

Benefits shown are for Kaiser Permanente Providers ONLY.

Benefit Description	Bronze 60 HDHP HMO 7200/0%	Silver 70 HDHP HMO 3200/25%	Gold 80 HDHP HMO 1900/15%
	HSA Compatible Plan	HSA Compatible Plan	HSA Compatible Plan
Annual Calendar Year Deductible (embedded)	Individual: \$7,200 <sup>(1)</sup> Family: \$14,400 <sup>(1)</sup>	Self only coverage: \$3,200 <sup>(1,1c)</sup> Individual within family: \$3,400 <sup>(1,1c)</sup> Family: \$6,400 <sup>(1,1c)</sup>	Self only coverage: \$1,900 <sup>(1,1c)</sup> Individual within family: \$3,300 <sup>(1,1c)</sup> Family: \$3,800 <sup>(1,1c)</sup>
Pharmacy Annual Deductible	Combined with medical deductible	Combined with medical deductible	Combined with medical deductible
Annual Calendar Year Out-of-Pocket Maximum (embedded)	Individual: \$7,200 <sup>(1,2)</sup> Family: \$14,400 <sup>(1,2)</sup>	Individual: \$8,300 <sup>(1,2)</sup> Family: \$16,600 <sup>(1,2)</sup>	Individual: \$4,500 <sup>(1,2)</sup> Family: \$9,000 <sup>(1,2)</sup>
<b>Amounts Listed are Member Payments</b>			
Office Visits (Primary/Specialist)	\$0/\$0 after plan deductible	25%/25% after plan deductible	15%/15% after plan deductible
Virtual Care <sup>(9)</sup>	\$0 after plan deductible	\$0 after plan deductible	\$0 after plan deductible
Preventive Exams <sup>(3)</sup>	\$0	\$0	\$0
Pre-Natal Care <sup>(5)</sup>	\$0	\$0	\$0
Postpartum Care <sup>(5)</sup>	\$0 after deductible	\$0 after deductible	\$0 after deductible
Well-Child Preventive Care Visits <sup>(6)</sup>	\$0 through age 23 months	\$0 through age 23 months	\$0 through age 23 months
X-Ray and Lab <sup>(4)</sup>			
Most lab tests	0% after plan deductible	25% after plan deductible	15% after plan deductible
Most X-Rays and diagnostic	0% after plan deductible	25% after plan deductible	15% after plan deductible
Most MRI/CT/PET Scan	0% after plan deductible	25% 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 <sup>(8,8a,8b)</sup>	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) <sup>(10)</sup>	Base: 0% after plan deductible Supplemental: 0% after plan deductible to \$2,000 max benefit/year	Base: 25% after plan deductible Supplemental: 25% after plan deductible to \$2,000 max benefit/year	Base: 15% after plan deductible 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 <sup>(12)</sup>	Not Covered	Not Covered	Not Covered

**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 1/1/26 to 12/31/26. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: [www.RealCareCAR.com](http://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.

California Association of REALTORS®



2026 January - December Kaiser Permanente Medical Plans Benefit Summary



Benefits shown are for Kaiser Permanente Providers ONLY.

Benefit Description	Bronze 60 HMO 5800/60	Silver 70 HMO 3100/75	Silver 70 HMO 2300/65	Silver 70 HMO 2500/55	Silver 70 HMO 2000/65
<b>Annual Calendar Year Deductible<sup>(1)</sup></b> (embedded)	Individual: \$5,800 Family: \$11,600	Individual: \$3,100 Family: \$6,200	Individual: \$2,300 Family: \$4,600	Individual: \$2,500 Family: \$5,000	Individual: \$2,000 Family: \$4,000
<b>Pharmacy Annual Deductible</b>	\$450 Indiv/\$900 Family <sup>(13)</sup>	Combined with medical deductible (Brand/Specialty only)	\$500 Indiv/\$1,000 Family (Brand/Specialty only) <sup>(13)</sup>	\$300 Indiv/\$600 Family (Brand/Specialty only) <sup>(13)</sup>	Combined with medical deductible (Specialty only)
<b>Annual Calendar Year Out-of-Pocket Maximum<sup>(1,2a)</sup></b> (embedded)	Individual: \$9,800 Family: \$19,600	Individual: \$9,800 Family: \$19,600	Individual: \$9,100 Family: \$18,200	Individual: \$8,750 Family: \$17,500	Individual: \$8,900 Family: \$17,800
<b>Amounts Listed are Member Payments</b>					
<b>Office Visits (Primary/Specialist)</b>	Primary Care: \$60 (Ded. waived) Specialist Visits: \$95 (Ded. waived for first 3 visits only) <sup>(1b)</sup>	\$75/\$100	\$65/\$100	\$55/\$90	\$65/\$100
<b>Virtual Care<sup>(9)</sup></b>	\$0	\$0	\$0	\$0	\$0
<b>Preventive Exams<sup>(3)</sup></b>	\$0	\$0	\$0	\$0	\$0
<b>Pre-Natal Care<sup>(5)</sup></b>	\$0	\$0	\$0	\$0	\$0
<b>Postpartum Care<sup>(6)</sup></b>	\$0	\$0	\$0	\$0	\$0
<b>Well-Child Preventive Care Visits<sup>(6)</sup></b>	\$0 through age 23 months	\$0 through age 23 months	\$0 through age 23 months	\$0 through age 23 months	\$0 through age 23 months
<b>X-Ray and Lab<sup>(4)</sup></b>					
Most lab tests	\$50	\$45 after plan deductible	\$45	\$55	\$35
Most X-Rays and diagnostic	40% after plan deductible	45% after plan deductible	\$80 after plan deductible	\$90	\$75 after plan deductible
Most MRI/CT/PET Scan	40% after plan deductible	\$400 after plan deductible	\$400 after plan deductible	\$300 after plan deductible	\$400 after plan deductible
<b>Inpatient Hospitalization</b>	40% after plan deductible	45% after plan deductible	45% after plan deductible	35% after plan deductible	45% after plan deductible
<b>Outpatient Surgery (per procedure)</b>	40% after plan deductible	45% after plan deductible	45% after plan deductible	35% after plan deductible	45% after plan deductible
<b>Ambulance Services</b>	40% after plan deductible	45% after plan deductible	45% after plan deductible	35% after plan deductible	45% after plan deductible
<b>Emergency Room (not resulting in direct hospital admission)</b>	40% after plan deductible	45% after plan deductible	45% after plan deductible	35% after plan deductible	45% after plan deductible
<b>Prescription Drugs<sup>(8,8a,8b)</sup></b>	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>	\$20 Deductible does not apply	\$20 Deductible does not apply	\$20 Deductible does not apply	\$19 Deductible does not apply	\$20 Deductible does not apply
<i>Brand Name</i>	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
<i>Specialty</i>	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
<b>Certain Durable Medical Equipment (DME)<sup>(10)</sup></b>	Base: 40% after plan deductible Supplemental: 40% after plan deductible to \$2,000 max benefit/year	Base: 45% Supplemental: 45% after plan deductible to \$2,000 max benefit/year	Base: 45% Supplemental: 45% after plan deductible to \$2,000 max benefit/year	Base: 35% Supplemental: 35% after plan deductible to \$2,000 max benefit/year	Base: 45% Supplemental: 45% after plan deductible to \$2,000 max benefit/year
<b>Pediatric Dental &amp; Vision Benefits</b>	<i>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.</i>				
<b>Adult Vision Exam for Refraction</b>	\$0	\$0	\$0	\$0	\$0
<b>Adult Optical Eye Wear<sup>(12)</sup></b>	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

**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 1/1/26 to 12/31/26. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: [www.RealCareCAR.com](http://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.

**California Association of REALTORS®**  
**2026 January - December Kaiser Permanente Medical Plans Benefit Summary**



*Benefits shown are for Kaiser Permanente Providers ONLY.*

Benefit Description	Gold 80 HRA HMO 2250/35	Gold 80 HMO 1000/40	Gold 80 HMO 500/35	Gold 80 HMO 250/35	Gold 80 HMO 0/40	Platinum 90 HMO 250/30	Platinum 90 HMO 0/20	Platinum 90 HMO 0/10
<b>Annual Calendar Year Deductible (Embedded)</b>	Individual: \$2,250 <sup>(1)</sup> Family: \$4,500 <sup>(1)</sup>	Individual: \$1,000 <sup>(1)</sup> Family: \$2,000 <sup>(1)</sup>	Individual: \$500 <sup>(1)</sup> Family: \$1,000 <sup>(1)</sup>	Individual: \$250 <sup>(1)</sup> Family: \$500 <sup>(1)</sup>	0 <sup>(1a)</sup>	Individual: \$250 Family: \$500 <sup>(1)</sup>	0 <sup>(1a)</sup>	0 <sup>(1a)</sup>
<b>Pharmacy Annual Deductible</b>	\$100 Indiv/\$200 Family <sup>(13)</sup> (Brand/Specialty only)	\$250 Indiv/\$500 Family <sup>(13)</sup> (Brand/Specialty only)	\$0	\$0	\$0	Combined with med. deductible (Specialty only)	\$0	\$0
<b>Annual Calendar Year Out-of-Pocket Maximum<sup>(1,2)</sup> (embedded)</b>	Individual: \$8,500 Family: \$17,000	Individual: \$8,200 Family: \$16,400	Individual: \$8,000 Family: \$16,000	Individual: \$7,800 Family: \$15,600	Individual: \$8,500 Family: \$17,000	Individual: \$3,250 Family: \$6,500	Individual: \$4,500 Family: \$9,000	Individual: \$3,000 Family: \$6,000
<b>Amounts Listed Are Member Payments</b>								
<b>Office Visits (Primary/Specialist)</b>	\$35/\$50	\$40/\$60	\$35/\$60	\$35/\$55	\$40/\$60	\$30/\$50	\$20/\$30	\$10/\$20
<b>Virtual Care<sup>(9)</sup></b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Preventive Exams<sup>(3)</sup></b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Pre-Natal Care<sup>(5)</sup></b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Postpartum Care<sup>(6)</sup></b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Well-Child Preventive Care Visits<sup>(6)</sup></b>	\$0 through age 23 months	\$0 through age 23 months	\$0 through age 23 months	\$0 through age 23 months	\$0 through age 23 months	\$0 through age 23 months	\$0 through age 23 months	\$0 through 23 months
<b>X-Ray and Lab<sup>(4)</sup></b>								
Most lab tests	25% after plan deductible	\$30	\$35	\$35	\$30	\$30	\$20	\$20
Most X-Rays and diagnostic	25% after plan deductible	\$60	\$50	\$55	\$40	\$50	\$30	\$40
Most MRI/CT/PET Scan	25% after plan deductible	\$350	\$350 after plan deductible	\$250 after plan deductible	\$250	\$150	\$100	\$150
<b>Inpatient Hospitalization</b>	25% after plan deductible	\$600/day up to 5 days per admission after plan deductible <sup>(7)</sup>	\$600/day up to 5 days per admission after plan deductible <sup>(7)</sup>	\$600/day up to 5 days per admission after plan deductible <sup>(7)</sup>	\$600/day up to 5 days per admission after plan deductible <sup>(7)</sup>	\$500 per admission after plan deductible <sup>(7)</sup>	\$250 per day up to 5 days per admission <sup>(7)</sup>	\$500 per admission
<b>Outpatient Surgery (Per procedure)</b>	25% after plan deductible	\$350	\$350 after plan deductible	\$335 after plan deductible	\$400	\$300	\$125	\$300
<b>Ambulance Services</b>	25% after plan deductible	\$350	\$350 after plan deductible	\$250 after plan deductible	\$250	\$150	\$150	\$150
<b>Emergency Room (not resulting in direct hospital admission)</b>	25% after plan deductible	\$350 (waived if admitted directly to hospital)	\$350 after plan deductible (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 if admitted directly to hospital)
<b>Prescription Drugs<sup>(8,9a,8b)</sup></b>	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
<i>Generic</i>	\$15 Deductible does not apply	\$15 Deductible does not apply	\$15 Deductible does not apply	\$15 Deductible does not apply	\$15	\$10 Deductible does not apply	\$5	\$5
<i>Brand Name</i>	After Rx deductible: \$30	After Rx deductible: \$50	\$50 Deductible does not apply	\$40 Deductible does not apply	\$50	\$20 Deductible does not apply	\$20	\$15
<i>Specialty</i>	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	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
<b>Certain Durable Medical<sup>(10)</sup> Equipment (DME)</b>	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: 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
<b>Pediatric Dental &amp; Vision Benefits</b>	<i>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.</i>							
<b>Adult Vision Exam for Refraction</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Adult Optical Eye Wear</b>	Not Covered <sup>(12)</sup>	Not Covered <sup>(12)</sup>	Not Covered <sup>(12)</sup>	Not Covered <sup>(12)</sup>	Not Covered <sup>(12)</sup>	Not Covered <sup>(12)</sup>	Not Covered <sup>(12)</sup>	\$175 allowance <sup>(11)</sup>

**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 1/1/26 to 12/31/26. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: [www.RealCareCAR.com](http://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.*



California Association of REALTORS®

2026 January - December Kaiser Permanente Medical Plans Benefit Summary



Benefits shown are for in and out of network providers

Benefit Description	Gold 80 PCP KP Plus 250/35		Platinum 90 PCP KP Plus 0/10	
	In Network <sup>(16)</sup>	Out of Network <sup>(14,15)</sup>	In Network <sup>(16)</sup>	Out of Network <sup>(14,15)</sup>
Annual Calendar Year Deductible (Embedded)	Individual: \$250 <sup>(1a)</sup> Family: \$500 <sup>(1a)</sup>	Not Applicable	\$0	\$0
Pharmacy Annual Deductible	\$0	\$0	\$0	\$0
Annual Calendar Year Out-of-Pocket Maximum <sup>(1,2)</sup> (embedded)	Individual: \$7,800 Family: \$15,600		Individual: \$3,000 Family: \$6,000	
<b>Amounts Listed Are Member Payments</b>				
Office Visits (Primary/Specialist)	\$35/\$55	\$55/\$75 <sup>(14)</sup>	\$10/\$20	\$30/\$40 <sup>(14)</sup>
Virtual Care <sup>(9)</sup>	\$0	\$20 <sup>(14)</sup>	\$0	\$20 <sup>(14)</sup>
Preventive Exams <sup>(3)</sup>	\$0	\$0	\$0	\$0
Pre-Natal Care <sup>(5)</sup>	\$0	\$0	\$0	\$0
Postpartum Care <sup>(5)</sup>	\$0	\$0	\$0	\$0
Well-Child Preventive Care Visits <sup>(6)</sup>	\$0 through age 23 months	\$0 through age 23 months	\$0 through 23 months	\$0 through age 23 months
X-Ray and Lab <sup>(4)</sup>				
Most lab tests	\$35	\$45 <sup>(14)</sup>	\$20	\$30 <sup>(14)</sup>
Most X-Rays and diagnostic	\$55	\$75 <sup>(14)</sup>	\$40	\$60 <sup>(14)</sup>
Most MRI/CT/PET Scan	\$250 after plan deductible	Not Covered	\$150	Not Covered
Inpatient Hospitalization	\$600/day up to 5 days per admission after plan deductible <sup>(7)</sup>	Not Covered	\$500 per admission	Not Covered
Outpatient Surgery (Per procedure)	\$335 after plan deductible	Not Covered	\$300	Not Covered
Ambulance Services	\$250 after plan deductible	\$250 after plan deductible	\$150	\$150
Emergency Room (not resulting in direct hospital admission)	\$250 after plan deductible (waived if admitted directly to hospital)	\$250 after plan deductible (waived if admitted directly to hospital)	\$200 (waived if admitted directly to hospital)	\$200 (waived if admitted directly to hospital)
Prescription Drugs <sup>(8,8b)</sup>	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 <sup>(15)</sup> Deductible does not apply	\$5	\$10 <sup>(15)</sup> Deductible does not apply
Brand Name	\$40 Deductible does not apply	\$60 <sup>(15)</sup> Deductible does not apply	\$15	\$35 <sup>(15)</sup> Deductible does not apply
Specialty	20% to \$250 maximum per prescription	Not Covered	10% to \$250 maximum per prescription	Not Covered
Certain Durable Medical <sup>(10)</sup> Equipment (DME)	Base: 20% Supplemental: 20% after plan deductible to \$2,000 max benefit/year	Not Covered	Base: 10% Supplemental: 10% after plan deductible to \$2,000 max benefit/year	Not Covered
Pediatric Dental & Vision Benefits	All Kaiser plans include mandatory coverage for pediatric dental and vision benefits. (Covered for in network providers only.) 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 <sup>(14)</sup>	\$0	\$0
Adult Optical Eye Wear	Not Covered <sup>(12)</sup>	Not Covered	\$175 allowance	Not Covered

**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 1/1/26 to 12/31/26. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: [www.RealCareCAR.com](http://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.

# 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.*

*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.*

*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](http://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 3 visits of Specialty 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 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](http://kp.org/formulary) or call our Member Service Contact Center.
- 8a. Insured is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when the insured requests a brand-name drug and a generic version is available.
- 8b. Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply.
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 information 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](http://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.
14. Limited to a combined total of 10 covered outpatient services from out of network (OON) providers. Refer to the Evidence of Coverage for a complete list of outpatient services that are covered.
15. Limited to 5 out-of-network (OON) prescription fills (combined from any tier). Refer to the Evidence of Coverage for a complete list of prescription drugs or items that are covered.
16. Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge may be less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.