2026 Benefit Summary	PPO Plan 17619 NCR / 17620 SCR	
	Participating Provider Tier[15]*	**Non-Participating Provider Tier***
	Precertification is required for certain services†	
The Accumulation Period for this Plan is **Calendar Year**		
Maximum benefit while insured	Unlimited	
	Insured pays	
Deductible per accumulation period[1][2]	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
Out-of-Pocket Maximum per accumulation period[2]	$4,500 Individual $9,000 Family	$9,000 Individual $18,000 Family
Hospital care	$500 Copayment per admission, then	$1,000 Copayment per admission, then
Room, board, and critical care units	20%	40%
Imaging, including X-rays and lab tests	20%	40%
Transplants	20%	40%
Physician, surgeon, and surgical services	20%	40%
Nursing care, anesthesia, and inpatient prescribed drugs	20%	40%
Birth Services[7]	20%	40%
Outpatient care		
Physician office visits	$30 Copayment[3]	40%
Specialty care	$30 Copayment[3]	40%
Telehealth visits[8]	$30 Copayment[3]	40%
Preventive screening services	No charge[3]	40%[3]
Routine adult physical exam	No charge[3][4]	40%[3][4]
Well-child preventive care visits	No charge[3][5]	40%[3][5]
Family planning visits	$30 Copayment[3]	40%
Prenatal care[6]	No charge[3]	40%[3]
Outpatient Surgery	$100 Copayment, then 20% per procedure	$150 Copayment, then 40% per procedure
Lab Test and Imaging, including X-rays	20%	40%
Hearing exams	No charge[3]	Not covered
Occupational, physical, respiratory, and speech therapy visits	20%	40%
Health Education	No charge[3]	40%
Diabetic Day Care Management Classes	No charge[3]	40%
Emergency Care (Emergency Copayment waived if admitted)	$150 Copayment per visit, then 20%	
Emergency Ambulance Service	40%	40%
Medically Necessary Non-emergency Ambulance Service	40%	40%
Urgent Care	$50 Copayment[3]	40%

2026 Benefit Summary	PPO Plan 17619 NCR / 17620 SCR	
	Participating Provider Tier[15]*	**Non-Participating Provider Tier***
	Precertification is required for certain services†	
	Insured pays	
Prescriptions[9]	**MedImpact Pharmacies**[10][16]	**Non-Participating Pharmacies**
Generic drugs (30-day supply)	$15 Copayment	Not covered
Brand drugs (30-day supply)	$40 Copayment	Not covered
Contraceptive drugs	No charge	Not covered
Specialty drugs[11]	30% with $250 per prescription maximum	Not covered
Mail-order generic drugs (maximum benefit of a 100-day supply)	$30 Copayment	Not covered
Mail-order brand drugs (maximum benefit of a 100-day supply)	$80 Copayment	Not covered
Mental health care		
Inpatient hospitalization	$500 Copayment per admission, then 20%	$1,000 Copayment per admission, then 40%
Outpatient individual therapy visits	$30 Copayment[3]	40%
Outpatient group therapy visits	$15 Copayment[3]	40%
Substance use disorder treatment		
Inpatient hospitalization	$500 Copayment per admission, then 20%	$1,000 Copayment per admission, then 40%
Outpatient individual therapy visits	$30 Copayment[3]	40%
Outpatient group therapy visits	$15 Copayment[3]	40%
Durable medical equipment[13]	30%	50%
Diabetic Equipment and Supplies[14]	30%	30%
Prosthetics, orthotics, and special footwear	20%	40%
Additional benefits		
Care in a skilled-nursing facility (60-day combined limit per benefit period)[17]	$500 Copayment per admission, then 20%	$1,000 Copayment per admission, then 40%
Home health care (100-day combined limit per accumulation period)[17]	20%[3]	20%[3]
Hospice care	20%	40%
Fertility services[12]	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 this summary in conjunction with the Kaiser Permanente Insurance Company Schedule of Coverage and *Certificate of Insurance*, which contains a complete explanation of benefits, exclusions, and limitations. The information provided in this Benefit Summary is not intended for use as a Summary Plan Description, nor is it designed to serve as the Schedule of Coverage or *Certificate of Insurance*.

Footnotes

(1) Deductibles contribute towards satisfying the Out-of-Pocket Maximum. 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. A family member can meet the individual annual Out-of-Pocket Maximum before the family Out-of-Pocket Maximum is satisfied.

(2) Covered Charges incurred toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Participating Provider Tier will accumulate toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Participating Provider Tier. Likewise, Covered Charges incurred toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Non-Participating Provider Tier will accumulate toward satisfaction of the Deductible or Out-of-Pocket Maximum on the Non-Participating Provider Tier. The Deductible, Copayments, and Coinsurance paid for most covered services contribute towards the satisfaction of the Out-of-Pocket Maximum.

(3) Exempt from Deductible.

(4) Routine adult physical exams are limited to one exam every 12 months.

(5) Well-child preventive care, including immunizations, is exempt from Deductible.

(6) 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.

(7) Birth Services including delivery and inpatient care for mother and baby are covered under your inpatient services benefit.

(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.

(9) 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.

(10) MedImpact Pharmacy Copayments and Coinsurance are not subject to, nor do they contribute toward satisfaction of the Deductible. However, they do contribute toward the satisfaction of the Out-of-Pocket Maximum. Select prescription drugs are excluded from coverage.

(11) Specialty drugs are limited to a 30-day maximum supply and are not available under the mail order service.

(12) Benefits payable for diagnosis and treatment of infertility and fertility services are covered on the same basis as any other medical service.

(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. Certain Durable Medical Equipment is not subject to the Deductible nor contributes to the Out-of-Pocket Maximum.

(14) Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on Actual Billed Charges and are not subject to the Durable Medical Equipment annual maximum limit of $2,000 per accumulation period.

(15) Online directories of Participating Providers can be found by visiting kp.org/kpic/ppo.

(16) An online directory of Pharmacies can be found by visiting kp.org/pharmacylocator/ppo.

(17) The visit maximum does not apply to medically necessary treatment of Mental Health and Substance Use Disorder.

†Precertification of services provided by Participating Providers and Non-Participating Providers
Precertification is required for most 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, and select 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 the precertification requirements, please refer to your Schedule of Coverage and *Certificate of Insurance.*

***Based on Maximum Allowable Charge for Covered Services**
Payments are based upon the 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 may be responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service.

PPO Benefits are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP)