lab tests | 30% after deductible | 30% after deductible | 50% after deductible |
| MRI, CT, PET | 30% after deductible | 30% after deductible | 50% after deductible |
| Outpatient surgery | 30% after deductible | 30% after deductible | 50% after deductible |
| Mental health visit | \$20 | \$30 | 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 |
| Maternity | | | |
| Routine prenatal care visits, first postpartum visit | No charge | | 50% after deductible |
| Delivery and inpatient well-baby care | 30% after deductible | | 50% after deductible |
| Worldwide emergency and urgent care | | | |
| Emergency department visit | \$100 copay, 30% after deductible | | |
| Urgent care visit | \$30 copay | 50% after deductible | 50% after deductible |
| Prescription drugs (up to 30-day supply) | | | |
| Tier 1: Preferred generic | \$5 | \$15 | Not covered |
| Tier 2: Preferred brand | \$15 | \$25 | Not covered |
| Tier 3: Non-preferred generic and brand | \$35 | \$45 | Not covered |
| Tier 4: Preferred specialty | 50% up to \$150 | 50% up to \$150 | Not covered |
| Mail order | 2X copay per 90-day supply | | Not covered |
| Alternative medicine | | | |
| 15 chiropractor visits and 12 acupuncture visits | \$30 copay | | 50% after deductible |
| Optical (hardware not covered) | | | |
| Exam | Covered in full | | |

| 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 |
| HSA-qualified | | | HSA-qualified | | |
| \$2,500 / \$5,000* | | Shared with in-network* | \$4,500 / \$9,000* | | Shared with in-network* |
| \$6,750 / \$7,900* | | Shared with in-network* | \$6,750 / \$7,900* | | Shared with in-network* |
| 20% (10% enhanced) | | 50% | 30% | | 50% |
| Benefits | | | | | |
| Preventive care | | | | | |
| No charge | No charge | 50% after deductible | No charge | No charge | 50% after deductible |
| Outpatient services | | | | | |
| 10% after deductible | 20% after deductible | 50% after deductible | 20% after deductible | 30% after deductible | 50% after deductible |
| 10% after deductible | 20% after deductible | 50% after deductible | 20% 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 |
| 20% after deductible | 20% after deductible | 50% after deductible | 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 |
| 20% after deductible | 20% after deductible | 50% after deductible | 30% after deductible | 30% after deductible | 50% after deductible |
| 10% after deductible | 20% after deductible | 50% after deductible | 20% after deductible | 30% after deductible | 50% after deductible |
| Inpatient hospital care | | | | | |
| 20% after deductible | 20% after deductible | 50% after deductible | 30% after deductible | 30% after deductible | 50% after deductible |
| Maternity | | | | | |
| No charge | | 50% after deductible | No charge | | 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 | | | | | |
| \$0 copay, 20% after deductible | | | \$0 copay, 30% 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) | | | | | |
| 10% after deductible | 20% after deductible | Not covered | 20% after deductible | 30% after deductible | Not covered |
| 10% after deductible | 20% after deductible | Not covered | 20% after deductible | 30% after deductible | Not covered |
| 10% after deductible | 20% after deductible | Not covered | 20% after deductible | 30% after deductible | Not covered |
| 10% after deductible | 20% after deductible | Not covered | 20% after deductible | 30% after deductible | Not covered |
| 3X enhanced copay, per 90-day supply | | Not covered | 3X enhanced copay, per 90-day supply | | |
| 20% after deductible | 20% after deductible | 50% after deductible | 30% after deductible | 30% after deductible | 50% after deductible |
| Alternative medicine | | | | | |
| Covered in full | | | Covered in full | | |

This is a brief summary of the benefits. Please review your Evidence of Coverage for more details. Plans are effective 1/1/21.
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*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. If enrolled on the family plan you must meet the family out-of-pocket limit. See your Evidence of Coverage for details.