



**Mulvane USD #263
PLAN P
BASE PLAN
SUMMARY OF BENEFITS**

Benefit Period: Benefits accumulate from January 1 to December 31

Employees and all covered Dependents covered under a HMO benefit Plan 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 the Plan. Services which are not provided or authorized by Your PCP 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.

<i>BENEFIT CATEGORY</i>	<i>MEMBER RESPONSIBILITY</i>
PHYSICIAN OFFICE VISIT PCP office visit Specialist office visit <i>OB/GYN services do not require a Referral Authorization.</i>	\$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; anti-cancer medications; or charges for Non-Covered Services.	\$200 Individual \$400 Family
DEDUCTIBLE CARRYOVER Covered amounts applied towards the 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; anti-cancer medications; or charges for Non-Covered Services.	\$3,000 Individual \$6,000 Family
ANNUAL MAXIMUM ON ESSENTIAL BENEFITS This annual maximum applies only to Essential Health Benefits as defined by Section 1302(b) of the Patient Protection and Affordable Care Act. Essential Health Benefits include the following benefit categories: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). If the Annual Maximum on Essential Benefits is exhausted, there will be no Coverage until the beginning of the following Benefit Period.	\$2,000,000
LIFETIME MAXIMUM	None
PREVENTIVE CARE SERVICES	100% Coverage
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 <i>Other services (e.g. lab, x-ray, anesthesia) are subject to applicable Copayments, Coinsurance and/or Deductible.</i>	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 the Plan. This benefit does not include preventive services such as routine physical exams and immunizations.	\$30 Copayment \$30 Copayment
INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>Services must be prior authorized by the Plan</i>	20% of Allowed Amounts

OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>Members may self-refer to Contracting Providers for office visits. Refer to Prior Authorization List for services that require Prior Authorization.</i> PCP or Specialist office visit This benefit includes intensive outpatient programs and partial day hospitalization.	\$20 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 <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. 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.	\$30 Copayment \$200 Copayment
AMBULANCE	20% of Allowed Amounts
DURABLE MEDICAL EQUIPMENT	20% of Allowed Amounts
DISPOSABLE MEDICAL SUPPLIES	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	20% of Allowed Amounts
INTRAVENOUS (IV) AND INJECTABLE MEDICATIONS Anti-Cancer Medications (chemotherapy)	20% of Allowed Amounts 20% of Allowed Amounts with a \$200 Coinsurance Maximum per Covered medication up to a \$2,000 out-of-pocket maximum (Deductible does not apply)
OUTPATIENT HOSPICE SERVICES	20% of Allowed Amounts
INPATIENT REHABILITATION (<i>Speech, Physical, Occupational, Cardiac</i>)	20% of Allowed Amounts
OUTPATIENT REHABILITATION (<i>Speech, Physical, Occupational, Cardiac, and Pulmonary</i>) PCP office visit Specialist office visit Coverage is provided following injuries, surgeries, or acute medical conditions.	\$20 Copayment \$30 Copayment
SPINAL MANIPULATION SERVICES PCP office visit Specialist office visit	\$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. This benefit maximum does not apply to Members under 18 years of age.	\$20 Copayment \$30 Copayment 20% of Allowed Amounts
TRANSPLANT SERVICES PCP office visit Specialist office visit Inpatient services	\$20 Copayment \$30 Copayment 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. Prior Authorization is the process of the Plan 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. 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).

Referral Process: Members are responsible for obtaining a Referral Authorization from their PCP for all Health Care Services rendered outside his/her office except Emergency Services, obstetrical and gynecological care (from a contracting OB/GYN), and annual diabetic retinal eye exam. Mental health and substance abuse services do not require a PCP Referral Authorization; however, some services must be prior authorized by the Plan.

Basic Exclusions

Services not provided, ordered or referred by Your PCP. *Services of Non-Contracting Providers. *Services not medically necessary. *Cosmetic treatment/surgery. *Surgical treatment of obesity, medical services in conjunction with prescription weight loss therapy, and weight loss programs unless approved by the Plan. *Experimental and investigational treatment. *Services for injuries or diseases related to employment and covered or required to be covered under 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 law. *Items not strictly to treat a medical condition.*Services or items for the convenience of the Member or Provider. *Services or supplies related to an excluded service and subsequent complications.

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.

We retain 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.