



**Healthcare Rate Proposal**  
**BETTER BUSINESS BUREAU**  
 Proposed Effective Date:  
 1/1/2010 to 12/31/2010

HDHP Benefit Category Accumulation Period: Calendar Year	Member Responsibility	
	Network	Non-Network
<b>Deductible</b> <ul style="list-style-type: none"> <li>• Single</li> <li>• Family</li> </ul> <b>All services are subject to Deductible unless otherwise indicated.</b>	\$3,500 \$7,000	\$7,000 \$14,000
<b>Coinsurance</b> (after satisfaction of deductible)	0%	0%
<b>Coinsurance Out-of-Pocket Maximum</b> (after satisfaction of deductible) <ul style="list-style-type: none"> <li>• Single</li> <li>• Family</li> </ul>	\$3,500 \$7,000	\$7,000 \$14,000
<b>Lifetime Maximum</b>	\$2 Million	
<b>Preventive Care Services</b> <ul style="list-style-type: none"> <li>• Well-Woman Exam</li> <li>• Well-Man Exam</li> <li>• Routine Eye Exam</li> <li>• Immunizations (up to 72 months); (over 72 months)</li> </ul>	\$0 \$0 \$0 \$0 \$0 0%	0% 0% 0% 0% \$0 0%
<b>Outpatient Lab and X-Ray</b> (excludes accidental injury to teeth)	0%	0%
<b>Outpatient Surgery</b>	0%	0%
<b>Maternity Care</b>	0%	0%
<b>Emergency Room Services</b> <ul style="list-style-type: none"> <li>• Emergency Medical Conditions</li> <li>• Non-Emergency Medical Conditions</li> <li>• Ambulance</li> </ul>	0% Not Covered 0%	0% Not Covered 0%
<b>Inpatient Benefits</b>	0%	0%
<b>Inpatient Mental Health/Substance Abuse</b>	0%	0%
<b>Outpatient Mental Health/Substance Abuse</b>	0%	0%
<b>Durable Medical Equipment and Supplies</b> (\$2,500 maximum)	0%	0%
<b>Disposable Medical Supplies</b> (\$500 maximum)	0%	0%
<b>Diabetic Equipment and Supplies</b>	0%	0%
<b>Home Health</b> (\$2,500 maximum)	0%	0%
<b>Outpatient Hospice</b>	0%	0%
<b>Outpatient Speech Therapy</b> (\$1,500 maximum)	0%	0%

**HDHP Option 3**

HDHP Benefit Category Accumulation Period: Calendar Year	Member Responsibility	
	Network	Non-Network
<b>Inpatient Rehabilitation</b> (60 day maximum)	0%	0%
<b>Outpatient Rehabilitation</b> (\$5,000 maximum)	0%	0%
<b>Transplants</b> (subject to lifetime maximums)	0%	0%  Kidney; Autologous Bone Marrow - \$100,000 Kidney/Pancreas; Pancreas - \$150,000 Allogenic Bone Marrow; Intestine; Liver - \$200,000 Heart; Lung; Heart/Lung - \$250,000
<b>All Other Covered Services</b>	0%	0%
<b>Outpatient Prescription Drugs</b>	Subject to Deductible and Coinsurance	
<b>Vision Hardware</b>	VS3: Exam Only	

# BETTER BUSINESS BUREAU

## ENROLLMENT INFORMATION

The monthly premium rates for Better Business Bureau Member businesses with 1-50 employees (including working owners and self employed) are as follows:

Effective January 1, 2010 – December 31, 2010

### *PHSIC Age Banded Rates – Monthly Premium Schedule HDHP RX Medical Plan \$3,500 Deductible, 100/100*

<i>HDHP Rx Medical</i>						
<i>Age</i>	<i>Male Single</i>	<i>Female Single</i>	<i>ES</i>	<i>Male EC</i>	<i>Female EC</i>	<i>Family</i>
<25	\$101.34	\$239.52	\$340.86	\$268.70	\$406.88	\$556.33
25-29	\$104.41	\$337.28	\$441.68	\$297.36	\$530.22	\$686.32
30-34	\$126.93	\$309.64	\$436.57	\$363.89	\$546.60	\$728.80
35-39	\$142.79	\$276.88	\$419.68	\$407.39	\$541.48	\$743.13
40-44	\$186.30	\$280.47	\$466.76	\$440.15	\$534.32	\$782.54
45-49	\$220.59	\$306.57	\$527.15	\$458.06	\$544.04	\$805.57
50-54	\$351.61	\$341.88	\$693.49	\$565.03	\$555.30	\$933.01
55-59	\$447.83	\$406.88	\$854.71	\$638.21	\$597.27	\$1,060.96
60-64	\$532.27	\$513.34	\$1,045.61	\$703.21	\$684.28	\$1,223.20
65+	\$635.66	\$592.66	\$1,228.32	\$788.17	\$745.18	\$1,381.35

## EXCLUSIONS

1. Any services which are not Medically Necessary.
2. Amounts in excess of the Allowed Amount(s) for the care, service or supply rendered.
3. Care for health conditions required by state or local law to be treated in a public facility.
4. Experimental, Investigational, unproven or obsolete treatments, procedures or devices and related services, unless otherwise described in this Certificate.
5. Transplants, except as described in this Certificate.
6. 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.
7. Membership costs or fees associated with health clubs, exercise programs, weight loss programs, smoking cessation programs, and commercial pain management programs.
8. Vitamins, minerals, nutritional supplements, or special diet foods whether or not required by a Physician.
9. Cosmetic, health, and beauty aids.
10. Evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody, or child visitation proceedings and any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto.
11. Treatment of teeth or structures directly supporting the teeth including, but not limited to: extraction of teeth (including bony impacted wisdom teeth); routine cleaning; dental examination, x-rays and repairs; fillings, scaling, scraping and/or root planing; dentures; bridges; dental implants; casts and splints; straightening of teeth; services for dental malocclusion; maxillofacial orthognathic and prognathic treatment/surgery; orthodontics; periodontics; or hospitalizations for non-covered services, except as specified in the Oral Surgery and Related Services and Transplant sections of this Certificate.
12. Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning.
13. Services or supplies related to intersex surgeries.

14. Non-medical ancillary services including, but not limited to: legal services; social rehabilitation; vocational rehabilitation; work reintegration training; work hardening or conditioning; behavioral training; sleep therapy; employment counseling; educational testing, training, or therapy, unless approved by PHSIC as part of treatment for traumatic head injury or stroke, or as specified in the Diabetic Services section of this Certificate.
15. Items of wearing apparel, except as described under the Disposable Medical Supply, Prosthetic Devices, Orthotic Devices, or Reconstructive Treatment/Surgery sections of this Certificate.
16. All charges for or related to autopsies, unless PHSIC requests the autopsy.
17. All charges related to complementary/alternative medicine including, but not limited to: sensory integrative techniques; music therapy; guided imagery; therapeutic touch; aroma therapy; acupressure; hydro-massage; Vax-D therapy; reflexology; cranio-sacral therapy; acupuncture; and therapy for the development of cognitive skills to improve attention, memory or problem solving, including compensatory training.
18. Prescription drugs, non-prescription drugs and Investigational and Experimental drugs, except as described as covered in this Certificate.
19. Routine foot care including the paring and removing of corns and calluses or trimming of nails, unless Medically Necessary for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity.
20. Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
21. Services for injuries or diseases related to your employment to the extent you are covered or are required to be covered by the workers' compensation law. If the Covered Person enters into a settlement giving up rights to recover past or future medical benefits under worker's compensation law, PHSIC will not pay past or future medical benefits that are the subject of or related to that settlement. In addition, if the Covered Person is covered by a worker's compensation program, which limits benefits other than specified by the program, PHSIC will not pay balances of charges from such non-specified Providers.
22. Benefits of this Certificate will not duplicate benefits provided under Federal, State or local laws, regulations or programs. Examples of such programs are: Medicare, CHAMPUS, Tricare, and services in any veteran's facility when services are eligible for coverage by the government. The Certificate will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid. This exclusion applies whether or not your chose to waive you rights to these services.
23. Injuries incurred while the Covered Person is in the commission or attempted commission of a felony.
24. Services resulting from war or an act of war.
25. Whole blood, and blood plasma or payments to donors for blood or payment to a blood collection site.
26. The costs of health services resulting from accidental bodily injuries arising out of the ownership, operation, maintenance, or use of motor vehicle to the extent such services are required to be covered by motor vehicle financial responsibility laws, regulations, or programs, or are payable under any medical expense payment provisions (by whatever terminology used-including such benefits mandated by law) of any automobile insurance policy.
27. Transportation, food and lodging unless otherwise described in this Certificate.
28. Services performed by the Covered Person or their parent, spouse, sibling or child.
29. Elective abortions.
30. Services or items for the convenience of the Covered Person or Provider including, but not limited to, home laboratory testing and duplication of covered durable medical equipment.
31. Services when the Covered Person is not present including, but not limited to: case management team conferences, telephone calls, electronic communication, telemedicine, and consultations with family members.
32. Any service(s) rendered where the Covered Person(s) receives monetary or in-kind enticement, incentive, rebate or kickback of any kind from a Provider(s) or agent(s) of a Provider(s).
33. Any service(s) rendered and/or billed by a Provider through misrepresentation of material fact or fraud.
34. Items not strictly for the purpose of treating a medical condition including, but not limited to: over-the-counter batteries, massagers, air/water purifiers, air conditioners, pillows, mattresses, communication devices/aids, whirlpools, bedwetting alarms, prenatal cradles, breast pumps, car seats, strollers, shower chairs, commodes, thermal therapy devices, or modifications to the Covered Person's home or vehicle.
35. Any portion of a Claim that PHSIC determines to be incorrectly or inappropriately billed by a Physician, Health Professional, Facility or Hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period, and inappropriate modifier use.
36. Costs associated with the replacement of items that are damaged, lost or stolen.
37. Any Service or supply that is provided or obtained relative to an excluded service and subsequent complications, which may occur. "Provided relative to" would be a service or supply that would not have been required if the excluded service had not been obtained by the Covered Person. This includes any inpatient or outpatient service by any Provider whether service is rendered face-to-face or without patient presence.