2026–2027 Kaiser Foundation Health Plan of Washington plans
Core Network

KAISER PERMANENTE®

Features	HMO 200 In-network	HMO 500 In-network	HMO 750 In-network	HMO 1,000 In-network	HMO 2,000 In-network	HMO 3,000 In-network	HMO 5,000 In-network	HMO HSA 2,500 In-network	HMO HSA 4,500 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	Subject to copay, deductible and coinsurance apply	Subject to copay, deductible and coinsurance apply	Subject to copay, deductible and coinsurance apply	Subject to copay, deductible and coinsurance apply	Subject to copay, deductible and coinsurance apply	Subject to copay, deductible and coinsurance apply	Subject to copay, deductible and coinsurance apply	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 (Copay waived if admitted)	$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 (primary/specialty)	$15 / $30	$15 / $30	$15 / $30	$15 / $30	$15 / $30	$15 / $30	$15 / $30	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: Nonpreferred 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 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	$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 and coinsurance apply	No copay, deductible and coinsurance apply

HSA = health savings account
This is a brief summary of the benefits. Please review your Evidence of Coverage for more details.
January renewing groups: Plan year 1/1/2026 - 12/31/2026
July renewing groups: Plan year 7/1/2026 - 6/30/2027
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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.

2026–2027 Kaiser Foundation Health Plan of Washington plans

Connect Network – Kaiser Permanente Virtual Plus®

KAISER PERMANENTE®

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%	VP 3000 / 6000 / 30%	VP 5000 / 8150 / 30%
Features				
Plan type	Virtual Plus	Virtual Plus	Virtual Plus	Virtual Plus
Annual medical deductible (individual/family)	$500 / $1,000	$1,000 / $2,000	$3,000 / $6,000	$5,000 / $10,000
Annual out-of-pocket maximum (individual/family) (All out-of-pocket expenses for covered services are included in the out-of-pocket limit.)	$3,000 / $6,000	$3,000 / $6,000	$6,000 / $12,000	$8,150 / $16,300
Coinsurance	20%	20%	30%	30%
Benefits				
Preventive care				
Routine physical exams, mammogram, etc.	No charge	No charge	No charge	No charge
Outpatient services				
Primary care office visit	$20 copay*	$20 copay*	$30 copay*	$40 copay*
Specialty care office visit	$40 copay*	$40 copay*	$60 copay*	$80 copay*
Most X-rays	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply
Most lab tests	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply
MRI, CT, PET	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply
Outpatient surgery	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply
Mental health visit	$20 copay*	$20 copay*	$30 copay*	$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	Deductible and coinsurance apply	Deductible and coinsurance apply
Maternity				
Routine prenatal care visits, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply
Worldwide emergency and urgent care				
Emergency department visit (Copay waived if admitted)	$200 copay Deductible and coinsurance apply	$200 copay Deductible and coinsurance apply	$200 copay Deductible and coinsurance apply	$200 copay Deductible and coinsurance apply
Urgent care visit	$20 copay primary / $40 copay specialty	$20 copay primary / $40 copay specialty	$30 copay primary / $60 copay specialty	$40 copay primary / $80 copay specialty
Prescription drugs (up to 30-day supply) (After first fill, maintenance drugs must be filled through Kaiser Permanente's mail-order pharmacy.)				
Tier 1: Preferred generic	$15	$15	$20	$20
Tier 2: Preferred brand	$35	$35	$40	$40
Tier 3: Nonpreferred generic and brand	NA	NA	NA	NA
Tier 4: Preferred specialty	$150 up to 30-day supply	$150 up to 30-day supply	$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	$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	$30 copay, deductible and coinsurance do not apply	$40 copay, deductible and coinsurance do not apply
Optical (hardware not covered)				
Exam	$20 copay, deductible and coinsurance waived	$20 copay, deductible and coinsurance waived	$30 copay, deductible and coinsurance waived	$40 copay, deductible and coinsurance waived

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*Virtual visits and the first nonpreventive 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. For more information regarding cost-share differences between authorized and non-authorized visits, please refer to your Evidence of Coverage.

Virtual Plus plans focus on virtual care

Our 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 rate.
- 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 online chat, 24/7 advice line, scheduled video visits and phone appointments, e-visits, or email for nonurgent questions.
- Virtual visits are with Kaiser Permanente doctors and other 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 through mail order. Get most refills and maintenance medications through mail order. Delivery is at no extra cost and usually takes 3 to 5 days.

2026–2027 Kaiser Foundation Health Plan of Washington Options, Inc., plans
Access PPO Network

KAISER PERMANENTE®

	PPO 200		PPO 500		PPO 750	
Features	**Preferred Provider network**	**Out-of-network**	**Preferred Provider Network**	**Out-of-network**	**Preferred Provider network**	**Out-of-network**
Plan type	Deductible		Deductible		Deductible	
Annual medical deductible (individual/family)	$200 / $400	$400 / $800	$500 / $1,000	$1,000 / $2,000	$750 / $1,500	$1,500 / $3,000
Annual out-of-pocket maximum (individual/family)	$2,500 / $5,000	Unlimited	$4,000 / $8,000	Unlimited	$5,000 / $10,000	Unlimited
Coinsurance	10%	50%	20%	50%	20%	50%
Benefits						
Preventive care						
Routine physical exams, mammogram, etc.	No charge	50% after deductible	No charge	50% after deductible	No charge	50% after deductible
Outpatient services						
Primary care office visit	$30	50% after deductible	$30	50% after deductible	$30	50% after deductible
Specialty care office visit	$60	50% after deductible	$60	50% after deductible	$60	50% after deductible
Most X-rays	10% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Most lab tests	10% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
MRI, CT, PET	10% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	10% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Mental health visit	$30	50% after deductible	$30	50% after deductible	$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 (Copay waived if admitted)	$100 copay, 10% after deductible		$100 copay, 20% after deductible		$100 copay, 20% after deductible	
Urgent care visit (primary/specialty)	$30 / $60	50% after deductible	$30 / $60	50% after deductible	$30 / $60	50% after deductible
Alternative medicine						
15 chiropractor visits and 12 acupuncture 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	
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	$5	$15	$5	$15	$5	$15
Tier 2: Preferred brand	$15	$25	$15	$25	$15	$25
Tier 3: Nonpreferred generic and brand	$35	$45	$35	$45	$35	$45
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
Mail order	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered

Prescription drugs (up to 30-day supply)	**Out-of-network**	**Out-of-network**
Tier 1: Preferred generic	Not covered	Not covered
Tier 2: Preferred brand	Not covered	Not covered
Tier 3: Nonpreferred generic and brand	Not covered	Not covered
Tier 4: Preferred specialty	Not covered	Not covered
Mail order	Not covered	Not covered

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July renewing groups: Plan year 7/1/2026 - 6/30/2027
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2026–2027 Kaiser Foundation Health Plan of Washington Options, Inc., plans
Access PPO Network

KAISER PERMANENTE®

	PPO 1,000		PPO 2,000		PPO 3,000	
Features	Preferred Provider network	Out-of-network	Preferred Provider network	Out-of-network	Preferred Provider network	Out-of-network
Plan type	Deductible		Deductible		Deductible	
Annual medical deductible (individual/family)	$1,000 / $2,000	$2,000 / $4,000	$2,000 / $4,000	$4,000 / $8,000	$3,000 / $6,000	$6,000 / $12,000
Annual out-of-pocket maximum (individual/family)	$6,600 / $13,200	Unlimited	$7,900 / $15,800	Unlimited	$7,900 / $15,800	Unlimited
Coinsurance	20%	50%	20%	50%	20%	50%
Benefits						
Preventive care						
Routine physical exams, mammogram, etc.	No charge	50% after deductible	No charge	50% after deductible	No charge	50% after deductible
Outpatient services						
Primary care office visit	$30	50% after deductible	$30	50% after deductible	$30	50% after deductible
Specialty care office visit	$60	50% after deductible	$60	50% after deductible	$60	50% after deductible
Most X-rays	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Most lab tests	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	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	$30	50% after deductible	$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 (Copay waived if admitted)	$100 copay, 20% after deductible		$100 copay, 20% after deductible		$100 copay, 20% after deductible	
Urgent care visit (primary/specialty)	$30 / $60	50% after deductible	$30 / $60	50% after deductible	$30 / $60	50% after deductible
Alternative medicine						
15 chiropractor visits and 12 acupuncture 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	
Prescription drugs (up to 30-day supply)	**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**
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: Nonpreferred 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 the preferred benefit prescription drug cost share up to a 90-day supply	Not covered / Not covered	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered / Not covered	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered / Not covered

HSA = health savings account
This is a brief summary of the benefits. Please review your Evidence of Coverage for more details.
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July renewing groups: Plan year 7/1/2026 - 6/30/2027
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2026–2027 Kaiser Foundation Health Plan of Washington Options, Inc., plans
Access PPO Network

KAISER PERMANENTE®

	PPO 5,000		PPO HSA 2,500		PPO HSA 4,500	
Features	Preferred Provider network	Out-of-network	Preferred Provider network	Out-of-network	Preferred Provider network	Out-of-network
Plan type	Deductible		HSA-qualified		HSA-qualified	
Annual medical deductible (individual/family)	$5,000 / $10,000	$10,000 / $20,000	$2,500 / $5,000*	$5,000 / $10,000	$4,500 / $7,350*	$9,000 / $14,700
Annual out-of-pocket maximum (individual/family)	$7,900 / $15,800	Unlimited	$6,750 / $7,900*	Unlimited	$6,750 / $7,900*	Unlimited
Coinsurance	30%	50%	20%	50%	30%	50%
Benefits						
Preventive care						
Routine physical exams, mammogram, etc.	No charge	50% after deductible	No charge	50% after deductible	No charge	50% after deductible
Outpatient services						
Primary care office visit	$30	50% after deductible	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Specialty care office visit	$60	50% after deductible	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Most X-rays	30% after deductible	50% after deductible	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Most lab tests	30% after deductible	50% after deductible	20% after deductible	50% after deductible	30% after deductible	50% after deductible
MRI, CT, PET	30% after deductible	50% after deductible	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	50% after deductible	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Mental health visit	$30	50% after deductible	20% after deductible	50% 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	50% 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	50% after deductible	30% after deductible	50% after deductible
Worldwide emergency and urgent care						
Emergency department visit (Copay waived if admitted)	$100 copay, 30% after deductible		$0 copay, 20% after deductible		$0 copay, 30% after deductible	
Urgent care visit (primary/specialty)	$30 / $60	50% after deductible	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Alternative medicine						
15 chiropractor visits and 12 acupuncture visits	$30 copay	50% after deductible	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Optical (hardware not covered)						
Exam	Covered in full		Covered in full		Covered in full	
Prescription drugs (up to 30-day supply)	**In-network Enhanced**	**In-network Standard**	**Out-of-network**		**In-network Enhanced**	**In-network Standard**	**Out-of-network**
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: Nonpreferred 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 the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	Not covered		2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	Not covered		2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	Not covered

HSA = health savings account
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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.

2026–2027 Kaiser Foundation Health Plan of Washington Options, Inc., plans
Summit PPO Network

KAISER PERMANENTE®

Features	Summit PPO 1500			Summit PPO 3000			Summit PPO HSA 3500		
	Preferred in-network	In-network	Out-of-network	Preferred in-network	In-network	Out-of-network	Preferred in-network	In-network	Out-of-network
Plan type	Deductible			Deductible			Deductible		
Annual medical deductible (individual/family)	$1,500 / $3,000		$4,500 / $9,000	$3,000 / $6,000		$9,000 / $18,000	$3,500 / $7,000*		$7,000 / $14,000
Annual out-of-pocket maximum (individual/family)	$5,000 / $10,000		Unlimited	$6,000 / $12,000		Unlimited	$6,000 / $8,500*		Unlimited
Coinsurance	10%	30%	50%	20%	40%	50%	20%	40%	50%
Benefits									
Preventive care									
Routine physical exams, mammogram, etc.	No charge		50% after deductible	No charge		50% after deductible	No charge		50% after deductible
Outpatient services									
Primary care office visit	$20	$40	50% after deductible	$20	$40	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Specialty care office visit	$40	$80	50% after deductible	$40	$80	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Most X-rays	10% coinsurance	30% coinsurance	50% after deductible	20% coinsurance	40% coinsurance	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Most lab tests	10% coinsurance	30% coinsurance	50% after deductible	20% coinsurance	40% coinsurance	50% after deductible	20% after deductible	40% after deductible	50% after deductible
MRI, CT, PET	10% coinsurance	30% coinsurance	50% after deductible	20% coinsurance	40% coinsurance	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Outpatient surgery	10% after deductible	30% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Mental health visit	$20	$40	50% after deductible	$20	$40	50% after deductible	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	10% after deductible	30% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Maternity									
Routine prenatal care visits, first postpartum visit	$0		50% after deductible	$0		50% after deductible	$0		50% after deductible
Delivery and inpatient well-baby care	10% after deductible	30% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Worldwide emergency and urgent care									
Emergency department visit (Copay waived if admitted)	$150, in-network deductible and coinsurance apply			$200, in-network deductible and coinsurance apply			In-network deductible and coinsurance apply		
Urgent care visit (primary/specialty)	$20 / $40	$40 / $80	50% after deductible	$20 / $40	$40 / $80	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Alternative medicine									
8 chiropractor visits and 12 acupuncture visits	$10	$20	50% after deductible	$20	$40	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Optical (hardware not covered)									
Exam	$10	$20	50% after deductible	$20	$40	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Prescription drugs (up to 30-day supply) (After first fill, maintenance drugs must be filled through Kaiser Permanente's mail-order pharmacy.)	**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**
Tier 1: Preferred generic	$10	$20	Not covered	$15	$25	Not covered	20% after deductible	40% after deductible	Not covered
Tier 2: Preferred brand	$20	$40	Not covered	$30	$50	Not covered	20% after deductible	40% after deductible	Not covered
Tier 3: Nonpreferred generic and brand	$30	$60	Not covered	$50	$80	Not covered	20% after deductible	40% after deductible	Not covered
Tier 4: Preferred specialty	$150	$150	Not covered	$150	$150	Not covered	20% after deductible	40% after deductible	Not covered
Tier 5: Nonpreferred specialty	30%	30%	Not covered	30%	30%	Not covered	20% after deductible	40% after deductible	Not covered
Mail order	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	Not covered	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	Not covered	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	Not covered

HSA = health savings account
This is a brief summary of the benefits. Please review your Evidence of Coverage for more details.
January renewing groups: Plan year 1/1/2026 - 12/31/2026
July renewing groups: Plan year 7/1/2026 - 6/30/2027
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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.

2026–2027 Kaiser Foundation Health Plan of Washington Options, Inc., plans
Options Network

KAISER PERMANENTE®

Features	Kaiser Permanente Plus™ KP Plus 250 In-network	Kaiser Permanente Plus™ KP Plus 250 Out-of-network (limited to 10 covered services per year, combined)	Kaiser Permanente Plus™ KP Plus 500 In-network	Kaiser Permanente Plus™ KP Plus 500 Out-of-network (limited to 10 covered services per year, combined)	Kaiser Permanente Plus™ KP Plus 2500 In-network	Kaiser Permanente Plus™ KP Plus 2500 Out-of-network (limited to 10 covered services per year, combined)
Plan type	Deductible		Deductible		Deductible	
Annual medical deductible (individual/family)	$250/$750	NA	$500/$1500	NA	$2500/$5000	NA
Annual out-of-pocket maximum (individual/family)	$3000/$9000	NA	$3000/$9000	NA	$6000/$12000	NA
Coinsurance	10%	NA	20%	NA	30%	NA
Benefits						
Preventive care						
Routine physical exams, mammogram, etc.	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient services						
Primary care office visit	$15	$35	$20	$40	$30	$50
Specialty care office visit	$25	$45	$20	$40	$30	$50
Most X-rays	$15	$35	20% after deductible	30% coinsurance	30% after deductible	40% coinsurance
Most lab tests	$15	$35	20% after deductible	30% coinsurance	30% after deductible	40% coinsurance
MRI, CT, PET	$100	Not Covered	20% after deductible	Not covered	30% after deductible	Not covered
Outpatient surgery	10% after deductible	Not Covered	20% after deductible	Not covered	30% after deductible	Not covered
Mental health visit	$15	$35	$20	$40	$30	$50
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	10% after deductible	Not Covered	20% after deductible	Not covered	30% after deductible	Not covered
Maternity						
Routine prenatal care visits, first postpartum visit	No charge	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	10% after deductible	Not covered	20% after deductible	Not covered	30% after deductible	Not covered
Worldwide emergency and urgent care						
Emergency department visit (Copay waived if admitted)	10% after in-network deductible*		$200, in-network deductible and coinsurace apply*		$200, in-network deductible and coinsurace apply*	
Urgent care visit (primary/specialty)	$15/$25	$35/$45	$20	$40	$30	$50
Alternative medicine						
12 chiropractor visits and 12 acupuncture visits	$15	$35	$20	$40	$30	$50
Optical (hardware not covered)						
Exam	$15/$25	$35/$45	$20	$40	$30	$50
Prescription drugs (up to 30-day supply)		Limted to 5 perscription fills per year.		Limted to 5 perscription fills per year.		Limted to 5 perscription fills per year.
Tier 1: Preferred generic	$15	$35	$10	$30	$25	$45
Tier 2: Preferred brand	$40	$60	$20	$40	$50	$70
Tier 3: Nonpreferred generic and brand	$60	$80	Not covered	Not covered	Not covered	Not covered
Tier 4: Preferred specialty	$150	Not covered	50% up to $150	Not covered	50% up to $150	Not covered
Tier 5: Nonpreferred specialty	30%	Not covered	Not covered	Not covered	Not Covered	Not covered
Mail order	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered	2X the preferred benefit prescription drug cost share up to a 90-day supply	Not covered

This is a brief summary of the benefits. Please review your Evidence of Coverage for more details.
January renewing groups: Plan year 1/1/2026 - 12/31/2026
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*The limit of 10 covered Services does not apply.