KAISER PERMANENTE®

Group: ANYWHEREWORKS, INC. #4040
Region: Northwest
Contract Period: 01/01/2026 to 12/31/2026
Summary of Benefits

DED PLAN F 2000/25/20%/5500

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.

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)	**Participating Providers**
Self-only Deductible per year (for a Family of one Member)	$2000
Individual Family Member Deductible per year (for each Member in a Family of two or more Members)	$2000
Family Deductible per year (for an entire Family)	$6000

Out-of-Pocket Maximum(s)[1]	**Participating Providers**
Self-only Out-of-Pocket Maximum per year (for a Family of one Member)	$5500
Individual Family Member Out-of-Pocket Maximum per year (for each Member in a Family of two or more Members)	$5500
Family Out-of-Pocket Maximum per year (for an entire Family)	$11000

Professional Services	**Participating Providers**
Primary care office visit[2]	$5 for first 3 visits, then $25 for additional visits in the same year
Specialty care office visit	$35 per visit
Telehealth[2]	$0
Routine physical maintenance exams, including well-woman exams	No Charge
Well-child preventive exams (through age 23 months)	No Charge
Physical, occupational, and speech therapy	$35 (20 visits per therapy per year)

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

Hospitalization and Emergency Services	Participating Providers
Urgent care	$45 per visit
Hospital room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance After Deductible
Ambulance services	20% Coinsurance After Deductible
Emergency department visits	20% Coinsurance After Deductible

Medication Coverage	Participating Providers
Retail Pharmacy (up to 30-day supply)	Kaiser Permanente Pharmacy: Generic: $15 Brand: $30 Non Preferred: $50
Mail order prescriptions (up to 90-day supply)	Kaiser Permanente Pharmacy: Two copayments at retail cost share
Administered medications, including injections (all outpatient settings)	20% Coinsurance After Deductible
Allergy injections (including allergy serum)	$10 per visit
Immunizations	No Charge

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

Durable Medical Equipment (DME)	Participating Providers
Durable medical equipment	20% Coinsurance After Deductible
Prosthetic and orthotic devices	20% Coinsurance After Deductible

Mental Health Services	Participating Providers
Inpatient psychiatric care	20% Coinsurance After Deductible
Outpatient individual therapy visits[2]	$5 for first 3 visits, then $25 for additional visits in the same year

Substance Use Disorder Treatment	Participating Providers
Inpatient detoxification	20% Coinsurance After Deductible
Outpatient individual therapy visits[2]	$5 for first 3 visits, then $25 for additional visits in the same year

Home Health Services	Participating Providers
Home health care	20% Coinsurance After Deductible (up to 130 visits per Year)

Alternative Care	Participating Providers
Benefit maximum	Not Applicable
Acupuncture care	Not Covered
Chiropractic care	Not Covered
Massage therapy	Not Covered
Naturopathic medicine[2]	$5 for first 3 visits, then $25 for additional visits in the same year

Other Professional Services	Participating Providers
Skilled nursing facility	20% Coinsurance After Deductible (up to 100 days per Year)
Hospice care	No Charge

Other Professional Services	Participating Providers
Fertility diagnosis	50% Coinsurance After Deductible
Fertility lab	50% Coinsurance After Deductible
Fertility treatment	Treatment Not Covered
Bariatric care	Covered
Adult hearing aid(s)	Not Covered
Pediatric hearing aid(s)	20% Coinsurance (1 per Ear / 36 Months)

Vision Services	Participating Providers
Pediatric Vision exam	$0 per visit
Adult Vision exam	$25 per visit
Pediatric optical eyewear	One Pair / 1 Calendar Year
Adult optical eyewear	$100 Allowance / 2 Calendar Years

1. Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.
2. 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 kp.org/plandocuments.

Questions? Call Member Services (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.

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 ad-judication procedures, please see your Evidence of Coverage or call Member Services. In the case of a conflict between this summary and the Evidence of Coverage, the Evidence of Coverage will prevail.

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