



Wichita Independent Business Association
PREMIUM OPTION
PPO 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
PHYSICIAN OFFICE VISIT Physical medicine services, outpatient speech therapy and outpatient rehabilitation services are not covered under the office visit Copayment.	\$25 per visit	50% of Allowed Amounts
DEDUCTIBLE (per Benefit Period) Individual Family The Deductibles for Network and Non-Network services are accumulated separately. At least two (2) family members must contribute toward the family Deductible. The following do not count toward meeting the Deductible: Copayments; penalty for failure to prior authorize inpatient services; charges related to TMJ services; charges for Non-Covered Services; or difference paid between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.	\$1,000 \$2,000	\$2,000 \$4,000
DEDUCTIBLE CARRYOVER Covered amounts applied towards the PHSIC Network Deductible in the last three (3) months of the Benefit Period will be credited to the next Benefit Period's Network Deductible. This carryover provision does not apply to the the Non-Network Deductible or any prescription drug benefit.		
COINSURANCE (The portion of the Allowed Amount payable by the Covered Person after the Deductible has been met)	20% of Allowed Amounts	50% of Allowed Amounts
COINSURANCE MAXIMUM Individual Family (after satisfaction of Deductible) After the Coinsurance maximum has been reached, benefits will increase to 100% of the Allowed Amounts for the remainder of the Benefit Period. The Covered Person will be responsible for the difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts. The following do not count towards meeting the Coinsurance maximum: Copayments; Deductible; penalty for failure to prior authorize inpatient services; charges related to TMJ services; charges for Non-Covered Services; or difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.	\$2,000 \$4,000	\$5,000 \$10,000
LIFETIME MAXIMUM This lifetime maximum will include benefits accumulated under another PHSIC Plan offered by the same employer prior to this coverage.	\$1,000,000	
PREVENTIVE CARE SERVICES <i>(For additional services, refer to page two)</i> <u>Routine Services & Limitations</u> Well-Baby or Well-Child Care - Unlimited for Covered Persons up to 2 years of age Routine Physical Exam - Annually for Covered Persons 2 years of age and older Routine and non-routine immunizations, including flu shots - 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. Routine lab-general health and lipid panel - Annually, includes glucose and cholesterol Routine Well-Woman Exam - Annually, includes Pap test, HPV screening, vaginal cultures and mammogram	100% Coverage after any applicable office visit Copayment	50% of Allowed Amounts unless otherwise noted

<p>PREVENTIVE CARE SERVICES <i>continued:</i> Routine Well-Man Exam - Annually, includes digital rectal exam and screening PSA test (Covered Persons 40 years of age or older) Colorectal cancer screening Fecal occult blood - Annually for Covered Persons 50 years of age or older if not part of the annual well-woman exam Barium enema or sigmoidoscopy - For Covered Persons 50 years of age or older once every 5 years or Colonoscopy - For Covered Persons 50 years of age or older once every 10 years Osteoporosis screening (bone density study) - For female Covered Persons 50 years of age or older once every 2 years</p>	100% Coverage after any applicable office visit Copayment	50% of Allowed Amounts unless otherwise noted
<p>OUTPATIENT LAB AND X-RAY The first \$350 of Allowed Amounts are combined Network and Non-Network. This benefit does not apply to services relating to accidental injury to teeth.</p>	100% Coverage up to \$350 of Allowed Amounts, then subject to Network Deductible and Coinsurance	100% Coverage up to \$350 of Allowed Amounts, then subject to Non-Network Deductible and Coinsurance
<p>DIAGNOSTIC TESTING except lab and x-ray This benefit does not apply to services relating to accidental injury to teeth.</p>	20% of Allowed Amounts	50% of Allowed Amounts
PHYSICIAN OFFICE PROCEDURES AND INJECTIONS	20% of Allowed Amounts	50% of Allowed Amounts
OUTPATIENT SURGERY	20% of Allowed Amounts	50% of Allowed Amounts
MATERNITY BENEFIT	20% of Allowed Amounts	50% of Allowed Amounts
<p>INPATIENT BENEFITS (<i>Semi-Private Room, ICU, SNU, Hospice</i>) <i>If inpatient services are not prior authorized, a \$500 penalty will apply per admission.</i></p>	20% of Allowed Amounts	50% of Allowed Amounts
<p>INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>If inpatient services are not prior authorized, a \$500 penalty will apply per admission.</i></p>	20% of Allowed Amounts	50% of Allowed Amounts
<p>OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>Some services require Prior Authorization.</i> This benefit includes intensive outpatient programs and partial day hospitalization.</p>	\$25 Copayment	50% of Allowed Amounts
<p>EMERGENCY ROOM SERVICES <i>There is no coverage for non-Emergency Medical Conditions treated in a Hospital emergency room.</i> Non-Network Emergency Services will be covered at the Network Copayment or the Network Deductible/Coinsurance level, if PHSIC is notified within twenty-four (24) hours or the next business day. The Covered Person will be responsible for the difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.</p>	\$150 Copayment (waived if admitted)	\$300 Copayment (waived if admitted)
AMBULANCE	20% of Allowed Amounts	20% of Allowed Amounts
<p>DURABLE MEDICAL EQUIPMENT AND SUPPLIES <i>(Deductible does not apply to Network services)</i> Durable Medical Equipment and supplies are limited to a maximum benefit of \$2,500 of Allowed Amounts per Covered Person, per Benefit Period, combined Network and Non-Network.</p>	\$0	50% of Allowed Amounts
<p>DISPOSABLE MEDICAL SUPPLIES Coverage is limited to a maximum benefit of \$500 of Allowed Amounts per Covered Person, per Benefit Period, combined Network and Non-Network.</p>	20% of Allowed Amounts	20% of Allowed Amounts
DIABETIC EQUIPMENT AND SUPPLIES	20% of Allowed Amounts	50% of Allowed Amounts
<p>RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY <i>Inpatient services are subject to inpatient benefits</i></p>	20% of Allowed Amounts	50% of Allowed Amounts
<p>HOME HEALTH CARE <i>(Deductible does not apply to Network services)</i> Maximum benefit limited to \$2,500 of Allowed Amounts per covered Person, per Benefit Period, combined Network and Non-Network.</p>	\$0	50% of Allowed Amounts
INTRAVENOUS (IV) AND INJECTABLE MEDICATIONS	20% of Allowed Amounts	50% of Allowed Amounts
<p>OUTPATIENT HOSPICE SERVICES (<i>Deductible does not apply to Network services</i>)</p>	\$0	50% of Allowed Amounts
<p>TMJ (<i>Deductible does not apply</i>) Maximum benefit limited to \$1,000 of Allowed Amounts per Covered Person, per Benefit Period, combined Network and Non-Network; \$5,000 of Allowed Amounts per lifetime</p>	30% of Allowed Amounts	30% of Allowed Amounts
<p>OUTPATIENT SPEECH THERAPY Maximum benefit limited to \$1,500 of Allowed Amounts per Covered Person, per Benefit Period, combined Network and Non-Network.</p>	20% of Allowed Amounts	50% of Allowed Amounts

INPATIENT REHABILITATION (<i>Speech, Physical, Occupational</i>) Maximum benefit limited to sixty (60) days , per medical condition, per Covered Person, per Benefit Period, combined Network and Non-Network.	20% of Allowed Amounts	50% of Allowed Amounts
OUTPATIENT REHABILITATION (<i>Physical, Occupational, Cardiac, and Pulmonary</i>) Maximum benefit limited to \$5,000 of Allowed Amounts per Covered Person, per Benefit Period, combined Network and Non-Network.	20% of Allowed Amounts	50% of Allowed Amounts
SPINAL MANIPULATION SERVICES Maximum benefit limited to \$500 of Allowed Amounts per Covered Person, per Benefit Period, combined Network and Non-Network.	20% of Allowed Amounts	50% of Allowed Amounts
ORTHOTICS AND PROSTHETICS Coverage is limited to the original device unless repair and/or replacement is Medically Necessary.	20% of Allowed Amounts	50% of Allowed Amounts
ORAL SURGERY AND RELATED SERVICES Services for accidental injury to sound, natural teeth will be covered at the Network Deductible and Coinsurance level up to a maximum benefit of \$1,000 of Allowed Amounts , if provided within twelve (12) months from the date of the injury.	20% of Allowed Amounts	50% of Allowed Amounts
TRANSPLANT SERVICES <i>All Organ Transplants must be prior authorized with PHSIC prior to the transplant.</i> <u>Non-Network services subject to lifetime maximums:</u> Kidney; Autologous Bone Marrow - \$100,000 Kidney/Pancreas; Pancreas - \$150,000 Allogenic Bone Marrow; Intestine; Liver - \$200,000 Heart; Lung; Heart/Lung - \$250,000	20% of Allowed Amounts	50% of Allowed Amounts
ANNUAL ROUTINE EYE EXAM	\$0	50% of Allowed Amounts
ALL OTHER COVERED SERVICES	20% of Allowed Amounts	50% of Allowed Amounts
PRESCRIPTION DRUGS Certain medications require Prior Authorization Retail Pharmacy: A 34-day supply, as specified by the quantity sufficient for a standard course of therapeutic treatment as defined by FDA guidelines, or 100 unit dose of tablets or capsules, whichever is less. Mail Order Pharmacy: A 90-day supply, as specified by the quantity sufficient for a standard course of therapeutic treatment as defined by FDA guidelines. <i>Please refer to your Prescription Drug Endorsement for complete plan provisions and limitations.</i>	34 Day Supply: \$3 generic Copayment; 50% name brand Coinsurance; 90 Day Supply: \$10 generic Copayment; 50% name brand Coinsurance	Covered Person reimbursed Allowed Amount minus the Covered Person's responsibility.

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 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, Copayments, 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.