Mulvane USD #263

Summary of Benefits

Effective October 1, 2009

Preferred
Health Systems

Premium Plan

Preferred Health Systems

PREFERRED PLUS OF KANSAS, INC.
Mulvane USD #263 - Premium
PLAN LL
2009 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*
PCP SERVICES	$30 Copayment
SPECIALIST PHYSICIAN SERVICES	$50 Copayment
COPAYMENT MAXIMUM	$2,000 Individual $4,000 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	
PCP office visit	$30 Copayment
Specialist office visit	$50 Copayment
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	
OUTPATIENT LAB AND X-RAY	$0
INPATIENT BENEFITS (Semi-Private Room, ICU, SNU, Hospice)	$300 per day
Member out-of-pocket maximum per Benefit Period	$1,200
Family out-of-pocket maximum per Benefit Period	$2,400
MATERNITY CARE	
Prenatal and Postpartum Services (in lieu of PCP or OB/GYN office visit Copayment)	$400 Copayment
Inpatient services	Subject to Inpatient Benefits
Services must be rendered by your PCP or contracting OB/GYN (with referral)	
OUTPATIENT SURGERY	$400 Facility Copayment
ALLERGY TREATMENTS	$0
DEPENDENT CHILDREN OUT OF AREA CARE	
Physician office visit	$50 Copayment
Physical therapy	$30 Copayment
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 routine or preventive services such as physicals, the annual well-woman exam, and immunizations.	
INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE *Services must be prior authorized by PPK*	Subject to Inpatient Benefits
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE *Services must be prior authorized by PPK*	
PCP office visit	$30 Copayment
Specialist office visit	$50 Copayment
This benefit includes intensive outpatient programs and partial day hospitalization.	

EMERGENCY SERVICES ***There is no coverage for non-Emergency Medical Conditions treated in a Hospital emergency room.*** 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 *If admitted, emergency room Copayment will be waived and inpatient benefits will apply.* 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.	 $50 Copayment $100 Copayment $200 Copayment
AMBULANCE	$0
DURABLE MEDICAL EQUIPMENT Maximum benefit **limited to $2,500 of Allowed Amounts** per Member, per Benefit Period.	$0
DISPOSABLE MEDICAL SUPPLIES Coverage is **limited to a maximum benefit of $500 of Allowed Amounts** per Member, per Benefit Period.	$0
DIABETIC EQUIPMENT AND SUPPLIES Must be purchased from Contracting Providers and referred by your PCP.	$0
RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY PCP office visit Specialist office visit Inpatient services	 $30 Copayment $50 Copayment Subject to Inpatient Benefits
HOME HEALTH CARE Maximum benefit **limited to $2,500 of Allowed Amounts** per Member, per Benefit Period.	$0
INTRAVENOUS (IV) AND INJECTABLE MEDICATIONS	$0
OUTPATIENT HOSPICE SERVICES	$0
OUTPATIENT SPEECH THERAPY Maximum benefit **limited to $1,500 of Allowed Amounts** per Member, per Benefit Period.	$30 Copayment
INPATIENT REHABILITATION *(Speech, Physical, Occupational, Cardiac)* Maximum benefit **limited to sixty (60) days** per Member, per medical condition, per Benefit Period.	Subject to Inpatient Benefits
OUTPATIENT REHABILITATION *(Physical, Occupational, Cardiac, Pulmonary and Spinal Manipulations)* PCP office visit Specialist office visit Maximum benefit **limited to $5,000 of Allowed Amounts** per Member, per Benefit Period.	 $30 Copayment $30 Copayment
ORTHOTICS AND PROSTHETICS Coverage is limited to the original device unless repair and/or replacement is Medically Necessary.	$0
ORAL SURGERY AND RELATED SERVICES PCP office visit Specialist office visit Inpatient services Services for accidental injury to sound, natural teeth will be covered up to a **maximum of $1,000 of Allowed Amounts**, if provided within twelve (12) months from the date of injury.	 $30 Copayment $50 Copayment Subject to Inpatient Benefits
TRANSPLANT SERVICES PCP office visit Specialist office visit Inpatient services	 $30 Copayment $50 Copayment Subject to Inpatient Benefits
ROUTINE VISION SERVICES One complete routine examination to a Contracting Provider each Benefit Period.	

PRESCRIPTION DRUGS Certain medications require Prior Authorization	$0 Deductible, 50% Coinsurance per Covered Prescription
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.	34 day Supply: $100 Coinsurance Maximum per Covered Prescription
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.	90 day Supply: $250 Coinsurance Maximum per Covered Prescription
Please refer to the Prescription Drug Endorsement for complete plan provisions and limitations.	

Some 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. Mental health and substance abuse services do not require a PCP Referral Authorization; however, they must be prior authorized by PPK.

Basic Exclusions
*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 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 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.

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.

Base Plan

Preferred Health Systems

PREFERRED PLUS OF KANSAS, INC.
Mulvane USD #263 - Base
PLAN P
2009 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	$20 Copayment
Specialist office visit	$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	
PCP office visit	$20 Copayment
Specialist office visit	$30 Copayment
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	
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	20% of Allowed Amounts
Inpatient services	20% of Allowed Amounts
Services must be rendered by your PCP or contracting OB/GYN (with referral)	

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 *Services must be prior authorized by PPK*	20% of Allowed Amounts
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE *Services must be prior authorized by PPK* PCP office visit Specialist office visit This benefit includes intensive outpatient programs and partial day hospitalization.	 $20 Copayment $30 Copayment
EMERGENCY SERVICES ***There is no coverage for non-Emergency Medical Conditions treated in a Hospital emergency room.*** 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 *If admitted, the emergency room Copayment will be waived and inpatient benefits will apply.* 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 *(Speech, Physical, Occupational, Cardiac)* Maximum benefit **limited to sixty (60) days** per Member, per medical condition, per Benefit Period.	20% of Allowed Amounts
OUTPATIENT REHABILITATION *(Physical, Occupational, Cardiac, Pulmonary and Spinal Manipulation Services)* 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
ORAL SURGERY AND RELATED SERVICES PCP office visit Specialist office visit Inpatient services Services for accidental injury to sound, natural teeth will be covered up to a **maximum of $1,000 of Allowed Amounts**, if provided within twelve (12) months from the date of injury.	 $20 Copayment $30 Copayment 20% of Allowed Amounts

TRANSPLANT SERVICES	
PCP office visit	$20 Copayment
Specialist office visit	$30 Copayment
Inpatient services	20% of Allowed Amounts
ALL OTHER COVERED SERVICES	20% of Allowed Amounts
ROUTINE VISION SERVICES One complete routine examination to a Contracting Provider each Benefit Period.	

Some 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. Mental health and substance abuse services do not require a PCP Referral Authorization; however, they must be prior authorized by PPK.

Basic Exclusions
*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 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 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.

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.

Additional Information

Preferred
Health Systems

Provider Directory

For the most up-to-date Provider Directory, simply download it from our website!

Go to www.phsystems.com

Click on **Find a Provider**

Click **Download Provider Directories (.pdf)**

You can chose to download a Primary Care Physician listing by selecting:
Preferred Plus of Kansas (PPK) Primary Care Physicians Only

or download a complete listing of doctors by selecting:
Preferred Plus of Kansas (PPK)

If you prefer to narrow your search down, click on **Use the Online Provider Search** from the provider lists.

Click on **Preferred Plus of Kansas (PPK – HMO/POS)** read the information on this page and then click on **I have read the info below...**

Select the option you prefer for finding your providers. Searches may be performed by:

- Provider Names
- Group Names
- Primary Care Physicians
- Specialty/Facilities/Hospitals
- Counties
- Cities
- Zip Codes and radius

Click on **Submit** and begin your search!

Directories may also be requested by contacting our office at 316.609.2788 or 800.990.0345 ext 2788.

When physicians have more than one location, in order for that location to be participating, that address must also be listed.

Member Services can also verify provider participation.
Please call them at 800-660-8114, Monday-Friday, 7:30am-5:30 pm.

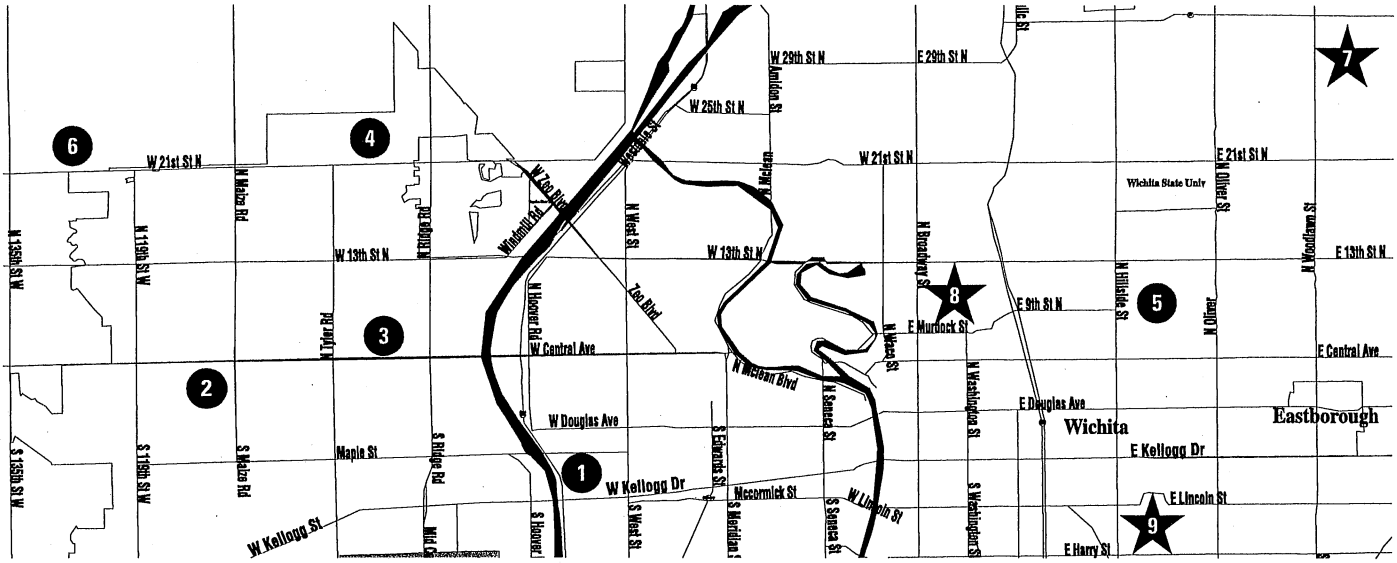
Important Information for Members

- **ALL ROUTINE MEDICAL SERVICES** must be provided or referred by your *Primary Care Physician* (PCP) except for the annual well woman visit, annual diabetic retinal exam, and prospective parent PCP visit. Any treatment or services recommended by a contracting specialist must also be referred by your PCP.
- **ALL REFERRAL AUTHORIZATIONS** for specialty care, if deemed medically appropriate by your PCP, must be obtained prior to seeking services from contracting specialists. Referrals will not be back-dated. Please request a copy of the Referral Authorization from your PCP. This way you can be aware of the number of visits authorized and the specific services to be performed.
- **SHOULD YOU SEEK** routine medical services without obtaining Referral Authorization in advance from your PCP, those services will not be covered. This includes vision services for treatment of a medical condition (e.g. eye infection).
- **BEHAVIORAL HEALTH CARE** does not require Referral Authorization from your PCP but must be prior authorized through PPK. Call **316.609.2541** or **1.866.338.4281**, Monday–Friday, 8 a.m.–5 p.m., to approve and coordinate your care. Staff is available after hours and on weekends and holidays to assist you with urgent situations.
- **IF YOU ARE A NEW MEMBER** and are currently seeing a specialist or have scheduled an outpatient visit or inpatient admission, contact your PCP so they may coordinate continued care/services with PPK.
- **ALL INPATIENT AND OUTPATIENT SERVICES** must be obtained from contracting facilities. Wesley Medical Center, Wesley West Emergency & Diagnostic Center, Kansas Medical Center and Kansas Spine Hospital are **NOT** contracting facilities.
- **ALL CARE FOR EMERGENCY MEDICAL CONDITIONS** should be obtained from Contracting Providers, if possible. Some plans assess penalties or deny coverage for using a **non-contracting facility. Wesley Medical Center, Wesley West Emergency & Diagnostic Center and Kansas Medical Center are not Contracting Providers. There is no coverage for non-Emergency Medical Conditions treated in a hospital emergency room.** We recommend you contact your PCP prior to going to an ER to ensure coverage. Your PCP or the covering doctor is available 24 hours a day to help you get the care you need. Any follow-up treatment for emergency services must be provided or referred in advance by your PCP.
- **ANY CHANGES** that need to be made to your policy, such as adding or removing Dependents due to marriage, divorce, or birth, must be done within 31 days to ensure coverage. Contact your employer's Personnel Office to make changes to your policy.
- **NEWBORNS** are not enrolled automatically. If your newborn is not added within 31 days of birth, you will have to wait until the next open enrollment period. If you are on a family plan, your child will be covered from the moment of birth for the first 31 days. To ensure continued coverage, you must add the child to your policy.
- **ALL PCP CHANGES** will become effective the first day of the month following notification to PPK. Any referral issued by your former PCP will no longer be valid on services received after the change is effective. You will need to get a referral from your new PCP.
- **YOU HAVE A RIGHT** to request the following:
  - A complete description of health care services and benefits, limitations or exclusions to coverage;
  - A listing of our Contracting Providers, their business addresses and phone numbers and the availability of these providers;
  - Notification in advance of any benefit year changes to your plan, which would result in a reduction in coverage or benefits or an increase in cost to you;
  - A description of the appeal procedures available to you under this health plan, as well as your rights regarding termination, disenrollment, non-renewal or cancellation of coverage.

Whenever you have questions regarding your coverage, please call Preferred Health Systems Member Services at **316.609.2390** or **1.800.660.8114**, Monday–Friday, 7:30 a.m.–5:30 p.m., or visit our Web site at **www.phsystems.com**.

Health insurance plans underwritten by:
Preferred Plus of Kansas
PHS-799-3/09

URGENT AND EMERGENT CARE LOCATIONS IN WICHITA



URGENT CARE FACILITIES

1 Immediate Medical Care
4722 W. Kellogg Dr.
Wichita, KS 67209
316.440.2565
www.immediatecarewichita.com
Mon. – Sat. 9 a.m. – 7 p.m.
Sun. 1 – 6 p.m.

2 Via Christi Occupational & Immediate Care West
501 N. Maize Road
Wichita, KS 67212
316.721.5000
www.via-christi.org
Mon. – Fri. 8 a.m. – 6 p.m.

3 West Wichita Minor Emergency
8200 W. Central
Wichita, KS 67212
316.721.4544
www.wwfppa.com
Mon. – Fri. 8 a.m. – 8 p.m.
Sat. – Sun. noon – 6 p.m.

4 PMA Immediate Care
8444 W. 21st St.
Wichita, KS 67205
316.721.9500
www.via-christi.org
Sat. – Sun. noon – 5 p.m.

5 Wichita Clinic Immediate Care East
3311 E. Murdock
Wichita, KS 67208
316.689.9107
www.wichitaclinic.com
Mon. – Fri. 8 a.m. – 8 p.m.
Sat. 9 a.m. – 6 p.m.
Sun. noon – 6 p.m.

6 Wichita Clinic Immediate Care West
13213 W. 21st. St. N.
Wichita, KS 67235
www.wichitaclinic.com
316.946.1789
Mon. – Fri. 5 – 8 p.m.
Sat. 9 a.m. – 5 p.m.
Sun. noon – 5 p.m.

EMERGENT CARE FACILITIES

7 Galichia Heart Hospital
2610 N. Woodlawn
Wichita, KS 67220
316.858.2610
www.ghhospital.com

8 Via Christi Regional Medical Center - St. Francis
929 N. St. Francis
Wichita, KS 67214
316.268.5178
www.via-christi.org

9 Via Christi Regional Medical Center - St. Joseph
3600 E. Harry St.
Wichita, KS 67218
316.689.6013
www.via-christi.org

URGENT CARE

Aches, pains and sprains. These are times when care is necessary but not critical. Medical conditions that are not an emergency should be treated in your family physician's office or at a contracting urgent care center. Doctors are available 24 hours a day to help you get the care you and your family need. Their after-hours message will instruct you on how to reach them. **In most cases, non-emergent care is not covered when received in a hospital emergency room.**

EMERGENT CARE

If you have an Emergency Medical Condition such as difficulty breathing, suspected heart attack, uncontrolled bleeding, unconsciousness or severe burns, try to use a **contracting** hospital emergency room. If you choose to go to a non-contracting hospital, your coverage may be limited. Please remember, **Wesley Medical Center and Kansas Medical Center** are **not** Contracting Providers and your out-of-pocket costs could be substantial.

Please call specific locations for hours of operation and holiday schedules.
For urgent and emergent care outside Wichita, refer to the Provider Directory.

Health plans that work. Preferred Health Systems

Health insurance plans underwritten by: Preferred Plus of Kansas. Preferred Health Systems Insurance Company
PHS-772-04/09

www.phsystems.com