



PREFERRED PLUS OF KANSAS, INC.
Wichita Independent Business Association

PLAN P

HMO-Premium Option

2010 SUMMARY OF BENEFITS

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. **For Non-Covered Services or services that exceed a benefit maximum, the Member will be responsible for the entire billed charges of a Provider.**

BENEFIT CATEGORY	MEMBER RESPONSIBILITY
PHYSICIAN OFFICE VISIT PCP office visit Specialist office visit	\$20 Copayment \$30 Copayment
DEDUCTIBLE (per Benefit Period) Applies to all Covered Services unless otherwise noted The following do not count towards meeting the Deductible: Copayments; penalties; or charges for Non-Covered Services.	\$200 Individual \$400 Family
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 Applies to all Covered Services unless otherwise noted (The portion of the Allowed Amount payable by the Member after the Deductible has been met)	20% of Allowed Amounts
COINSURANCE MAXIMUM After the 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 Coinsurance maximum: Copayments; Deductible; penalties; or charges for Non-Covered Services.	\$3,000 Individual \$6,000 Family
LIFETIME MAXIMUM The lifetime maximum will include benefits you have accumulated under another PPK health plan offered by the same employer prior to this coverage.	\$2,000,000
PREVENTIVE CARE SERVICES Routine Services and Limitations Well-Baby or Well-Child Care - Unlimited for Members up to 2 years of age Routine Physical Exam - Annually for Members 2 years of age and older Routine and non-routine immunizations, including flu shots - Copayment does not apply 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. Services may be rendered by your PCP or Contracting OB/GYN (no referral required). Routine Well-Man Exam - Annually, includes digital rectal exam and screening PSA test (Members 40 years of age or older). Colorectal cancer screening Fecal occult blood - Annually for Members 50 years of age or older if not part of the annual well woman exam; and Barium enema or sigmoidoscopy - For Members 50 years of age or older once every 5 years or Colonoscopy - For Members 50 years of age or older once every 10 years Osteoporosis screening (bone density study) - For female Members 50 years of age or older once every 2 years	100% Coverage after any applicable office visit Copayment
OUTPATIENT LAB, X-RAY AND DIAGNOSTIC TESTING	20% of Allowed Amounts
INPATIENT BENEFITS (Semi-Private Room, ICU, SNU, Hospice)	20% of Allowed Amounts
MATERNITY CARE Prenatal and Postpartum Services Inpatient services <i>Services must be rendered by your PCP or contracting OB/GYN (no referral required)</i>	20% of Allowed Amounts 20% of Allowed Amounts

OUTPATIENT SURGERY	20% of Allowed Amounts
ALLERGY TESTING OR TREATMENT	20% of Allowed Amounts
DEPENDENT CHILDREN OUT OF AREA CARE Physician office visit Physical therapy Coverage outside the Service Area for Dependent children is limited to Physician office visits (including Medically Necessary lab and x-ray services), 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 preventive services such as routine physical exams, the annual well-woman exam, or immunizations.	\$30 Copayment \$30 Copayment
INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>Services must be prior authorized by PPK</i>	20% of Allowed Amounts
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>Some services must be prior authorized by PPK</i> PCP office visit Specialist office visit This benefit includes intensive outpatient programs and partial day hospitalization.	\$20 Copayment \$30 Copayment
EMERGENCY SERVICES <i>There is no coverage for non-Emergency Medical Conditions treated in a Hospital emergency room.</i> Urgent Care Facility Emergency room: Contracting Hospital or Non-Contracting Hospital out of the Service Area Emergency room: Non-Contracting Hospital in the Service Area <i>If admitted, the emergency room Copayment will be waived and inpatient benefits will apply.</i> 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.	\$30 Copayment \$200 Copayment \$250 Copayment
AMBULANCE	20% of Allowed Amounts
DURABLE MEDICAL EQUIPMENT Maximum benefit limited to \$2,500 of Allowed Amounts per Member, per Benefit Period.	20% of Allowed Amounts
DISPOSABLE MEDICAL SUPPLIES Coverage is limited to a maximum benefit of \$500 of Allowed Amounts per Member, per Benefit Period.	20% of Allowed Amounts
DIABETIC EQUIPMENT AND SUPPLIES Must be purchased from Contracting Providers and referred by your PCP.	20% of Allowed Amounts
RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY PCP office visit Specialist office visit Inpatient services	\$20 Copayment \$30 Copayment 20% of Allowed Amounts
HOME HEALTH CARE Maximum benefit limited to \$2,500 of Allowed Amounts per Member, per Benefit Period.	20% of Allowed Amounts
INTRAVENOUS (IV) AND INJECTABLE MEDICATIONS	20% of Allowed Amounts
OUTPATIENT HOSPICE SERVICES	20% of Allowed Amounts
OUTPATIENT SPEECH THERAPY Maximum benefit limited to \$1,500 of Allowed Amounts per Member, per Benefit Period.	\$30 Copayment
INPATIENT REHABILITATION (<i>Speech, Physical, Occupational, Cardiac</i>) Maximum benefit limited to sixty (60) days per Member, per medical condition, per Benefit Period.	20% of Allowed Amounts
OUTPATIENT REHABILITATION (<i>Physical, Occupational, Cardiac, Pulmonary and Spinal Manipulation Services</i>) PCP office visit Specialist office visit Maximum benefit limited to \$5,000 of Allowed Amounts per Member, per Benefit Period.	\$20 Copayment \$30 Copayment
ORTHOTICS AND PROSTHETICS Coverage is limited to the original device unless repair and/or replacement is Medically Necessary.	20% of Allowed Amounts

