



**BETTER BUSINESS BUREAU OF KANSAS, INC.**  
**PPO HDHP PLAN QA5000-0**  
**OPTION 3**  
**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
<b>PHYSICIAN OFFICE VISIT</b> 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.	\$0 Copayment after the Deductible  \$0 Copayment after the Deductible	Deductible + Coinsurance  Deductible + Coinsurance
<b>DEDUCTIBLE</b> (per Benefit Period) <b>Includes medical and prescription benefits.</b>  Individual Family <b>(at least two (2) family members must contribute toward the family Deductible)</b>  <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	\$7,000 \$14,000
<b>COINSURANCE</b> Individual Family (The portion of the Allowed Amount You pay <b>after the Deductible has been met</b> )	None None	50% 50%
<b>OUT-OF-POCKET MAXIMUM</b> <b>Includes Deductible, Copayments and Coinsurance for medical and prescription benefits.</b>  Individual Family <b>(at least two (2) family members must contribute toward the family Out-of-Pocket Maximum)</b>  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. <b>You will be responsible for the difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts.</b> 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.	\$5,000 \$10,000	\$9,000 \$18,000
<b>ANNUAL MAXIMUM ON ESSENTIAL BENEFITS</b> 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	
<b>PREVENTIVE CARE SERVICES</b> 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

<b>OUTPATIENT LAB AND X-RAY</b>	Deductible	Deductible + Coinsurance
<b>DIAGNOSTIC TESTING</b>	Deductible	Deductible + Coinsurance
<b>MRI, CT SCANS, AND PET SCANS</b>	Deductible	Deductible + Coinsurance
<b>PHYSICIAN OFFICE PROCEDURES AND INJECTIONS</b>	Deductible	Deductible + Coinsurance
<b>OUTPATIENT SURGERY</b>	Deductible	Deductible + Coinsurance
<b>ALLERGY TREATMENT</b>	Deductible	Deductible + Coinsurance
<b>MATERNITY BENEFIT</b> 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.	\$0 Copayment after the Deductible Subject to inpatient benefits	Deductible + Coinsurance Deductible + Coinsurance
<b>INPATIENT BENEFITS</b> ( <i>Semi-private room, ICU, SNU, Hospice</i> ) <b>If inpatient services are not prior authorized, a \$500 penalty will apply per admission.</b>	Deductible	Deductible + Coinsurance
<b>INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE</b> <i>If inpatient services are not prior authorized, a \$500 penalty will apply per admission.</i>	Subject to inpatient benefits	Deductible + Coinsurance
<b>OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE</b> <i>Some services require Prior Authorization.</i> This benefit includes intensive outpatient programs, partial day hospitalization, and psychological testing.	\$0 Copayment after the Deductible	Deductible + Coinsurance
<b>EMERGENCY SERVICES</b> <b><i>There is no coverage for non-Emergency Medical Conditions treated in a Hospital emergency room.</i></b> Urgent Care Facility  Emergency Room  <b>You will be responsible for the difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts.</b>	\$0 Copayment after the Deductible  \$0 Copayment after the Deductible	Deductible + Coinsurance  Network Deductible + \$150 Copayment (Copayment waived if admitted)
<b>AMBULANCE</b>	\$0 Copayment after the Deductible	Network Deductible + \$150 Copayment
<b>DURABLE MEDICAL EQUIPMENT AND SUPPLIES</b>	Deductible	Deductible + Coinsurance
<b>DISPOSABLE MEDICAL SUPPLIES</b>	Deductible	Deductible + Coinsurance
<b>DIABETIC EQUIPMENT AND SUPPLIES</b>	Deductible	Deductible + Coinsurance
<b>HOME HEALTH CARE</b>	Deductible	Deductible + Coinsurance
<b>THERAPEUTIC INJECTIONS AND IV INFUSIONS</b>	Deductible	Deductible + Coinsurance
<b>OUTPATIENT HOSPICE SERVICES</b>	Deductible	Deductible + Coinsurance
<b>INPATIENT REHABILITATION</b> ( <i>Speech, Physical, Occupational</i> )	Subject to inpatient benefits	Deductible + Coinsurance
<b>OUTPATIENT REHABILITATION</b> ( <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.	\$0 Copayment after the Deductible \$0 Copayment after the Deductible	Deductible + Coinsurance Deductible + Coinsurance
<b>ORTHOTICS AND PROSTHETICS</b> Coverage is limited to the original device unless repair and/or replacement is Medically Necessary.	Deductible	Deductible + Coinsurance
<b>DENTAL/ORAL SURGERY SERVICES</b> 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 <b>maximum benefit of \$1,000 of Allowed Amounts</b> , 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.	\$0 Copayment after the Deductible \$0 Copayment after the Deductible Subject to inpatient benefits	Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance
<b>TRANSPLANT SERVICES</b> <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.	\$0 Copayment after the Deductible \$0 Copayment after the Deductible Subject to Inpatient benefits	Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance



# 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 QA5000-0 High Deductible Health Plan*

<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>
<b>&lt;25</b>	<b>\$128.79</b>	<b>\$279.18</b>	<b>\$407.97</b>	<b>\$357.60</b>	<b>\$507.98</b>	<b>\$684.99</b>
<b>25-29</b>	<b>\$123.04</b>	<b>\$407.25</b>	<b>\$530.29</b>	<b>\$388.54</b>	<b>\$672.76</b>	<b>\$854.80</b>
<b>30-34</b>	<b>\$158.30</b>	<b>\$378.47</b>	<b>\$536.77</b>	<b>\$491.44</b>	<b>\$711.61</b>	<b>\$943.30</b>
<b>35-39</b>	<b>\$192.83</b>	<b>\$341.77</b>	<b>\$534.61</b>	<b>\$563.39</b>	<b>\$712.33</b>	<b>\$995.82</b>
<b>40-44</b>	<b>\$232.41</b>	<b>\$359.76</b>	<b>\$592.17</b>	<b>\$593.61</b>	<b>\$720.96</b>	<b>\$1,045.47</b>
<b>45-49</b>	<b>\$295.72</b>	<b>\$400.78</b>	<b>\$696.50</b>	<b>\$651.89</b>	<b>\$756.94</b>	<b>\$1,119.58</b>
<b>50-54</b>	<b>\$478.48</b>	<b>\$434.59</b>	<b>\$913.08</b>	<b>\$787.88</b>	<b>\$743.99</b>	<b>\$1,261.33</b>
<b>55-59</b>	<b>\$549.72</b>	<b>\$539.64</b>	<b>\$1,089.36</b>	<b>\$826.01</b>	<b>\$815.94</b>	<b>\$1,390.84</b>
<b>60-64</b>	<b>\$684.99</b>	<b>\$664.12</b>	<b>\$1,349.11</b>	<b>\$927.47</b>	<b>\$906.60</b>	<b>\$1,600.94</b>
<b>65+</b>	<b>\$836.81</b>	<b>\$750.46</b>	<b>\$1,587.27</b>	<b>\$1,051.94</b>	<b>\$965.60</b>	<b>1,803.13</b>

## 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 #: \_\_\_\_\_

<b>Plan Selection:</b> <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:** \_\_\_\_\_