



HAYSVILLE USD 261
PPO SUMMARY OF BENEFITS
 Proposed Group Effective Date:
 10/1/2010

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.	\$30 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	None	
PREVENTIVE CARE SERVICES	\$0	50% of Allowed Amounts unless otherwise noted
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.	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
DIAGNOSTIC TESTING except lab and x-ray This benefit does not apply to services relating to accidental injury to teeth.	20% of Allowed Amounts	50% of Allowed Amounts
PHYSICIAN OFFICE PROCEDURES AND INJECTIONS	20% of Allowed Amounts	50% of Allowed Amounts
OUTPATIENT SURGERY <i>Other services (e.g. lab, x-ray, anesthesia) are subject to applicable Copayments, Coinsurance and/or Deductible.</i>	20% of Allowed Amounts	50% of Allowed Amounts
MATERNITY BENEFIT	20% of Allowed Amounts	50% of Allowed Amounts

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>	20% of Allowed Amounts	50% of Allowed Amounts
INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>If inpatient services are not prior authorized, a \$500 penalty will apply per admission.</i>	20% of Allowed Amounts	50% of Allowed Amounts
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>Some services require Prior Authorization.</i> This benefit includes intensive outpatient programs and partial day hospitalization.	\$30 Copayment	50% of Allowed Amounts
EMERGENCY ROOM SERVICES <i>There is no coverage for non-Emergency Medical Conditions treated in a Hospital emergency room.</i> The Covered Person will be responsible for the difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.	\$150 Copayment (waived if admitted)	\$150 Copayment (waived if admitted)
AMBULANCE	20% of Allowed Amounts	20% of Allowed Amounts
DURABLE MEDICAL EQUIPMENT AND SUPPLIES <i>(Deductible does not apply to Network services)</i>	\$0	50% of Allowed Amounts
DISPOSABLE MEDICAL SUPPLIES	20% of Allowed Amounts	20% of Allowed Amounts
DIABETIC EQUIPMENT AND SUPPLIES	20% of Allowed Amounts	50% of Allowed Amounts
RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY <i>Inpatient services are subject to inpatient benefits</i>	20% of Allowed Amounts	50% of Allowed Amounts
HOME HEALTH CARE <i>Visit limit may apply</i> <i>(Deductible does not apply to Network services)</i>	\$0	50% of Allowed Amounts
INTRAVENOUS (IV) AND INJECTABLE MEDICATIONS	20% of Allowed Amounts	50% of Allowed Amounts
OUTPATIENT HOSPICE SERVICES (<i>Deductible does not apply to Network services</i>)	\$0	50% of Allowed Amounts
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	30% of Allowed Amounts	30% of Allowed Amounts
OUTPATIENT SPEECH THERAPY <i>Visit limit may apply</i>	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>) <i>Visit limit may apply</i>	20% of Allowed Amounts	50% of Allowed Amounts
SPINAL MANIPULATION SERVICES <i>Visit limit may apply</i>	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. For Covered Persons under 18 years of age, Coverage is provided without a dollar limitation.	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

<p>PRESCRIPTION DRUGS Certain medications require Prior Authorization</p> <p>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.</p> <p>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.</p> <p><i>Please refer to your Prescription Drug Endorsement for complete plan provisions and limitations.</i></p>	<p>\$0 Deductible, 50% Coinsurance per Covered Prescription</p> <p>34 Day Supply: \$100 Coinsurance Maximum per Covered Prescription</p> <p>90 Day Supply: \$250 Coinsurance Maximum per Covered Prescription</p>	<p>Covered Person reimbursed Allowed Amount minus the Covered Person's responsibility.</p>
--	---	--

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.

PHS retains the right to adjust benefits as necessary to comply with changes in any federal or state law, statute or regulation, including but not limited to the federal Patient Protection and Affordable Care Act, as amended.