# California Association of REALTORS®

KAISER PERMANENTE®

## 2025 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 6650/0% | 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: $6,650(1)<br>Family: $13,300(1) | Self only coverage: $2,850(1,1c)<br>Individual within family: $3,300(1,1c)<br>Family: $5,700(1,1c) | Self only coverage: $1,750(1,1c)<br>Individual within family: $3,300(1,1c)<br>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: $6,650(1,2a)<br>Family: $13,300(1,2a) | Individual: $7,500(1,2)<br>Family: $15,000(1,2) | Individual: $4,000(1,2)<br>Family: $8,000(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)**<br>**Most lab tests**<br>**Most X-Rays and diagnostic**<br>**Most MRI/CT/PET Scan** | <br>0% after plan deductible<br>0% after plan deductible<br>0% after plan deductible | <br>25% after plan deductible<br>25% after plan deductible<br>25% after plan deductible | <br>15% after plan deductible<br>15% after plan deductible<br>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* | After plan deductible: 0% per prescription | After plan deductible: 25% to $250 maximum per prescription | After plan deductible: 15% to $250 maximum per prescription |
| **Certain Durable Medical Equipment (DME)(10)** | Base: 0% after plan deductible<br>Supplemental: 0% after plan deductible to $2,000 max benefit/year | Base: 25% after plan deductible<br>Supplemental: 25% after plan deductible to $2,000 max benefit/year | Base: 15% after plan deductible<br>Supplemental: 15% after plan deductible to $2,000 max benefit/year |
| **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: $5,800<br>Family: $11,600 | Individual: $2,900<br>Family: $5,800 | Individual : $2,300<br>Family: $4,600 | Individual: $2,500<br>Family: $5,000 | Individual: $1,900<br>Family: $3,800 |
| **Pharmacy Annual Deductible** | $450 Indiv/$900 Family [13] | Combined with medical deductible<br>**(Brand/Specialty only)** | $500 Indiv/$1,000 Family<br>**(Brand/Specialty only)** [13] | $300 Indiv/$600 Family<br>**(Brand/Specialty only)** [13] | Combined with medical deductible<br>**(Specialty only)** |
| **Annual Calendar Year Out-of-Pocket Maximum** [1] (embedded) | Individual: $8,850<br>Family: $17,700 | Individual: $9,100<br>Family: $18,200 | Individual: $8,750<br>Family: $17,500 | Individual: $8,750<br>Family: $17,500 | Individual: $8,750<br>Family: $17,500 |
| | ***Amounts Listed are Member Payments*** | | | | |
| **Office Visits (Primary/Specialist)** | Primary Care: $60 (Ded. waived)<br>Specialist Visits: $95 (Ded. waived for first 3 visits only) [1b] | $65/$100 | $65/$100 | $55/$90 | $65/$100 |
| **Virtual Care** | $0 | $0 | $0 | $0 | $0 |
| **Preventive Exams** [3] | $0 | $0 | $0 | $0 | $0 |
| **Pre-Natal Care** [5] | $0 | $0 | $0 | $0 | $0 |
| **Postpartum Care** [5] | $0 | $0 | $0 | $0 | $0 |
| **Well-Child Preventive Care Visits** [6] | $0 | $0 | $0 | $0 | $0 |
| **X-Ray and Lab** [4]<br>**Most lab tests**<br>**Most X-Rays and diagnostic**<br>**Most MRI/CT/PET Scan** | <br>$40<br>40% after plan deductible<br>40% after plan deductible | <br>$30 after plan deductible<br>$75 after plan deductible<br>$400 after plan deductible | <br>$30<br>$75<br>$400 after plan deductible | <br>$55<br>$90<br>$300 after plan deductible | <br>$30<br>$75<br>$400 after plan deductible |
| **Inpatient Hospitalization** | 40% after plan deductible | 45% after plan deductible | 45% after plan deductible | 35% after plan deductible | 45% after plan deductible |
| **Outpatient Surgery** (per procedure) | 40% after plan deductible | 45% after plan deductible | 45% after plan deductible | 35% after plan deductible | 45% after plan deductible |
| **Ambulance Services** | 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) | 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 |
| *Generic* | $19<br>Deductible does not apply | $20<br>Deductible does not apply | $20<br>Deductible does not apply | $19<br>Deductible does not apply | $20<br>Deductible does not apply |
| *Brand Name* | After Rx deductible: 40% per prescription up to $500 maximum | After plan deductible: $100 | After Rx deductible: $100 | After Rx deductible: $85 | $100<br>Deductible does not apply |
| *Specialty* | After Rx deductible: 40% to $500 maximum per prescription | After plan deductible: 45% to $250 maximum per prescription | After Rx deductible: 20% to $250 maximum per prescription | After Rx Deductible: 30% to $250 maximum per prescription | After plan deductible: 20% to $250 maximum per prescription |
| **Certain Durable Medical Equipment (DME)** [10] | Base: 40% after plan deductible<br>Supplemental: 40% after plan deductible to $2,000 max benefit/year | Base: 45%<br>Supplemental: 45% after plan deductible to $2,000 max benefit/year | Base: 45%<br>Supplemental: 45% after plan deductible to $2,000 max benefit/year | Base: 35%<br>Supplemental: 35% after plan deductible to $2,000 max benefit/year | Base: 45%<br>Supplemental: 45% after plan deductible to $2,000 max benefit/year |
| **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 |
| **Adult Optical Eye Wear** [12] | 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[13] **(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: $8,200 Family: $16,400 | Individual: $7,800 Family: $15,600 | Individual: $7,700 Family: $15,000 | 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]**<br>**Most lab tests**<br>**Most X-Rays and diagnostic**<br>**Most MRI/CT/PET Scan** | <br>25% after plan deductible<br>25% after plan deductible<br>25% after plan deductible | <br>$30<br>$60<br>$350 after plan deductible | <br>$35<br>$55<br>$250 after plan deductible | <br>$30<br>$40<br>$250 | <br>$30<br>$50<br>$150 | <br>$20<br>$30<br>$100 | <br>$20<br>$40<br>$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% to $250 maximum per prescription | After Rx deductible: 20% to $250 maximum per prescription | 20% to $250 maximum per prescription | 20% to $250 maximum per prescription | After plan deductible: 10% to $250 maximum per prescription | 10% to $250 maximum per prescription | 10% to $250 maximum per prescription |
| **Certain Durable Medical[10] Equipment (DME)** | Base: 50% Supplemental: 50% after plan deductible to $2,000 max benefit/year | Base: 20% Supplemental: 20% after plan deductible to $2,000 max benefit/year | Base: 20% Supplemental: 20% after plan deductible to $2,000 max benefit/year | Base: 20% Supplemental: 20% after plan deductible to $2,000 max benefit/year | Base: 10% Supplemental: 10% after plan deductible to $2,000 max benefit/year | Base: 10% Supplemental: 10% after plan deductible to $2,000 max benefit/year | Base: 10% Supplemental: 10% after plan deductible to $2,000 max benefit/year |
| **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 non-preventive primary care, other practitioner care, urgent care, and individual mental/behavioral health and substance use disorder outpatient services. Deductible is waived for first 3 visits of Specialist care.

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 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 specific drug deductible 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.