California Association of REALTORS®

KAISER PERMANENTE®

2024 January - December Kaiser Permanente Medical Plans Benefit Summary

RealCare INSURANCE MARKETING INC

Benefits shown are for Kaiser Permanente Providers ONLY.

Benefit Description	Bronze 60 HDHP HMO 7050/0%	Silver 70 HDHP HMO 2850/25%	Gold 80 HDHP HMO 1750/15%
	HSA Compatible Plan	**HSA Compatible Plan**	**HSA Compatible Plan**
Annual Calendar Year Deductible (embedded)	Individual: $7,050(1) Family: $14,100(1)	Self only coverage: $2,850(1,1c) Individual within family: $3,200(1,1c) Family: $5,700(1,1c)	Self only coverage: $1,750(1,1c) Individual within family: $3,200(1,1c) Family: $3,500(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: $7,050(1,2a) Family: $14,100(1,2a)	Individual: $7,500(1,2) Family: $15,000(1,2)	Individual: $3,700(1,2) Family: $7,400(1,2)
	Amounts Listed are Member Payments		
Office Visits (Primary/Specialist)	$0/$0 after plan deductible	25%/25% after plan deductible	15%/15% after plan deductible
Virtual Care(9)	$0 after plan deductible	$0 after plan deductible	$0 after plan deductible
Preventive Exams(3)	$0	$0	$0
Pre-Natal Care(5)	$0	$0	$0
Postpartum Care(5)	$0 after deductible	$0 after deductible	$0 after deductible
Well-Child Preventive Care Visits(6)	$0	$0	$0
X-Ray and Lab(4) **Most lab tests** **Most X-Rays and diagnostic** **Most MRI/CT/PET Scan**	 0% after plan deductible 0% after plan deductible 0% after plan deductible	 25% after plan deductible 25% after plan deductible 25% after plan deductible	 15% after plan deductible 15% after plan deductible 15% after plan deductible
Inpatient Hospitalization	0% after plan deductible	25% after plan deductible	15% after plan deductible
Outpatient Surgery (per procedure)	0% after plan deductible	25% after plan deductible	15% after plan deductible
Ambulance Services	0% after plan deductible	25% after plan deductible	15% after plan deductible
Emergency Room (not resulting in direct hospital admission)	0% after plan deductible	25% after plan deductible	15% after plan deductible
Prescription Drugs(8)	Up to 30 Day Supply	Up to 30 Day Supply	Up to 30 Day Supply
Generic	0% after plan deductible	25% per prescription up to a $250 maximum after plan deductible	$15 after plan deductible
Brand Name	0% after plan deductible	25% per prescription up to a $250 maximum after plan deductible	$45 after plan deductible
Specialty	0% per prescription after plan deductible	25% per prescription up to a $250 maximum after plan deductible	15% up to $250 maximum (after plan deductible)
Certain Durable Medical Equipment (DME)(10)	0% after plan deductible (supplemental & base)	25% (supplemental & base)	15% (supplemental & base)
Pediatric Dental & Vision Benefits	*All Kaiser plans include mandatory coverage for pediatric dental and vision benefits. For details of coverage, please refer to the specific plan Summary of Benefits or the Evidence of Coverage document.*		
Adult Vision Exam for Refraction	$0	$0	$0
Adult Optical Eye Wear(12)	Not Covered	Not Covered	Not Covered

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Annual Calendar Year Deductible [1] **(embedded)**	Individual: $5,400 Family: $10,800	Individual: $6,300 Family: $12,600	Individual: $2,950 Family: $5,900	Individual : $2,300 Family: $4,600	Individual: $2,500 Family: $5,000	Individual: $1,900 Family: $3,800
Pharmacy Annual Deductible	Combined with medical deductible **(Brand/Specialty only)**	$500 Indiv/$1,000 Family[13]	Combined with medical deductible **(Brand/Specialty only)**	$500 Indiv/$1,000 Family **(Brand/Specialty only)**[13]	$300 Indiv/$600 Family **(Brand/Specialty only)**[14]	Combined with medical deductible **(Specialty only)**
Annual Calendar Year Out-of-Pocket Maximum[1,2a] **(embedded)**	Individual: $8,600 Family: $17,200	Individual: $9,100 Family: $18,200	Individual: $9,100 Family: $18,200	Individual: $8,750 Family: $17,500	Individual: $8,750 Family: $17,500	Individual: $8,750 Family: $17,500
	Amounts Listed Are Member Payments					
Office Visits (Primary/Specialist)	$60/$80 after deductible[1b]	$60/$95 after plan deductible[1b]	$65/$100	$65/$100	$55/$90	$65/$100
Virtual Care	$0	$0	$0	$0	$0	$0
Preventive Exams[3]	$0	$0	$0	$0	$0	$0
Pre-Natal Care[5]	$0	$0	$0	$0	$0	$0
Postpartum Care[5]	$0	$0	$0	$0	$0	$0
Well-Child Preventive Care Visits[6]	$0	$0	$0	$0	$0	$0
X-Ray and Lab[4] **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 plan deductible 40% after plan deductible	$30 after plan deductible $75 after plan deductible $400 after plan deductible	$30 $75 $400 after plan deductible	$55 $90 $300 after plan deductible	$30 $75 $400 after plan deductible
Inpatient Hospitalization	50% after deductible	40% after plan deductible	45% after plan deductible	45% after plan deductible	35% after plan deductible	45% after plan deductible
Outpatient Surgery (per procedure)	50% after deductible	40% after plan deductible	45% after plan deductible	45% after plan deductible	35% after plan deductible	45% after plan deductible
Ambulance Services	50% after deductible	40% after plan deductible	45% after plan deductible	45% after plan deductible	35% after plan deductible	45% after plan deductible
Emergency Room (not resulting in direct hospital admission)	50% after deductible	40% after plan deductible	45% after plan deductible	45% after plan deductible	35% after plan deductible	45% after plan deductible
Prescription Drugs[8]	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 Deductible does not apply	After Rx deductible: $17	$20 Deductible does not apply	$20 Deductible does not apply	$19 Deductible does not apply	$20 Deductible does not apply
Brand Name	After plan deductible: 50% per prescription up to $500 maximum	After Rx deductible: 40% per prescription up to $500 maximum	After plan deductible: $100	After Rx deductible: $100	After Rx deductible: $85	$100 Deductible does not apply
Specialty	After plan deductible: 50% per prescription up to $500 maximum	After Rx deductible: 40% per prescription up to $500 maximum	After plan deductible: 45% per prescription up to $250 maximum	After Rx deductible: 20% per prescription up to $250 maximum	After Rx Deductible: 30% per prescription	After plan deductible: 20% per prescription up to $250 maximum
Certain Durable Medical Equipment (DME)[10]	50% after plan deductible (supplemental & base)	40% after plan deductible (supplemental & base)	45% (supplemental & base)	45% (supplemental & base)	35% (supplemental & base)	45% (supplemental & base)
Pediatric Dental & Vision Benefits	*All Kaiser plans include mandatory coverage for pediatric dental and vision benefits. For details of coverage, please refer to the specific plan Summary of Benefits or the Evidence of Coverage document.*					
Adult Vision Exam for Refraction	$0	$0	$0	$0	$0	$0
Adult Optical Eye Wear[12]	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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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 0/35	Platinum 90 HMO 250/30	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[1a]	Individual: $250 Family: $500[1]	0[1a]	0[1a]
Pharmacy Annual Deductible	$100 Indiv/$200 Family[15] **(Brand/Specialty only)**	$250 Indiv/$500 Family[13] **(Brand/Specialty only)**	$0	$0	Combined with med. deductible **(Specialty only)**	$0	$0
Annual Calendar Year Out-of-Pocket Maximum [2a] (embedded)	Individual: $8,500 Family: $17,000	Individual: $7,800 Family: $15,600	Individual: $7,800 Family: $15,600	Individual: $7,700 Family: $15,400	Individual: $3000 Family: $6,000	Individual: $4,500 Family: $9,000	Individual: $3,000 Family: $6,000
	Amounts Listed Are Member Payments						
Office Visits (Primary/Specialist)	$35/$50	$40/$60	$35/$55	$35/$60	$30/$50	$20/$30	$10/$20
Virtual Care	$0	$0	$0	$0	$0	$0	$0
Preventive Exams[3]	$0	$0	$0	$0	$0	$0	$0
Pre-Natal Care[5]	$0	$0	$0	$0	$0	$0	$0
Postpartum Care[5]	$0	$0	$0	$0	$0	$0	$0
Well-Child Preventive Care Visits	$0	$0	$0	$0	$0	$0	$0
X-Ray and Lab[4] **Most lab tests** **Most X-Rays and diagnostic** **Most MRI/CT/PET Scan**	 25% after plan deductible 25% after plan deductible 25% after plan deductible	 $30 $60 $350 after plan deductible	 $35 $55 $250 after plan deductible	 $30 $40 $250	 $30 $50 $150	 $20 $30 $100	 $20 $40 $150
Inpatient Hospitalization	25% after plan deductible	$600/day up to 5 days per admission after plan deductible[7]	$600/day up to 5 days per admission after plan deductible[7]	$600/day up to 5 days per admission[7]	$500 per admission after plan deductible[7]	$250 per day up to 5 days per admission[7]	$500 per admission
Outpatient Surgery (Per procedure)	25% after plan deductible	$350	$335 after plan deductible	$320	$300	$125	$300
Ambulance Services	25% after plan deductible	$350	$250 after plan deductible	$250	$150	$150	$150
Emergency Room (not resulting in direct hospital admission)	25% after plan deductible	$350 (waived if admitted directly to hospital)	$250 after plan deductible (waived if admitted directly to hospital)	$350 (waived if admitted directly to hospital)	$250 (waived if admitted directly to hospital)	$150 (waived if admitted directly to hospital)	$200 (waived it admitted directly to hospital)
Prescription Drugs[8]	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	$15 Deductible does not apply	$20 Deductible does not apply	$15 Deductible does not apply	$15	$10 Deductible does not apply	$5	$5
Brand Name	After Rx deductible: $30	After Rx deductible: $50	$40 Deductible does not apply	$50	$20 Deductible does not apply	$20	$15
Specialty	After Rx deductible: 20% per prescription up to $250 maximum	After Rx deductible: 20% per prescription up to $250 maximum	20% per prescription up to $250 maximum	20% per prescription up to $250 maximum	After plan deductible: 10% per prescription up to $250 maximum	10% per prescription up to $250 maximum	10% per prescription up to $250 maximum
Certain Durable Medical[10] Equipment (DME)	50% (supplemental & base)	20% (supplemental & base)	20% (supplemental & base)	20% (supplemental & base)	10% (supplemental and base)	10% (supplemental and base)	10% (supplemental and base)
Pediatric Dental & Vision Benefits	*All Kaiser plans include mandatory coverage for pediatric dental and vision benefits. For details of coverage, please refer to the specific plan Summary of Benefits or the Evidence of Coverage document.*						
Adult Vision Exam for Refraction	$0	$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]	$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. Laboratory and diagnostic test, X-Rays, and MRI/CT/PET scans related to preventive services are no charge.

5. 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, all scheduled, 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 inforrmation on what's included in your DME benefit.

11. Allowance toward the cost of eyeglass lenses, frames, and contract 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.

13 This plan has a drug deductible of $250 per individual and $500 for family for prescription costs and out of pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out of pocket maximum (depending on the benefit) or when the family deductible is satisfied. Individual family members aren't subject to cost sharing when they reach the individual out of pocket maximum, or when the family out of pocket maximum is met.

14 This plan has a drug deductible of $300 per individual and $600 for family for prescription costs and out of pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out of pocket maximum (depending on the benefit) or when the family deductible is satisfied. Individual family members aren't subject to cost sharing when they reach the individual out of pocket maximum, or when the family out of pocket maximum is met.

15 This plan has a drug deductible of $100 per individual and $200 for family for prescription costs and out of pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out of pocket maximum (depending on the benefit) or when the family deductible is satisfied. Individual family members aren't subject to cost sharing when they reach the individual out of pocket maximum, or when the family out of pocket maximum is met.