KAISER PERMANENTE®

California Association of REALTORS®

2021 January - December Kaiser Permanente Medical Plans Benefit Summary

RealCare INSURANCE MARKETING INC

Benefits shown are for Kaiser Permanente Providers ONLY.

Benefit Description	Bronze 60 HMO 5400/60	Bronze 60 HMO 6300/65	Bronze 60 HDHP HMO 7000/0% HSA Compatible Plan	Silver 70 HMO 1650/55	Silver 70 HMO 2100/55	Silver 70 HMO 2250/55	Silver 70 HMO 2600/55	Silver 70 HDHP HMO 2500/20% HSA Compatible Plan
Annual Calendar Year Deductible (embedded)	Individual: $5,400(10) Family: $10,800(10)	Individual: $6,300(10) Family: $12,600(10)	Individual: $7,000(10) Family: $14,000(10)	Individual: $1,650(10) Family: $3,300(10)	Individual : $2,100(10) Family: $4,200(10)	Individual: $2,250(10) Family: $4,500(10)	Individual: $2,600(10) Family: $5,200(10)	Self only coverage: $2,500(10,32) Individual within family: $2,800(10,32) Family: $5,000(10,32)
Pharmacy Annual Deductible	Combined with medical deductible **(Brand/Specialty only)**	$500 per individual	Combined with medical deductible	$350 per individual **(Brand/Specialty only)**	$500 per individual **(Brand/Specialty only)**	$300 per individual **(Brand/Specialty only)**	Combined with medical deductible **(Brand/Specialty only)**	Combined with medical deductible
Annual Calendar Year Out-of-Pocket Maximum (embedded)	Individual: $8,200(1,10) Family: $16,400(1,10)	Individual: $8,200(1,10) Family: $16,400(1,10)	Individual: $7,000(10,29) Family: $14,000(10,29)	Individual: $8,200(1,10) Family: $16,400(1,10)	Individual: $8,200(1,10) Family: $16,400(1,10)	Individual: $8,200(1,10) Family: $16,400(1,10)	Individual: $8,200(1,10) Family: $16,400(1,10)	Individual: $6,850(10,29) Family: $13,700(10,29)
	Amounts Listed Are Member Payments							
Office Visits (Primary/Specialist)	$60/$80 after deductible(2)	$65/$95 after deductible(2)	$0/$0 after deductible	$55/$80	$55/$80	$55/$90	$55/$80	20%/20% after deductible
Preventive Exams	$0(12)	$0(12)	$0(12)	$0(12)	$0(12)	$0(12)	$0(12)	$0(12)
Pre-Natal Care	$0(3)	$0(3)	$0(4)	$0(3)	$0(3)	$0(3)	$0(3)	$0(4)
Postpartum Care	$0(3)	$0(3)	$0 after deductible(16)	$0(3)	$0(3)	$0(3)	$0(3)	$0 after deductible(16)
X-Ray and Lab **Most lab tests** **Most X-Rays and diagnostic** **Most MRI/CT/PET Scan**	 $30 after deductible 50% after deductible 50% after deductible	 $40 40% after deductible 40% after deductible	 $0 after deductible $0 after deductible $0 after deductible	 $30 $75 $350 after deductible	 $30 $75 $350 after deductible	 $55 $90 $300 after deductible	 $30 after deductible $75 after deductible $350 after deductible	 20% after deductible 20% after deductible 20% after deductible
Inpatient Hospitalization	50% after deductible	40% after deductible	$0 after deductible	40% after deductible	45% after deductible	30% after deductible	45% after deductible	20% after deductible
Outpatient Surgery (per procedure)	50% after deductible	40% after deductible	$0 after deductible	40% after deductible	45% after deductible	30% after deductible	45% after deductible	20% after deductible
Ambulance Services	50% after deductible	40% after deductible	$0 after deductible	40% after deductible	45% after deductible	30% after deductible	45% after deductible	20% after deductible
Emergency Room (not resulting in direct hospital admission)	50% after deductible	40% after deductible	$0 after deductible	40% after deductible	45% after deductible	30% after deductible	45% after deductible	20% after deductible
Prescription Drugs	Up to 30 day supply	Up to 30 day supply	Up to 30 Day Supply	Up to 30 Day Supply	Up to 30 Day Supply	Up to 30 Day Supply	Up to 30 Day Supply	Up to 30 Day Supply
Generic	$20(24)	$18 (after $500 drug deduct.)(24)	$0 per prescription after medical deductible(24)	$20(24)	$20(24)	$17(24)	$20(24)	20% per prescription up to a $250 maximum after medical deductible(24)
Brand Name	50% per prescription up to $500 maximum (after plan deductible) (24)	40% per prescription up to $500 maximum (after $500 drug deductible) (24)	$0 per prescription after medical deductible(24)	$75 after $350 drug deductible(24)	$75 after $500 drug deductible(24)	$80 after $300 drug deductible(24)	$75 after plan deductible(24)	20% per prescription up to a $250 maximum after medical deductible(24)
Specialty	50% per prescription up to $500 maximum (after plan deductible) (24)	40% per prescription up to $500 maximum (after $500 drug deductible) (24)	0% per prescription after medical deductible(24)	20% per prescription up to $250 maximum (after $350 drug deductible)(24)	20% per prescription up to $250 maximum (after $500 drug deductible)(24)	30% per prescription up to $250 maximum (after $300 drug deductible) (24)	45% per prescription up to $250 maximum (after plan deductible) (24)	20% per prescription up to a $250 maximum after medical deductible(24)
Certain Durable Medical Equipment (DME)	50% after deductible(5, 6) (supplemental & base)	40% after deductible(5, 6) (supplemental & base)	$0 after deductible(5, 6) (supplemental & base)	40% (5, 6, 27) (supplemental & base)	45% (5, 6, 27) (supplemental & base)	30% (5, 6, 27) (supplemental & base)	45% (5, 6, 27) (supplemental & base)	20% after deductible (5, 6) (supplemental & base)
Adult Vision Exam for Refraction	$0	$0	$0	$0	$0	$0	$0	$0
Adult Optical Eye Wear	Not Covered (8)	Not Covered (8)	Not Covered(8)	Not Covered(8)	Not Covered(8)	Not Covered(8)	Not Covered(8)	Not Covered(8)

Benefit Disclaimer Notification! We do not guarantee or warrant the correctness or completeness of the benefit information contained herein and shall not be liable for any loss or damage arising out of use of the quoted benefit information. Additionally, information contained in this report is limited in scope, subject to change without notice, and does not contain all the terms, conditions, limitations, or exclusions of the referenced benefit plans. Only the insurance company Plan Documents and Policies contain the exact terms and conditions of coverage. This report may not be relied upon as a guarantee of your eligibility for coverage under these benefit plans. Benefits valid for plan year 1/1/21 to 12/31/21. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.RealCareCAR.com

The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the Evidence of Coverage or Certificate of Insurance.

Kaiser Permanente is not available in all areas. Please check Kaiser Permanente's Medical rating regions to determine whether you qualify.

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Benefit Description	Gold 80 HMO 0/30	Gold 80 HMO 250/35	Gold 80 HMO 1000/40	Gold 80 HRA-HMO 2250/35	Platinum 90 HMO 0/10	Platinum 90 HMO 0/20
Annual Calendar Year Deductible (Embedded)	$0	Individual: $250(10) Family: $500(10)	Individual: $1,000(10) Family: $2,000(10)	Individual: $2,250(10) Family: $4,500(10)	$0	$0
Pharmacy Annual Deductible	$0	$0	$250 per individual **(Brand/Specialty only)**	$100 per individual **(Brand/Specialty only)**	$0	$0
Annual Calendar Year Out-of-Pocket Maximum (Embedded)	Individual: $7,000(1,28) Family: $14,000(1,28)	Individual: $7,800(1,10) Family: $15,600(1,10)	Individual: $7,800(1,10) Family: $15,600(1,10)	Individual: $7,800(1,10) Family: $15,600(1,10)	Individual: $3,000(1,28) Family: $6,000(1,28)	Individual: $4,500(1,28) Family: $9,000(1,28)
	Amounts Listed Are Member Payments					
Office Visits (Primary/Specialist)	$30/$35	$35/$55	$40/$60	$35/$50	$10/$20	$20/$30
Preventive Exams	$0(12)	$0(12)	$0(12)	$0(12)	$0(12)	$0(12)
Pre-Natal Care	$0(3)	$0(3)	$0(3)	$0(3)	$0(3)	$0(3)
Postpartum Care	$0(3)	$0(3)	$0(3)	$0(3)	$0(3)	$0(3)
X-Ray and Lab **Most lab tests** **Most X-Rays and diagnostic** **Most MRI/CT/PET Scan**	 $30 $40 $250	 $35 $55 $250 after deductible	 $30 $60 $350 after deductible	 25% after deductible 25% after deductible 25% after deductible	 $20 $40 $150	 $20 $30 $100
Inpatient Hospitalization	$600/day up to 5 days per admission(26)	$600/day up to 5 days per admission after deductible(26)	$600/day up to 5 days per admission after deductible(26)	25% after deductible	$500 per admission	$250 per day up to 5 days per admission(26)
Outpatient Surgery (Per procedure)	$320	$335 after deductible	$350	25% after deductible	$300	$125
Ambulance Services	$250	$250 after deductible	$350	25% after deductible	$150	$150
Emergency Room (not resulting in direct hospital admission)	$250 (waived if admitted directly to hospital)	$250 after deductible (waived if admitted directly to hospital)	$350 (waived if admitted directly to hospital)	25% after deductible	$200 (waived it admitted directly to hospital)	$150 (waived if admitted directly to hospital)
Prescription Drugs	Up to 30 Day Supply	Up to 30 day supply	Up to 30 Day Supply	Up to 30 Day Supply	Up to 30 day Supply	Up to 30 Day Supply
Generic	$15(24)	$15(24)	$20(24)	$15(24)	$5(24)	$5(24)
Brand Name	$40(24)	$40(24)	$50 after $250 drug deductible(24)	$30 after $100 drug deductible(24)	$15(24)	$20(24)
Specialty	20% per prescription up to $250 maximum(24)	20% per prescription up to $250 maximum(24)	20% per prescription up to $250 maximum after $250 drug deductible(24)	20% per prescription up to $250 maximum after $100 drug deductible(24)	10% per prescription up to $250 maximum(24)	10% per prescription up to $250 maximum(24)
Certain Durable Medical Equipment (DME)	20% (5, 6) (supplemental & base)	20% (5, 6, 27) (supplemental & base)	20% (5, 6, 27) (supplemental & base)	50% (5, 6, 27) (supplemental & base)	10% (5, 6) (supplemental and base)	10% (5, 6) (supplemental and base)
Adult Vision Exam for Refraction	$0	$0	$0	$0	$0	$0
Adult Optical Eye Wear	Not Covered(8)	Not Covered(8)	Not Covered(8)	Not Covered(8)	$175 allowance (31)	Not Covered(8)

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LUD 10-14-19

Kaiser Plan Comparison Footnotes

Cost-share amounts for all in-network services accumulate toward the out of pocket maximum.

Only footnotes pertaining to the plans displayed in this comparison are shown.

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Preventive services are available at no cost share except for services from non-participating providers. For a complete list of preventive services, please refer to the Evidence of Coverage, Certificate of Insurance, at ***www.RealCareCAR.com/notices.***

Kaiser Permanente plans do not include a pre-existing condition clause.

1. Out of pocket maximum is the maximum amount an individual or family will pay for certain services in a year.
2. Deductible is waived for first three visits combined for non-preventive primary care, specialty care, other practitioner care, urgent care, and individual mental/behavioral health and substance use disorder outpatient services.
3. Scheduled prenatal visits and the first postpartum visit.
4. Scheduled prenatal visits
5. Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of $2,000 per year for services.
6. Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit.
8. Kaiser Permanente members are entitled to a discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts can't be combined with any other Health Plan vision benefit. The discounts won't apply to any sale, promotion, or packaged eyewear program, for any contact lenses extended purchase agreement or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.
10. This plan has an embedded deductible and out of pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual deductible or out of pocket maximum (depending on the benefit), or when the family deductible or out of pocket maximum is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out of pocket maximum, or when the family out of pocket maximum is met.
12. Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
16. First postpartum visit only covered at no charge.
24. Prescription drugs are covered in accordance with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copays. For information on our formulary, including the drugs on the specialty tier, go to **kp.org/formulary** or call our Member Service Contact Center.
26. After the 5 days, additional days for the same admission are covered at no charge.
27. Supplemental coverage: $2,000 benefit limit per year (after deductible).
28. This plan has an embedded out of pocket maximum. Individual family members aren't subject to cost sharing when they reach their individual out of pocket maximum, or when the family out of pocket maximum is met.
29. Out-of-pocket maximum is the maximum amount an individual or family will pay for all covered services in a year.
31. Allowance toward the cost of eyeglass lenses, frames, and contract lenses fitting and dispensing every 24 months.
32. **Self-only**: a family of 1 member; **Individual**: each member in a family of 2 or more members; **Family**: entire family of 2 or more members.