KAISER PERMANENTE®

Group: REED COLLEGE #1780
Region: Northwest
Contract Period: 01/01/2026 to 12/31/2026
Summary of Benefits

DUAL CHOICE PPO PLAN D 1000/25/20%/5000

Accumulation Details

The accumulation period is calendar year, and the accumulation type is Embedded.

Deductible(s) and Out-of-Pocket Maximum(s) Details

Cost Share amounts that count toward the Deductible are shown below. The In-Network Deductible and the Out-of-Network Deductible do not cross accumulate. This means that the amounts you pay for covered services received from In-Network Providers only count toward the In-Network Deductible, and the amounts you pay for covered services received from Out-of-Network Providers only count toward the Out-of-Network Deductible.

For services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Deductible(s)	**In-Network Providers**	**Out-of-Network Providers**[1]
Self-only Deductible per year (for a Family of one Member)	$1000	$3000
Individual Family Member Deductible per year (for each Member in a Family of two or more Members)	$1000	$3000
Family Deductible per year (for an entire Family)	$3000	$9000

Out-of-Pocket Maximum(s)[2]	**In-Network Providers**	**Out-of-Network Providers**
Self-only Out-of-Pocket Maximum per year (for a Family of one Member)	$5000	$9000
Individual Family Member Out-of-Pocket Maximum per year (for each Member in a Family of two or more Members)	$5000	$9000
Family Out-of-Pocket Maximum per year (for an entire Family)	$15000	$27000

Professional Services[3]	**In-Network Providers**	**Out-of-Network Providers**
Primary care office visit[4]	$5 for first 3 visits, then $45 for additional visits in the same year Enhanced Benefit: $5 for first 3 visits, then $25 for additional visits in the same year	40% Coinsurance After Deductible
Specialty care office visit	$55 per visit Enhanced Benefit: $35 per visit	40% Coinsurance After Deductible
Telehealth[4]	$0	40% Coinsurance After Deductible
Routine physical maintenance exams, including well-woman exams	No Charge	40% Coinsurance After Deductible
Well-child preventive exams (through age 23 months)	No Charge	40% Coinsurance After Deductible
Physical, occupational, and speech therapy	$55 (20 visits per therapy per year across provider networks) Enhanced Benefit: $35 (20 visits per therapy per year across provider networks)	40% Coinsurance After Deductible (20 visits per therapy per year across provider networks)

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Outpatient Services	In-Network Providers	Out-of-Network Providers
Outpatient surgery visits and certain other outpatient procedures	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Diagnostic X-rays	$25 per department visit	40% Coinsurance After Deductible
Laboratory services	$25 per department visit	40% Coinsurance After Deductible
Preventive X-rays, screenings, and laboratory tests	No Charge	40% Coinsurance After Deductible
Advanced imaging (CT / MRI / PET)	$100 per department visit	40% Coinsurance After Deductible
Chemotherapy/radiation therapy visit	$35 per visit After Deductible	40% Coinsurance After Deductible

Medication Coverage	In-Network Providers	Out-of-Network Providers
Retail Pharmacy (up to 30-day supply)	Kaiser Permanente Pharmacy: Generic: $20 Brand: $40 Non Preferred: $60 Specialty: $250 MedImpact Pharmacy: Generic: $30 Brand: $60 Non Preferred: $90 Specialty: 30%	Not Covered
Mail order prescriptions (up to 90-day supply)	Kaiser Permanente Pharmacy: Two copayments at retail cost share MedImpact Pharmacy/ CVS Caremark: Three copayments at retail cost share.	Not Covered
Administered medications, including injections (all outpatient settings)	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Allergy injections (including allergy serum)	$10 per visit	40% Coinsurance After Deductible
Immunizations	No Charge	No Charge

Maternity Care	In-Network Providers	Out-of-Network Providers
Scheduled prenatal care exams and postpartum visit	No Charge	40% Coinsurance After Deductible
Laboratory	$25 per department visit	40% Coinsurance After Deductible
X-Ray, imaging, and special diagnostic procedures	$25 per department visit	40% Coinsurance After Deductible
Labor and Delivery Hospital Services	20% Coinsurance After Deductible	40% Coinsurance After Deductible

Durable Medical Equipment (DME)	In-Network Providers	Out-of-Network Providers
Durable medical equipment	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Prosthetic and orthotic devices	20% Coinsurance After Deductible	40% Coinsurance After Deductible

Mental Health Services	In-Network Providers	Out-of-Network Providers
Inpatient psychiatric care	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Outpatient individual therapy visits[4]	$5 for first 3 visits, then $45 for additional visits in the same year Enhanced Benefit: $5 for first 3 visits, then $25 for additional visits in the same year	40% Coinsurance After Deductible

Substance Use Disorder Treatment	In-Network Providers	Out-of-Network Providers
Inpatient detoxification	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Outpatient individual therapy visits[4]	$5 for first 3 visits, then $45 for additional visits in the same year Enhanced Benefit: $5 for first 3 visits, then $25 for additional visits in the same year	40% Coinsurance After Deductible

Home Health Services	In-Network Providers	Out-of-Network Providers
Home health care	20% Coinsurance After Deductible (up to 130 visits per year across provider networks)	40% Coinsurance After Deductible (up to 130 visits per year across provider networks)

Alternative Care	In-Network Providers	Out-of-Network Providers
Benefit maximum	Not Applicable	Not Applicable
Acupuncture care	$25 up to 12 visits per calendar year across provider networks	40% Coinsurance up to 12 visits per calendar year across provider networks
Chiropractic care	$25 up to 20 visits per calendar year across provider networks	40% Coinsurance up to 20 visits per calendar year across provider networks
Massage therapy	$25 up to 12 visits per calendar year across provider networks	40% coinsurance up to 12 visits per calendar year across provider networks
Naturopathic medicine[4]	$5 for first 3 visits, then $25 for additional visits in the same year	40% Coinsurance After Deductible

Other Professional Services	In-Network Providers	Out-of-Network Providers
Skilled nursing facility	20% Coinsurance After Deductible (up to 100 days per year across provider networks)	40% Coinsurance After Deductible (up to 100 days per year across provider networks)
Hospice care	No Charge	No Charge
Fertility diagnosis	50% Coinsurance After Deductible	50% Coinsurance After Deductible
Fertility lab	50% Coinsurance After Deductible	50% Coinsurance After Deductible
Fertility treatment	50% Coinsurance	Treatment Not Covered
Bariatric care	Covered	Not Covered
Adult hearing aid(s)	Not Covered	Not Covered
Pediatric hearing aid(s)	20% Coinsurance (1 per Ear / 36 months across provider networks)	40% Coinsurance (1 per Ear / 36 months across provider networks)

Vision Services	In-Network Providers	Out-of-Network Providers
Pediatric Vision exam	$25 per visit	40% Coinsurance After Deductible
Adult Vision exam	$45 per visit Enhanced Benefit: $25 per visit	40% Coinsurance After Deductible
Pediatric optical eyewear	Not Covered	Not Covered
Adult optical eyewear	Not Covered	Not Covered

1. Out-of-Network Providers may bill you for any charges in excess of the Allowed Amount (balance billing).
2. Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.
3. You pay the lowest Cost Share when you receive certain covered Services from a designated group of In-Network Providers. This is called "Enhanced Benefits." Enhanced Benefits are shown in this summary. In-Network Providers who offer Enhanced Benefits are identified with an asterisk (*) in the provider directory. Visit **kp.org/choiceproducts/nw** for a searchable provider directory.
4. First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services from all contracted providers combined.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample Evidence of Coverages are available upon request or you may go to http://www.kp.org/plandocuments

Questions? Call Customer Service: 1-866-616-0047 (M-F, 8 am-6 pm) or visit **kp.org.**
All areas: 1-800-813-2000. TTY: 711. Language Interpretation Services, all areas: 1-800-324-8010.

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This is not a contract. This condensed summary of benefits does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your Evidence of Coverage or call Customer Service. In the case of a conflict between this summary and the Evidence of Coverage, the Evidence of Coverage will prevail.