KAISER PERMANENTE

California Association of REALTORS®

Kaiser Permanente Medical Plans Benefit Summary (1)

RealCare INSURANCE MARKETING INC

Benefits shown are for Kaiser Permanente Providers ONLY.

Benefit Description	$5 Co-Pay Plan	$15 Co-Pay Plan	$20 Co-Pay Plan	$30 Co-Pay Plan	$50 Co-Pay Plan
Annual Calendar Year Deductible	None	None	None	None	None
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Annual Calendar Year Out-of-Pocket Maximum: (2)	$1,500/person $3,000/ family	$2,500/person $5,000/family	$2,500/person $5,000/family	$3,000/person $6,000/family	$3,500/person $7,000/family
	Amounts Listed Are Member Payments				
Office Visits	$5	$15	$20	$30	$50
Preventive Exams	$0	$0	$0	$0	$0
Maternity/Pre-Natal (Scheduled pre-natal visits and first postpartum visit)	No Charge	No Charge	No Charge	No Charge	No Charge
X-Ray and Lab **Most labs and imaging** **MRI/CT/PET Scan**	 $10 $50	 $10 $50	 $10 $50	 $10 $50	 $10 $50
Inpatient Hospitalization	$0	$200 per day	$300 per day	$400 per day	$500 per day
Outpatient Surgery	$5 per procedure	$100 per procedure	$150 per procedure	$200 per procedure	$250 per procedure
Ambulance Services	$75	$75	$75	$75	$300
Emergency Room (not resulting in direct hospital admission)	$100	$100	$100	$100	$150
Prescription Drugs (3):	Up to 100 Day Supply	Up to 30 Day Supply	Up to 30 Day Supply	Up to 100 Day Supply	Up to 100 Day Supply
Brand-Name Deductible	None	None	None	$250	$250
RX Co-Pays:					
Brand Name	$15	$25	$30	$35	$35
Generic	$5	$10	$10	$10 (4)	$10 (4)
Certain Durable Medical Equipment (DME)	20% ($2,000 maximum)	20% ($2,000 maximum)	20% ($2,000 maximum)	50% (5)	50% (5)
Preventive Vision Screening	$0	$0	$0	$0	$0
Eye Exam for Refraction	$5	$15	$20	$30	$50
Optical Eye Wear	Up to $150 allowance (6)	Up to $150 allowance (6)	Not covered (7)	Not covered (7)	Not covered (7)

(1) This document is a summary of benefits only. Refer to contract for a detailed explanation of plan benefits, features, exclusions and limitations. Benefits valid for plan year 6/1/11 to 5/31/12 and subject to change without notice. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.Realcare.biz/eoc

(2) The annual out of pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the Evidence of Coverage).

(3) Prescription drugs are covered in accord with Kaiser Permanente's formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the Evidence of Coverage for detailed information about prescription drug copayments.

(4) Not subject to a deductible.

(5) Please refer to the Evidence of Coverage for more information; most DME is not covered.

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

(7) Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional or packaged eyeware program, for any contact lense extended purchase agreement, or to low-vision aids or devices.

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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	HSA Qualified Plans			*Deductible HMO Plans (Not HSA Compatible)*		
Benefit Description	**$0/$2,000 Plan (HSA Qualified)**	**$0/$2,700 Plan (HSA Qualified)**	**30/$3,000 Plan (HSA Qualified)**	**$30/$1,000 Plan**	**$30/$1,500 Plan**	**$40/$2,000 Plan**
Annual Calendar Year Deductible	$2,000/person $4,000/family (2)	$2,700/person $5,450/family (3)	$3,000/person $6,000/family (3)	$1,000/person $2,000/family (3)	$1,500/person $3,000/family (3)	$2,000/person $4,000/family (3)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Annual Calendar Year Out-of-Pocket Maximum	$3,500/person $7,000/family (2,4)	$4,500/person $9,000/family (3,4)	$5,950/person $11,900/family (3,4)	$3,500/person $7,000/family (3,4)	$3,500/person $7,000/family (3,4)	$4,500/person $9,000/family (3,4)
	Amounts Listed Are Member Payments			***Amounts Listed Are Member Payments***		
Office Visits	$0 (after deductible)	$0 (after deductible)	$30 (after deductible)	$30 (5)	$30 (5)	$40 (5)
Preventive Exams (5)	$0	$0	$0	$0	$0	$0
Maternity/Pre-Natal (Scheduled pre-natal visits and first postpartum visit) (5)	$0 (6)	$0 (6)	$0 (6)	$0 (6)	$0 (6)	$0 (6)
X-Ray and Lab **Most labs and imaging** **MRI/CT/PET Scan**	$0 (after deductible) $50 (after deductible)	$0 (after deductible) $50 (after deductible)	$10 (after deductible) $50 (after deductible)	$10 (after deductible) $50 (after deductible)	$10 (after deductible) $50 (after deductible)	$10 (after deductible) $50 (after deductible)
Inpatient Hospitalization	$300 per day (after deductible)	$450 per day (after deductible)	30% per admission (after deductible)	$500 per day (after deductible)	$500 per day (after deductible)	30% per admission (after deductible)
Outpatient Surgery	$150 (after deductible)	$250 (after deductible)	30% (after deductible)	$250 (after deductible)	$250 (after deductible)	30% (after deductible)
Ambulance Services	$100 (after deductible)	$100 (after deductible)	$100 (after deductible)	$75 (after deductible)	$75 (after deductible)	$100 (after deductible)
Emergency Room (Not resulting in direct hospital admission)	$100 (after deductible)	$100 (after deductible)	30% (after deductible)	$100 (after deductible)	$100 (after deductible)	30% (after deductible)
Prescription Drugs (7)	**Up to 30 Day Supply**			**Up to 30 Day Supply**		
Rx Deductible	***Same as medical deductible***	***Same as medical deductible***	***Same as medical deductible***	No Deductible	No Deductible	No Deductible
RX Co-Pays: *Brand Name* *Generic*	$30 $10	$30 $10	$30 $10	$30 $10	$30 $10	$35 $10
Certain Durable Medical Equipment (DME) (8)	$0 (after deductible)	$0 (after deductible)	20% (after deductible)	30%; no deductible	30%; no deductible	30%; no deductible
Preventive Vision Screening	$0 (5)	$0 (5)	$0 (5)	$0 (5)	$0 (5)	$0 (5)
Eye Exam for Refraction	$0 (after deductible)	$0 (after deductible)	$30 (after deductible)	$30	$30	$40
Optical Eye Wear (9)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

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(2) Plan has an aggregate deductible. For family enrollment, there is only one deductible for the whole family. Once it's met, either individually or collectively, the family pays only copayments and coinsurance for the remainder of the calendar year, or until the family out-of-pocket maximum is satisfied.

(3) This plan carries an embedded deductible. Each famiy member becomes eligible for copayments or coinsurance after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

(4) The annual out of pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the Evidence of Coverage).

(5) Not subject to a deductible.

(6) Note: Well-child preventive care visits through age 23 months are also included at the stated co-pay of $0 with no deductible.

(7) Prescription drugs are covered in accord with Kaiser Permanente's formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the Evidence of Coverage for detailed information about prescription drug copayments.

(8) Please refer to the Evidence of Coverage for more information; most DME is not covered.

(9) Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional or packaged eyeware program, for any contact lense extended purchase agreement, or to low-vision aids or devices.

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