



**WICHITA INDEPENDENT BUSINESS ASSN
HDHP**

Proposed Group Effective Date:
6/1/2008

(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.**

BENEFIT CATEGORY	NETWORK	NON-NETWORK
DEDUCTIBLE (per Benefit Period) Individual <i>(applicable to single Coverage only)</i> Family	\$2,500 \$5,000 The Deductibles for Network and Non-Network services are accumulated separately. All services are subject to Deductible unless otherwise indicated. The following do not count toward meeting the Deductible: penalty for failure to prior authorize inpatient services; or difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.	\$5,000 \$10,000
COINSURANCE (after satisfaction of Deductible)	80% of Allowed Amounts	60% of Allowed Amounts
OUT-OF-POCKET MAXIMUM Individual <i>(applicable to single Coverage only)</i> Family	Includes Deductible and Coinsurance for medical and prescription benefits \$4,000 \$8,000	\$8,000 \$16,000
LIFETIME MAXIMUM	\$1,000,000	
PREVENTIVE SERVICES	100% (not subject to Deductible)	60% (Deductible applies)
	Coverage limited to: routine physicals for Covered Persons up to 72 months of age, an annual eye exam, an annual routine physical for Covered Persons over 72 months of age, and annual well woman exam (includes pap and mammogram), PSA, flu shot, and pneumonia shot.	
OUTPATIENT LAB AND X-RAY SERVICES	80% (Deductible applies)	60% (Deductible applies)
	This benefit does not apply to services relating to accidental injury to teeth. PHSIC requires Prior Authorization of PET scans.**	
INPATIENT BENEFITS* Semi-Private Room, ICU, SNU, Hospice	80% (Deductible applies)	60% (Deductible applies)
MATERNITY BENEFIT	80% (Deductible applies)	60% (Deductible applies)
OUTPATIENT SURGERY	80% (Deductible applies)	60% (Deductible applies)
PHYSICIAN OFFICE PROCEDURES AND INJECTIONS	80% (Deductible applies)	60% (Deductible applies)
IMMUNIZATIONS Covered Persons up to 72 months of age Covered Persons over 72 months of age	100% (not subject to Deductible) 80% (Deductible applies)	100% (not subject to Deductible) 60% (Deductible applies)
INPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE*	80% (Deductible applies)	60% (Deductible applies)
	Maximum benefit limited to thirty (30) days per Covered Person, per Benefit Period. Each partial day session will count as one-half inpatient day toward the thirty (30) day benefit.	
INPATIENT BIOLOGICALLY BASED MENTAL ILLNESS*	80% (Deductible applies)	60% (Deductible applies)
	Maximum benefit limit to forty-five (45) days per Covered Person, per Benefit Period. Each partial day session will count as one-half inpatient day toward the forty-five (45) day benefit.	
OUTPATIENT BEHAVIORAL HEALTH	80% (Deductible applies)	60% (Deductible applies)

BENEFIT CATEGORY	NETWORK	NON-NETWORK
OUTPATIENT SUBSTANCE ABUSE	80% (Deductible applies) Maximum benefit limited to \$2,500 of Allowed Amounts per Covered Person, per Benefit Period and Maximum benefit limited to \$7,500 of Allowed Amounts per Covered Person, per lifetime.	60% (Deductible applies)
OUTPATIENT BIOLOGICALLY BASED MENTAL ILLNESS	80% (Deductible applies) Maximum benefit limited to forty-five (45) visits per Covered Person, per Benefit Period.	60% (Deductible applies)
EMERGENCY ROOM SERVICES <i>There is no coverage for non Emergency Medical Conditions treated in a Hospital emergency room.</i>	80% (Deductible applies) An observation stay of twenty-four (24) hours or longer will be treated as an inpatient admission at the applicable Network or Non-Network level.	60% (Deductible applies) Non-Network Emergency Services will be covered at the Network Deductible and Coinsurance level (if admitted), 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.
AMBULANCE	80% (Deductible applies)	60% (Deductible applies)
DURABLE MEDICAL EQUIPMENT** AND SUPPLIES	80% (Deductible applies) Durable Medical Equipment and supplies are limited to a maximum benefit of \$2,500 of Allowed Amounts per Covered Person, per Benefit Period.	60% (Deductible applies)
DISPOSABLE MEDICAL SUPPLIES	80% (Deductible applies) Coverage is limited to a maximum benefit of \$500 of Allowed Amounts per Covered Person, per Benefit Period: - 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 - Compression stockings - Inhaler supplies (aero chamber masks, spacers, peak flow meters)	60% (Deductible applies)
DIABETIC EQUIPMENT** AND SUPPLIES	80% (Deductible applies)	60% (Deductible applies)
RECONSTRUCTIVE SURGERY** FOLLOWING A MASTECTOMY	80% (Deductible applies) 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.	60% (Deductible applies)
HOME HEALTH CARE	80% (Deductible applies) Maximum benefit limited to \$2,500 of Allowed Amounts per Covered Person, per Benefit Period.	60% (Deductible applies)
INTRAVENOUS (IV) AND INJECTABLE MEDICATIONS**	80% (Deductible applies) Prior Authorization recommended if given in the home.	60% (Deductible applies)
OUTPATIENT HOSPICE SERVICES	80% (Deductible applies)	60% (Deductible applies)
TMJ	80% (Deductible applies) Maximum benefit limited to \$1,000 of Allowed Amounts per Covered Person, per Benefit Period; \$5,000 of Allowed Amounts per lifetime.	60% (Deductible applies)
OUTPATIENT SPEECH THERAPY	80% (Deductible applies) Maximum benefit limited to \$1,500 of Allowed Amounts per Covered Person, per Benefit Period.	60% (Deductible applies)
INPATIENT REHABILITATION* (speech, physical, occupational)	80% (Deductible applies) Maximum benefit limited to sixty (60) days per medical condition, per Covered Person, per Benefit Period.	60% (Deductible applies)
OUTPATIENT REHABILITATION (physical and occupational)	80% (Deductible applies) Maximum benefit limited to \$5,000 of Allowed Amounts per Covered Person, per Benefit Period.	60% (Deductible applies)
SPINAL MANIPULATION SERVICES	80% (Deductible applies) Limited to a maximum benefit of \$500 of Allowed Amounts per Covered Person, per Benefit Period.	60% (Deductible applies)
ORTHOTICS AND PROSTHETICS** (orthotic shoes**)	80% (Deductible applies)	60% (Deductible applies)
ORAL SURGERY AND RELATED SERVICES**	80% (Deductible applies) 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 maximum of \$1,000 of Allowed Amounts, if provided within twelve (12) months from the date of the injury.	60% (Deductible applies)

BENEFIT CATEGORY	NETWORK	NON-NETWORK
TRANSPLANT SERVICES* <i>All Organ Transplants must be Prior Authorized with PHSIC prior to the transplant. This applies to both Network and Non-Network benefits. Network transplant limitations will be determined at time of Prior Authorization.</i>	80% (Deductible applies) Covered Persons are entitled to receive benefits for human organ and tissue transplant services through Contracting Providers.	60% (Deductible applies) <u>Subject to lifetime maximums</u> Kidney: \$100,000 Kidney/Pancreas; Heart; Heart/Lung; Autologous Bone Marrow: \$150,000 Allogenic Bone Marrow; Intestine; Liver; Lung (single or double): \$200,000
ALL OTHER COVERED SERVICES	80% (Deductible applies)	60% (Deductible applies)
PRESCRIPTION DRUGS	80% (Deductible applies) Certain medications require Prior Authorization	

***The Covered Person or provider is responsible for obtaining Prior Authorization from PHSIC. If inpatient services are not Prior Authorized, a \$500 penalty will apply.**

****PHSIC recommends Prior Authorization of these services.**

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 Member Services 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.

Limitations and Exclusions:

- Any services which are not Medically Necessary.
- Experimental and investigational treatment unless otherwise described in Certificate.
- Surgical treatment and all services related to such treatment of obesity (including morbid obesity) and weight reduction. Any medical services rendered in conjunction with prescription drug therapy for weight control. Such services include prescriptions, hospitalizations, laboratory and x-ray services, and Physician office visits.
- Cosmetic, health, and beauty aids.
- Services for injuries or diseases related to employment to the extent you are covered or are required to be covered by workers' compensation law and services resulting from injuries related to a motor vehicle accident and should be or are covered under automobile insurance.
- Duplication of benefits provided by Federal, State or local laws such as Medicare, CHAMPUS, Tricare, and services in any veteran's facility.
- Items not strictly for the purpose of treating a medical condition including, but not limited to, shower chairs, breast pumps, and prenatal cradles.

Please consult your Certificate for complete plan provisions, limitations, and exclusions.