

Grandfathered health plan benefit highlights

If your desired plan is to the right of your current plan, you may switch to that plan. Please note that you will not be able to return to your old plan after you switch.

	Copayment 25	Deductible 20/500	Copayment 40	Deductible 25/1000	Copayment 50
Features					
Individual plan annual deductible (subscriber only)	None	\$500	None	\$1,000	None
Family plan annual deductible (individual/family)	None/None	\$500/\$1,000	None/None	\$1,000/\$2,000	None/None
Individual plan annual out-of-pocket maximum (subscriber only)	\$2,500	\$2,500	\$3,000	\$3,000	\$3,500
Family plan annual out-of-pocket maximum (individual/family)	\$2,500/\$5,000	\$2,500/\$5,000	\$3,000/\$6,000	\$3,000/\$6,000	\$3,500/\$7,000
Benefits					
Preventive care					
Routine physical exam, mammograms, etc.	\$25	\$20	\$40	\$25	\$50
Outpatient services (per visit or procedure)					
Primary care office visit	\$25	\$20	\$40	\$25	\$50
Specialty care office visit	\$25	\$20	\$40	\$25	\$50
Most X-rays	\$10	\$10 after deductible	\$10	\$10 after deductible	\$10
Most lab tests	\$10	\$10 after deductible	\$10	\$10 after deductible	\$10
MRI, CT, and PET	\$50	\$10 after deductible	\$50	\$50 after deductible	\$50
Outpatient surgery	\$100	\$50 after deductible	\$200	\$150 after deductible	\$250
Mental health visit	\$25	\$20	\$40	\$25	\$50
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications	\$200 per day	\$100 per day after deductible	\$350 per day	\$250 per day after deductible	\$500 per day
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	\$10	\$10	\$15
Delivery and inpatient well-baby care	\$200 per day	\$100 per day after deductible	\$350 per day	\$250 per day after deductible	\$500 per day
Emergency and urgent care					
Emergency Department visit	\$100	\$100 after deductible	\$100	\$100 after deductible	\$150
Urgent care visit	\$25	\$20	\$40	\$25	\$50
Ambulance services	\$100 per trip	\$150 per trip after deductible	\$200 per trip	\$150 per trip after deductible	\$300 per trip
Prescription drugs					
Plan pharmacy (up to a 30-day supply)	Generic: \$10 Brand: \$35	Generic: \$10 Brand: \$35	Generic: \$10 Brand: \$35 after deductible	Generic: \$10 Brand: \$35 after deductible	Not covered except female contraceptives Generic: \$10 Brand: \$35
Mail order (up to a 100-day supply)	Generic: \$20 Brand: \$70	Generic: \$20 Brand: \$70	Generic: \$20 Brand: \$70 after deductible	Generic: \$20 Brand: \$70 after deductible	Not covered

This plan summary is intended to highlight only some of the most frequently asked-about benefits and their copays, coinsurance, and deductibles. Please refer to the *Membership Agreement, Disclosure Form, and Evidence of Coverage* for more details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement, Disclosure Form, and Evidence of Coverage*, please visit kp.org/plandocuments, call us at 1-800-464-4000, or contact your broker. For services subject to the deductible, you'll have to pay health care expenses out of pocket until you meet your deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

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	Deductible 30/1500	Deductible 40/2000	Deductible 0/1500 with HSA	Deductible 0/2700 with HSA	Deductible 30/2700 with HSA
Features					
Individual plan annual deductible (subscriber only)	\$1,500	\$2,000	\$1,500	\$2,700	\$2,700
Family plan annual deductible (individual/family)	\$1,500/\$3,000	\$2,000/\$4,000	\$3,000/\$3,000	\$5,450/\$5,450	\$5,450/\$5,450
Individual plan annual out-of-pocket maximum (subscriber only)	\$3,500	\$4,000	\$3,000	\$5,000	\$5,250
Family plan annual out-of-pocket maximum (individual/family)	\$3,500/\$7,000	\$4,000/\$8,000	\$6,000/\$6,000	\$10,000/\$10,000	\$10,500/\$10,500
Benefits					
Preventive care					
Routine physical exam, mammograms, etc.	\$30	\$40	No charge	No charge	\$30
Outpatient services (per visit or procedure)					
Primary care office visit	\$30	\$40	No charge after deductible	No charge after deductible	\$30 after deductible
Specialty care office visit	\$30	\$40	No charge after deductible	No charge after deductible	\$30 after deductible
Most X-rays	\$10 after deductible	\$10 after deductible	\$10 after deductible	\$10 after deductible	\$10 after deductible
Most lab tests	\$10 after deductible	\$10 after deductible	\$10 after deductible	\$10 after deductible	\$10 after deductible
MRI, CT, PET	\$50 after deductible	\$50 after deductible	\$50 after deductible	\$50 after deductible	\$50 after deductible
Outpatient surgery	\$250 after deductible	\$250 after deductible	\$150 after deductible	\$200 after deductible	30% coinsurance (after deductible)
Mental health visit	\$30	\$40	No charge	No charge	\$30 after deductible
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications	\$500 per day after deductible	\$500 per day after deductible	\$300 per day after deductible	\$400 per day after deductible	30% coinsurance after deductible
Maternity					
Routine prenatal care visit, first postpartum visit	\$30	\$40	No charge	No charge	\$10
Delivery and inpatient well-baby care	\$500 per day after deductible	\$500 per day after deductible	\$300 per day after deductible	\$400 per day after deductible	30% coinsurance after deductible
Emergency and urgent care					
Emergency Department visit	\$150 after deductible	\$150 after deductible	\$100 after deductible	\$100 after deductible	30% coinsurance after deductible
Urgent care visit	\$30	\$40	No charge after deductible	No charge after deductible	\$30 after deductible
Ambulance services	\$150 per trip after deductible	\$150 per trip after deductible	\$100 per trip after deductible	\$100 per trip after deductible	\$100 per trip after deductible
Prescription drugs					
Plan pharmacy (up to a 30-day supply)	Generic: \$10 Brand: \$35	Generic: \$10 Brand: \$35	Generic: \$10 Brand: \$35 after deductible	Generic: \$10 Brand: \$35 after deductible	Not covered except female contraceptives Generic: \$10 Brand: \$35
Mail order (up to a 100-day supply)	Generic: \$20 Brand: \$70	Generic: \$20 Brand: \$70	Generic: \$20 Brand: \$70 after deductible	Generic: \$20 Brand: \$70 after deductible	Not covered

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