

California Association of REALTORS®



2023 January - December Kaiser Permanente Medical Plans Benefit Summary



Benefits shown are for Kaiser Permanente Providers ONLY.

Benefit Description	Bronze 60 HDHP HMO 7000/0	Silver 70 HDHP HMO 2700/25%	Gold 80 HDHP HMO 1600/15%
	HSA Compatible Plan	HSA Compatible Plan	HSA Compatible Plan
Annual Calendar Year Deductible (embedded)	Individual: \$7,000 ⁽¹⁾ Family: \$14,000 ⁽¹⁾	Self only coverage: \$2,700 ^(1,1c) Individual within family: \$3,000 ^(1,1c) Family: \$5,400 ^(1,1c)	Self only coverage: \$1,600 ^(1,1c) Individual within family: \$3,000 ^(1,1c) Family: \$3,200 ^(1,1c)
Pharmacy Annual Deductible	Combined with medical deductible	Combined with medical deductible	Combined with medical deductible
Annual Calendar Year Out-of-Pocket Maximum (embedded)	Individual: \$7,000 ^(1,2) Family: \$14,000 ^(1,2)	Individual: \$7,200 ^(1,2) Family: \$14,400 ^(1,2)	Individual: \$3,550 ^(1,2) Family: \$7,100 ^(1,2)
Amounts Listed are Member Payments			
Office Visits (Primary/Specialist)	\$0/\$0 after deductible	25%/25% after deductible	15%/15% after deductible
Televisits	\$0 after deductible ⁽⁹⁾	\$0 after deductible ⁽⁹⁾	\$0 after deductible ⁽⁹⁾
Preventive Exams	\$0 ⁽³⁾	\$0 ⁽³⁾	\$0 ⁽³⁾
Pre-Natal Care	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾
Postpartum Care	\$0 after deductible ⁽⁵⁾	\$0 after deductible ⁽⁵⁾	\$0 after deductible ⁽⁵⁾
Well-Child Preventive Care Visits	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾
X-Ray and Lab			
Most lab tests	\$0 after deductible	25% after deductible	15% after deductible
Most X-Rays and diagnostic	\$0 after deductible	25% after deductible	15% after deductible
Most MRI/CT/PET Scan	\$0 after deductible	25% after deductible	15% after deductible
Inpatient Hospitalization	\$0 after deductible	25% after deductible	15% after deductible
Outpatient Surgery (per procedure)	\$0 after deductible	25% after deductible	15% after deductible
Ambulance Services	\$0 after deductible	25% after deductible	15% after deductible
Emergency Room (not resulting in direct hospital admission)	\$0 after deductible	25% after deductible	15% after deductible
Prescription Drugs	Up to 30 Day Supply	Up to 30 Day Supply	Up to 30 Day Supply
Generic	\$0 per prescription after medical deductible ⁽⁸⁾	25% per prescription up to a \$250 maximum after medical deductible ⁽⁸⁾	\$15 after deductible ⁽⁸⁾
Brand Name	\$0 per prescription after medical deductible ⁽⁸⁾	25% per prescription up to a \$250 maximum after medical deductible ⁽⁸⁾	\$45 after deductible ⁽⁸⁾
Specialty	\$0 per prescription after medical deductible ⁽⁸⁾	25% per prescription up to a \$250 maximum after medical deductible ⁽⁸⁾	15% per prescription up to \$250 maximum (after deductible) ⁽⁸⁾
Certain Durable Medical Equipment (DME)	\$0 after deductible ⁽¹⁰⁾ (supplemental & base)	25% after deductible ⁽¹⁰⁾ (supplemental & base)	15% after deductible ⁽¹⁰⁾ (supplemental & base)
Adult Vision Exam for Refraction	\$0	\$0	\$0
Adult Optical Eye Wear	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾

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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.

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Annual Calendar Year Deductible (embedded)	Individual: \$5,400 ⁽¹⁾ Family: \$10,800 ⁽¹⁾	Individual: \$6,300 ⁽¹⁾ Family: \$12,600 ⁽¹⁾	Individual: \$2,800 ⁽¹⁾ Family: \$5,600 ⁽¹⁾	Individual : \$2,300 ⁽¹⁾ Family: \$4,600 ⁽¹⁾	Individual: \$2,500 ⁽¹⁾ Family: \$5,000 ⁽¹⁾	Individual: \$1,900 ⁽¹⁾ Family: \$3,800 ⁽¹⁾
Pharmacy Annual Deductible	Combined with medical deductible (Brand/Specialty only)	\$500 per individual	Combined with medical deductible (Brand/Specialty only)	\$500 per individual (Brand/Specialty only)	\$370 per individual (Brand/Specialty only)	Combined with medical deductible (Specialty only)
Annual Calendar Year Out-of-Pocket Maximum (embedded)	Individual: \$8,300 ^(1,2a) Family: \$16,600 ^(1,2a)	Individual: \$8,600 ^(1,2a) Family: \$17,200 ^(1,2a)	Individual: \$8,750 ^(1,2a) Family: \$17,500 ^(1,2a)	Individual: \$8,750 ^(1,2a) Family: \$17,500 ^(1,2a)	Individual: \$8,750 ^(1,2a) Family: \$17,500 ^(1,2a)	Individual: \$8,750 ^(1,2a) Family: \$17,500 ^(1,2a)
Amounts Listed Are Member Payments						
Office Visits (Primary/Specialist)	\$60/\$80 after deductible ^(1b)	\$65/\$95 after deductible ^(1b)	\$65/\$100	\$65/\$100	\$55/\$90	\$65/\$100
Televisits	\$0	\$0	\$0	\$0	\$0	\$0
Preventive Exams	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾
Pre-Natal Care	\$0 ^(5a)	\$0 ^(5a)	\$0 ^(5a)	\$0 ^(5a)	\$0 ^(5a)	\$0 ^(5a)
Postpartum Care	\$0 ^(5a)	\$0 ^(5a)	\$0 ^(5a)	\$0 ^(5a)	\$0 ^(5a)	\$0 ^(5a)
Well-Child Preventive Care Visits	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾
X-Ray and Lab						
Most lab tests	\$30 after deductible	\$40	\$30 after deductible	\$30	\$55	\$30
Most X-Rays and diagnostic	50% after deductible	40% after deductible	\$75 after deductible	\$75	\$90	\$75
Most MRI/CT/PET Scan	50% after deductible	40% after deductible	\$400 after deductible	\$400 after deductible	\$300 after deductible	\$400 after deductible
Inpatient Hospitalization	50% after deductible	40% after deductible	45% after deductible	45% after deductible	40% after deductible	45% after deductible
Outpatient Surgery (per procedure)	50% after deductible	40% after deductible	45% after deductible	45% after deductible	35% after deductible	45% after deductible
Ambulance Services	50% after deductible	40% after deductible	45% after deductible	45% after deductible	30% after deductible	45% after deductible
Emergency Room (not resulting in direct hospital admission)	50% after deductible	40% after deductible	45% after deductible	45% after deductible	30% after deductible	45% 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
Generic	\$20 ⁽⁸⁾	\$18 (after \$500 drug deduct.) ⁽⁸⁾	\$20 ⁽⁸⁾	\$20 ⁽⁸⁾	\$19 ⁽⁸⁾	\$20 ⁽⁸⁾
Brand Name	50% per prescription up to \$500 maximum (after plan deductible) ⁽⁸⁾	40% per prescription up to \$500 maximum (after \$500 drug deductible) ⁽⁸⁾	\$100 after plan deductible ⁽⁸⁾	\$100 after \$500 drug deductible ⁽⁸⁾	\$85 after \$370 drug deductible ⁽⁸⁾	\$100 ⁽⁸⁾
Specialty	50% per prescription up to \$500 maximum (after plan deductible) ⁽⁸⁾	40% per prescription up to \$500 maximum (after \$500 drug deductible) ⁽⁸⁾	45% per prescription up to \$250 maximum (after plan deductible) ⁽⁸⁾	20% per prescription up to \$250 maximum (after \$500 drug deductible) ⁽⁸⁾	30% per prescription up to \$250 maximum (after \$370 drug deductible) ⁽⁸⁾	20% per prescription up to \$250 maximum (after plan deductible) ⁽⁸⁾
Certain Durable Medical Equipment (DME)	50% after deductible ⁽¹⁰⁾ (supplemental & base)	40% after deductible ⁽¹⁰⁾ (supplemental & base)	45% ⁽¹⁰⁾ (supplemental & base)	45% ⁽¹⁰⁾ (supplemental & base)	40% ⁽¹⁰⁾ (supplemental & base)	45% ⁽¹⁰⁾ (supplemental & base)
Adult Vision Exam for Refraction	\$0	\$0	\$0	\$0	\$0	\$0
Adult Optical Eye Wear	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾

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Benefit Description	Gold 80 HRA HMO 2250/35	Gold 80 HMO 1000/40	Gold 80 HMO 250/35	Gold 80 HMO 0/30	Platinum 90 HMO 0/20	Platinum 90 HMO 0/10
Annual Calendar Year Deductible (Embedded)	Individual: \$2,250 ⁽¹⁾ Family: \$4,500 ⁽¹⁾	Individual: \$1,000 ⁽¹⁾ Family: \$2,000 ⁽¹⁾	Individual: \$250 ⁽¹⁾ Family: \$500 ⁽¹⁾	\$0	\$0	\$0
Pharmacy Annual Deductible	\$100 per individual (Brand/Specialty only)	\$250 per individual (Brand/Specialty only)	\$0	\$0	\$0	\$0
Annual Calendar Year Out-of-Pocket Maximum (embedded)	Individual: \$8,500 ^(1,2a) Family: \$17,000 ^(1,2a)	Individual: \$7,800 ^(1,2a) Family: \$15,600 ^(1,2a)	Individual: \$7,800 ^(1,2a) Family: \$15,600 ^(1,2a)	Individual: \$7,500 ^(1a,2a) Family: \$15,000 ^(1a,2a)	Individual: \$4,500 ^(1a,2a) Family: \$9,000 ^(1a,2a)	Individual: \$3,000 ^(1a,2a) Family: \$6,000 ^(1a,2a)
Amounts Listed Are Member Payments						
Office Visits (Primary/Specialist)	\$35/\$50	\$40/\$60	\$35/\$55	\$30/\$50	\$20/\$30	\$10/\$20
Televisits	\$0	\$0	\$0	\$0	\$0	\$0
Preventive Exams	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾	\$0 ⁽⁴⁾
Pre-Natal Care	\$0 ⁽⁵⁾	\$0 ⁽⁵⁾	\$0 ⁽⁵⁾	\$0 ^(5a)	\$0 ⁽⁵⁾	\$0 ⁽⁵⁾
Postpartum Care	\$0 ⁽⁵⁾	\$0 ⁽⁵⁾	\$0 ⁽⁵⁾	\$0 ^(5a)	\$0 ⁽⁵⁾	\$0 ⁽⁵⁾
Well-Child Preventive Care Visits	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾	\$0 ⁽⁶⁾
X-Ray and Lab						
Most lab tests	25% after deductible	\$30	\$35	\$30	\$20	\$20
Most X-Rays and diagnostic	25% after deductible	\$60	\$55	\$40	\$30	\$40
Most MRI/CT/PET Scan	25% after deductible	\$350 after deductible	\$250 after deductible	\$250	\$100	\$150
Inpatient Hospitalization	25% after deductible	\$600/day up to 5 days per admission after deductible ⁽⁷⁾	\$600/day up to 5 days per admission after deductible ⁽⁷⁾	\$600/day up to 5 days per admission ⁽⁷⁾	\$250 per day up to 5 days per admission ⁽⁷⁾	\$500 per admission
Outpatient Surgery (Per procedure)	25% after deductible	\$350	\$335 after deductible	\$320	\$125	\$300
Ambulance Services	25% after deductible	\$350	\$250 after deductible	\$250	\$150	\$150
Emergency Room (not resulting in direct hospital admission)	25% after deductible	\$350 (waived if admitted directly to hospital)	\$250 after deductible (waived if admitted directly to hospital)	\$250 (waived if admitted directly to hospital)	\$150 (waived if admitted directly to hospital)	\$200 (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
<i>Generic</i>	\$15 ⁽⁸⁾	\$20 ⁽⁸⁾	\$15 ⁽⁸⁾	\$15 ⁽⁸⁾	\$5 ⁽⁸⁾	\$5 ⁽⁸⁾
<i>Brand Name</i>	\$30 after \$100 drug deductible ⁽⁸⁾	\$50 after \$250 drug deductible ⁽⁸⁾	\$40 ⁽⁸⁾	\$50 ⁽⁸⁾	\$20 ⁽⁸⁾	\$15 ⁽⁸⁾
<i>Specialty</i>	20% per prescription up to \$250 maximum after \$100 drug deductible ⁽⁸⁾	20% per prescription up to \$250 maximum after \$250 drug deductible ⁽⁸⁾	20% per prescription up to \$250 maximum ⁽⁸⁾	20% per prescription up to \$250 maximum ⁽⁸⁾	10% per prescription up to \$250 maximum ⁽⁸⁾	10% per prescription up to \$250 maximum ⁽⁸⁾
Certain Durable Medical Equipment (DME)	50% ⁽¹⁰⁾ (supplemental & base)	20% ⁽¹⁰⁾ (supplemental & base)	20% ⁽¹⁰⁾ (supplemental & base)	20% ⁽¹⁰⁾ (supplemental & base)	10% ⁽¹⁰⁾ (supplemental and base)	10% ⁽¹⁰⁾ (supplemental and base)
Adult Vision Exam for Refraction	\$0	\$0	\$0	\$0	\$0	\$0
Adult Optical Eye Wear	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾	Not Covered ⁽¹²⁾	\$175 allowance ⁽¹¹⁾

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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. 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.

1a. 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.

1b. 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.

1c. **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.

2. Out-of-pocket maximum is the maximum amount an individual or family will pay for all covered services in a year.

2a. Out of pocket maximum is the maximum amount an individual or family will pay for certain services in a year.

3. Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.

4. Scheduled prenatal visits

5. First postpartum visit only, covered at no charge.

5a. Scheduled prenatal visits and postpartum visits.

6. Well-child visits through age 23 months

7. After the 5 days, additional days for the same admission are covered at no charge.

8. 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.

9. For HSA-qualified HDHP HMO members, allscheduled, non-preventive telehealth visits (phone and video).

10. Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of \$2,000 per year for services. Refer to Evidence of Coverage for information on what's included in your DME benefit.

11. Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months.

12 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.