



BETTER BUSINESS BUREAU OF KANSAS, INC.
PPO HDHP PLAN QA2500
OPTION 2
SUMMARY OF BENEFITS
Proposed Group Effective Date:
1/1/2012

Benefit Period: benefits accumulate from January 1 to December 31

In a Preferred Provider Organization (PPO) benefit Plan You may utilize any provider. If a Participating Provider is utilized, You will receive the Network level of benefits. If You utilize a Non-Participating Provider, You will receive the Non-Network level of benefits. **You will also be responsible for the difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts, which could be substantial. For Non-Covered Services or services that exceed a benefit maximum, You will be responsible for the entire billed charges of a Provider.**

BENEFIT CATEGORY	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
PHYSICIAN OFFICE VISIT Family Physician office visit Specialist office visit Physical medicine services and outpatient rehabilitation services are not covered under the office visit Copayment. Family physicians generally include those providers who practice in the specialties of Family Practice, Internal Medicine, General Practice, Pediatrics, or Geriatrics.	\$20 Copayment after the Deductible \$40 Copayment after the Deductible	Deductible + Coinsurance Deductible + Coinsurance
DEDUCTIBLE (per Benefit Period) Includes medical and prescription benefits. Individual \$2,500 Family \$5,000 (at least two (2) family members must contribute toward the family Deductible) <i>The Deductibles for Network and Non-Network services are accumulated separately.</i> The following do not count toward meeting the Deductible: penalty for failure to prior authorize inpatient services; charges for Non-Covered Services; or difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts.		\$5,000 \$10,000
COINSURANCE Individual Family (The portion of the Allowed Amount You pay after the Deductible has been met)	None None	30% 30%
OUT-OF-POCKET MAXIMUM Includes Deductible, Copayments and Coinsurance for medical and prescription benefits. Individual \$4,500 Family \$9,000 (at least two (2) family members must contribute toward the family Out-of-Pocket Maximum) After the Out-of-Pocket maximum has been reached, benefits will increase to 100% of the Allowed Amounts for the remainder of the Benefit Period. You will be responsible for the difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts. The following do not count towards meeting the Out-of-Pocket maximum: penalty for failure to prior authorize inpatient services; charges for Non-Covered Services; or difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts.	\$4,500 \$9,000	\$7,000 \$14,000
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	
PREVENTIVE CARE SERVICES Includes services such as immunizations (covered at 100% of Allowed Amounts for Dependents up to 72 months of age), well-woman exam, mammograms, well-man exam, PSA test, and osteoporosis screenings. For a complete list, please visit Our website.	\$0	Deductible + Coinsurance unless otherwise noted

OUTPATIENT LAB AND X-RAY	Deductible	Deductible + Coinsurance
DIAGNOSTIC TESTING	Deductible	Deductible + Coinsurance
MRI, CT SCANS, AND PET SCANS	Deductible	Deductible + Coinsurance
PHYSICIAN OFFICE PROCEDURES AND INJECTIONS	Deductible	Deductible + Coinsurance
OUTPATIENT SURGERY	Deductible	Deductible + Coinsurance
ALLERGY TREATMENT	Deductible	Deductible + Coinsurance
MATERNITY BENEFIT Prenatal and Post Partum Office Visits Inpatient Services For other services, such as lab and x-ray, refer to the Outpatient Lab and X-Ray and Diagnostic Testing sections of this Summary of Benefits.	\$20 Copayment for initial visit only after the Deductible Subject to inpatient benefits	Deductible + Coinsurance Deductible + Coinsurance
INPATIENT BENEFITS (<i>Semi-private room, ICU, SNU, Hospice</i>) If inpatient services are not prior authorized, a \$500 penalty will apply per admission.	Deductible	Deductible + Coinsurance
INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>If inpatient services are not prior authorized, a \$500 penalty will apply per admission.</i>	Subject to inpatient benefits	Deductible + Coinsurance
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE <i>Some services require Prior Authorization.</i> This benefit includes intensive outpatient programs, partial day hospitalization, and psychological testing.	\$20 Copayment after the Deductible	Deductible + Coinsurance
EMERGENCY SERVICES <i>There is no coverage for non-Emergency Medical Conditions treated in a Hospital emergency room.</i> Urgent Care Facility Emergency Room You will be responsible for the difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts.	\$40 Copayment per visit after the Deductible Deductible + \$150 Copayment (Copayment waived if admitted)	Deductible + Coinsurance Network Deductible + \$150 Copayment (Copayment waived if admitted)
AMBULANCE	Deductible + \$150 Copayment	Network Deductible + \$150 Copayment
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	Deductible	Deductible + Coinsurance
DISPOSABLE MEDICAL SUPPLIES	Deductible	Deductible + Coinsurance
DIABETIC EQUIPMENT AND SUPPLIES	Deductible	Deductible + Coinsurance
HOME HEALTH CARE	Deductible	Deductible + Coinsurance
THERAPEUTIC INJECTIONS AND IV INFUSIONS	Deductible	Deductible + Coinsurance
OUTPATIENT HOSPICE SERVICES	Deductible	Deductible + Coinsurance
INPATIENT REHABILITATION (<i>Speech, Physical, Occupational</i>)	Subject to inpatient benefits	Deductible + Coinsurance
OUTPATIENT REHABILITATION (<i>Speech, Physical, Occupational, Cardiac, Pulmonary, and Spinal Manipulations</i>) Family Physician office visit Specialist office visit Coverage is provided following injuries, surgeries, or acute medical conditions.	\$20 Copayment after the Deductible \$40 Copayment after the Deductible	Deductible + Coinsurance Deductible + Coinsurance
ORTHOTICS AND PROSTHETICS Coverage is limited to the original device unless repair and/or replacement is Medically Necessary.	Deductible	Deductible + Coinsurance
DENTAL/ORAL SURGERY SERVICES Family Physician office visit Specialist office visit Inpatient services Services for accidental injury to sound, natural teeth will be covered at the Network level up to a maximum benefit of \$1,000 of Allowed Amounts , if provided within twelve (12) months from the date of the injury. This benefit maximum does not apply to individuals under 18 years of age.	\$20 Copayment after the Deductible \$40 Copayment after the Deductible Subject to inpatient benefits	Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance
TRANSPLANT SERVICES <i>All Organ Transplants must be Prior Authorized prior to the transplant.</i> Family Physician office visit Specialist office visit Inpatient services Limited to two (2) procedures for the same condition per lifetime.	\$20 Copayment after the Deductible \$40 Copayment after the Deductible Subject to Inpatient benefits	Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance

ANNUAL ROUTINE EYE EXAM Limited to one (1) exam and refraction per Benefit Period.	\$0	Deductible + Coinsurance
ALL OTHER COVERED SERVICES	Deductible	Deductible + Coinsurance
PRESCRIPTION DRUGS Certain medications require Prior Authorization The Copayments under this section will apply to Covered Prescriptions dispensed at a Participating Mail Order or Retail Pharmacy who agrees in writing to the same terms and conditions that apply to the contractual agreement offered to any Participating Mail Order Pharmacy. Retail Pharmacy: A 34-day supply, as specified by the quantity sufficient for a standard course of therapeutic treatment as defined by the Plan. Mail Order Pharmacy: A 90-day supply, as specified by the quantity sufficient for a standard course of therapeutic treatment as defined by the Plan. Oral Anti-Cancer Medications if these have an equivalent intravenous or injectable <i>Please refer to the Prescription Drug Rider for complete plan provisions and limitations.</i>	34-day supply: Tier 1 Formulary - \$10 Copayment after the Deductible Tier 2 Formulary - \$30 Copayment after the Deductible Tier 3 Non-Formulary - \$55 Copayment after the Deductible 90-day supply: Tier 1 Formulary - \$25 Copayment after the Deductible Tier 2 Formulary - \$75 Copayment after the Deductible Tier 3 Non-Formulary - \$137.50 Copayment after the Deductible 0% of Allowed Amounts	34-day supply: Tier 1 Formulary - \$10 Copayment after the Deductible Tier 2 Formulary - \$30 Copayment after the Deductible Tier 3 Non-Formulary - \$55 Copayment after the Deductible 90-day supply: Tier 1 Formulary - \$25 Copayment after the Deductible Tier 2 Formulary - \$75 Copayment after the Deductible Tier 3 Non-Formulary - \$137.50 Copayment after the Deductible 0% of Allowed Amounts

To comply with Internal Revenue Service rules for qualified health plans, the following rules apply:

Out-of-Pocket Maximums: The Out-of-Pocket Maximum includes the Deductible, Coinsurance and Copayments. The following do not accrue toward Your Out-of-Pocket Maximum: (1) penalties; (2) costs incurred due to failure to follow prior authorization requirements; (3) payments for denied benefits; or (4) differences between the actual billed charges and the Allowed Amount when a Non-Participating Provider is used.

The individual Out-of-Pocket Maximum is a limit on the amount You must incur out of pocket for specified Covered Services if You have individual coverage. When You have individual coverage and You meet the individual Out-of-Pocket Maximum, Covered Services are paid at 100% of the applicable Allowed Amount without any Coinsurance for the remainder of the Benefit Period. The family Out-of-Pocket Maximum is the limit on the total amount members of the same family covered under this plan must incur in the aggregate for specific Covered Services. If You have family coverage and the covered family members, in aggregate, meet the Out-of-Pocket Maximum, Covered Services for all individuals are paid at 100% of the applicable Allowed Amount without any Coinsurance for the remainder of the Benefit Period.

Some services require Prior Authorization. You or the Provider are 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 Customer Service at 316-609-2390 or 1-800-660-8114 (outside Wichita).

All benefits and the coinsurance percentage are based on Allowed Amounts.

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 individual 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.

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, 2012 – December 31, 2012

PHS Age Banded Rates – Monthly Premium Schedule PPO QA2500 High Deductible Health Plan

HDHP Rx Medical

<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>
<i><25</i>	<i>\$147.93</i>	<i>\$320.66</i>	<i>\$468.59</i>	<i>\$410.74</i>	<i>\$583.46</i>	<i>\$786.76</i>
<i>25-29</i>	<i>\$141.32</i>	<i>\$467.76</i>	<i>\$609.08</i>	<i>\$446.27</i>	<i>\$772.71</i>	<i>\$981.80</i>
<i>30-34</i>	<i>\$181.81</i>	<i>\$434.70</i>	<i>\$616.52</i>	<i>\$564.45</i>	<i>\$817.34</i>	<i>\$1,083.45</i>
<i>35-39</i>	<i>\$221.48</i>	<i>\$392.55</i>	<i>\$614.04</i>	<i>\$647.10</i>	<i>\$818.17</i>	<i>\$1,143.78</i>
<i>40-44</i>	<i>\$266.94</i>	<i>\$413.22</i>	<i>\$680.15</i>	<i>\$681.81</i>	<i>\$828.08</i>	<i>\$1,200.81</i>
<i>45-49</i>	<i>\$339.66</i>	<i>\$460.32</i>	<i>\$799.99</i>	<i>\$748.75</i>	<i>\$869.41</i>	<i>\$1,285.93</i>
<i>50-54</i>	<i>\$549.58</i>	<i>\$499.16</i>	<i>\$1,048.74</i>	<i>\$904.94</i>	<i>\$854.53</i>	<i>\$1,448.73</i>
<i>55-59</i>	<i>\$631.39</i>	<i>\$619.82</i>	<i>\$1,251.22</i>	<i>\$948.74</i>	<i>\$937.17</i>	<i>\$1,597.49</i>
<i>60-64</i>	<i>\$786.76</i>	<i>\$762.80</i>	<i>\$1,549.56</i>	<i>\$1,065.27</i>	<i>\$1,041.30</i>	<i>\$1,838.81</i>
<i>65+</i>	<i>\$961.14</i>	<i>\$861.97</i>	<i>\$1,823.11</i>	<i>\$1,208.24</i>	<i>\$1,109.07</i>	<i>\$2,071.04</i>

EXCLUSIONS

- Any services which are not Medically Necessary.
- Amounts in excess of the Allowed Amount(s) for the care, service or supply rendered.
- Care for health conditions required by state or local law to be treated in a public facility.
- Experimental, Investigational, unproven or obsolete treatments, procedures or devices and related services, unless otherwise described in this Certificate.
- Transplants, except as described in this Certificate.
- 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.
- Membership costs or fees associated with health clubs, exercise programs, weight loss programs, smoking cessation programs, and commercial pain management programs.
- Vitamins, minerals, nutritional supplements, or special diet foods whether or not required by a Physician.
- Cosmetic, health, and beauty aids.
- 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.
- 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.
- 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 PHS 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 PHS 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, PHS 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, PHS 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 PHS 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.



PPO Plans Enrollment Form *Please type or print*

IMPORTANT: Enrollments cannot be processed without both pages being completed and returned.

Group #: _____

Plan Selection: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3 <input type="checkbox"/> _____			Your Employer / Company Name:			
SSN:		Employee's Legal Last Name:		Legal First Name:		MI:
Street Address:				City, State and Zip:		
Home Phone:		Work Phone:		Birth Date:	Sex:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law Married (attach Affidavit)

Please list spouse you wish to enroll in medical coverage.

Spouse's Legal Last Name:		Legal First Name:		MI:	Birth Date:	Sex:	SSN:
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Please list children and other eligible dependents you wish to enroll in medical coverage (list address if different).

Legal Last Name	Legal First Name	MI	Birth Date	Sex	SSN	Relationship

Employee's Legal Last Name:	Legal First Name:	MI:
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Please complete the following:

- After you are enrolled in the Plan, will you or any person listed above be covered by other health insurance? No Yes If yes, what insurance? _____
Insurance Company's Phone Number: _____ Policyholder's I.D. # _____
Policyholder's Name and Date of Birth: _____ Names of those covered: _____
- Is a dependent child listed above mentally or physically disabled? No Yes (call Us to obtain form) If yes, name of child? _____
- When selecting a qualified high deductible health plan, I understand that I am required to establish a federally qualified health savings account on the effective date of the policy.
_____ (please initial if applicable)
- I hereby apply for enrollment for the individual(s) listed above. I authorize my employer to deduct from my earnings my contribution to the premium. I hereby consent to the release of information or medical records concerning services or supplies provided to me or my covered dependents by any health care provider, allied health professional, hospital or medical care institution to the Plan, or its designee for the purpose of quality or utilization review or payment of a claim. A copy of this consent is available upon request. The consent is valid for the duration of the coverage. I represent that the information I have provided on this form is correct and that I do hereby agree to the terms and conditions set out in the Plan.

Employee's Signature (required): _____ **Date:** _____

EMPLOYER: COMPLETE THE SECTION BELOW IN FULL, SIGN AND DATE - ALL INFORMATION IS REQUIRED (completed form may be faxed to: 316-609-2327)

Check One and Furnish Dates: Date of Employment of New Hire: _____ Open Enrollment Loss of Other Group Coverage, Date of Loss: _____
 Other, List Reason (e.g. family status change, PT to FT): _____ Date of Qualifying Event: _____

Effective Date of Coverage: _____ **Employer's Signature:** _____ **Date:** _____