

PLAN UPDATES

WASHINGTON, DC
2026

What's new for Washington, DC, small business group plans with coverage effective on or after January 1, 2026



This booklet contains a summary of important information about our Washington, DC, small group plans. For more details on plan information, see the *Administrative Guide for Off-Exchange Plans*.

Your partner in good health

At Kaiser Permanente, we offer a fully integrated health care delivery system with providers, hospitals, pharmacies, and labs working together to provide coordinated care for our members.

What's new at Kaiser Permanente



Updated **kp.org** website and app experience

Our members can expect a newly modernized digital experience with the addition of MyChart by Epic on **kp.org** and the Kaiser Permanente app. The latest MyChart features give members easier access to their favorite self-service tools and greater compatibility with outside care providers.



NEW – Walk-ins accepted at 2 of our After Hours Care locations: Ashburn and Fredericksburg

Our After Hours Care locations are designed to care for minor health concerns like:

- Ear pain
- Cold, sinus, and flu-like symptoms
- Rash
- Minor injuries
- Neck pain
- Urinary tract infection (UTI)
- And more



External behavioral health care providers

The following behavioral health care providers in our contracted network offer app-based teletherapy services to Kaiser Permanente members at no additional cost:

- Grow Therapy
- Headway
- NOCD (No to Compulsive Disorder)
- Open Mind Health
- Rula
- SonderMind
- UpLift

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Skip the appointment line with our wait list service¹

Kaiser Permanente now offers an automated wait list option that can get members in to their physician's office sooner (by 21 days on average) if an appointment becomes available. NOTE: The new appointment will be for the same service and same clinician as initially booked.



Top-rated health plans

Out of more than 1,200 health plans evaluated in 2024, Kaiser Permanente of the Mid-Atlantic States received the region's highest rating from the National Committee for Quality Assurance for every commercial, Medicare, and Medicaid plan we offer.²



Going all in against cancer

Our cancer care team leads the way in early detection, clinical trials, and innovative treatments, giving patients more options in the fight against cancer.



Furthering our mission with community health

We help people experiencing health inequities address the clinical, genetic, social, economic, and environmental factors that affect their ability to thrive. In 2023 alone, we invested nearly \$200 million in the community.³



High marks in the industry

In the **Insure.com** survey *Best Health Insurance Company of 2025*, Kaiser Permanente as a national enterprise is tied for #1 overall among 65 competitors. We also received top marks in their 2025 health insurance customer survey: We earned the top rating for affordability and customer satisfaction.

¹ Sooner appointments are available for phone, video, or in-person appointments. Availability varies by service and department.

² NCQA evaluated over 1,200 health plans based on clinical performance, member satisfaction, and NCQA Accreditation. In the NCQA Commercial Health Plan Ratings 2024, our commercial plan is rated 5 out of 5, the highest rating in the region; our Medicare plan is rated 4.5 out of 5, the highest rating in the region; and our Medicaid plan is rated 4.5 out of 5, the highest rating in the region.

³ According to year-end financial result, 2023 at mykp.kp.org.

2026 Medical plan portfolio

Our plan portfolio offers choice and flexibility with multiple plans to choose from in all four metal levels. We've made necessary cost-sharing changes to keep plans within their respective metal levels. A few plans have been discontinued: the Virtual Forward products, the Gold 500 Deductible plan, and the Select delivery system versions of the Gold 1000 Deductible and Gold 1500 Deductible plans. Two higher-deductible options have been added in the Gold and Silver tiers. New plan names and specific cost-sharing changes for each plan are provided under the 2026 medical plan changes on pages 7 through 17. Groups may choose to renew with their current plan or select any other plan in our portfolio

2026 Dental plan portfolio

At Kaiser Permanente, we believe dental care is a vital part of living a balanced, healthy life. In partnership with LIBERTY Dental Plan—we offer versions of three of our most popular health plans with comprehensive dental benefits for adults.

These adult benefits seamlessly coordinate with the included child dental benefits in each health plan. They offer a robust network with no need for referrals for specialist procedures. There are no office visit charges, and benefits are not subject to a deductible, maximum annual limit, or waiting period. Each plan includes comprehensive coverage of the full range of common dental procedures, including preventive, diagnostic, and restorative services. For more information visit kp.org/dental/mas.

Pediatric dental services and coverage for your renewal

Pediatric dental coverage for members is required by law, so all our medical plans are offered along with an ACA-compliant pediatric dental plan. The KP Smile Kids Embedded Dental PPO is included with Kaiser Permanente's Flexible Choice and Added Choice POS medical plans, and can only be paired with adult dental PPO or POS plans. The KP Smile Kids Dental EPO is included with Kaiser Permanente HMO/DHMO medical plans.

Both plans include preventive care procedures—such as oral evaluations, routine cleanings, bitewing X-rays, and topical fluoride treatments—every 6 months, at no additional cost. Additional diagnostic and restorative services and medically necessary orthodontia are also covered. For more information, visit kp.org/dental/mas.

Automatic renewals

Your coverage will renew automatically at the 2026 rates and plan changes unless you notify us at least 30 days prior to November 1, 2025. Your acceptance of this renewal also confirms that you meet the definition of small employer as defined by applicable federal and state laws.

2026 Plan highlights and reminders

Prescription drug coverage is automatically covered on all medical plans

All our plans come with built-in coverage for outpatient prescription drugs. All prescription drug plans have a four-tiered benefit design with different cost-sharing amounts for generic, preferred brand, non-preferred brand, and specialty drugs.

Your employees can save time and money by ordering prescription refills online or by phone. Members can get a 90-day supply for only two times the 30-day supply copay when using Kaiser Permanente Mail Order Pharmacy.¹ We can mail most prescription medications to you within 3 to 5 days, and you don't pay anything extra for standard U.S. postage.

Employee assistance program

We've teamed with a national vendor to deliver nonclinical support for mental health by offering an optional employee assistance program for small and mid-size employers. Please reach out to your account manager for more information.

Routine adult vision eye exam and hardware benefits

All our plans include an adult vision benefit at Vision Essentials by Kaiser Permanente (located in many of our medical centers). Routine eye exams with an optometrist are available at each plan's primary care office visit cost share. A discount of \$125 is offered off the retail price of combined frames and lenses once per year. The discount may be applied to contact lenses; it may also be applied to initial fit and the first purchase of contact lenses at Vision Essentials. Go to kp2020.org for more information, including our optical locations.

Pediatric vision coverage on all medical plans

All our plans cover routine pediatric vision exams and one pair of standard frames from a select group with lenses per year, at no additional charge. Regular contacts may be substituted for pediatric frames and lenses once per contract year. Go to kp2020.org for more information, including our optical locations.

Standard plans

Our plan portfolio includes standard plans that have been designed by the District of Columbia, and all carriers are required to offer these plans. Because they were not designed by Kaiser Permanente, the coverage may differ from our typical plans. Please refer to the Summary of Benefits for details.

Benefits that accrue to the medical out-of-pocket maximum

Most benefits, including copays and coinsurance for services not subject to deductible, as well as the deductible itself, accrue to the medical out-of-pocket maximum. Copays and coinsurance that accrue to the out-of-pocket maximum are waived once an individual or has reached that maximum.

¹ Some medications are not eligible for Mail Order Pharmacy. Mail Order Pharmacy can deliver to addresses in MD, VA, DC, and certain locations outside the service area.

Summary of 2026 plan changes for Washington, DC

This document provides an overview of changes Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is making to your small group plan offerings effective upon your group's 2026 renewal date.

For more information, please refer to your Summary of Benefits and Coverage (SBC) and/or your *Evidence of Coverage (EOC)*.



Male sterilization

DC law prohibits cost sharing for male sterilization. The cost share will be no charge for in-network HMO and DHMO plans.



Travel dialysis

The limit for travel dialysis is being changed from 60 travel days per year to 26 dialysis sessions per year. This change applies to the in-network HMO tier (Tier 1).



Mental health and chemical dependency

The applicable cost shares have been changed for the following services: crisis intervention, electroconvulsive therapy, partial hospitalization, psychological and neuropsychological testing, and all other outpatient services (non-office visits).

Plan-specific changes:

In-network (Tier 1)

- HMO/DHMO: No charge
- HDHP/HSA: No charge after deductible

Added Choice plans: Out-of-network

- No charge after deductible

Plus plans - Out-of-network

- Psychological and neuropsychological testing: Not covered

Crisis intervention and stabilization: Out-of-network

- Plus plans: Changed from "not covered" to "covered in plan"
- Added Choice plans: Applicable plan-specific cost shares changed to "covered in plan"

Psychological and neuropsychological testing: Out-of-network

- Plus plans: Not covered
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HMO and DHMO Essential Plans - HIV

Treatment for individuals living with HIV will be provided at no charge for primary care physician office visits, specified lab tests, and generic prescription drugs for HMO and DHMO Essential Plans.

2026 Medical plan changes

DC HMO plans

YEAR	2025	2026
Plan name	KP DC Platinum 0 Ded/Vision	KP DC Platinum 0 Ded/Vision
Self-only out-of-pocket maximum	\$2,600	\$2,650
Family out-of-pocket maximum	\$2,600 individual / \$5,200 family	\$2,650 individual / \$5,300 family
Inpatient hospital services and skilled nursing facility care	\$150 per admission	\$200 per admission
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$5, \$25, \$50	\$10, \$45, \$65
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$10, \$50, \$100	\$20, \$90, \$130
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$8, \$38, \$75	\$15, \$68, \$98
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$15, \$35, \$60	\$20, \$55, \$75
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$30, \$70, \$120	\$40, \$110, \$150
Plan name	KP DC Essential Platinum 0 Ded/Vision	KP DC Essential Platinum 0 Ded/Vision
Outpatient surgery facility fee	\$250	\$200
Outpatient surgery physician services	No charge	\$50

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Gold 0 Ded/Vision	KP DC Gold 0 Ded/Vision
Self-only out-of-pocket maximum	\$8,600	\$9,000
Family out-of-pocket maximum	\$8,600 individual / \$17,200 family	\$9,000 individual / \$18,000 family
Outpatient surgery physician services	\$40	\$50
Inpatient physician and surgical services	\$40 per admission	\$50 per admission
Emergency services	\$300	\$500
Primary care office visits, allergy injection visit and serum, applied behavioral analysis, medical nutrition therapy and counseling, mental health office visits, eye exam by an optometrist	\$20	\$25
Specialty care office visits, accidental dental, allergy evaluation and treatment, dialysis services, radiation therapy, chemotherapy, routine foot care, transplant dental services office visit, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$50	\$55
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$50	\$55
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$10, \$60, \$100	\$15, \$50, \$70
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$20, \$120, \$200	\$30, \$100, \$140
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$15, \$90, \$150	\$23, \$75, \$105
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$20, \$70, \$110	\$25, \$60, \$80
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$40, \$140, \$220	\$50, \$120, \$160

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Gold 0 Ded/Vision/Adl Dental	KP DC Gold 0 Ded/Vision/Dental
Self-only out-of-pocket maximum	\$8,600	\$9,000
Family out-of-pocket maximum	\$8,600 individual / \$17,200 family	\$9,000 individual / \$18,000 family
Outpatient surgery physician services	\$40	\$50
Inpatient physician and surgical services	\$40 per admission	\$50 per admission
Emergency services	\$300	\$500
Primary care office visits, allergy injection visit and serum, applied behavioral analysis, medical nutrition therapy and counseling, mental health office visits, eye exam (optometrist)	\$20	\$25
Specialty care office visits, accidental dental, allergy evaluation and treatment, dialysis services, radiation therapy, chemotherapy, routine foot care, transplant dental services office visit, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$50	\$55
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$50	\$55
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$10, \$60, \$100	\$15, \$50, \$70
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$20, \$120, \$200	\$30, \$100, \$140
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$15, \$90, \$150	\$23, \$75, \$105
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$20, \$70, \$110	\$25, \$60, \$80
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$40, \$140, \$220	\$50, \$120, \$160

2026 Medical plan changes (continued)

DC HMO Plus plans

YEAR	2025	2026
Plan name	KP DC Platinum Plus 0 Ded/Vision	KP DC Platinum Plus 0 Ded/Vision
In-plan changes	The following changes apply	
Self-only out-of-pocket maximum	\$2,600	\$2,650
Family out-of-pocket maximum	\$2,600 individual / \$5,200 family	\$2,650 individual / \$5,300 family
Inpatient hospital services and skilled nursing facility care	\$150 per admission	\$200 per admission
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$5, \$25, \$50	\$10, \$45, \$65
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$10, \$50, \$100	\$20, \$90, \$130
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$8, \$38, \$75	\$15, \$68, \$98
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$15, \$35, \$60	\$20, \$55, \$75
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$30, \$70, \$120	\$40, \$110, \$150
Out-of-network changes	The following changes apply	
Prescription drugs		
Tier 1, Tier 2, Tier 3 (non-participating pharmacy)	\$25, \$45, \$70	\$30, \$65, \$85
Infertility drugs	Covered	Not covered

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Gold Plus 0 Ded/Vision	KP DC Gold Plus 0 Ded/Vision
In-plan changes	The following changes apply	
Self-only out-of-pocket maximum	\$8,600	\$9,000
Family out-of-pocket maximum	\$8,600 individual / \$17,200 family	\$9,000 individual / \$18,000 family
Outpatient surgery physician services	\$40	\$50
Inpatient physician and surgical services	\$40 per admission	\$50 per admission
Emergency services	\$300	\$500
Primary care office visits, allergy injection visit and serum, applied behavioral analysis, medical nutrition therapy and counseling, mental health office visits, eye exam by an optometrist	\$20	\$25
Specialty care office visits, accidental dental, allergy evaluation and treatment, dialysis services, radiation therapy, chemotherapy, routine foot care, transplant dental services office visit, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$50	\$55
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$50	\$55
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$10, \$60, \$100	\$15, \$50, \$70
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$20, \$120, \$200	\$30, \$100, \$140
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$15, \$90, \$150	\$23, \$75, \$105
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$20, \$70, \$110	\$25, \$60, \$80
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$40, \$140, \$200	\$50, \$120, \$160

2026 Medical plan changes (continued)

YEAR	2025	2026
Out-of-network changes	The following changes apply	
Primary care office visits, allergy injection visit and serum, applied behavioral analysis, medical nutrition therapy and counseling, mental health office visits, eye exam by an optometrist	\$40	\$45
Specialty care office visits, accidental dental, allergy evaluation and treatment, routine foot care, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$70	\$75
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$70	\$75
Prescription drugs		
Tier 1, Tier 2, Tier 3 (non-participating pharmacy)	\$30, \$80, \$120	\$35, \$70, \$90
Infertility drugs	Covered	Not covered

2026 Medical plan changes (continued)

DC DHMO plans

YEAR	2025	2026
Plan name	KP DC Platinum 500 Ded/Vision	KP DC Platinum 500 Ded/Vision
Self-only out-of-pocket maximum	\$2,600	\$2,700
Family out-of-pocket maximum	\$2,600 individual / \$5,200 family	\$2,700 individual / \$5,400 family
Laboratory outpatient and professional services	\$10	\$20
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$5, \$40, \$60	\$10, \$45, \$65
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$10, \$80, \$120	\$20, \$90, \$130
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$8, \$60, \$90	\$15, \$68, \$98
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$15, \$50, \$70	\$20, \$55, \$75
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$30, \$100, \$140	\$40, \$110, \$150
Plan name	KP DC Gold 500 Ded/Vision	KP DC Essential Gold 500 Ded/Vision
Self-only out-of-pocket maximum	\$6,750	\$6,950
Family out-of-pocket maximum	\$6,750 individual / \$13,500 family	\$6,950 individual / \$13,900 family
Inpatient hospital services	\$500 per admission after deductible	\$600 per day not to exceed \$3,000 per admission after deductible
Inpatient physician and surgical services	\$50 per admission after deductible	No charge after deductible
Skilled nursing facility care	\$500 per admission after deductible	\$300 per day not to exceed \$1,500 per admission after deductible
Outpatient surgery facility fee	\$250 after deductible	\$500
Outpatient surgery physician services	\$60 after deductible	No charge
Primary care office visits, allergy injection visit and serum, applied behavioral analysis, medical nutrition therapy and counseling, mental health office visits, eye exam by an optometrist	\$20	\$25

2026 Medical plan changes (continued)

YEAR	2025	2026
Specialty imaging, sleep laboratory, and interventional radiology	\$350 after deductible	\$250
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$50	\$30
Laboratory outpatient and professional services	\$50	\$30
Ambulance services	No charge after deductible	\$300
Blood, blood products and their administration	No charge after deductible	No charge
Durable medical equipment, TMJ appliances, external prosthetics, and orthotics	No charge after deductible	20%
Peak flow meters	No charge	20%
Home health care services	No charge after deductible	\$30
Hospice care services	No charge after deductible	No charge
After-hours urgent care or urgent care center	\$50	\$60
Prescription drugs		
Tier 1, Tier 2, Tier 3, Tier 4 (plan pharmacy and mail delivery) 30-day supply	\$10, \$60, \$100, 50% up to \$150	\$15, \$50, \$70, \$150
Tier 1, Tier 2, Tier 3, Tier 4 (plan pharmacy) 90-day supply	\$20, \$120, \$200, 50% up to \$300	\$30, \$100, \$140, \$300
Tier 1, Tier 2, Tier 3, Tier 4 (plan pharmacy mail delivery) 90-day supply	\$15, \$90, \$150, 50% up to \$300	\$23, \$75, \$105, \$300
Tier 1, Tier 2, Tier 3, Tier 4 (participating network pharmacy) 30-day supply	\$20, \$70, \$110, 50% up to \$150	Not covered
Tier 1, Tier 2, Tier 3, Tier 4 (participating network pharmacy) 90-day supply	\$40, \$140, \$220, 50% up to \$300	Not covered
Plan name	KP DC Essential Gold 500 Ded/Vision	KP DC Essential Gold 500 Ded/Vision
Self-only out-of-pocket maximum	\$6,050	\$6,950
Family out-of-pocket maximum	\$6,050 individual / \$12,100 family	\$6,950 individual / \$13,900 family

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Gold 1000 Ded/300 RxDed/ Vision	KP DC Gold 1000 Ded/300 RxDed/ Vision (Signature only)
Self-only out-of-pocket maximum	\$6,750	\$7,200
Family out-of-pocket maximum	\$6,750 individual / \$13,500 family	\$7,200 individual / \$14,400 family
Emergency services	\$400 after deductible	\$500 after deductible
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$10, \$60 after Rx deductible, \$100 after Rx deductible	\$15, \$50 after Rx deductible, \$65 after Rx deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$20, \$120 after Rx deductible, \$200 after Rx deductible	\$30, \$100 after Rx deductible, \$130 after Rx deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$15, \$90 after Rx deductible, \$150 after Rx deductible	\$23, \$75 after Rx deductible, \$98 after Rx deductible
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$20, \$70 after Rx deductible, \$110 after Rx deductible	\$25, \$60 after Rx deductible, \$75 after Rx deductible
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$40, \$140 after Rx deductible, \$220 after Rx deductible	\$50, \$120 after Rx deductible, \$150 after Rx deductible
Plan name	KP DC Gold 1500 Ded/300 RxDed/ Vision	KP DC Gold 1500 Ded/300 RxDed/ Vision (Signature only)
Self-only out-of-pocket maximum	\$7,100	\$7,500
Family out-of-pocket maximum	\$7,100 individual / \$14,200 family	\$7,500 individual / \$15,000 family
Outpatient surgery physician services	\$70 after deductible	\$60 after deductible
Inpatient physician and surgical services	\$70 per admission after deductible	\$60 per admission after deductible
Emergency services	\$350 after deductible	\$500 after deductible
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$10, \$60 after Rx deductible, \$100 after Rx deductible	\$15, \$50 after Rx deductible, \$65 after Rx deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$20, \$120 after Rx deductible, \$200 after Rx deductible	\$30, \$100 after Rx deductible, \$130 after Rx deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$15, \$90 after Rx deductible, \$150 after Rx deductible	\$23, \$75 after Rx deductible, \$98 after Rx deductible
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$20, \$70 after Rx deductible, \$110 after Rx deductible	\$25, \$60 after Rx deductible, \$75 after Rx deductible
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$40, \$140 after Rx deductible, \$220 after Rx deductible	\$50, \$120 after Rx deductible, \$150 after Rx deductible

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Gold Virtual Complete 2000 Ded	KP DC Gold Virtual Complete 2000 Ded
Self-only out-of-pocket maximum	\$5,500	\$6,400
Family out-of-pocket maximum	\$5,500 individual / \$11,000 family	\$6,400 individual / \$12,800 family
Plan name	KP DC Silver 1750 Ded/250 RxDed/ Vision	KP DC Silver 1850 Ded/300 RxDed/ Vision
Self-only deductible	\$1,750	\$1,850
Family deductible	\$1,750 individual / \$3,500 family	\$1,850 individual / \$3,700 family
Self-only out-of-pocket maximum	\$8,600	\$8,700
Family out-of-pocket maximum	\$8,600 individual / \$17,200 family	\$8,700 individual / \$17,400 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	\$500 per day not to exceed \$2,500 per admission after deductible
Inpatient physician and surgical services	\$80 per day not to exceed \$240 per admission after deductible	\$60 per day not to exceed \$300 per admission after deductible
Outpatient surgery physician services	\$80 after deductible	\$60 after deductible
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$80 after deductible	\$60 after deductible
X-rays and diagnostic imaging	\$80 after deductible	\$60 after deductible
Prescription drugs		
Prescription drug deductible	\$250	\$300
Oral chemotherapy drugs	No charge	No charge after deductible

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Silver 2500 Ded/250 RxDed/ Vision	KP DC Silver 2500 Ded/500 RxDed/ Vision
Self-only out-of-pocket maximum	\$9,100	\$9,500
Family out-of-pocket maximum	\$9,100 individual / \$18,200 family	\$9,500 individual / \$19,000 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	\$500 per day not to exceed \$2,500 per admission after deductible
Inpatient physician and surgical services	\$80 per day not to exceed \$240 per admission after deductible	\$80 per day not to exceed \$400 per admission after deductible
Outpatient surgery physician services	\$100 after deductible	\$60 after deductible
Specialty care office visits, accidental dental, allergy evaluation and treatment, dialysis services, radiation therapy, chemotherapy, routine foot care, transplant dental services office visit, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$80	\$60
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$80 after deductible	\$60 after deductible
Laboratory outpatient and professional services	\$40	\$60
X-rays and diagnostic imaging	\$80	\$60
Prescription drugs		
Prescription drug deductible	\$250	\$500
Tier 1 (plan pharmacy and mail delivery) 30-day supply	\$20	\$25
Tier 1 (plan pharmacy) 90-day supply	\$40	\$50
Tier 1 (plan pharmacy mail delivery) 90-day supply	\$30	\$38
Tier 1 (participating network pharmacy) 30-day supply	\$30	\$35
Tier 1 (participating network pharmacy) 90-day supply	\$60	\$70

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Silver 2500 Ded/250 RxDed/ Vision/Adl Dental	KP DC Silver 2500 Ded/500 RxDed/ Vision/Dental
Self-only out-of-pocket maximum	\$9,100	\$9,500
Family out-of-pocket maximum	\$9,100 individual / \$18,200 family	\$9,500 individual / \$19,000 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	\$500 per day not to exceed \$2,500 per admission after deductible
Inpatient physician and surgical services	\$80 per day not to exceed \$240 per admission after deductible	\$80 per day not to exceed \$400 per admission after deductible
Outpatient surgery physician services	\$100 after deductible	\$60 after deductible
Specialty care office visits, accidental dental, allergy evaluation and treatment, dialysis services, radiation therapy, chemotherapy, routine foot care, transplant dental services office visit, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$80	\$60
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$80 after deductible	\$60 after deductible
Laboratory outpatient and professional services	\$40	\$60
X-rays and diagnostic imaging	\$80	\$60
Prescription drug (Rx) deductible	\$250	\$500
Tier 1 (plan pharmacy and mail delivery) 30-day supply	\$20	\$25
Tier 1 (plan pharmacy) 90-day supply	\$40	\$50
Tier 1 (plan pharmacy mail delivery) 90-day supply	\$30	\$38
Tier 1 (participating network pharmacy) 30-day supply	\$30	\$35
Tier 1 (participating network pharmacy) 90-day supply	\$60	\$70
Plan name	KP DC Essential Silver 4850 Ded/350 RxDed	KP DC Essential Silver 4850 Ded/350 RxDed
Self-only out-of-pocket maximum	\$8,850	\$9,150
Family out-of-pocket maximum	\$8,850 individual / \$17,700 family	\$9,150 individual / \$18,300 family

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Silver Virtual Forward 3000 Ded	KP DC Silver 5000 Ded/450 RxDed/ Vision
Self-only deductible	\$3,000	\$5,000
Family deductible	\$3,000 individual / \$6,000 family	\$5,000 individual / \$10,000 family
Self-only out-of-pocket maximum	\$8,650	\$9,000
Family out-of-pocket maximum	\$8,650 individual / \$17,300 family	\$9,000 individual / \$18,000 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	30% after deductible
Inpatient physician and surgical services	\$80 per day not to exceed \$240 per admission after deductible	30% after deductible
Outpatient surgery facility fee	\$350 after deductible	30% after deductible
Outpatient surgery physician services	\$80 after deductible	30% after deductible
Primary care office visits, allergy injection visit and serum, applied behavioral analysis, medical nutrition therapy and counseling, mental health office visits, eye exam by an optometrist	No charge for the first visit, then \$40 after deductible	\$50
Specialty care office visits, accidental dental, allergy evaluation and treatment, dialysis services, radiation therapy, chemotherapy, routine foot care, transplant dental services office visit, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$80 after deductible	\$75
Emergency services	\$450 after deductible	30% after deductible
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$80 after deductible	\$25 after deductible
Laboratory outpatient and professional services	\$40 after deductible	\$25 after deductible
X-rays and diagnostic imaging	\$80 after deductible	\$50 after deductible
Specialty imaging, sleep laboratory, and interventional radiology	\$400 after deductible	30% after deductible
Blood, blood products and their administration, durable medical equipment, medical foods, TMJ appliances, prosthetic and orthotic devices	No charge after deductible	30% after deductible
Diabetic equipment and supplies	No charge	20%

2026 Medical plan changes (continued)

YEAR	2025	2026
Peak flow meters	No charge	30%
Prescription drugs		
Prescription drug deductible	Medical	\$450
Tier 1 (plan pharmacy and mail delivery) 30-day supply	\$20 after deductible	\$20
Tier 1 (plan pharmacy) 90-day supply	\$40 after deductible	\$40
Tier 1 (plan pharmacy mail delivery) 90-day supply	\$30 after deductible	\$30
Tier 1 (participating network pharmacy) 30-day supply	\$30 after deductible	\$30
Tier 1 (participating network pharmacy) 90-day supply	\$60 after deductible	\$60
Plan name	KP DC Bronze 6500 Ded/Vision	KP DC Bronze 6500 Ded/Vision
Self-only out-of-pocket maximum	\$9,100	\$10,000
Family out-of-pocket maximum	\$9,100 individual / \$18,200 family	\$10,000 individual / \$20,000 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	40% after deductible
Inpatient physician and surgical services	\$80 per day not to exceed \$240 per admission after deductible	40% after deductible
Outpatient surgery facility fee	\$350 after deductible	\$400 after deductible
Outpatient surgery physician services	\$80 after deductible	\$60 after deductible
Emergency services	\$500 after deductible	40% after deductible
Laboratory outpatient and professional services	\$80 after deductible	\$60 after deductible
X-rays and diagnostic imaging	\$200 after deductible	\$100 after deductible
Blood, blood products and their administration, durable medical equipment, medical foods, TMJ appliances, prosthetic and orthotic devices	No charge after deductible	40% after deductible
Diabetic equipment and supplies	No charge	20%
Peak flow meters	No charge	40%

2026 Medical plan changes (continued)

YEAR	2025	2026
Prescription drugs		
Tier 1, Tier 2 (plan pharmacy and mail delivery) 30-day supply	\$35, \$100 after deductible	\$30, \$65 after deductible
Tier 1, Tier 2 (plan pharmacy) 90-day supply	\$70, \$200 after deductible	\$60, \$130 after deductible
Tier 1, Tier 2 (plan pharmacy mail delivery) 90-day supply	\$53, \$150 after deductible	\$45, \$98 after deductible
Tier 1, Tier 2 (participating network pharmacy) 30-day supply	\$45, \$110 after deductible	\$40, \$75 after deductible
Tier 1, Tier 2 (participating network pharmacy) 90-day supply	\$90, \$220 after deductible	\$80, \$150 after deductible
Plan name	KP DC Bronze 6500 Ded/Vision/Adl Dental	KP DC Bronze 6500 Ded/Vision/Dental
Self-only out-of-pocket maximum	\$9,100	\$10,000
Family out-of-pocket maximum	\$9,100 individual / \$18,000 family	\$10,000 individual / \$20,000 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	40% after deductible
Inpatient physician and surgical services	\$80 per day not to exceed \$240 per admission after deductible	40% after deductible
Outpatient surgery facility fee	\$350 after deductible	\$450 after deductible
Outpatient surgery physician services	\$80 after deductible	\$60 after deductible
Emergency services	\$500 after deductible	40% after deductible
Laboratory outpatient and professional services	\$80 after deductible	\$60 after deductible
X-rays and diagnostic imaging	\$200 after deductible	\$100 after deductible
Blood, blood products and their administration, durable medical equipment, medical foods, TMJ appliances, prosthetic and orthotic devices	No charge after deductible	40% after deductible
Diabetic equipment and supplies	No charge	20%
Peak flow meters	No charge	40%
Prescription drugs		
Tier 1, Tier 2 (plan pharmacy and mail delivery) 30-day supply	\$35, \$100 after deductible	\$30, \$65 after deductible
Tier 1, Tier 2 (plan pharmacy) 90-day supply	\$70, \$200 after deductible	\$60, \$130 after deductible

2026 Medical plan changes (continued)

YEAR	2025	2026
Tier 1, Tier 2 (plan pharmacy mail delivery) 90-day supply	\$53, \$150 after deductible	\$45, \$98 after deductible
Tier 1, Tier 2 (participating network pharmacy) 30-day supply	\$45, \$110 after deductible	\$40, \$75 after deductible
Tier 1, Tier 2 (participating network pharmacy) 90-day supply	\$90, \$220 after deductible	\$80, \$150 after deductible
Plan name	KP DC Essential Bronze 7500 Ded/850 RxDed	KP DC Essential Bronze 7500 Ded/1000 RxDed
Self-only out-of-pocket maximum	\$9,150	\$10,150
Family out-of-pocket maximum	\$9,150 individual / \$18,300 family	\$10,150 individual / \$20,300 family
Prescription drug deductible	\$850	\$1,000

2026 Medical plan changes (continued)

DC DHMO Plus plans

YEAR	2025	2026
Plan name	KP DC Gold Plus 1500 Ded/300 RxDed/Vision	KP DC Gold Plus 1500 Ded/300 RxDed/Vision
In-plan changes	The following changes apply	
Self-only out-of-pocket maximum	\$7,100	\$7,500
Family out-of-pocket maximum	\$7,100 individual / \$14,200 family	\$7,500 individual / \$15,000 family
Outpatient surgery physician services	\$70 after deductible	\$60 after deductible
Inpatient physician and surgical services	\$70 per admission after deductible	\$60 per admission after deductible
Emergency services	\$350 after deductible	\$500 after deductible
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$10, \$60 after Rx deductible, \$100 after Rx deductible	\$15, \$50 after Rx deductible, \$65 after Rx deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$20, \$120 after Rx deductible, \$200 after Rx deductible	\$30, \$100 after Rx deductible, \$130 after Rx deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$15, \$90 after Rx deductible, \$150 after Rx deductible	\$23, \$75 after Rx deductible, \$98 after Rx deductible
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$20, \$70 after Rx deductible, \$110 after Rx deductible	\$25, \$60 after Rx deductible, \$75 after Rx deductible
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$40, \$140 after Rx deductible, \$220 after Rx deductible	\$50, \$120 after Rx deductible, \$150 after Rx deductible
Out-of-network changes	The following changes apply	
Prescription drugs		
Tier 1, Tier 2 (non-participating pharmacy)	\$30, \$80	\$35, \$70
Infertility drugs	Covered	Not covered

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Silver Plus 1750 Ded/250 RxDed/Vision	KP DC Silver Plus 1800 Ded/300 RxDed/Vision
In-plan changes	The following changes apply	
Self-only deductible	\$1,750	\$1,800
Family deductible	\$1,750 individual / \$3,500 family	\$1,800 individual / \$3,600 family
Self-only out-of-pocket maximum	\$8,600	\$9,100
Family out-of-pocket maximum	\$8,600 individual / \$17,200 family	\$9,100 individual / \$18,200 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	\$500 per day not to exceed \$2,500 per admission after deductible
Inpatient physician and surgical services	\$80 per day not to exceed \$240 per admission after deductible	\$60 per day not to exceed \$300 per admission after deductible
Specialty care office visits, accidental dental, allergy evaluation and treatment, dialysis services, radiation therapy, chemotherapy, routine foot care, transplant dental services office visit, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$50 after deductible	\$70 after deductible
Prescription drugs		
Prescription drug deductible	\$250	\$300

2026 Medical plan changes (continued)

DC HDHP plans

YEAR	2025	2026
Plan name	KP DC Gold 1700 Ded/HSA/Vision	KP DC Gold 1700 Ded/HSA/Vision
Self-only out-of-pocket maximum	\$5,000	\$5,500
Family out-of-pocket maximum	\$5,000 individual / \$10,000 family	\$5,500 individual / \$11,000 family
Inpatient hospital services and skilled nursing facility care	\$100 per admission after deductible	\$200 per admission after deductible
Inpatient physician and surgical services	\$10 per admission after deductible	\$30 per admission after deductible
Outpatient surgery physician services	\$10 after deductible	\$30 after deductible
Emergency services	\$200 after deductible	\$250 after deductible
Specialty imaging, sleep laboratory, and interventional radiology	No charge after deductible	\$75 after deductible
Prescription drugs		
Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$75 after deductible	\$65 after deductible
Tier 3 (plan pharmacy) 90-day supply	\$150 after deductible	\$130 after deductible
Tier 3 (plan pharmacy mail delivery) 90-day supply	\$113 after deductible	\$98 after deductible
Tier 3 (participating network pharmacy) 30-day supply	\$85 after deductible	\$75 after deductible
Tier 3 (participating network pharmacy) 90-day supply	\$170 after deductible	\$150 after deductible
Plan name	KP DC Silver 2000 Ded/HSA/Vision	KP DC Silver 2000 Ded/HSA/Vision
Self-only out-of-pocket maximum	\$7,500	\$8,500
Family out-of-pocket maximum	\$7,500 individual / \$15,000 family	\$8,500 individual / \$17,000 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	\$500 per admission after deductible
Inpatient physician and surgical services	\$40 per day not to exceed \$120 per admission after deductible	\$50 per admission after deductible
Outpatient surgery physician services	\$40 after deductible	\$50 after deductible
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$40 after deductible	\$50 after deductible
X-rays and diagnostic imaging	\$40 after deductible	\$50 after deductible

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Silver 3000 Ded/HSA/Vision	KP DC Silver 3000 Ded/HSA/Vision
Self-only out-of-pocket maximum	\$7,500	\$8,000
Family out-of-pocket maximum	\$7,500 individual / \$15,000 family	\$8,000 individual / \$16,000 family
Inpatient physician and surgical services	\$40 per day not to exceed \$120 per admission after deductible	\$50 per day not to exceed \$150 per admission after deductible
Specialty care office visits, accidental dental, allergy evaluation and treatment, dialysis services, radiation therapy, chemotherapy, routine foot care, transplant dental services office visit, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$40 after deductible	\$50 after deductible
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$40 after deductible	\$50 after deductible
X-rays and diagnostic imaging	\$40 after deductible	\$50 after deductible
Plan name	KP DC Bronze 6000/50/HSA/Vision	KP DC Bronze 6000 Ded/HSA/Vision
Self-only out-of-pocket maximum	\$7,200	\$7,600
Family out-of-pocket maximum	\$7,200 individual / \$14,400 family	\$7,600 individual / \$15,200 family
Inpatient physician and surgical services	\$50 per admission after deductible	\$60 per admission after deductible
Outpatient surgery facility fee	\$300 after deductible	\$350 after deductible
Outpatient surgery physician services	\$50 after deductible	\$60 after deductible
Emergency services	\$250 after deductible	\$350 after deductible
X-rays and diagnostic imaging	\$70 after deductible	\$75 after deductible
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$25 after deductible, \$45 after deductible, \$65 after deductible	\$20 after deductible, \$50 after deductible, \$80 after deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$50 after deductible, \$90 after deductible, \$130 after deductible	\$40 after deductible, \$100 after deductible, \$160 after deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$38 after deductible, \$68 after deductible, \$98 after deductible	\$30 after deductible, \$75 after deductible, \$120 after deductible
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$35 after deductible, \$55 after deductible, \$75 after deductible	\$30 after deductible, \$60 after deductible, \$90 after deductible

2026 Medical plan changes (continued)

YEAR	2025	2026
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$70 after deductible, \$110 after deductible, \$150 after deductible	\$60 after deductible, \$120 after deductible, \$180 after deductible
Plan name	KP DC Bronze 7000 Ded/HSA/Vision	KP DC Bronze 7100 Ded/HSA/Vision
Self-only deductible	\$7,000	\$7,100
Family deductible	\$7,000 individual / \$14,000 family	\$7,100 individual / \$14,200 family
Self-only out-of-pocket maximum	\$7,000	\$7,100
Family out-of-pocket maximum	\$7,000 individual / \$14,000 family	\$7,100 individual / \$14,200 family
Plan name	KP DC Bronze 6350 Ded/HSA/Vision	KP DC Bronze 6350 Ded/HSA/Vision
Self-only out-of-pocket maximum	\$7,200	\$7,300
Family out-of-pocket maximum	\$7,200 individual / \$14,400 family	\$7,300 individual / \$14,600 family

2026 Medical plan changes (continued)

DC POS plans

YEAR	2025	2026
Plan name	KP DC Platinum Added Choice 0 Ded/Vision	KP DC Platinum Added Choice 0 Ded/Vision
In-plan changes	The following changes apply	
Self-only out-of-pocket maximum	\$2,600	\$2,650
Family out-of-pocket maximum	\$2,600 individual / \$5,200 family	\$2,650 individual / \$5,300 family
Inpatient hospital services and skilled nursing facility care	\$150 per admission	\$200 per admission
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$5, \$25, \$50	\$10, \$45, \$65
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$10, \$50, \$100	\$20, \$90, \$130
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$8, \$38, \$75	\$15, \$68, \$98
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$15, \$35, \$60	\$20, \$55, \$75
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$30, \$70, \$120	\$40, \$110, \$150
Out-of-network changes	The following changes apply	
Self-only out-of-pocket maximum	\$5,200	\$5,300
Family out-of-pocket maximum	\$5,200 individual / \$10,400 family	\$5,300 individual / \$10,600 family
Inpatient hospital admission skilled nursing facility services	\$300 per admission after deductible	\$400 per admission after deductible
Prescription drugs		
Tier 1, Tier 2, Tier 3 (non-participating pharmacy) 30-day	\$15 after deductible, \$35 after deductible, \$60 after deductible	\$20 after deductible, \$55 after deductible, \$75 after deductible
Tier 1, Tier 2, Tier 3 (non-participating pharmacy) 90-day	\$30 after deductible, \$70 after deductible, \$120 after deductible	\$40 after deductible, \$110 after deductible, \$150 after deductible

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Platinum Added Choice 500 Ded/Vision	KP DC Platinum Added Choice 500 Ded/Vision
In-plan changes	The following changes apply	
Self-only out-of-pocket maximum	\$2,600	\$2,700
Family out-of-pocket maximum	\$2,600 individual / \$5,200 family	\$2,700 individual / \$5,400 family
Laboratory outpatient and professional services	\$10	\$20
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$5, \$40, \$60	\$10, \$45, \$65
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$10, \$80, \$120	\$20, \$90, \$130
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$8, \$60, \$90	\$15, \$68, \$98
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$15, \$50, \$70	\$20, \$55, \$75
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$30, \$100, \$140	\$40, \$110, \$150
Out-of-network changes	The following changes apply	
Self-only out-of-pocket maximum	\$5,200	\$5,400
Family out-of-pocket maximum	\$5,200 individual / \$10,400 family	\$5,400 individual / \$10,800 family
Tier 1, Tier 2, Tier 3 (non-participating pharmacy) 30-day supply	\$15 after deductible, \$35 after deductible, \$60 after deductible	\$20 after deductible, \$55 after deductible, \$75 after deductible
Tier 1, Tier 2, Tier 3 (non-participating pharmacy) 90-day supply	\$30 after deductible, \$70 after deductible, \$120 after deductible	\$40 after deductible, \$110 after deductible, \$150 after deductible
Plan name	KP DC Gold Added Choice 1000 Ded/300 RxDed	KP DC Gold Added Choice 1000 Ded/300 RxDed
In-plan changes	The following changes apply	
Self-only out-of-pocket maximum	\$6,750	\$7,200
Family out-of-pocket maximum	\$6,750 individual / \$13,500 family	\$7,200 individual / \$14,400 family
Emergency services	\$400 after deductible	\$500 after deductible

2026 Medical plan changes (continued)

YEAR	2025	2026
Prescription drugs		
Tier 1, Tier 2, Tier 3 (plan pharmacy and mail delivery) 30-day supply	\$10, \$60 after Rx deductible, \$100 after Rx deductible	\$15, \$50 after Rx deductible, \$65 after Rx deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy) 90-day supply	\$20, \$120 after Rx deductible, \$200 after Rx deductible	\$30, \$100 after Rx deductible, \$130 after Rx deductible
Tier 1, Tier 2, Tier 3 (plan pharmacy mail delivery) 90-day supply	\$15, \$90 after Rx deductible, \$150 after Rx deductible	\$23, \$75 after Rx deductible, \$98 after Rx deductible
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 30-day supply	\$20, \$70 after Rx deductible, \$110 after Rx deductible	\$25, \$60 after Rx deductible, \$75 after Rx deductible
Tier 1, Tier 2, Tier 3 (participating network pharmacy) 90-day supply	\$40, \$140 after Rx deductible, \$220 after Rx deductible	\$50, \$120 after Rx deductible, \$150 after Rx deductible
Out-of-network changes	The following changes apply	
Self-only out-of-pocket maximum	\$13,500	\$14,400
Family out-of-pocket maximum	\$13,500 individual / \$27,000 family	\$14,400 individual / \$28,800 family
Emergency services	\$400 after deductible	\$500 after deductible
Tier 1, Tier 2, Tier 3 (non-participating pharmacy) 30-day supply	\$20 after deductible, \$70 after deductible, \$110 after deductible	\$25 after deductible, \$60 after deductible, \$75 after deductible
Tier 1, Tier 2, Tier 3 (non-participating pharmacy) 90-day supply	\$40 after deductible, \$140 after deductible, \$220 after deductible	\$50 after deductible, \$120 after deductible, \$150 after deductible
Plan name	KP DC Silver Added Choice 2500 Ded/250 RxDed	KP DC Silver Added Choice 2500 Ded/500 RxDed
In-plan changes	The following changes apply	
Self-only out-of-pocket maximum	\$9,100	\$9,500
Family out-of-pocket maximum	\$9,100 individual / \$18,200 family	\$9,500 individual / \$19,000 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	\$500 per day not to exceed \$2,500 per admission after deductible
Inpatient physician and surgical services	\$80 per day not to exceed \$240 per admission after deductible	\$80 per day not to exceed \$400 per admission after deductible
Outpatient surgery physician services	\$100 after deductible	\$60 after deductible
Specialty care office visits, accidental dental, allergy evaluation and treatment, dialysis services, radiation therapy, chemotherapy, routine foot care, transplant dental services office visit, after-hours urgent care or urgent care center in service area, eye exam by an ophthalmologist, sleep studies	\$80	\$60

2026 Medical plan changes (continued)

YEAR	2025	2026
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$80 after deductible	\$60 after deductible
Laboratory outpatient and professional services	\$40	\$60
X-rays and diagnostic imaging	\$80	\$60
Prescription drugs		
Prescription drug deductible	\$250	\$500
Tier 1 (plan pharmacy and mail delivery) 30-day supply	\$20	\$25
Tier 1 (plan pharmacy) 90-day supply	\$40	\$50
Tier 1 (plan pharmacy mail delivery) 90-day supply	\$30	\$38
Tier 1 (participating network pharmacy) 30-day supply	\$30	\$35
Tier 1 (participating network pharmacy) 90-day supply	\$60	\$70
Out-of-network changes	The following changes apply	
Self-only out-of-pocket maximum	\$18,200	\$19,000
Family out-of-pocket maximum	\$18,200 individual / \$36,400 family	\$19,000 individual / \$38,000 family
Inpatient hospital admission skilled nursing facility services	\$600 per day not to exceed \$1,800 per admission after deductible	\$600 per day not to exceed \$3,000 per admission after deductible
Inpatient Hospital Physician services	\$80 per day not to exceed \$240 per admission after deductible	\$90 per day not to exceed \$450 per admission after deductible
Outpatient surgery physician services	\$120 after deductible	\$80 after deductible
Habilitative, therapy and rehabilitative services - outpatient physical, occupational or speech therapy	\$100 after deductible	\$80 after deductible
Prescription drugs		
Tier 1 (non-participating pharmacy) 30-day supply	\$30 after deductible	\$35 after deductible
Tier 1 (non-participating pharmacy) 90-day supply	\$60 after deductible	\$70 after deductible

2026 Medical plan changes (continued)

YEAR	2025	2026
Plan name	KP DC Bronze Added Choice 6500/55/POS/Vision	KP DC Bronze Added Choice 6500 Ded/Vision
In-plan changes	The following changes apply	
Self-only out-of-pocket maximum	\$9,100	\$10,000
Family out-of-pocket maximum	\$9,100 individual / \$18,200 family	\$10,000 individual / \$20,000 family
Inpatient hospital services and skilled nursing facility care	\$500 per day not to exceed \$1,500 per admission after deductible	40% after deductible
Inpatient physician and surgical services	\$80 per day not to exceed \$240 per admission after deductible	40% after deductible
Outpatient surgery facility fee	\$350 after deductible	\$400 after deductible
Outpatient surgery physician services	\$80 after deductible	\$60 after deductible
Emergency services	\$500 after deductible	40% after deductible
Laboratory outpatient and professional services	\$80 after deductible	\$60 after deductible
X-rays and diagnostic imaging	\$200 after deductible	\$100 after deductible
Blood, blood products and their administration, durable medical equipment, medical foods, TMJ appliances, prosthetic and orthotic devices,	No charge after deductible	40% after deductible
Diabetic equipment and supplies	No charge	20%
Peak flow meters	No charge	40%
Prescription drugs		
Tier 1, Tier 2 (plan pharmacy and mail delivery) 30-day supply	\$35, \$100 after deductible	\$30, \$65 after deductible
Tier 1, Tier 2 (plan pharmacy) 90-day supply	\$70, \$200 after deductible	\$60, \$130 after deductible
Tier 1, Tier 2 (plan pharmacy mail delivery) 90-day supply	\$53, \$150 after deductible	\$45, \$98 after deductible
Tier 1, Tier 2 (participating network pharmacy) 30-day supply	\$45, \$110 after deductible	\$40, \$75 after deductible
Tier 1, Tier 2 (participating network pharmacy) 90-day supply	\$90, \$220 after deductible	\$80, \$150 after deductible

2026 Medical plan changes (continued)

YEAR	2025	2026
Out-of-network changes	The following changes apply	
Self-only out-of-pocket maximum	\$18,200	\$20,000
Family out-of-pocket maximum	\$18,200 individual / \$36,400 family	\$20,000 individual / \$40,000 family
Inpatient hospital admission skilled nursing facility services	\$600 per day not to exceed \$1,800 per admission after deductible	50% after deductible
Inpatient hospital physician services	\$100 per day not to exceed \$300 per admission after deductible	50% after deductible
Outpatient surgery facility fee	\$450 after deductible	\$500 after deductible
Outpatient surgery physician services	\$100 after deductible	\$80 after deductible
Emergency services	\$500 after deductible	40% after deductible
Laboratory outpatient and professional services	\$100 after deductible	\$80 after deductible
X-rays and diagnostic imaging	\$250 after deductible	\$120 after deductible
Blood, blood products and their administration, durable medical equipment, medical foods, TMJ appliances, prosthetic and orthotic devices,	No charge after deductible	50% after deductible
Peak flow meters	40% after deductible	50% after deductible
Home ultraviolet (UV) light box	40% after deductible	50% after deductible
Home health care services, hospice care services	\$350 after deductible	\$400 after deductible
House calls	\$100 after deductible	\$80 after deductible
Annual screening mammogram and adjuvant breast cancer screening	40%	50%
Vision hardware - eyeglass lenses and frames and contact lenses	40% after deductible	50% after deductible
Prescription drugs		
Tier 1, Tier 2 (participating network pharmacy) 30-day supply	\$45 after deductible, \$110 after deductible	\$40 after deductible, \$75 after deductible
Tier 1, Tier 2 (participating network pharmacy) 90-day supply	\$90 after deductible, \$220 after deductible	\$80 after deductible, \$150 after deductible

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This notice is available at <https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/language-assistance/nondiscrimination-notice>

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆኑ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-777-7902** ይደውሉ (TTY: **711**)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-777-7902** (TTY: **711**).

Bàsòwò Wùdù (Bassa) Mbi sog: nia maa Bàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tson ni sonj, niij ma kénjèn yé, mbi èyem. Wò nàj **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, আপনি বিনামূল্যে, উপযুক্ত সহায়ক পরিষেবা ও সাহায্য সমেত ভাষা সহায়তা পরিষেবা পেতে পারেন। **1-800-777-7902** (TTY: **711**)-এ ফোন করুন।

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-777-7902** (TTY: **711**)。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenten mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-777-7902** an (TTY: **711**).

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો યોગ્ય સહાયક સહાય અને સેવાઓ સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. **1-800-777-7902** (TTY: **711**) પર કોલ કરો.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale kreyòl, w ap jwenn sèvis asistans lang tankou ed ak sèvis konplemantè adapte gratis. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएं मुफ्त उपलब्ध हैं। **1-800-777-7902** पर कॉल करें (TTY: **711**).

Igbo (Igbo) TINYE UCHE: O buru na i na-asu Igbo, Oru enyemaka nke asusu gunyere udi enyemaka na oru kwesiri ekwesị, n'efu, di nye gi. Kpọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE. Se parla italiano, può usufruire gratuitamente dei servizi di assistenza linguistica compresi gli opportuni aiuti e servizi ausiliari. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-777-7902** までお電話ください (TTY: **711**)。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-777-7902** 로 전화해 주세요 (TTY: **711**).

Naabeehó (Navajo) Díí BAA AKÓ NÍNÍZIN: Díí saad bee yánítí'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'l bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiiik'eh, éí ná hóló, koji' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, temos à sua disposição serviços gratuitos de assistência linguística, incluindo serviços e materiais de apoio adequados. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

أردو (Urdu) توجه: اگر آپ اردو بولتے ہیں تو آپ مفت زبان کی معاونت کی خدمات حاصل کر سکتے ہیں، جیسے مناسب معاون امداد اور خدمات۔ کال کریں **1-800-777-7902** (TTY: **711**)۔

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá n sọ èdè Yorùbá, àwọn isẹ̀ ìrànlọ́wọ̀ èdè tó fi kún àwọn ohun èlò ìrànlọ́wọ̀ tó yẹ àti àwọn isẹ̀ láísí idíyelé wà fún ọ. Pe **1-800-777-7902** (TTY: **711**).

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