



**Wichita Independent Business Association  
Base Option**

**HDHP RX SUMMARY OF BENEFITS**

Proposed Group Effective Date:

6/1/2010

**(Benefit Period: benefits accumulate on a calendar year basis)**

Preferred Health Systems Insurance Company is offering a Preferred Provider Organization (PPO) benefit plan through the Preferred Health Care (PHC) network of Contracting Providers or its affiliated contracting networks. A Covered Person may utilize any provider. If a Contracting Provider is utilized, the Covered Person will receive the Network level of benefits. If the Covered Person utilizes a Non-Contracting Provider, the Covered Person will receive the Non-Network level of benefits. **The Covered Person will also be responsible for the difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts, which could be substantial. For Non-Covered Services or services that exceed a benefit maximum, the Covered Person will be responsible for the entire billed charges of a Provider.**

| BENEFIT CATEGORY   | COVERED PERSON RESPONSIBILITY |   |
|--|-------------------------------|---|
|  | NETWORK                       | NON-NETWORK                                   |
| <b>DEDUCTIBLE</b> (per Benefit Period)<br><i>Includes medical and prescription benefits</i><br>Individual \$4,000<br>Family \$8,000<br><b>(at least two (2) family members must contribute toward the family Deductible)</b><br>The Deductibles for Network and Non-Network services are accumulated separately.<br><b>All services are subject to Deductible unless otherwise indicated.</b><br>The following do not count toward meeting the Deductible: penalty for failure to prior authorize inpatient services; charges for Non-Covered Services; or difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.   |                               |   |
| <b>COINSURANCE</b><br>(The portion of the Allowed Amount payable by the Covered Person <b>after the Deductible has been met</b> )  | 50% of Allowed Amounts        | 50% of Allowed Amounts                        |
| <b>OUT-OF-POCKET MAXIMUM</b><br><i>Includes Deductible and Coinsurance for medical and prescription benefits</i><br>Individual \$5,000<br>Family \$10,000<br><b>(at least two (2) family members must contribute toward the family out-of-pocket maximum)</b><br>After the out-of-pocket maximum has been reached, benefits will increase to 100% of the Allowed Amounts for the remainder of the Benefit Period. <b>The Covered Person will still be responsible for the difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.</b> The following do not count towards meeting the out-of-pocket maximum: penalty for failure to prior authorize inpatient services; charges for Non-Covered Services; or difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.  |                               |   |
| <b>LIFETIME MAXIMUM</b><br>This lifetime maximum will include benefits accumulated under another PHSIC Plan offered by the same employer prior to this Coverage.   | \$1,000,000                   |   |
| <b>PREVENTIVE CARE SERVICES</b><br><u>Routine Services &amp; Limitations</u><br><b>Routine Eye Exam</b> - Annually, includes testing and refraction<br><b>Well-Baby or Well-Child Care</b> - Unlimited for Covered Persons up to 2 years of age<br><b>Routine Physical Exam</b> - Annually for Covered Persons 2 years of age and older<br><b>Routine and Non-Routine Immunizations, including flu shots</b> - Covered at 100% of Allowed Amounts at the Network level. For Covered Persons up to 72 months of age, Non-Network services are covered at 100% of Allowed Amounts.<br><b>Routine Lab-general health and lipid panel</b> - Annually, includes glucose and cholesterol<br><b>Routine Well-Woman Exam</b> - Annually, includes Pap test, HPV screening, vaginal cultures and mammogram<br><b>Routine Well-Man Exam</b> - Annually, includes digital rectal exam and screening PSA test (Covered Persons 40 years of age or older)<br><b>Colorectal Cancer Screening</b><br><b>Fecal occult blood</b> - Annually for Covered Persons 50 years of age or older if not part of the annual well-woman exam<br><b>Barium enema or sigmoidoscopy</b> - For Covered Persons 50 years of age or older once every 5 years<br><b>or Colonoscopy</b> - For Covered Persons 50 years of age or older once every 10 years<br><b>Osteoporosis Screening (bone density study)</b> - For female Covered Persons 50 years of age or older once every 2 years | \$0                           | 50% of Allowed Amounts unless otherwise noted |

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| <b>OUTPATIENT LAB AND X-RAY SERVICES</b><br>This benefit does not apply to services relating to accidental injury to teeth.   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>PHYSICIAN OFFICE PROCEDURES AND INJECTIONS</b>   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>OUTPATIENT SURGERY</b>   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>MATERNITY BENEFIT</b>  | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>INPATIENT BENEFITS</b> ( <i>Semi-Private Room, ICU, SNU, Hospice</i> )<br><i>If inpatient services are not prior authorized, a \$500 penalty will apply per admission.</i>   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE</b><br><i>If inpatient services are not prior authorized, a \$500 penalty will apply per admission.</i>  | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE</b><br><i>Some services require Prior Authorization.</i><br>This benefit includes intensive outpatient programs and partial day hospitalization.  | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>EMERGENCY ROOM SERVICES</b><br><br><b><i>There is no coverage for non-Emergency Medical Conditions treated in a Hospital emergency room.</i></b><br><br>Non-Network Emergency Services will be covered at the Network Deductible and Coinsurance level, if PHSIC is notified within twenty-four (24) hours or the next business day. <b>The Covered Person will be responsible for the difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.</b> | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>AMBULANCE</b>  | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>DURABLE MEDICAL EQUIPMENT AND SUPPLIES</b><br>Durable Medical Equipment and supplies are <b>limited to a maximum benefit of \$2,500 of Allowed Amounts</b> per Covered Person, per Benefit Period, combined Network and Non-Network.   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>DISPOSABLE MEDICAL SUPPLIES</b><br>Coverage is <b>limited to a maximum benefit of \$500 of Allowed Amounts</b> per Covered Person, per Benefit Period, combined Network and Non-Network.   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>DIABETIC EQUIPMENT AND SUPPLIES</b>  | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY</b><br><i>Inpatient services are subject to inpatient benefits</i>   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>HOME HEALTH CARE</b><br>Maximum benefit <b>limited to \$2,500 of Allowed Amounts</b> per Covered Person, per Benefit Period, combined Network and Non-Network.   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>INTRAVENOUS (IV) AND INJECTABLE MEDICATIONS</b>  | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>OUTPATIENT HOSPICE SERVICES</b>  | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>TMJ</b><br>Maximum benefit <b>limited to \$1,000 of Allowed Amounts</b> per Covered Person, per Benefit Period, combined Network and Non-Network; \$5,000 of Allowed Amounts per lifetime.   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>OUTPATIENT SPEECH THERAPY</b><br>Maximum benefit <b>limited to \$1,500 of Allowed Amounts</b> per Covered Person, per Benefit Period, combined Network and Non-Network.  | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>INPATIENT REHABILITATION</b> ( <i>Speech, Physical, Occupational</i> )<br>Maximum benefit <b>limited to sixty (60) days</b> per medical condition, per Covered Person, per Benefit Period, combined Network and Non-Network.   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>OUTPATIENT REHABILITATION</b> ( <i>Physical, Occupational, Cardiac, and Pulmonary</i> )<br>Maximum benefit <b>limited to \$5,000 of Allowed Amounts</b> per Covered Person, per Benefit Period, combined Network and Non-Network.  | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>SPINAL MANIPULATION SERVICES</b><br>Maximum benefit <b>limited to \$500 of Allowed Amounts</b> per Covered Person, per Benefit Period, combined Network and Non-Network.   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>ORTHOTICS AND PROSTHETICS</b><br>Coverage is limited to the original device unless repair and/or replacement is Medically Necessary.   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>ORAL SURGERY AND RELATED SERVICES</b><br>Services for accidental injury (not from biting or chewing) to sound, natural teeth will be covered at the Network Deductible and Coinsurance level up to a <b>maximum of \$1,000 of Allowed Amounts</b> , if provided within twelve (12) months from the date of the injury.   | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>TRANSPLANT SERVICES</b><br><br><b><i>All Organ Transplants must be prior authorized with PHSIC before the transplant.</i></b><br><br><u>Non-Network services subject to lifetime maximums:</u><br>Kidney; Autologous Bone Marrow - \$100,000<br>Kidney/Pancreas; Pancreas - \$150,000<br>Allogenic Bone Marrow; Intestine; Liver - \$200,000<br>Heart; Lung; Heart/Lung - \$250,000  | 50% of Allowed Amounts | 50% of Allowed Amounts |

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|---|------------------------|------------------------|
| <b>ALL OTHER COVERED SERVICES</b>               | 50% of Allowed Amounts | 50% of Allowed Amounts |
| <b>PRESCRIPTION DRUGS</b>                       | 50% of Allowed Amounts |                        |
| Certain medications require Prior Authorization |                        |                        |

Some services require Prior Authorization from PHSIC. The Covered Person or Provider is responsible for obtaining Prior Authorization. If inpatient services are not prior authorized, a \$500 penalty will apply. The Prior Authorization List is subject to change. An up-to-date Prior Authorization List can be found at [www.phsystems.com](http://www.phsystems.com) or by calling the Member Services department at 316-609-2390 or 1-800-660-8114 (outside Wichita).

All benefits and the Coinsurance percentage are based on Allowed Amounts. All benefits are subject to Deductible and/or Coinsurance unless otherwise stated.

**Basic Exclusions**

\*Any services which are not Medically Necessary. \*Experimental and investigational treatment. \*All services related to treatment of obesity and weight reduction. Any medical services rendered in conjunction with prescription drug therapy for weight control. \*Cosmetic treatment/surgery. \*Services for injuries or diseases related to employment and covered or required to be covered by a Workers Compensation program. \*Services resulting from injuries related to the use of a motor vehicle which are covered or required to be covered under automobile insurance. \*Duplication of benefits provided by Federal, State or local laws. \*Items not strictly to treat a medical condition. \*Services or items for the convenience of the Covered Person or Provider. \*Services or supplies related to an excluded service and subsequent complications.

This plan provides access to an exclusive network which does not include Wesley Medical Center.

This is a brief summary of the coverage available under this plan. It is not a legal document. The complete plan provisions, limitations, and exclusions are contained in the Certificate you will receive when you enroll.