Chambers of Kansas
Community Health Plan

Keeping our communities healthy, economically strong and thriving

COORDINATED BY

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Your Local Chamber

Chambers of Kansas
Community Health Plan

Plan Description

The Chambers of Kansas Community Health Plan is a non-grandfathered benefit plan under the Patient Protection and Affordable Care Act of 2010. This means the plan includes the mandated coverage(s) as required in the law for the benefit of plan participants. For additional information regarding the benefits provided due to this legislation, as well as all other available coverage levels limitations, please refer to the plan description and the summary plan document.

PARTICIPATING CHAMBERS

Coffeyville Area Chamber of Commerce

Gardner Chamber of Commerce

Iola Area Chamber of Commerce & Tourism

Larned Area Chamber of Commerce

Northeast Johnson County Chamber of Commerce

Norton Area Chamber of Commerce

Paola Chamber of Commerce

Phillipsburg Chamber & Mainstreet

Spring Hill Chamber of Commerce

The Chamber in Hays, Kansas

The CKCHP is:

- A welfare benefit plan established under Internal Revenue Service Code and applicable Department of Labor regulations.
- A plan where contributions are held in a trust that is directed by a board of trustees chosen from the member participants of the plan.
- A plan governed by the CKCHP insurance board, the plan sponsor, and its board of directors who assigns a plan administrator; all working for the benefit of the participants.
- A plan where Corporate Plan Management, Inc. (CPM) retains administrative services as needed for the management of the plan.
- A plan where claims are processed by the contracted claims administrator (TPA), CPM as directed by applicable state and federal laws, the trust document, the plan declaration and the summary plan description(s) of the benefit programs offered and administered by the alliance.
- A trust which contracts with insurance and/or reinsurance companies in order to ensure the overall financial stability of the trust and of the benefits offered. These contracts may change from time to time and are voted upon and approved by the CKCHP board and the trust board or its designee.
- A plan where the benefits offered are reviewed annually to determine their viability for the members and participants. The board of trustees, with available contracted counsel and advice, may alter these benefits, remove a plan of benefits completely and/or add new plans for consideration, without the consent of participating employers or participating employees.
- A trust that is participant-owned along with any surplus or deficits incurred.

Claims Administered by:
(800) 999-1781

CPM
CORPORATE PLAN MANAGEMENT

Program Objectives

- More stability in insurance premiums, now and in the future
- Broader accessibility to health insurance and coverage options within the community
- Creation of a community-wide wellness mind-set and culture
- Education about access to a broader range of choices to promote better healthcare decision making

For years, employers have provided benefits for employees and planned for those benefits to meet the needs of those employees and their families. The challenge for employers is that healthcare has become much more specialized and variable while benefit programs have adhered to a more "one- size-fits-all" model.

Due to evolving benefit needs of employees and their families, CKCHP wants to be progressive in providing additional chamber benefits to assist employers. By offering a health benefit plan, CKCHP continues supporting employers in their efforts to stay economically strong and competitive in the marketplace, keeping employers and employees in the community.

One benefit plan DOES NOT fit all employees' healthcare needs!

EMPLOYEES CHOOSE
the benefit program that best fits their needs and their ability to afford the premiums for that benefit plan choice. Any amount of premium for coverage, which is more than the employer contribution, is withheld from employee compensation pre-tax. (See your employer for more information.)

Enrollment Requirements/Contingencies:

- The employer must be a current member in good standing for at least 60 days, of at least one participating chamber of commerce, prior to effective date of coverage.
- Each employer must have a minimum of 65% of eligible employees participating (after qualified waivers). Minimum group size is one if they are a sole proprietor.
- Completed Health Questionnaires are required from each employee in order to qualify. Following underwriting, the premium rates will be supplied. Each employer that chooses the CKCHP is required to submit an Individual Medical Questionnaire (IMQ), Employee enrollment/waiver applications from each employee.
- The plan's renewal date is January 1st of each calendar year. Regardless of when enrollment is completed, any changes to the plan rates and/or benefits will take place on January 1st. Open enrollment (the ability to add employees who waived coverage or dependents which had previously waived) is 11/15 – 12/15 of each year for each participating employer (subject to HIPAA qualifying event rules).
- Premium contributions are made by the employer directly into the trust account and are used as described in the trust document, summary plan description and plan declaration. The trust is governed by a board of trustees, elected as described in the trust document.
- Employer must contribute a minimum of 50% of the single premium of the most affordable plan option of each employee's premium, contributing too little for employee's premium may have tax implications under the ACA (for Applicable Large Employers).

Health Plan Options

Medical	Plan A		Plan B		Plan C – HDHP / HSA	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Deductible						
Single	$1,000	$2,000	$3,000	$6,000	$6,000	$12,000
Family	$2,000	$4,000	$6,000	$12,000	$12,000	$24,000
Co-Insurance						
	80/20	60/40	80/20	60/40	N/A	N/A
Max OOP	Single		Single		Single	
	$2,000	$4,000	$6,000	$12,000	$6,000	$12,000
	Family		Family		Family	
	$4,000	$8,000	$12,000	$24,000	$12,000	$24,000
	Max out of pocket is deductible + co-insurance				Co-pays count to MAX OOP	
Preventative	100%	Ded. / Co-ins	100%	Ded. / Co-ins	100%	Ded. / Co-ins
Office Co-pay						
Primary Care	$25	Ded. / Co-ins	$25	Ded. / Co-ins	N/A	Ded. / Co-ins
Specialist	$25	Ded. / Co-ins	$25	Ded. / Co-ins	N/A	Ded. / Co-ins
Urgent Care	$75	Ded. / Co-ins	$75	Ded. / Co-ins	N/A	Ded. / Co-ins
ER	$250	Ded. / Co-ins	$250	Ded. / Co-ins	N/A	Ded. / Co-ins

*** Plan C – HDHP / HSA includes all co-pay options, health and Rx ***

All Plans Include:

- Medically necessary ambulance coverage (air and ground)
- Pre-existing conditions covered
- Unlimited lifetime maximum
- Out-of-pocket maximum = deductible amount + co-insurance amount
- Includes chiropractic and physical / speech therapy benefits (when medically appropriate)
- Routine wellness (health, dental & vision)- paid at 100% (based on physician codes)
- Non-network paid at the 60th percentile of reasonable & customary
- Dr. office co-pay - no annual visit limitation
- Choice of prescription coverage

Provider Networks

Location	PPO Network Name	PPO Website	Phone Number
In KS	ProviDR's Care Network	www.providrscare.net	800-801-9772
NE KS	Preferred Health Professionals	www.phpkc.com	800-544-3014
Outside of KS	First Health Network	www.firsthealth.com	800-226-5116

Prescription Plan Options

	Plan 1	Plan 2
Generic	$1	$1
Preferred Brand	20/80 co-insurance MAX $500	20/80 co-insurance MAX $500
Non-Preferred Brand	35/65 co-insurance MAX $500	35/65 co-insurance MAX $500
Specialty	20/80 co-insurance MAX $1,000	EXCLUDED

CKCHP will be utilizing all available drug manufacturer co-pay assistance programs for brand and specialty drugs. The plan will retain all the rebates for those drugs to make it little to no cost to the member and significantly reduce the plan's spending. Local partners and facilities will be utilized to help enhance plan efficiencies.

This is a partial listing of the Benefits and Exclusions provided under the medical plan and is NOT intended to provide complete details of benefits and/or exclusions and limitations. Please refer to the Summary Plan Description (SPD) for details of benefits, limitations and the applicability of these benefits to each situation.

Benefits available...but NOT limited to:

Allergy tests and allergy injections
Ambulatory/outpatient surgery facility care
Anesthesia charges
Assistant surgeon charges (if required due to the surgical aspects)
Birthing center
Blood and blood related products
Cardiac rehabilitation
Chemotherapy for treatment of a malignancy
Chiropractic. manipulation or adjustment of the spinal column
Colonoscopy (diagnostic)
Diabetes education. Equipment and supplies for persons with diabetes
Durable medical equipment Elective sterilization Emergency room
Hospital inpatient or outpatient services
Laboratory services Mastectomy due to diagnosed breast cancer
Mental & nervous treatment
Nursing services Occupational therapy Orthopedic braces
Oxygen & the equipment for its administration
Pathological services
Physical therapy
Prescription drugs requiring a prescription under federal law
Professional ambulance service if medically necessary (Includes air ambulance)
Prowsthetic orthotics Radiation therapy
Respiratory/Inhalation therapy Services of physicians
a. hospital visits
b. doctor's office calls
c. doctor's office surgery
Speech therapy, but not only to restore speech abilities lost due to illness or injury
Surgery charges X-ray services

Benefits Exclusion:

Abortion; excepting "risk to mother", rape or incest
Acupuncture or acupressure therapy
Adoption or surrogate expenses
Biofeedback Therapy
Blood handling and storage charges
Cosmetic surgery Chelation therapy, except for heavy metal poisoning
Non-prescribed corrective footwear
Cosmetic services Custodial care
(Under medical) Dental & dental Implants
Developmental delays
Preferred provider discount amounts or "cash discounts"
educational or vocational testing
Excess charges
Exercise
Experimental or investigational Cosmetic eyelid and Eyebrow Surgery
Failure to keep appointments
Illegal acts
Food
Cosmetic foot care
Foreign medical care or government provided services
Hair loss
Hypnotism
Liposuction
Mailing expenses
Massage therapy
No obligation to pay
No physician recommendation
Nonprescription items
Not appropriate or not medically necessary
Occupational
Personal comfort of convenience items
Providing medical information
Relative giving services
Riot
Sales tax Self-inflicted
Services before or after coverage
Sex changes
Smoking cessation (except under Preventative Care)
Surgical sterilization reversal
Telephone consultations
Third party liability
Visual training or orthoptics
War or acts of war Worker's compensation

	Network	Non-Network
Deductible • Individual • Family Unit	Plan A / Plan B / Plan C $1,000 / $3,000 / $6,000 $2,000 / $6,000 / $12,000	Plan A / Plan B / Plan C $2,000 / $6,00 / $12,000 $4,000 / $12,000 / $24,000
Co-Insurance Level (Participant)	20% / 20% / ›N/A	40% / 40% / N/A
Maximum Out-of-Pocket[1] • Individual • Family Unit	Plan A / Plan B / Plan C $2,000 / $6,000 / $6,000 $4,000 / $12,000 / $12,000	Plan A / Plan B / Plan C $4,000 / $12,000 / $12,000 $8,000/$24,000/$24,000

Covered Medical Expenses:	Network	Non-Network	Max. Ins. Pays[2]
1. Ambulance	Ded./co-ins.	Ded./co-ins.	No Max
2. Birthing Center	Ded./co-ins.	Ded./co-ins.	No Max
3. Blood & Plasma	Ded./co-ins.	Ded./co-ins.	No Max
4. Breast Pump	100%	100%	1 per year
5. Chiropractic Care	$25 co-pay	Ded./co-ins.	20 visits per year
6. Durable Medical Equipment	Ded./co-ins.	Ded./co-ins.	No Max
7. Emergency Room Visit	$250 co-pay	Ded./co-ins.	No Max
8. Hearing Aids	Ded./co-ins.	Ded./co-ins.	One pair of hearing aids every 3 years. $5,000 max benefit
9. Hospice Care • Inpatient/Outpatient	Ded./co-ins.	Ded./co-ins.	Inpatient 30 days Outpatient 60 visits
10. Hospital • Inpatient & Outpatient Treatment	Ded./co-ins.	Ded./co-ins.	
11. Newborn Care	Ded./co-ins.	Ded./co-ins.	No Max
12. Outpatient Diagnostic X-ray and Lab	Ded./co-ins.	Ded./co-ins.	No Max
13. Outpatient Services	Ded./co-ins.	Ded./co-ins.	No Max
14. Physician Office Visit	$25 co-pay	Ded./co-ins.	No Max
15. Pregnancy Expenses	Ded./co-ins.	Ded./co-ins.	No Max
16. Scans – CT and MRI	Ded./co-ins.	Ded./co-ins.	No Max
17. Smoking/Tobacco Cessation	Ded./co-ins.	Ded./co-ins.	$500 plan credit
17. Specialist Office Visit	$25 co-pay	Ded./co-ins.	No Max
18. Surgery	Ded./co-ins.	Ded./co-ins.	No Max
19. Surgical Consultation	$25 co-pay	Ded./co-ins.	No Max
20. Temporomandibular Joint Disorder (TMJ)	Ded./co-ins.	Ded./co-ins.	$2,500 Lifetime Max.
21. Therapy • Chemotherapy/Radiation Therapy • Occupational Therapy - Inpatient • Occupational Therapy - Outpatient • Physical Therapy - Inpatient • Physical Therapy - Outpatient • Respiration Therapy - Inpatient • Respiration Therapy - Outpatient • Speech Therapy – Inpatient • Speech Therapy - Outpatient	 Ded./co-ins. Ded./co-ins. $25 co-pay Ded./co-ins. $25 co-pay Ded./co-ins. $25 co-pay Ded./co-ins. $25 co-pay	No Max Ded./co-ins. Ded./co-ins. Ded./co-ins. Ded./co-ins. Ded./co-ins. Ded./co-ins. Ded./co-ins. Ded./co-ins. Ded./co-ins.	
22. Transplants	Ded./co-ins.	Ded./co-ins.	No Max
23. Urgent Care Services	$75 co-pay	Ded./co-ins.	No Max
24. All Other Covered Services	Ded./co-ins.	Ded./co-ins.	No Max

NOTE: Copayments and co-insurance do not apply to members enrolled in Plan C – HDHP/ HSA. All charges will be subject to the member's deductible until the deductible/MOP amount is met. Once the deductible/MOP is met, all other charges will be covered by the plan at 100%

Prescription Benefits

Covered Prescription Drug Expenses:	Participating Pharmacy	Limits
Pharmacy Option – Plan 1:		
Copayment, per prescription or refill, for generic	$1	See Article XVI
Copayment, per prescription or refill, for preferred name brands	20/80 co-insurance MAX $500	See Article XVI
Copayment, per prescription or refill, for non-preferred name brands	35/65 co-insurance MAX $500	See Article XVI
Copayment, per prescription or refill, for specialty	20/80 co-insurance MAX $1000	See Article XVI

Covered Prescription Drug Expenses:	Participating Pharmacy	Limits
Pharmacy Option - Plan 2:		
Copayment, per prescription or refill, for generic	$1	See Article XVI
Copayment, per prescription or refill, for preferred name brands	20/80 co-insurance MAX $500	See Article XVI
Copayment, per prescription or refill, for non-preferred name brands	35/65 co-insurance MAX $500	See Article XVI
Copayment, per prescription or refill, for specialty	**EXCLUDED**	See Article XVI

Dental Benefits

Maximum benefit per calendar year for Class 1, 2, and 3 Services	$1,500
Deductible per Participant for Class 2 and Class 3 Services	$25
Covered Dental Expenses:	**Benefits:**
Class 1 Services (Preventive Care)	100%
Class 2 Services (Repair and Restoration)	80%
Class 3 Services (Major Dental Repair)	50%
Charges are limited to Usual, Customary, and Reasonable Fees	

Class 1 Services (Preventive Care)

- Routine oral examinations and prophylaxis (cleaning, scaling, and polishing teeth), but not more than twice per year.
- Problem focused examinations, but not more than two times per year.
- Bitewing x-rays, but not more than twice per year.
- Full mouth x-rays, but not more than once in any period of five years.
- Panoramic x-rays, but not more than once in any period of five years.
- Sealants for dependent children under age 19, but not more than twice per year; and
- Topical application of fluoride for dependent children under age 19, but not more than twice per year.

Class 2 Services (Repair and Restoration)

- All medically necessary x-rays.
- Periapical x-rays, as required.
- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.
- Extractions.
- Occlusal guards.
- Endodontics, including pulpotomy, direct pulp capping, and root canal treatment.
- Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a dentist, other than the operating Dentist, or his or her assistant.
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age nine. No payment will be made for duplicate space maintainers.
- Palliative emergency treatment of an acute condition requiring immediate care.
- Periodontal examinations, treatment and surgery; and
- Consultations.

Class 3 Services (Major Dental Repair)

Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered.

- Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth.
- Repair or recementing of crowns, inlays, bridgework, or dentures and relining of dentures.
- Unless otherwise required by law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth.
    - Where the existing denture or bridgework was installed at least five years prior to its replacement, and it cannot be made serviceable; or
    - Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months.
- Periodontal scaling.
- Oral surgery.
- Re-lines.
- Post and core; and
- Stainless steel crowns.

Exclusions

Including, but not limited to:

- Adjustments.
- Cosmetic.
- Education.
- Experimental.
- Job Related.
- Missing appliances.
- Orthodontics.
- Replacements; and
- Self-Inflicted.

Vision Benefits

Maximum benefit per calendar year	$500
Covered Vision Expenses:	**Benefits:**
Frames and Lenses	80%
Contact Lenses	80%

Covered Expenses

Subject to the limits listed in the Chambers of Kansas Community Health Plan Document, the plan pays 80% of the charge for vision care services, as follows:

- Frames, lenses, and contact lenses. Recommended and approved by a physician or optometrist.

Exclusions

Including, but not limited to:

- Consultations.
- Eye refractions.
- Non-prescription lenses.
- Orthoptics
- Radial keratotomy; and
- Vision training.

2022 Dental / Vision Rates		
	Dental	**Vision**
Single	$25.00	$10.00
EE Child	$50.00	$15.00
EE Spouse	$55.00	$20.00
Family	$80.00	$30.00

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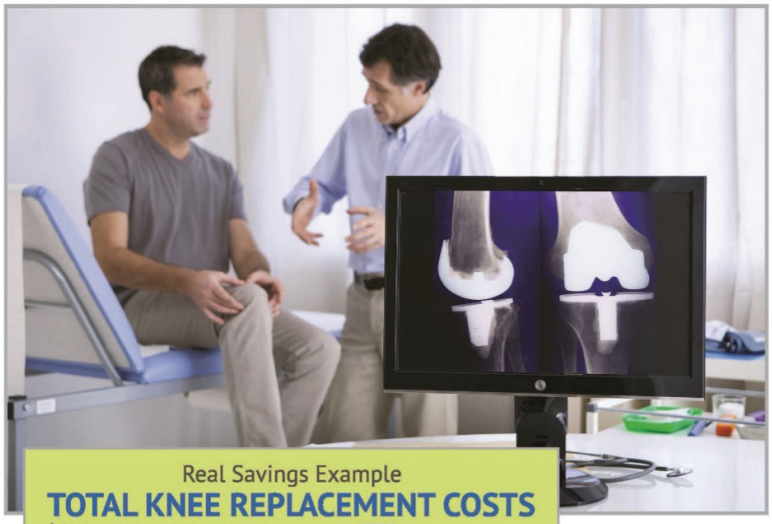

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FAQ's

1. I am a sole proprietor, can I participate?
Yes, as long as your chamber membership is a business membership under your business name, then you have access to this coverage.

2. What is my financial responsibility as a participating employer?
Because this health plan is 100% ACA compliant, you are only required to con- tribute 50% of the most economical single option offered, toward your employees' premium. For example, if an employee chooses one of the family options, the employer is still only federally required to contribute at least 50% of the most economical single option toward that family premium.

3. Are the premiums tax deductible?
Yes, they are.

4. Can the employee portion be withheld from their paycheck?
Yes, if you so choose.

5. Will I get my own invoice for my participating employees?
Yes, each month you will receive an invoice for your participating employees. You can pay that premium with check, EFT, ACH, etc.

6. Am I limited by the number of office visits I can have?
No, you can see your doctor as many times as you need to make sure your health is taken care of.

7. Will my provider be in network?
This plan utilizes two provider networks. For any provider in Kansas, you can search the ProviDRs Care Network by selecting this link (www.providrscare.net). Nation- wide, the First Health Network (www.firsthealth.com).

8. The chamber plan renewal is January 1, what if my current plan renewal is July 1(or any other time)?
You can still come onto the chamber plan at your renewal. Please keep in mind, coming onto the chamber plan mid-year like that will result in renewing again with the totality of the group at the chamber plan renewal of January 1. Your renewal will align with the chamber plan at this point.

9. How many employees need to participate for the employer to offer this plan to them?
The participation percentage is 65%. Meaning, 65% of the full time, (30+ hours per week) eligible employees have to participate for the employer to be able to offer it. Please keep in mind that waivers do not count against your participation total. Waivers such as they are on their spouse, parents, the marketplace, etc. If the employee has coverage anywhere else, and they elect not to participate, they do not count against your total participation percentage. We recommend you have all of your employees complete the questionnaire so they will have the option to participate if they so choose, however, if they decline to provide health information initially, they will not be able to participate until open enrollment of next year or if they experience a qualifying life event.

10. How much is this plan going to cost?
There are several health and prescription options to choose from, so the cost will vary plan to plan. However, if your group is reviewed by the underwriter and everything checks out fine, then your group will come on at the current rates. If the risk assessed for the new group is higher than the totality of the plan, then your rates may be higher.

11. What about pre-existing conditions, will they be covered?
Yes, per the ACA federal requirement, individuals with pre-existing conditions cannot be denied coverage.

12. What about preventative care? Well-woman checkups? Man checks?
Yes, again, per the ACA federal requirement, preventive care will be covered at 100% for health, dental and vision.

13. Will I be able to continue using the local pharmacy?
Yes. This effort is to try to use as many local resources as possible.

14. What about the dental and vision network? Will my eye doctor/dentist be in network?
With the dental and vision plan, there will be no network, so all dental and vision providers are considered in network.

15. I am NOT a chamber member; can I still participate and have access to the coverage?
You can participate and include yourself in all of the underwriting processes, however, if you enroll in the coverage, you will be required to be current on your chamber business membership prior to the coverage start date.

16. When is open enrollment for the chamber plan?
Open enrollment is from 11/15-12/15 each plan year.

Chambers of Kansas
Community Health Plan

FOR MORE INFORMATION CONTACT

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