Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $15,000 and the allowed amount for a Non-Network provider (120% of Medicare) is $500, the provider may bill you for the remaining $14,500. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Salina Regional Hospital is a Non-Network Facility. If you decide to utilize Salina Regional Hospital **or any other Non-Network Facility for services**, other than an emergent situation, you will be subject to:

- Your out-of-network Deductible
- Your Co-Insurance
- The potential that you might receive a bill for the difference between the provider's charge and what our plan allows (balance billing). Depending on the procedure, Balance Billing from Non-Network Facilities can easily be thousands of additional dollars that the employee will be responsible for.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, by calling 1-866-792-9151. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers and out-of-network providers$1,200 individual / $2,400 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Network office visits with copay; prescription drugs; and preventive services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $3,200 individual / $6,400 family; for out-of-network providers $5,200 individual / $10,400 family; Network and non-network out-of-pocket limits accumulate together	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.providrscare.net or call 1-800-801-9772 for a list of network providers in Kansas. When traveling out of Kansas see www.myfirsthealth.com or call 1-800-226-5115.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	All other covered services rendered during the visit are subject to applicable plan benefits. Telemedicine provided by TelaDoc at www.MyDrConsult.com or 800-DOC-CONSULT (362-2667) Pre-certification required for certain services including, but not limited to: Infusion therapy or any drug above $1,500/dose, Biologic drugs, and Chemotherapeutic drugs. Pre-certification required for Dialysis and On-going wound care.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No Charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. .
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Pre-certification required for tests including, but not limited to: Genetic Testing, radiation treatments and endoscopic procedures. Pre-certification required for EBCT, MRI, CT, PET scans (bone density studies are excluded).
	Imaging (CT/PET scans, MRIs)		40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 855-677-5613	Generic drugs (Tier 1)	Retail and Maintenance Medications:$10 copay/prescription, deductible does not apply.	Reimbursement is at the network allowed amount for the drug. You may have higher out-of-pocket expenses if you use a non-participating pharmacy.	Covers up to a 90-day supply. Prescription Drugs do not apply to the Medical out-of-pocket. If a Generic equivalent is available, then that equivalent is the benefit. If the patient or Physician, for whatever reason, demands the more expensive branded product be dispensed, the patient pays in addition to the appropriate cost-share, the difference in cost between the generic and brand name copay. The difference in cost will not be used to satisfy any out-of-pocket maximums. Experimental & investigational drugs are not covered. Payer Matrix provides a list of over 350 high cost and specialty medications which will reject at the point of sale. Elixir will only authorize any medications on the Payer Matrix list if directed to do so by Payer Matrix. Walgreen's, CVS, and Target providers have different benefits that apply. Contact FCMI for more information.
	Preferred brand drugs (Tier 2)	Retail Medication:20% up to a $60 copay/prescription, deductible does not apply. Maintenance Medication:20% up to a $150 copay/ prescription, deductible does not apply.		
	Non-preferred brand drugs (Tier 3)	Retail Medication: 20% up to $120 copay/prescription , deductible does not apply. Retail Medication:20% up to a $150 copay/prescription, deductible does not apply		
	Specialty drugs (Tier 4)	20% up to $300 copay/prescription , deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-certification required for certain services including, but not limited to outpatient surgery not performed in an office setting, deviated septum/nasal surgery, endoscopic procedures, and epidural/facet and trigger point injections, varicose vein ligation, and on-going wound care.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance.	20% coinsurance.	Pre-certification required for observation stays that exceed 48 hours. Transportation limited to the nearest hospital

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	or skilled nursing facility that can provide the necessary medical treatment.
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification is required. Semi-private room rate will be applied.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Licensed mental health professional only. Inpatient: Pre-certification required for certain services.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	Based on type of service and place of service	40% coinsurance	Pre-natal and post-natal office visits that are not billed as office visits but are billed under the global maternity charge may be subject to deductible and coinsurance. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Pre-certification is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Medical necessity needed for certain services. Pre-certification is required for certain services.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limit of 60 days per plan year. Pre-certification is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental up to the purchase price. Pre-certification required for services over $2,500.
	Hospice services	20% coinsurance	40% coinsurance	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limit one per plan year. Under age of 19
	Children's glasses	Not covered	Not covered.	
	Children's dental check-up	Not covered.	Not covered	Dental coverage provided if enrolled in separate dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic Surgery	• Dental Care (Adult) • Infertility treatment • Long term Care	• Routine foot care • Weight Loss Program
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Hearing Aids	• Non-emergency Treatment when traveling outside the U.S.	• Private Duty Nursing • Spinal Manipulations (30 visits per year) • Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Freedom Claims Management, Inc. at 1-866-792-9151.Additionally, a consumer assistance program can help you file your appeal. Contact the Kansas Insurance Dept at 1-800-432-2484 or visit www.ksinsurance.org.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 620-792-9151.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 620-792-9151.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 620-792-9151.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 620-792-9151.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,200
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,200
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$40
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$3,270**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,200
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$0
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,340**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.