

	Copay Option	Investor 80	Investor 100
Annual Deductible Options Individual/Family	<input type="checkbox"/> \$500/\$1,500 - Par \$500/\$1,500 - NonPar <input type="checkbox"/> \$1,000/\$3,000 - Par \$1,000/\$3,000 - NonPar <input type="checkbox"/> \$1,500/\$4,500 - Par \$1,500/\$4,500 - NonPar	If more than one family member is on the plan, the entire family deductible must be met before benefits are paid. <input type="checkbox"/> \$1,500/\$3,000 Par \$1,500/\$4,500 NonPar <input type="checkbox"/> \$2,000/\$4,000 Par \$2,000/\$6,000 NonPar <input type="checkbox"/> \$2,500/\$5,000 Par \$2,500/\$7,500 NonPar <input type="checkbox"/> \$3,000/\$6,000 Par \$3,000/\$9,000 NonPar	<input type="checkbox"/> \$4,000/\$8,000 Par \$4,000/\$12,000 NonPar <input type="checkbox"/> \$5,000/\$10,000 Par \$5,000/\$15,000 NonPar
Annual Coinsurance Maximum Options Individual/Family	Does not include deductible or copayments.	Option below must correspond to the same sequential deductible option above	
		Includes deductible. If more than one family member is on the plan, the entire family coinsurance maximum must be met before benefits are paid at 100%.	
	<input type="checkbox"/> \$2,000/\$6,000 - Par \$10,000/\$30,000 - NonPar <input type="checkbox"/> \$5,000/\$15,000 - Par \$10,000/\$30,000 - NonPar	<input type="checkbox"/> \$4,000/\$8,000 Par \$10,000/\$30,000 NonPar <input type="checkbox"/> \$4,500/\$9,000 Par \$10,000/\$30,000 NonPar <input type="checkbox"/> \$5,000/\$10,000 Par \$10,000/\$30,000 NonPar <input type="checkbox"/> \$5,500/\$11,000 Par \$10,000/\$30,000 NonPar	<input type="checkbox"/> \$4,000/\$8,000 Par \$10,000/\$30,000 NonPar <input type="checkbox"/> \$5,000/\$10,000 Par \$10,000/\$30,000 NonPar
Lifetime Maximum	\$2,000,000	\$2,000,000	\$2,000,000
Office Visit Copayment Options	\$30	N/A	N/A
Non-Par Provider Coinsurance	50% (except for Emergency Services)	50% (except for Emergency Services)	50% (except for Emergency Services)
Preventive Care	No Deductible	No Deductible	No Deductible
Annual Routine Physical Exam (\$500)	100%	80%	100%
Well Baby (to 24 months of age)	80%	80%	100%
Outpatient Lab & X-Ray			
Facility (inpatient hospital, ambulatory surgery center, ER)	80%	80%	100%
All other Lab and X-ray	80%	80%	100%
Mammography and PSA-Routine	100%, no deductible	80%, no deductible	100%, no deductible
Mammography and PSA-Diagnostic	100%, no deductible	80%	100%
Colorectal Cancer Screening			
Routine	100%, no deductible	80%, no deductible	100%, no deductible
Diagnostic	See Professional/Hospital Services Sections	80%	100%
Professional Services/Physician, Naturopath, Chiropractor, Acupuncturist, Outpatient Mental Health Counselor	100% after copay, no deductible	80%	100%
Spinal & Extremity Manipulation (12 visits)	See Professional Office Visits	80%	100%
Acupuncture (12 treatments)	See Professional Office Visits	80%	100%
Prescription Drug Options (at participating pharmacies only)	<input type="checkbox"/> \$10 / \$30 / \$50 or <input type="checkbox"/> \$15 / \$40 / \$60	80% subject to deductible and coinsurance maximum	100% subject to deductible and coinsurance maximum
Maternity (subscriber and spouse only, except complications for eligible dependents)	See Facility/Hospital and Professional Services Sections	See Facility/Hospital and Professional Services Sections	See Facility/Hospital and Professional Services Sections
Facility/Hospital Services			
Inpatient	80% after \$300 copay per admit	80%	100%
Outpatient Surgery	80%	80%	100%
Emergency Room & Supplies	80% after \$150 copay	80%	100%
Ambulance (to hospital only)			
Ground \$2,000	80% per year	80% per year	100% per year
Air \$5,000	80% per trip	80% per trip	100% per trip
Substance Use Disorder Treatment (Chemical Dependency) (requires preauthorization; \$15,000 maximum per 24-month period; no lifetime maximum)	80%	80%	100%
Organ Transplants \$350,000 Lifetime Maximum for All Transplants	80%	80%	100%
Rehabilitation (Physical, Speech, Massage & Occupational Therapy)			
Inpatient (up to \$10,000)	80%	80%	100%
Outpatient (up to \$2,000)	80%	80%	100%
Home Health Care (130 visits) & Hospice (6 months)	80%	80%	100%
Mental Health			
Inpatient (requires preauthorization) (up to 8 days)	80%	80%	100%
Outpatient (12 visits)	See Facility/Hospital and Professional Services Sections	80%	100%
Temporomandibular Joint Disorders (up to \$1,000 per year; \$5,000 lifetime maximum)	80%	80%	100%
Medical Equipment & Supplies (\$2,500)	80%	80%	100%
Occupational Injury (owners and officers only) (\$100,000)	80%	80%	100%
Optional Riders			
Vision	✓	✓	✓
Dental (through Washington Dental Service)	✓	✓	✓

All benefits are subject to annual deductible and coinsurance unless otherwise stated. Day/visit limits and dollar maximums are combined between participating and non-participating providers and are for the calendar year unless otherwise noted. If you choose a non-participating provider, your out-of-pocket costs are higher because benefits will be paid at fifty percent (50%) of the KPS allowed amount for covered services. In addition, it is your responsibility to pay the difference between any amounts billed by the non-participating provider or facility and the amount paid by KPS. Please refer to our website at <http://www.kpshealthplans.com> to see if your provider is participating or to find more information about KPS. The Summary of Benefits contains only a brief explanation of the more important coverage features offered. To obtain a detailed listing of all of the benefits included please contact KPS health plans. contract. Complete coverage details, including waiting periods, and other limitations and exclusions, are in the Benefits Booklet. In the event of discrepancies, the Benefits Booklet shall govern. **After member satisfies the annual deductible and coinsurance maximum, KPS pays 100% of covered benefits for the remainder of the calendar year.**