

2026 Benefit Summary	Kaiser Permanente Point-of-Service Plan 19615 NCR / 19616 SCR		
	HMO Tier (Kaiser Permanente Plan Providers)	Participating Provider Tier <sup>(18)</sup> *	Non-Participating Provider Tier*
		Precertification is required for certain services†	
The Accumulation Period for this Plan is <b>Calendar Year</b>			
Maximum benefit while insured	Unlimited		
	Member pays		
Deductible per accumulation period <sup>(1)(2)</sup>	\$3,500 Individual \$7,000 Family	\$5,500 Individual \$11,000 Family	\$14,000 Individual \$28,000 Family
Out-of-Pocket Maximum per accumulation period <sup>(1)(2)</sup>	\$6,000 Individual \$12,000 Family	\$9,000 Individual \$18,000 Family	\$24,000 Individual \$48,000 Family
Hospital care			
Room and board, including obstetrics	30%	40%	50%
Imaging, including X-rays and lab tests	30%	40%	50%
Physician, surgeon, and surgical services	30%	40%	50%
Nursing care, anesthesia, and medications	30%	40%	50%
Birth Services <sup>(6)</sup>	30%	40%	50%
Outpatient care			
Physician office visits	\$30 Copayment	\$50 Copayment	50%
Specialty Care	\$30 Copayment	\$50 Copayment	50%
Telehealth visits <sup>(8)</sup>	No charge	\$50 Copayment	50%
Preventive screening services	No charge <sup>(3)</sup>	No charge <sup>(3)</sup>	50% <sup>(3)</sup>
Routine adult physical exams <sup>(4)</sup>	No charge <sup>(3)</sup>	No charge <sup>(3)</sup>	50% <sup>(3)</sup>
Well-child preventive care visits <sup>(22)</sup>	No charge <sup>(3)</sup>	No charge <sup>(3)</sup>	50% <sup>(3)</sup>
Family planning visits	No charge	\$50 Copayment	50%
Scheduled prenatal and first post-partum visits <sup>(5)</sup>	No charge <sup>(3)</sup>	No charge <sup>(3)</sup>	50% <sup>(3)</sup>
Outpatient surgery	30% per procedure	40% per procedure	50% per procedure
Imaging, including X-rays and lab tests	\$15 Copayment	\$50 Copayment	50%
Hearing exams	No charge <sup>(3)</sup>	Covered under the HMO Tier Only	Covered under the HMO Tier Only
Physical, occupational, and speech therapy visits	\$30 Copayment	\$50 Copayment	50%
Health education	No charge <sup>(3)</sup>	Covered under the HMO Tier Only	Covered under the HMO Tier Only
Emergency Care (Waived if admitted directly to hospital)	30% regardless of facility/hospital accessed <sup>(7)</sup>		
Emergency Ambulance Service	Covered under the HMO Tier, subject to a 30% charge		
Medically Necessary Non-emergency ambulance service	30%	50%	50%
Urgent Care	\$30 Copayment	40%	50%

2026 Benefit Summary	Kaiser Permanente Point-of-Service Plan 17847 NCR / 17848 SCR			
	HMO Tier (Kaiser Permanente Plan Providers)	Participating Provider Tier <sup>(18)</sup> *		Non-Participating Provider Tier*
		Precertification is required for certain services <sup>†</sup>		
	Member pays			
<b>Prescriptions<sup>(9)(19)</sup> (30-day supply)</b> Generic preferred tier Generic non-preferred tier Brand preferred tier Brand non-preferred tier Specialty tier <sup>(16)</sup>	<b>Kaiser Permanente Pharmacies</b> \$15 Copayment \$15 Copayment <sup>(17)</sup> \$35 Copayment \$35 Copayment <sup>(17)</sup> 30% with \$250 per prescription maximum	<b>MedImpact Pharmacies<sup>(10)</sup></b> \$30 Copayment \$55 Copayment \$45 Copayment \$55 Copayment 40% with \$250 per prescription maximum		<b>Non-Participating Pharmacies</b> Not covered Not covered Not covered Not covered Not covered
<b>Mail-order Prescriptions<sup>(9)</sup></b> Generic drugs (maximum 100-day supply) Brand preferred drugs (maximum 100-day supply)	\$30 Copayment \$70 Copayment	Most prescriptions from Participating/Non-Participating Providers may be filled at Kaiser Permanente Pharmacies and refilled through mail-order. Mail-order service is not available at MedImpact Pharmacies.		
<b>Mental health services</b> Inpatient hospitalization  Outpatient individual therapy visits Outpatient group therapy visits	30%  \$30 Copayment \$15 Copayment	40%  \$50 Copayment \$25 Copayment		50%  50% 50%
<b>Substance use disorder treatment</b> Inpatient hospitalization  Outpatient individual therapy visits Outpatient group therapy visits	30%  \$30 Copayment \$5 Copayment	40%  \$50 Copayment \$25 Copayment		50%  50% 50%
<b>Durable medical equipment</b> Diabetic Equipment and Supplies <sup>(14)</sup> Prosthetics, orthotics, and special footwear <sup>(15)</sup>	30% 30% No charge	40% <sup>(13)</sup> 30% 40%		50% <sup>(13)</sup> 30% 50%
<b>Additional benefits</b> Skilled nursing facility care <sup>(20)</sup>	30% (100-day limit per benefit period)	40% <sup>(11)</sup>		50% <sup>(11)</sup>
Home health care (100-day limit per accumulation period) <sup>(20)</sup>	No charge	20% <sup>(12)</sup>		20% <sup>(12)</sup>
Hospice care	No charge	40%		50%
Fertility services <sup>(21)</sup>	Same as medical benefit	Same as medical benefit	Same as medical benefit	

**Note: These benefits are subject to regulatory approval.**

This chart only describes a summary of the benefits. For a complete understanding of benefits, please read the Kaiser Permanente Point-of-Service Disclosure Form and Evidence of Coverage and the Kaiser Permanente Insurance Company *Schedule of Coverage and Certificate of Insurance*. The Disclosure Form, Evidence of Coverage, *Schedule of Coverage*, and the *Certificate of Insurance* together contain a complete explanation of benefits, exclusions, and limitations. The information provided in this chart is not intended for use as a Summary Plan Description, the Disclosure Form, Evidence of Coverage, *Schedule of Coverage*, or the *Certificate of Insurance*.

**Footnotes**

- (1) This plan carries an embedded Deductible and Out-of-Pocket Maximum. Benefits become payable for each family member after their individual annual Deductible is met, or when the family Deductible is satisfied. Deductibles contribute towards satisfying the Out-of-Pocket Maximum. A family member can meet the individual annual Out-of-Pocket Maximum before the family Out-of-Pocket Maximum is satisfied.
- (2) Cost Shares applied to satisfy the Deductible at the Participating Provider tier will be applied to satisfy the Deductible at the HMO tier. And vice-versa.  
Cost Shares applied to satisfy the Out-of-Pocket Maximum at the Participating Provider tier will be applied to satisfy the Out-of-Pocket Maximum at the HMO tier. And vice-versa.  
Cost Shares applied to satisfy the Deductible or Out-of-Pocket Maximum at the Non-participating Provider Tier will not apply toward satisfaction of the Deductible or Out-of-Pocket Maximum at the HMO tier or Participating Provider Tier. And vice-versa.
- (3) Deductibles, Coinsurance and Copayments do not apply to Preventive Benefits required under the Patient Protection Affordable Care Act (PPACA) provided by Kaiser Permanente Plan Providers and Participating Providers. Preventive Benefits received at the Non-Participating Provider Tier are subject to Coinsurance and Copayments.
- (4) Routine adult physical exams are limited to one exam every 12 months.
- (5) Routine prenatal care office visits are covered as required under the Patient Protection Affordable Care Act (PPACA). This includes the initial and subsequent histories, physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis.
- (6) Birth Services including delivery and inpatient care for mother and baby are covered under your inpatient services benefit.
- (7) Emergency medical services are covered under the HMO Tier. Non-emergency medical services received in an emergency care setting that are not covered under the HMO Tier may be eligible for coverage under the Participating Provider or Non-Participating Provider Tiers.
- (8) Telehealth care is provided where applicable and available via communication methods such as telephone, video, or email. Cost shares vary depending on the type of service provided and are equivalent to an in-person visit specific to that service except when using the HMO tier where the cost share is \$0 (no charge).
- (9) Pharmacy Copayment and Coinsurance are subject to the satisfaction of the Deductible or the Out-of-Pocket Maximum. Select prescription drugs are excluded from coverage.
- (10) Member is responsible for paying the brand name Copayment plus the difference in cost between the generic drug and the brand name drug when patient requests brand name drug and a generic version is prescribed by the physician.
- (11) Skilled Nursing Facility care is limited to a maximum of 60 days per benefit period combined for services provided by Participating Providers and Non-Participating Providers.
- (12) Home Health Care is limited to a maximum of 100 visits per accumulation period combined for services provided by Participating Providers and Non-Participating Providers.

- (13) Certain Durable Medical Equipment is limited to a maximum of \$2,000 per accumulation period combined for services provided by Participating Providers and Non-Participating Providers.
- (14) Some diabetic equipment and supplies such as: infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes and transparent film are payable based on actual billed charges and are not subject to the DME annual maximum of \$2,000 per accumulation period.
- (15) Most items are not covered.
- (16) Specialty drugs are not eligible for mail order incentive and may not be available under the mail order service.
- (17) Non-preferred drugs are covered at a Kaiser Permanente pharmacy only when prescribed by Kaiser Permanente Plan Providers through exception process or when related to emergency care, out-of-area urgent care, or an authorized referral.
- (18) Online directories of Participating Providers can be found by visiting [kp.org/kpic/pos](http://kp.org/kpic/pos).
- (19) An online directory of Pharmacies can be found by visiting [kp.org/pharmacylocator/pos](http://kp.org/pharmacylocator/pos).
- (20) The visit maximum does not apply to medically necessary treatment of Mental Health and Substance Use Disorder.
- (21) Benefits payable for diagnosis and treatment of infertility and fertility services are covered on the same basis as any other medical service.
- (22) Well-child preventive care includes immunizations and is exempt from Deductibles.

**†Precertification of services provided by Participating Providers and Non-Participating Providers**

Precertification is required for all hospital confinements, including preadmission testing, inpatient care at a Skilled Nursing Facility, or other licensed, freestanding facilities, such as Hospice Care, Home Health Care, or care at a rehabilitation facility, or selected outpatient procedures. Failure to obtain precertification will result in a penalty of \$500 per occurrence for covered charges incurred in connection with these services. This penalty will not count toward the satisfaction of any Deductibles or Out-of-Pocket Maximums. For a complete understanding of precertification requirements, please refer to your *Schedule of Coverage and Certificate of Insurance*.

**\*Payments Based on Maximum Allowable Charge for Covered Services**

Maximum Allowable charge means the lesser of: the Usual, Customary, and Reasonable Charges or the Negotiated Rate or the Actual Billed Charges. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service.

**The HMO Tier of the Point-of-Service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) while the Participating Provider and Non-Participating Provider Tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.**