



PREFERRED PLUS OF KANSAS, INC.
Wichita Independent Business Ass'n PLAN P
SUMMARY OF BENEFITS
2008

Benefit Period: Benefits accumulate from January 1 to December 31

Preferred Health Systems is offering a HMO benefit plan through Preferred Plus of Kansas (PPK). To enroll for coverage in PPK, employees and all covered Dependents must select a Primary Care Physician (PCP). When you or your Dependents are in need of health care, services must be provided or referred in advance by your PCP or prior authorized by PPK. Services which are not provided or referred by your PCP or prior authorized by PPK are not covered.

BENEFIT CATEGORY	MEMBER RESPONSIBILITY
PCP OFFICE VISIT	\$20 Copayment
SPECIALIST PHYSICIAN VISIT	\$30 Copayment
WELL WOMAN EXAM	\$20 PCP or \$30 OB/GYN Copayment Must be rendered by your PCP or contracting OB/GYN (a referral is not required)
DEDUCTIBLE (per Benefit Period)	Applies to all services unless otherwise noted Individual \$200 Family \$400 The following do not count towards meeting the Deductible: Copayments; services listed as covered at 100% of Allowed Amounts; or outpatient behavioral health and substance abuse (BH/SA).
DEDUCTIBLE CARRYOVER	Covered amounts applied towards the PPK Deductible in the last three (3) months of the Benefit Period will be credited to the next Benefit Period's Deductible. This carryover provision does not apply to any prescription drug benefit.
COINSURANCE (after satisfaction of Deductible)	Applies to all services unless otherwise noted The Plan is responsible for 80% of Allowed Amounts after Deductible See Definition section of the Certificate for explanation of Allowed Amounts
OUT OF POCKET COINSURANCE MAXIMUM (after satisfaction of Deductible)	Individual \$3,000 Family \$6,000 After the out-of-pocket Coinsurance maximum has been reached, benefits will increase to 100% of the Allowed Amounts for the remainder of the Benefit Period. The following do not count towards meeting the out-of-pocket Coinsurance maximum: Copayments; Deductible; penalty; or outpatient behavioral health and substance abuse (BH/SA).
LIFETIME MAXIMUM	\$2,000,000 The lifetime maximum will include benefits you have accumulated under another PPK health plan offered by the same employer prior to this coverage.
OUTPATIENT LAB, X-RAY, AND DIAGNOSTIC TESTING	80% of Allowed Amounts
PHYSICIAN OFFICE PROCEDURES AND INJECTIONS	80% of Allowed Amounts
INPATIENT BENEFITS* (Semi-Private Room, ICU, SNU, Hospice)	80% of Allowed Amounts
MATERNITY CARE Prenatal and Postpartum Services Inpatient Services*	Services must be rendered by your PCP or contracting OB/GYN 80% of Allowed Amounts Subject to inpatient benefits
OUTPATIENT SURGERY*	80% of Allowed Amounts
ALLERGY TESTING OR TREATMENT	80% of Allowed Amounts
IMMUNIZATIONS for Members up to 72 months of age for Members over 72 months of age	100% of Allowed Amounts 80% of Allowed Amounts
DEPENDENT CHILDREN OUT OF AREA CARE*	Physician Office Visit \$30 Copayment Physical Therapy \$30 Copayment Coverage outside the Service Area for Dependent children is limited to Physician office visits, allergy shots, allergy treatment, and physical therapy. Services must be received from Contracting Providers, referred by the Dependent's PCP, and prior authorized by PPK. This benefit does not include routine or preventive services such as immunizations, physicals, or maternity care.
INPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE*	Subject to inpatient benefits Services must be prior authorized by PPK by callin 316-609-2541 or 1-866-338-4281 (outside Wichita). Maximum benefit limited to thirty (30) days per Member, per Benefit Period. Each partial day session will count as one half inpatient day toward the 30 day benefit.

INPATIENT BIOLOGICALLY BASED MENTAL ILLNESS*	<p>Subject to inpatient benefits</p> <p>Services must be prior authorized by PPK by calling 316-609-2541 or 1-866-338-4281 (outside Wichita).</p> <p>Maximum benefit limited to forty-five (45) days per Member, per Benefit Period.</p> <p>Each partial day session will count as one half inpatient day toward the forty-five (45) day benefit.</p>
OUTPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE*	<p>100% of Allowed Amounts of the first three (3) visits; then 70% of Allowed Amounts.</p> <p>Services must be prior authorized by PPK by calling 316-609-2541 or 1-866-338-4281 (outside Wichita).</p>
OUTPATIENT BIOLOGICALLY BASED MENTAL ILLNESS*	<p>Subject to Applicable PCP or Specialist Physician Copayments</p> <p>Services must be prior authorized by PPK by calling 316-609-2541 or 1-866-338-4281 (outside Wichita).</p> <p>Maximum benefit limited to forty-five (45) visits per Member, per Benefit Period.</p>
EMERGENCY SERVICES IN THE SERVICE AREA <i>There is no coverage for non Emergency Medical Conditions treated in a Hospital emergency room.</i>	<p>\$200 Hospital emergency room Copayment at a contracting Hospital; \$250 Hospital emergency room Copayment at a non contracting Hospital \$30 urgent care facility Copayment</p> <p>If admitted, Copayment will be waived and inpatient benefits will apply.</p> <p>If you receive Emergency Services from a non-contracting Hospital within the Service Area under circumstances where you have the ability to determine when or where to seek such services, you will be responsible for the difference between the Provider's billed charges and Allowed Amounts. If admitted, you will also be responsible for a \$1,000 penalty, per admission. In situations where you require Emergency Services and have no control when or where such services are rendered, you will not be responsible for the difference between the Provider's billed charges and Allowed Amounts, or the \$1,000 penalty.</p>
EMERGENCY SERVICES OUT OF THE SERVICE AREA (if Emergency Medical Condition)	<p>\$200 Hospital emergency room Copayment \$30 urgent care facility Copayment</p> <p>If admitted, Copayment will be waived and inpatient benefits will apply.</p>
AMBULANCE	80% of Allowed Amounts
DURABLE MEDICAL EQUIPMENT*	<p>80% of Allowed Amounts</p> <p>Maximum benefit limited to \$1,000 of Allowed Amounts per Member, per Benefit Period.</p>
DISPOSABLE MEDICAL SUPPLIES	<p>80% of Allowed Amounts</p> <p>Coverage is limited to \$500 per Member, per Benefit Period for the following:</p> <ul style="list-style-type: none"> - Ostomy (appliance pouches, skin care agents, support belts) - Open wound (gauze pads, wound packing strips, ABD pads) - Venous access catheter (alcohol pads, benzoin, dressings) - Urinary supplies (catheter and bag supplies) - Tracheostomy supplies - Supplies used in conjunction with Durable Medical Equipment - Inhaler supplies (aero chamber mask, spacers, peak flow meters)
DIABETIC EQUIPMENT AND SUPPLIES	<p>80% of Allowed Amounts</p> <p>Must be purchased from Contracting Providers and referred by your PCP.</p>
RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY	<p>80% of Allowed Amounts</p> <p>Coverage will be provided in a manner determined in consultation with the treating Physician and the Member for reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses and physical complications during all stages of the mastectomy, including lymphedema.</p>
HOME HEALTH CARE	<p>80% of Allowed Amounts</p> <p>Maximum benefit limited to \$2,500 of Allowed Amounts per Member, per Benefit Period.</p>
INTRAVENOUS (IV) AND INJECTABLE MEDICATIONS*	<p>80% of Allowed Amounts</p> <p>Prior Authorization is required for outpatient Facility and if given in the home</p>
OUTPATIENT HOSPICE SERVICES	80% of Allowed Amounts
OUTPATIENT SPEECH THERAPY	<p>\$30 Copayment</p> <p>Maximum benefit limited to \$1,500 of Allowed Amounts per Member, per Benefit Period.</p>
INPATIENT REHABILITATION* (Speech, Physical, Occupational, Cardiac)	<p>Subject to inpatient benefits</p> <p>Maximum benefit limited to sixty (60) days per Member, per medical condition, per Benefit Period</p>
OUTPATIENT REHABILITATION (Physical, Occupational, Cardiac, Spinal Manipulations)	<p>\$20 PCP Copayment \$30 Specialist Copayment</p> <p>Maximum limited to \$5,000 of Allowed Amounts per Member, per Benefit Period.</p>
ORTHOTICS AND PROSTHETICS*	<p>80% of Allowed Amounts</p> <p>Coverage is limited to the original device unless repair and/or replacement is Medically Necessary.</p>
ORAL SURGERY AND RELATED SERVICES	<p>80% of Allowed Amounts</p> <p>Services for accidental injury to sound, natural teeth will be covered up to a maximum of \$1,000 of Allowed Amounts, if provided within 12 months from the date of injury.</p>

TRANSPLANT SERVICES*	Subject to Applicable Coinsurance or Copayments Members are entitled to receive benefits for human organ and tissue transplant services through Contracting Providers. Transplants covered include: Bone marrow (allogenic or autologous); Cornea; Heart; Heart-Lung; Lung (single or double); Intestine; Liver; Kidney; Pancreas.
ALL OTHER COVERED SERVICES	80% of Allowed Amounts
PRESCRIPTION DRUGS	Certain medications require Prior Authorization
NETWORK	Preferred Options Network
34 DAY SUPPLY	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.
BENEFIT	Covered generic prescriptions are subject to a \$3 Copayment. Covered brand name prescriptions are subject to a 50% Coinsurance payment, per prescription. However, no Member will be required to pay more than \$100 in Coinsurance per Covered Prescription. The difference between the actual billed charges of a Non-Contracting Pharmacy and the PPK Allowed Amounts does not apply to the out-of-pocket maximum. Oral Contraceptives may be dispensed in a three month supply at a retail pharmacy; however, the Copayment/Coinsurance is required for each month's supply
90 DAY SUPPLY	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.
BENEFIT	Generic prescriptions are subject to \$10 Copayment, per Covered Prescription. Brand name prescriptions are subject to a 50% Coinsurance payment, per Covered Prescription. However, the Member will not be required to pay more than \$250 in Coinsurance, per Covered Prescriptive
FORMULARY	Preferred Choice Formulary

*These services require Prior Authorization by PPK.

Prior Authorization Process:

Prior Authorization is the process of PPK determining whether the Health Care Service is a Covered Service, Medically Necessary, and being rendered by Contracting Providers. Coverage is subject to eligibility and benefits remaining at the time services are rendered.

Referral Process

PPK Members are responsible for obtaining a referral authorization from their PCP for all Health Care Services (except Emergency Services, annual well-woman exam, annual diabetic retinal eye exam, and prospective parent PCP visit) rendered outside his/her office. Behavioral health, substance abuse, and Biologically Based Mental Illness services do not require a PCP referral authorization; however, they must be Prior Authorized by PPK.

Limitations and Exclusion:

*Services not provided, ordered or referred by your PCP, (except for emergency services, annual well-woman exam, annual diabetic retinal eye exam, and prospective parent visit).

*Services not medically necessary

*Cosmetic treatment/surgery primarily to restore or alter appearance, surgical treatment of obesity (including morbid obesity), medical services in conjunction with prescription weight loss therapy, and weight loss programs unless approved by PPK.

*Experimental and investigational treatment unless otherwise specified in Certificate.

*Services for injuries or diseases related to employment and covered under a Workers Compensation program and services resulting from injury related to a motor vehicle accident and should be or are covered under automobile insurance.

*Duplication of benefits provided by Federal, State or local law, such as Medicare, CHAMPUS, and services in any veteran's facility.

*Services from non-contracting providers unless referred by your PCP and prior authorized by PPK.

*Items not strictly to treat a medical condition, including but not limited to, shower chairs, breast pumps, prenatal cradle.

The Certificate you will receive when you enroll will contain complete benefit descriptions, exclusions and limitations.