KAISER PERMANENTE®

Group Name: Sunstone Circuits, LLC #29038
Region: Northwest
Contract Period: 01/01/2026 to 12/31/2026
Summary of Benefits

DUAL CHOICE PPO HDHP PLAN E 3400/10%/6000

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)	$3400	$5000
Individual Family Member Deductible per year (for each Member in a Family of two or more Members)	$3400	$5000
Family Deductible per year (for an entire Family)	$6800	$15000

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)	$6000	$15000
Individual Family Member Out-of-Pocket Maximum per year (for each Member in a Family of two or more Members)	$6000	$15000
Family Out-of-Pocket Maximum per year (for an entire Family)	$9000	$30000

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Professional Services*	In-Network Providers	Out-of-Network Providers
Primary care office visit[3]	$5 After Deductible for first 3 visits, then 20% After Deductible for additional visits in the same year Enhanced Benefit: $5 After Deductible for first 3 visits, then 10% After Deductible for additional visits in the same year	30% Coinsurance After Deductible
Specialty care office visit	20% Coinsurance After Deductible Enhanced Benefit: 10% Coinsurance After Deductible	30% Coinsurance After Deductible
Telehealth[3]	0% After Deductible for first 3 visits, then 0% After Deductible for additional visits in the same year	30% Coinsurance After Deductible
Routine physical maintenance exams, including well-woman exams	No Charge	30% Coinsurance After Deductible
Well-child preventive exams (through age 23 months)	No Charge	30% Coinsurance After Deductible
Physical, occupational, and speech therapy	20% Coinsurance After Deductible (20 visits per therapy per year across provider networks) Enhanced Benefit: 10% Coinsurance After Deductible (20 visits per therapy per year across provider networks)	30% Coinsurance After Deductible (20 visits per therapy per year across provider networks)

Outpatient Services	In-Network Providers	Out-of-Network Providers
Outpatient surgery visits and certain other outpatient procedures	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Diagnostic X-rays	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Laboratory services	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Preventive X-rays, screenings, and laboratory tests	No Charge	30% Coinsurance After Deductible
Advanced imaging (CT / MRI / PET)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Chemotherapy/radiation therapy visit	10% Coinsurance After Deductible	30% Coinsurance After Deductible

Medication Coverage	In-Network Providers	Out-of-Network Providers
Retail Pharmacy (up to a 30-day supply)	Kaiser Permanente Pharmacy: Generic: $15 Aft Ded Brand: $30 Aft Ded Non Preferred: $50 Aft Ded Specialty: $250 Aft Ded MedImpact Pharmacy: Generic: $25 Aft Ded Brand: $50 Aft Ded Non Preferred: $80 Aft Ded Specialty: 30% Aft Ded	Not Covered

Medication Coverage	In-Network Providers	Out-of-Network Providers
Mail order prescriptions (up to a 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)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Allergy injections	10% Coinsurance After Deductible	30% 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	30% Coinsurance After Deductible
Laboratory	10% Coinsurance After Deductible	30% Coinsurance After Deductible
X-Ray, imaging, and special diagnostic procedures	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Labor and Delivery Hospital Services	10% Coinsurance After Deductible	30% Coinsurance After Deductible

Hospitalization and Emergency Services	In-Network Providers	Out-of-Network Providers
Urgent care	20% Coinsurance After Deductible Enhanced Benefit: 10% Coinsurance After Deductible	30% Coinsurance After Deductible
Hospital room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Ambulance services (emergency transport)	10% Coinsurance After Deductible	Covered at the In-Network Providers cost share
Emergency department visits	10% Coinsurance After Deductible	Covered at the In-Network Providers cost share

Durable Medical Equipment (DME)	In-Network Providers	Out-of-Network Providers
Durable medical equipment	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Prosthetic and orthotic devices	20% Coinsurance After Deductible	30% Coinsurance After Deductible

Mental Health Services	In-Network Providers	Out-of-Network Providers
Inpatient psychiatric care	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Outpatient individual therapy visits[3]	$5 After Deductible for first 3 visits, then 20% After Deductible for additional visits in the same year Enhanced Benefit: $5 After Deductible for first 3 visits, then 10% After Deductible for additional visits in the same year	30% Coinsurance After Deductible

Substance Use Disorder Treatment	In-Network Providers	Out-of-Network Providers
Inpatient detoxification	10% Coinsurance After Deductible	30% Coinsurance After Deductible

Substance Use Disorder Treatment	In-Network Providers	Out-of-Network Providers
Outpatient individual therapy visits[3]	$5 After Deductible for first 3 visits, then 20% After Deductible for additional visits in the same year Enhanced Benefit: $5 After Deductible for first 3 visits, then 10% After Deductible for additional visits in the same year	30% Coinsurance After Deductible

Home Health Services	In-Network Providers	Out-of-Network Providers
Home health care	10% Coinsurance After Deductible (up to 130 visits per year across provider networks)	30% 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 after deductible up to 12 visits per calendar year across provider networks	40% after deductible up to 12 visits per calendar year across provider networks
Chiropractic care	$25 after deductible up to 20 visits per calendar year across provider networks	40% Coinsurance after deductible up to 20 visits per calendar year across provider networks
Massage therapy	$25 after deductible up to 12 visits per calendar year across provider networks	40% coinsurance after deductible up to 12 visits per calendar year across provider networks
Naturopathic medicine[3]	$5 After Deductible for first 3 visits, then 10% After Deductible for additional visits in the same year	30% Coinsurance After Deductible

Other Professional Services	In-Network Providers	Out-of-Network Providers
Skilled nursing facility	10% Coinsurance After Deductible (up to 100 days per year across provider networks)	30% Coinsurance After Deductible (up to 100 days per year across provider networks)
Hospice care	0% Coinsurance After Deductible	0% Coinsurance After Deductible
Fertility diagnosis	50% Coinsurance After Deductible	50% Coinsurance After Deductible
Fertility lab	50% Coinsurance After Deductible	50% Coinsurance After Deductible
Fertility treatment	Treatment Not Covered	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)	30% Coinsurance After Deductible (1 per Ear / 36 months across provider networks)

Vision Services	In-Network Providers	Out-of-Network Providers
Pediatric Vision exam	10% Coinsurance After Deductible	30% Coinsurance After Deductible

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Vision Services	In-Network Providers	Out-of-Network Providers
Adult Vision exam	20% Coinsurance After Deductible Enhanced Benefit: 10% Coinsurance After Deductible	30% 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. 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.

* 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.

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.

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.