

# City of Wichita

## 2017 Premium PPO & Select PPO Benefit Comparison

Employee Share of:	Premium PPO		Select PPO	
Benefit Level	In Network	Out of Network	In Network	Out of Network
<b>Deductibles</b>	\$250/ Individual \$500/Family	\$500 / Individual \$1000 Family	\$750/ Individual \$1,500/Family	\$1,000/Individual \$2,000/Family
<b>Coinsurance</b>	0%	50%	20%	50%
<b>Out of Pocket Maximum</b>	Includes Deductible, Coinsurance and Copays \$1,500 Individual \$3,000 Family	Includes Deductible, Coinsurance and Copays \$2,000 Individual \$4,000 Family	Includes Deductible, Coinsurance and Copays \$2,500 Individual \$5,000 Family	Includes Deductible, Coinsurance and Copays \$5,000 Individual \$10,000 Family
<b>Medical Annual Lifetime</b>	<b>No Annual Maximum No Lifetime Maximum</b>			
<b>Cochlear Implants &amp; Services</b>	<b>Limited to One Per Ear, Per Lifetime</b>			
<b>Pharmacy Lifetime</b>	<b>No Lifetime Limit</b>			
<b>Physician Services</b>	\$20 Copayment	Deductible Plus 50% Coinsurance	\$25 Copayment*	Deductible Plus 50% Coinsurance
<b>Specialist Services</b>	\$40 Copayment	Deductible Plus 50% Coinsurance	\$50 Copayment*	Deductible Plus 50% Coinsurance
<b>Preventive Care</b>	Covered in Full	Deductible Plus 50% Coinsurance	Covered in Full	Deductible and 50%
<b>Prescription Drug Plan</b>	\$5 Generic Copayment \$15 Brand Formulary Copayment \$40 Brand Non-Formulary Copayment	\$10 Generic Copayment \$30 Brand-Formulary Copayment \$80 Brand Non-Formulary Copayment	\$10 Generic Copayment \$25 Brand-Formulary Copayment \$50 Brand Non-Formulary Copayment	\$20 Generic Copayment \$50 Brand-Formulary Copayment \$100 Brand Non-Formulary Copayment
<b>Formulary Generic Formulary Brand Non-Formulary</b>	<b>SEE <a href="http://www.medtrakservices.com">www.medtrakservices.com</a></b>			
<b>Inpatient Hospital Services</b>	\$100 per Day Copayment, after deductible (up to a \$500 maximum)  \$500 Inpatient Copayment limit per person per Calendar Year \$1,000 Inpatient Copayment per Calendar Year	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
<b>Outpatient Lab Services</b>	\$0 Copayment after deductible	Deductible Plus 50% Coinsurance	\$0 Copayment, after deductible	Deductible Plus 50% Coinsurance
<b>Hospital Outpatient Surgery and Scopes</b>	\$200 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance

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<b>Hospital Surgery and Scopes in an Ambulatory Surgery Center</b>	\$200 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
<b>Outpatient X-rays</b>	\$0 Copayment, after deductible	Deductible Plus 50% Coinsurance	\$0 Copayment, after deductible	Deductible Plus 50% Coinsurance
<b>Outpatient Diagnostic Testing and Services</b>	\$0 Copayment, after deductible	Deductible Plus 50% Coinsurance	\$0 Copayment, after deductible	Deductible Plus 50% Coinsurance
<b>Emergency Services At a Hospital Emergency Room (waived if admitted)</b>	\$100 Copayment for facility charges	\$100 Copayment for facility charges	\$150 Copayment for facility charges	\$150 Copayment for facility charges
<b>Ambulance Emergency Transportation (Ground or Air)</b>	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
<b>Urgent Care Facility</b>	\$20 Copayment	\$20 Copayment	\$25 Copayment	\$25 Copayment
<b>Short-Term Therapies Physical* Speech* Occupational*</b> <i>Limited to 60 visits per Calendar Year</i>	\$40 Copayment	Deductible Plus 50% Coinsurance	\$50 Copayment	Deductible Plus 50% Coinsurance
<b>Rehabilitation -Inpatient</b>	\$100 per Day, after deductible (Copayment up to a \$500 Maximum) <i>\$500 Inpatient Copayment limit per person per Calendar Year</i> <i>\$1,000 Inpatient Copayment per family per CalendarYear</i>	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
<b>Rehabilitation - Partial Day Programs ( 4 hours or greater) Limited to 60 visits per Calendar Year</b>	\$40 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
<b>Outpatient Pulmonary &amp; Cardiac</b> <i>Limited to 60 visits per Calendar Year Benefit Maximum</i>	\$40 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
<b>Home Health Care</b>	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
<b>Skilled Nursing Facility</b>	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
<b>Hospice</b>	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
<b>Durable Medical</b>	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
<b>Prosthetics &amp; Braces</b>	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
	\$40 Copayment		\$50 Copayment	Not covered

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<b>Chiropractic Services / Spinal Manipulation</b> <i>26 visits per Calendar Year</i>		No coverage for out-of-network providers		
<b>Cochlear Implant</b> <i>Limited to one implant per ear; per lifetime</i>	See Appropriate Benefits	Deductible Plus 50% Coinsurance	See Appropriate Benefits	Deductible Plus 50% Coinsurance
<b>Organ Transplant</b>	See Appropriate Benefits	Not Covered	See Appropriate Benefits	Not Covered
<b>Transportation, Lodging &amp; Meals</b> when related to Organ Transplants	\$0 Copayment <i>Limited to \$2,000 per Calendar Year Benefit Maximum</i>	Not Covered	\$0 Copayment <i>Limited to \$2,000 per Calendar Year Benefit Maximum</i>	Not Covered
<b>Mental/Nervous Treatment</b> <i>Inpatient – Limited to 45 days per Calendar Year Benefit Maximum</i>	\$100 per Day. After deductible (Copayment up to a \$500 Maximum) <i>\$500 Inpatient Copayment limit per person per Calendar Year</i> <i>\$1,000 Inpatient copayment per family per Calendar Year</i>	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
<b>Mental/Nervous Treatment (continued) Outpatient</b> <i>First 2 visits covered at 100%, then applicable copay. Limited to 45 visits per Calendar Year Benefit Maximum</i>	\$40 Copayment	Deductible Plus 50% Coinsurance	\$50 Copayment	Deductible Plus 50% Coinsurance
<b>Substance Abuse &amp; Chemical Dependency Inpatient</b> <i>Limited to 30 days per Calendar Year Benefit Maximum</i>	\$100 per Day, after deductible (Copayment up to a \$500 Maximum) <i>\$500 Inpatient Copayment limit per person per Calendar Year</i> <i>\$1,000 Inpatient Copayment per family per Calendar Year</i>	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
<b>Substance Abuse &amp; Chemical Dependency Outpatient</b>	\$40 Copayment	Deductible Plus 50% Coinsurance	\$50 Copayment	Deductible Plus 50% Coinsurance
<b>Injectable Medications</b> Not listed elsewhere	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
<b>Outpatient Dialysis</b>	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance

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<b>Infertility</b> Includes diagnosis and diagnostic surgical treatment only	\$40 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
<b>Nutritional Evaluation &amp; Diabetes Management / Self-Training</b>	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
<b>Dental Services</b> -Accidental Injury Limited to \$1,000 per accident during a consecutive 12 month period	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Impacted Wisdom Teeth	Out of Network Deductible Plus 50% Coinsurance			
Intraoral X-rays <i>When in connection with Covered oral surgery services</i>	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Myofascial Pain & Temporomandibular Joint (TMJ) Dysfunction Syndromes	Out of Network Deductible Plus 50% Coinsurance			

\*\*\*\*Please refer to the Summary Plan Description and applicable modified documents for complete benefits. This document is for discussion purposes only. \*\*\*\*\*

### **Notes**

\* Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP payment will apply. If you receive these services from a Specialist, your Specialist payment will apply.

\*\*Please consult your Summary Plan Description and applicable modifications to determine the exact terms, conditions and scope of coverage including all exclusions and limitations. This summary is designed as a partial description of the plan being offered and in no way details all the benefits, limitations, or exclusions.