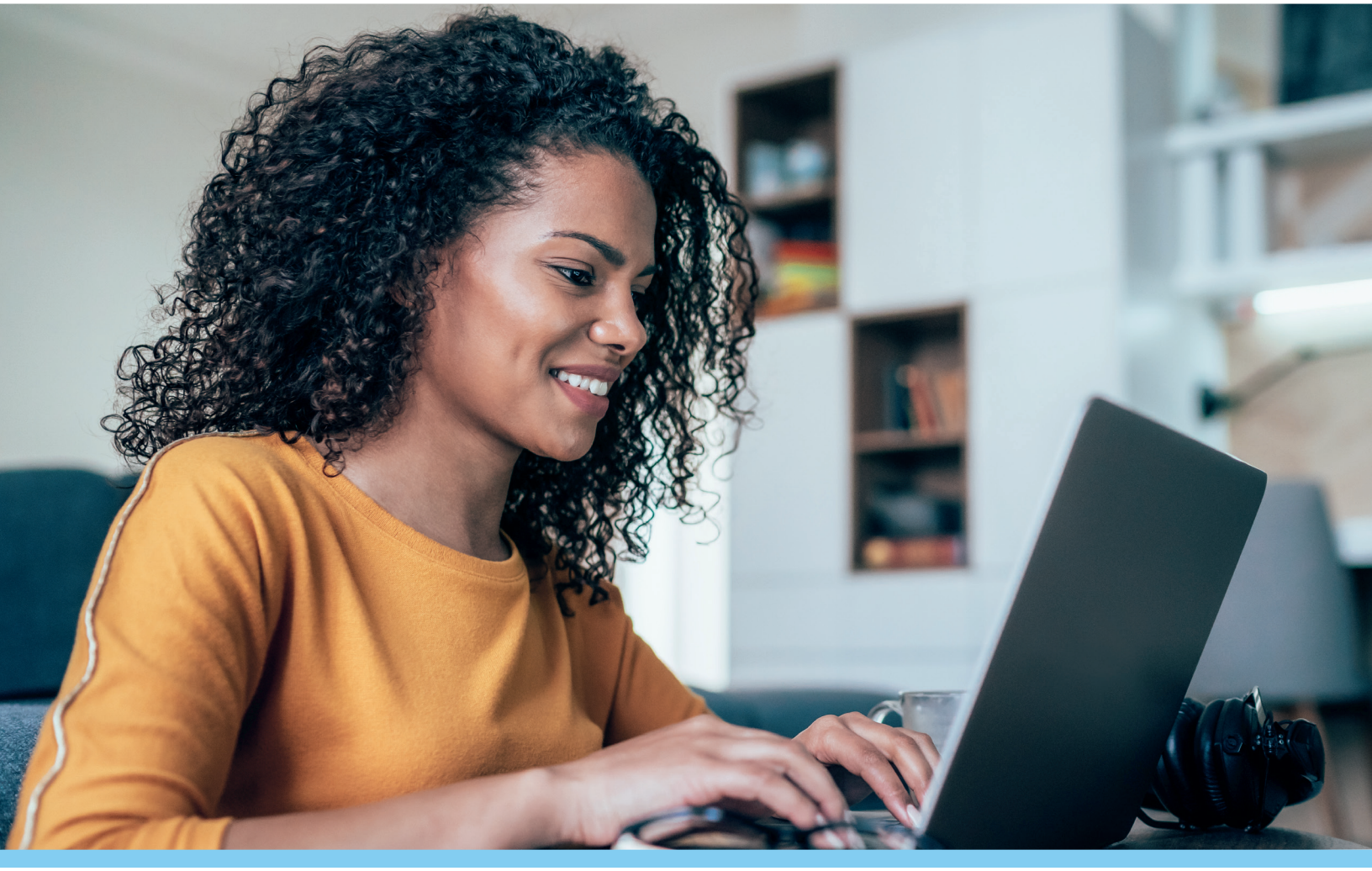
SMALL GROUP | WASHINGTON

2025 Compare your plan options



kp.org/wa/business

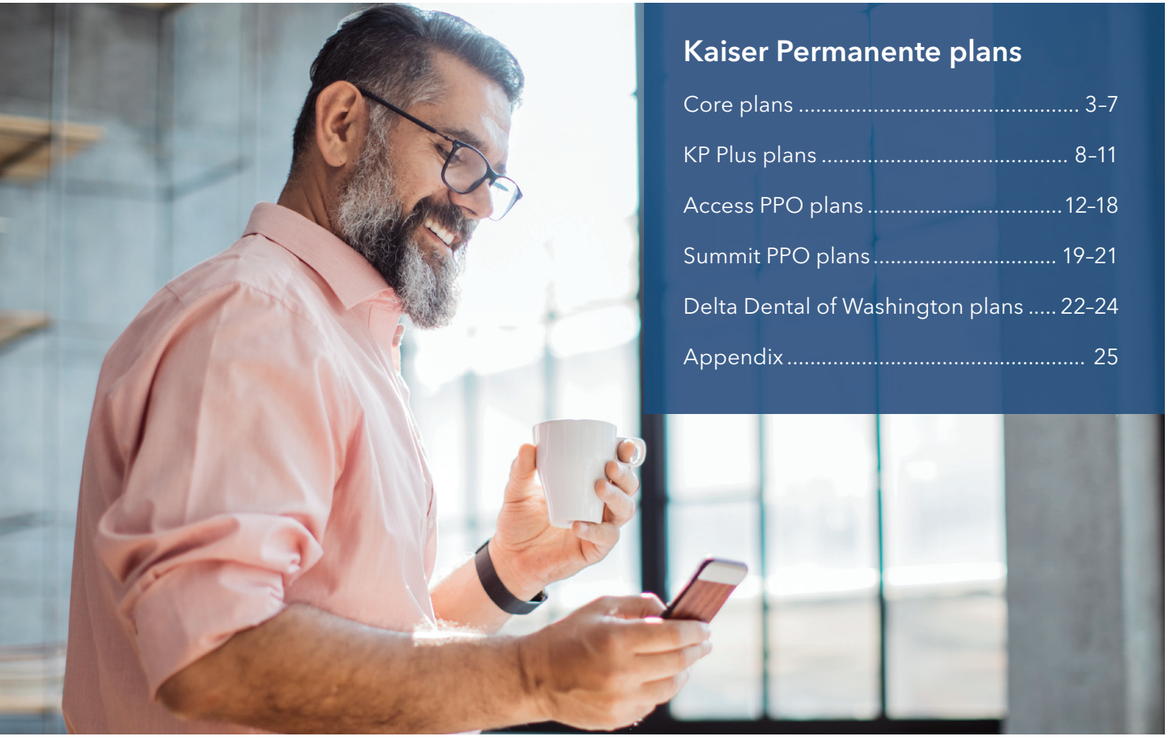
KAISER PERMANENTE®

Big health care solutions for small business needs

Services at Kaiser Permanente offer fully integrated care and coverage, so our health plans make great sense for your business and employees:

- Priced right for businesses with 1 to 50 employees
- Cost-effective, high-quality care, including virtual care options at no charge on most plans
- Easy to use, easy to administer
- Flexible for maximum choice and affordability

Central to all our plans is care from Kaiser Permanente providers, one of the top ranked medical groups in the state.* Our doctors, specialists, nurses, and other health professionals all work as a team to support our members' health. This coordinated patient-centered care helps employees live healthier, happier, more productive lives – which all contribute to the growth and success of your business.



Kaiser Permanente plans

Find the right plan in 3 easy steps

1 Determine how many plans you want to offer

Groups with 1 to 5 employees may offer up to 4 plans.

Groups with 6 to 50 employees may offer any number of plans.

Federal regulations require that groups must have at least one common law employee enrolled to offer coverage.

2 Decide on your provider network(s)

- Core network
- Options network
- Summit PPO network
  (Plans only offered in select counties: King, Kitsap, Pierce, Snohomish, Spokane, and Thurston)
- Access PPO network

3 Choose your coverage level(s)

All of our bronze, silver, gold, and platinum plans include the same benefits. The main differences are seen in the monthly premiums versus the member's cost shares.

Applying for new coverage or renewing coverage?

New groups

- Complete the master application for small groups.
- Submit it to a Kaiser Permanente sales executive by the 20th of the month prior to your coverage's effective date.

Renewing groups

- Complete the master application for small groups when making plan changes. Groups will be auto-renewed to mapped plan unless notification is received.
- Submit it to your Kaiser Permanente account manager no later than the 10th of the month before the month anniversary date.

Alternate purchasing options

Kaiser Permanente also participates in private exchanges and trusts to provide you with additional ways to give your employees choice of plans along with other ancillary offerings:

Business Health Trust

- Fully insured
- Multiple plans can be offered
- Ancillary products

*Washington Health Alliance 2008–2024 Community Checkup reports, https://www.wacommunitycheckup.org/reports/2024-community-checkup-report/

The 2017–2024 year rankings apply to Kaiser Permanente Washington's medical group, Washington Permanente Medical Group, P.C. Ranking for years prior to 2017 apply to the then-named Group Health Cooperative's medical group, formerly named Group Health Permanente, P.C. and now named Washington Permanente Medical Group, P.C.

2025 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	$2,500/$5,000	$2,500/$5,000
Annual out-of-pocket maximum (individual/family)	$7,000/$14,000	$7,500/$14,000	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000
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	$30	$30
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	$30	$30
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	45% 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	$30	$30
Optical					
Pediatric exam and hardware (18 and younger)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Adult optical hardware (19 and over)	$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
Adult optical exam	40% after deductible	20% after deductible	$30 after deductible primary/ $60 after deductible specialty	$30 primary/$65 specialty	$30 primary/$65 specialty

Plan and benefit details

Lab and 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.

2025 Kaiser Foundation Health Plan of Washington plans

Core provider network

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

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)	$6,500/$13,000	$7,500/$15,000	$7,500/$15,000	$2,500/$5,000
Coinsurance	30%	25%	25%	10%
Benefits				
Preventive care				
Routine physical exam, mammogram, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)	Upfront office visits prior to deductible	Upfront office visits prior to deductible	Upfront office visits prior to deductible	Upfront office visits prior to deductible
Primary care office visit	$25	$15	$15	$5
Specialty care office visit	$60	$35	$35	$20
Most X-rays	$20	$25	$25	$10
Most lab tests	$20	$25	$25	$10
MRI, CT, PET	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Outpatient surgery	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Mental health visit	$25	$15	$15	$5
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Maternity				
Routine prenatal care visits, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Worldwide emergency and urgent care				
Emergency department visit	30% after deductible	25% after deductible	25% after deductible	10% after deductible
Urgent care visit	$60	$35	$35	$20
Retail prescription drugs (up to 30-day supply)				
Tier 1: Preferred generic	$20	$15	$15	$5
Tier 2: Preferred brand	$45	$45	$45	$20
Tier 3: Nonpreferred generic and brand	40% after deductible	40% after deductible	40% after deductible	40% after deductible
Tier 4: Specialty	40% after deductible	40% after deductible	40% after deductible	40% after deductible
Alternative medicine				
10 chiropractic visits and 12 acupuncture visits	$25	$15	$15	$5
Optical				
Pediatric exam and hardware (18 and younger)	Covered in full	Covered in full	Covered in full	Covered in full
Adult optical hardware (19 and over)	$100 allowance per calendar year	$100 allowance per calendar year	$100 allowance per calendar year	$100 allowance per calendar year
Adult optical exam	$25 primary/$60 specialty	$15 primary/$35 specialty	$15 primary/$35 specialty	$5 primary/$20 specialty

Pharmacy coverage

Members can fill the first prescription for a new medication at an In-network pharmacy or through our mail-order service.

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.

2025 Kaiser Foundation Health Plan of Washington Options, Inc., plans

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

Options provider network

Features	Kaiser Permanente Plus™ Silver		Kaiser Permanente Plus™ Gold	
	In network	Out of network Limited to 10 covered services per calendar year, combined	In network	Out of network Limited to 10 covered services per calendar year, combined
Plan type	Deductible	Deductible	Deductible	Deductible
Annual medical deductible (individual/family)	$2,500/$5,000	NA	$600/$1,200	NA
Annual out-of-pocket maximum (individual/family)	$8,000/$16,000	NA	$7,500/$15,000	NA
Coinsurance	30%	40%	25%	35%
Benefits				
Preventive care				
Routine physical exam, mammogram, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	$30	$50	$15	$35
Specialty care office visit	$65	$85	$35	$55
Most X-rays	$55	$75	$25	$45
Most lab tests	$55	$75	$25	$45
MRI, CT, PET	30% after deductible	Not covered	25% after deductible	Not covered
Outpatient surgery	30% after deductible	Not covered	25% after deductible	Not covered
Mental health visit	$30	$50	$15	$35
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	Not covered	25% after deductible	Not covered
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	Not covered	25% after deductible	Not covered
Worldwide emergency and urgent care*				
Emergency department visit	30% after deductible	30% after in-network deductible	25% after deductible	25% after in-network deductible
Urgent care visit	$65	30% in-network deductible	$35	25% after in-network deductible
Retail prescription drugs (up to 30-day supply)		Limited to 5 prescription fills per year		Limited to 5 prescription fills per year
Tier 1: Preferred generic	$30	$50	$15	$35
Tier 2: Preferred brand	$65	$85	$45	$65
Tier 3: Nonpreferred generic and brand	50% after deductible	50%	40% after deductible	50%
Tier 4: Specialty	50% after deductible	Not covered	40% after deductible	Not covered
Alternative medicine				
10 chiropractic visits and 12 acupuncture visits	$30	$50	$15	$35
Optical				
Pediatric (18 and younger)	Covered in full	Exam covered in full, hardware not covered	Covered in full	Exam covered in full, hardware not covered
Adult optical hardware (19 and over)	$100 allowance per calendar year	Not covered	$100 allowance per calendar year	Not covered
Adult optical exam	$30 primary care/ $65 specialty care	$50 primary care/ $85 specialty care	$15 primary care/ $35 specialty care	$35 primary care/ $55 specialty care

Kaiser Permanente Plus™ plan

Kaiser Permanente Plus (KP Plus) is an affordable health plan that gives your employees access to high-quality care from Kaiser Permanente and affiliated providers, plus the flexibility to get a defined amount of care from out-of-network providers each year.

KP Plus highlights

- Comprehensive coverage of care from Kaiser Permanente and affiliated providers.
- Up to 10 out-of-network outpatient medical services and 5 prescription fills or refills per year.

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.

*The limit of 10 covered services does not apply.

2025 Kaiser Foundation Health Plan of Washington Options, Inc., plans

Options provider network

Features	Kaiser Permanente Plus™ Platinum In network	Kaiser Permanente Plus™ Platinum Out of network Limited to 10 covered services per calendar year, combined
Plan type	Deductible	Deductible
Annual medical deductible (individual/family)	$250/$500	NA
Annual out-of-pocket maximum (individual/family)	$2,500/$5,000	NA
Coinsurance	10%	20%
Benefits		
Preventive care		
Routine physical exam, mammogram, etc.	No charge	No charge
Outpatient services (per visit or procedure)		
Primary care office visit	$5	$25
Specialty care office visit	$20	$40
Most X-rays	$10	$30
Most lab tests	$10	$30
MRI, CT, PET	10% after deductible	Not covered
Outpatient surgery	10% after deductible	Not covered
Mental health visit	$5	$25
Inpatient hospital care		
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	10% after deductible	Not covered
Maternity		
Routine prenatal care visits, first postpartum visit	No charge	No charge
Delivery and inpatient well-baby care	10% after deductible	Not covered
Worldwide emergency and urgent care*		
Emergency department visit	10% after deductible	10% after in-network deductible
Urgent care visit	$20	10% after in-network deductible
Retail prescription drugs (up to 30-day supply)		Limited to 5 prescription fills per year
Tier 1: Preferred generic	$5	$25
Tier 2: Preferred brand	$20	$40
Tier 3: Nonpreferred generic and brand	40% after deductible	50%
Tier 4: Specialty	40% after deductible	Not covered
Alternative medicine		
10 chiropractic visits and 12 acupuncture visits	$5	$25
Optical		
Pediatric (18 and younger)	Covered in full	Exam covered in full, hardware not covered
Adult optical hardware (19 and over)	$100 allowance per calendar year	Not covered
Adult optical exam	$5 primary care/ $20 specialty care	$25 primary care/ $40 specialty care

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.

*The limit of 10 covered services does not apply.

2025 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	$3,300/$6,600	$7,000/$14,000	$6,000/$12,000	$12,000/$24,000
Annual out-of-pocket maximum (individual/family)	$7,000/$14,000	No limit	$7,000/$14,000	No limit	$8,000/$16,000	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						
Pediatric exam and hardware (18 and younger)	Covered in full		Covered in full		Covered in full	
Adult optical hardware (19 and over)	$100 allowance per calendar year		$100 allowance per calendar year		$100 allowance per calendar year	
Adult optical exam	40% after deductible In network/50% after deductible out of network		35% after deductible In network/50% after deductible out of network		$40 primary/$65 specialty	

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.

2025 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 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)	$8,000/$16,000	No limit	$7,500/$15,000	No limit	$7,500/$15,000	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						
Pediatric exam and hardware (18 and younger)	Covered in full		Covered in full		Covered in full	
Adult optical hardware (19 and older)	$100 allowance per calendar year		$100 allowance per calendar year		$100 allowance per calendar year	
Adult optical exam	In network: $35 primary/$65 specialty out of network: 50% after deductible		In network: $45 primary/$65 specialty out of network: 50% after deductible		In network: $45 primary/$65 specialty out of network: 50% after deductible	

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.

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.

2025 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 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	$6,500/$13,000	No limit	$3,000/$6,000	No limit
Coinsurance	20%	50%	20%	50%	20%	50%
Benefits						
Preventive care						
Routine physical exam, mammogram, etc.	No charge	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	$25	50% after deductible	$30	50% after deductible	$10	50% after deductible
Specialty care office visit	$50	50% after deductible	$50	50% after deductible	$25	50% after deductible
Most X-rays	$40	50% after deductible	$30	50% after deductible	$20	50% after deductible
Most lab tests	$40	50% after deductible	$30	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	$15 / $20	Not covered	$5 / $10	Not covered
Tier 2: Preferred brand	$45 / $50	Not covered	$25 / $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	$30 primary/$50 specialty	50% after deductible	$10 primary/$25 specialty	50% after deductible
Optical						
Pediatric exam and hardware (18 and younger)	Covered in full		Covered in full		Covered in full	
Adult optical hardware (19 and older)	$100 allowance per calendar year		$100 allowance per calendar year		$100 allowance per calendar year	
Adult optical exam	In network: $25 primary/$50 specialty Out of network: 50% after deductible		In network: $30 primary/$50 specialty Out of network: 50% after deductible		In network: $10 primary/$25 specialty Out of network: 50% after deductible	

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.

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.

2025 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			
Pediatric exam and hardware (18 and younger)	Covered in full		
Adult optical hardware (19 and older)	$100 allowance per calendar year		
Adult optical exam	In network: $20 primary/$35 specialty Out of network: 50% after deductible		

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.

2025 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)	$7,250/$14,500		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			
Pediatric exam and hardware (18 and younger)	Covered in full		
Adult optical hardware (19 and older)	$100 allowance per calendar year		
Adult optical exam	Tier 1 In network: 20% after deductible Tier 2 In network: 40% after deductible; Out of network: 50% after deductible		

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.

2025 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)	$8,000/$16,000		No limit	$6,000/$12,000		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									
Pediatric exam and hardware (18 and younger)	Covered in full			Covered in full			Covered in full		
Adult optical hardware (19 and older)	$100 allowance per calendar year			$100 allowance per calendar year			$100 allowance per calendar year		
Adult optical exam	Tier 1 In network: $25 primary/$45 specialty; Tier 2 In network: $45 primary/$65 specialty; Out of network: 50% after deductible			Tier 1 In network: $10 primary/$30 specialty; Tier 2 In network: $30 primary/$50 specialty; Out of network: 50% after deductible			Tier 1 In network: $5 primary/$25 specialty; Tier 2 In network: $25 primary/$40 specialty; Out of network: 50% after deductible		

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.

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.

2025 Adult and pediatric dental coverage

When you select a 2025 Kaiser Permanente medical plan, you can choose to add dental coverage offered through Delta Dental of Washington. Adult coverage is for members and their dependents 19 and older; mandated pediatric coverage is for members or their dependents 18 and younger.

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

Summary of dental benefits

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

Extra dental benefit for members with qualifying conditions

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

Delta Dental of Washington will notify those who qualify for this extra benefit. Importantly, the member's specific diagnosis will remain confidential. This extra cleaning and exam does apply to the annual maximum benefit.

Pediatric benefits: Only fees paid to a Delta Dental PPO Plus Premier™ dentist accrue to the annual out-of-pocket maximum. Dental premiums will be assessed and billed separately from the medical premiums.

1. TMJ = Temporomandibular joint. **2.** Requires preauthorization.

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

Visit a participating Delta Dental network dentist

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

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

Finding a Delta Dental network dentist

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

2025 Pediatric dental coverage

Although coverage for adults is optional, the federal government requires dental coverage for any person 18 and younger. This coverage is referred to as pediatric dental coverage. When you select a 2025 Kaiser Permanente medical plan, it will be paired with the pediatric dental plan that is offered by Delta Dental of Washington unless you select one of the 2 Delta Dental family plans that include this coverage. Here is a summary of Delta Dental's pediatric dental plan benefits.

Summary of dental benefits

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

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

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

Appendix

Primary care includes:

- Acupuncture
- Chemical dependency/ Substance abuse
- Chiropractic
- Emergency medicine (where ER copay doesn't apply)
- Family planning
- Family practice
- General practice
- Gerontology/Geriatrics
- Internal medicine
- Mental health
- Midwifery
- Naturopathy
- Obstetrics and gynecology
- Optometry
- Osteopathy
- Pediatrics
- Pharmacist
- Urgent care
- Women's health care (nonpreventive)

Specialty care includes:

- Allergy and immunology
- Anesthesiology
- Audiology
- Cardiology (pediatric and cardiovascular disease)
- Critical care medicine
- Dentistry
- Dermatology
- Endocrinology
- Enterostomal therapy
- Gastroenterology
- Genetics
- Hepatology
- Infectious disease
- Massage therapy
- Neonatal-perinatal medicine
- Nephrology
- Neurology
- Hematology/Oncology
- Nutrition (nonpreventive)
- Occupational medicine
- Occupational therapy
- Oncology pharmacist
- Ophthalmology
- Orthopedics
- ENT/Otolaryngology
- Pain management
- Pathology
- Physiatry (physical medicine)
- Physical therapy
- Podiatry
- Pulmonary medicine/disease
- Radiology (nuclear medicine, radiation therapy)
- Respiratory therapy
- Rheumatology
- Speech therapy
- Sports medicine
- General surgery (all specific surgeries)
- Urology

For more information

- Contact your producer (agent/broker)
- Contact your Kaiser Permanente sales representative directly or call **1-800-542-6312**
- Visit **kp.org/wa/smallgroup**

Please refer to your *Evidence of Coverage* for details.

Our medical group has been one of the top-ranked medical groups in the state for 17 years in a row*

*Washington Health Alliance 2008–2024 Community Checkup reports, https://www.wacommunitycheckup.org/reports/2024-community-checkup-report/. The 2017–2024 year rankings apply to Kaiser Permanente Washington's medical group, Washington Permanente Medical Group, P.C. Ranking for years prior to 2017 apply to the then-named Group Health Cooperative's medical group, formerly named Group Health Permanente, P.C. and now named Washington Permanente Medical Group, P.C.

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