

**KPS HOME CHOICE—\$350 DEDUCTIBLE PLAN**

**KPS HOME CHOICE—\$750 DEDUCTIBLE PLAN**

	KPS Home Choice Network <sup>+</sup>	KPS Participating Networks <sup>+</sup>		KPS Home Choice Network <sup>+</sup>	KPS Participating Networks <sup>+</sup>
<b>Annual Deductible</b> Individual (family deductible three (3) times individual)	\$350	\$700	<b>Annual Deductible</b> Individual (family deductible three (3) times individual)	\$750	\$1,500
<b>Annual Coinsurance Maximum * (does not include deductible)</b> Individual (family coinsurance maximum three (3) times individual)	\$3,500	\$7,000	<b>Annual Coinsurance Maximum * (does not include deductible)</b> Individual (family coinsurance maximum three (3) times individual)	\$3,500	\$7,000
<b>Lifetime Maximum</b>	\$1,000,000 per individual		<b>Lifetime Maximum</b>	\$1,000,000 per individual	
<b>Preventive Care (\$350 maximum per year)</b> Annual Routine Physical Exam Immunizations Well-Baby Care (to 24 months of age) Annual Eye Exam	Not subject to deductible – 100% 100% 100% 100%	Subject to deductible – 60% 60% 60% 60%	<b>Preventive Care (\$350 maximum per year)</b> Annual Routine Physical Exam Immunizations Well-Baby Care (to 24 months of age) Annual Eye Exam	Not subject to deductible – 100% 100% 100% 100%	Subject to deductible – 60% 60% 60% 60%
<b>Professional Services</b> Office, home, naturopath, mental health and urgent care visits  Other outpatient professional services	100% after \$20 per-visit copay for first 3 visits combined (no deductible), subsequent visits 80% subject to deductible  80%	60%  60%	<b>Professional Services</b> Office, home, naturopath or urgent care visits  Other outpatient professional services	80%  80%	60%  60%
<b>Outpatient Lab &amp; X-Ray</b> Mammography Services and Prostate Cancer Screening-Routine Mammography Services and Prostate Cancer Screening-Diagnostic	80% 100%, not subject to deductible 80%, subject to deductible	60% 60%, subject to deductible 60%, subject to deductible	<b>Outpatient Lab &amp; X-Ray</b> Mammography Services and Prostate Cancer Screening-Routine Mammography Services and Prostate Cancer Screening-Diagnostic	80% 100%, not subject to deductible 80%, subject to deductible	60% 60%, subject to deductible 60%, subject to deductible
<b>Facilities/ Hospitals (inpatient &amp; outpatient)</b>	80%	60%	<b>Facilities/ Hospitals (inpatient &amp; outpatient)</b>	80%	60%
<b>Emergency</b> Professional Services Laboratory & X-Ray Emergency Room & Supplies (copay waived if admitted)	80% 80% 80% after \$100 copay per visit	80% 80% 80% after \$100 copay per visit	<b>Emergency</b> Professional Services Laboratory & X-Ray Emergency Room & Supplies (copay waived if admitted)	80% 80% 80% after \$100 copay per visit	80% 80% 80% after \$100 copay per visit
<b>Acupuncture (12 treatments per year maximum)</b>	80%	60%	<b>Acupuncture (12 treatments per year maximum)</b>	80%	60%
<b>Ambulance (\$5,000 maximum per year air &amp; ground combined; does not apply to annual coinsurance maximum; \$150 copay per ground trip; \$500 copay per air trip)</b>	100%		<b>Ambulance (\$5,000 maximum per year air &amp; ground combined; does not apply to annual coinsurance maximum; \$150 copay per ground trip; \$500 copay per air trip)</b>	100%	
<b>Home Health Care (130 visits per year maximum)</b>	80%	60%	<b>Home Health Care (130 visits per year maximum)</b>	80%	60%
<b>Hospice (6 months per year maximum)</b>	80%	60%	<b>Hospice (6 months per year maximum)</b>	80%	60%
<b>Maternity</b>	See Professional & Hospital Services	See Professional & Hospital Services	<b>Maternity</b>	See Professional & Hospital Services	See Professional & Hospital Services
<b>Medical Equipment &amp; Supplies (\$2,500 maximum per year)</b>	80%	60%	<b>Medical Equipment &amp; Supplies (\$2,500 maximum per year)</b>	80%	60%
<b>Mental Health</b> Inpatient (prior authorization required) - 10 days per year maximum Outpatient - 12 visits per year maximum	80% See Professional Services	60% 60%	<b>Mental Health</b> Inpatient (prior authorization required) - 10 days per year maximum Outpatient - 12 visits per year maximum	80% 80%	60% 60%
<b>Nutritional Guidance (\$400 maximum per year)</b>	80%	60%	<b>Nutritional Guidance (\$400 maximum per year)</b>	80%	60%
<b>Outpatient Rehabilitation (\$1,000 maximum per year includes Physical, Speech, Massage &amp; Occupational Therapy)</b>	80%	60%	<b>Outpatient Rehabilitation (\$1,000 maximum per year includes Physical, Speech, Massage &amp; Occupational Therapy)</b>	80%	60%
<b>Prescription Drug (not subject to deductible; \$2,000 maximum per year except for diabetic meds &amp; supplies)</b> Tier 1: Generic Tier 2: Preferred Brand Name Tier 3: Non-Preferred Brand Name	Tier 1: \$5 copay Tier 2: \$35 copay Tier 3: 50% coinsurance	Tier 1: \$5 copay Tier 2: \$35 copay Tier 3: 50% coinsurance	<b>Prescription Drug (not subject to deductible; \$2,000 maximum per year except for diabetic meds &amp; supplies)</b> Tier 1: Generic Tier 2: Preferred Brand Name Tier 3: Non-Preferred Brand Name	Tier 1: \$5 copay Tier 2: \$35 copay Tier 3: 50% coinsurance	Tier 1: \$5 copay Tier 2: \$35 copay Tier 3: 50% coinsurance
<b>Skilled Nursing Facility (in lieu of medically necessary hospitalization)</b>	80%	60%	<b>Skilled Nursing Facility (in lieu of medically necessary hospitalization)</b>	80%	60%
<b>Smoking Cessation (subscriber &amp; spouse; medications paid under prescription benefit; OTC not covered)</b> Professional Services (\$150 lifetime maximum)	80%, not subject to deductible	60%, subject to deductible	<b>Smoking Cessation (subscriber &amp; spouse; medications paid under prescription benefit; OTC not covered)</b> Professional Services (\$150 lifetime maximum)	80%, not subject to deductible	60%, subject to deductible
<b>Spinal and Extremity Manipulations (12 office visits per year maximum)</b>	80%	60%	<b>Spinal and Extremity Manipulations (12 office visits per year maximum)</b>	80%	60%
<b>Sterilization</b>	80%	60%	<b>Sterilization</b>	80%	60%
<b>Vision Hardware (\$100 maximum per year; not subject to deductible)</b>	100%		<b>Vision Hardware (\$100 maximum per year; not subject to deductible)</b>	100%	

This is not a contract, nor is it a complete explanation of benefits. Unless otherwise stated, all benefits are subject to deductible in addition to any copays and coinsurance. Please refer to the plan contract for complete coverage details, including waiting periods and other limits and exclusions. \*After member satisfies the annual deductible and coinsurance maximum, this plan will pay 100% of covered benefits for the remainder of the calendar year for the services of KPS Home Choice Network and KPS Participating Networks only, unless otherwise specified. Please refer to our website at [www.kpshealthplans.com](http://www.kpshealthplans.com) to find KPS Home Choice Network providers. The **KPS Home Choice Network** includes contracted providers who provide services to you within Kitsap, Mason, Jefferson and Clallam counties. +The KPS Participating Networks include providers contracted directly with KPS, the First Choice Health Network (FCHN) or the Providence Preferred Provider Organization who provide services to you outside this four county area and the MultiPlan Network of contracted providers outside the state of Washington.