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, call 1-800-290-1368 or go to www.benefitmanagementllc.com. 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.healthcare.gov/sbc-glossary or call 1-800-290-1368 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Per plan year: Network and non-network providers $700/individual, $1,400/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. Prescription drugs, preventive care and immunizations are covered before you meet your deductible.	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?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Per plan year: Network providers $1,700/individual, $3,400/family; non-network $2,700/individual, $5,400/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?	Premiums, prescription drugs, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain pre-certification for services.	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. In Kansas www.providrscare.net or call (800) 801-9772. Northeast Kansas & Missouri-Freedom Network Select information available through www.providrscare.net. All other Employees: www.myfirsthealth.net call (800) 226-5116. Refer to the member ID card for assigned network.	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 a non-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 a non-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 don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

All 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: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Chiropractic care is limited to 30 visits/plan year. Pre-certification required for 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 (Limited to plan payment of $400/plan year.)	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 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)	20% coinsurance	40% coinsurance	

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com	Drug Tier	Network Pharmacy	Walgreen's, CVS & Target	Non-Network	**Prescription drugs have a separate out–of–pocket limit of $6,200/individual, $12,400/family.** Once the Prescription Drug **out–of–pocket limit** has been satisfied, eligible drugs are covered at 100% by the Plan. ***Generic Drugs are mandated. Brand Name Drugs are subject to the Brand copay plus the difference in the cost of the Generic when a Generic is available.*** Acute Medication: up to a 34-day supply. Maintenance Medication: Mail Order or Performance 90 Pharmacies: up to a 90-day supply. Specialty Drugs: 30-day supply and must be purchased from a MedTrak Specialty Pharmacy Experimental & investigational drugs are not covered. For Diabetic monitor & supplies covered at 100% by the Plan: Contact LivingConnected (800) 274-1853.
	Generic drugs	$10 copay	$20 copay	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.	
	Formulary Drugs **Brand Tier I**	**34-Day:** 20% of allowed amount up to $60 copay **90-Day:** 20% up to $150 copay	**34-Day:** 35% of allowed amount up to $120 copay **90-Day:** 35% up to $300 copay		
	Formulary Drugs **Brand Tier II**	**34-Day:** 20% of allowed amount up to $120 copay **90-Day:** 20% up to $300 copay	**34-Day:** 35% of allowed amount up to $240 copay **90-Day:** 35% up to $600 copay		
	Specialty Drugs	**30-Day only:** 20% of allowed amount up to $300 copay/ prescription	Not Available	Not Available	

All **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)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-certification required for outpatient surgery not performed in an office setting, Deviated Septum/Nasal surgery, Endoscopic procedures, and Epidural/facet and trigger point injections, Varicose vein ligation, on-going wound care.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance		Pre-certification required for observation stays that exceed 48 hours.
	Emergency medical transportation	20% coinsurance		Transportation limited to the nearest hospital or skilled nursing facility that can provide the necessary medical treatment.
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification required. Failure to pre-certify will result in a benefit reduction of 50% up to a maximum penalty of $750/confinement.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Pre-certification required for Intensive Outpatient, Residential or Partial Hospitalization Treatment Programs. Inpatient Pre-certification required. Failure to pre-certify will result in a benefit reduction of 50% up to a maximum penalty of $750/confinement.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

All 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)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Pre-certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Pre-certification required for Physical, Occupational & Speech therapies and Inpatient Rehabilitation.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days/plan year. Pre-certification required. Failure to pre-certify will result in a benefit reduction of 50% up to a maximum penalty of $750/confinement.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental up to the purchase price. Pre-certification required for Durable medical equipment over $2,500 or from a non-network provider.
	Hospice services	20% coinsurance	40% coinsurance	Pre-certification required; for Inpatient stays, failure to pre-certify will result in a benefit reduction of 50% up to a maximum penalty of $750/confinement.
If your child needs dental or eye care	Children's eye exam	No Charge		Limited to one exam including refraction/plan year.
	Children's glasses	Not Covered		
	Children's dental check-up	No Charge – Ages birth up to 19 years		Limited to one (1) exam including cleaning & polishing/plan year. X-rays not included.

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
- Infertility Treatment
- Long-Term Care
- Routine Foot Care
- Weight Loss Programs

* For more information about limitations and exceptions, see the plan or policy document at www.benefitmanagementllc.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery – when Medically Necessary for Morbid Obesity • Chiropractic Care	• Hearing Aids (limited to 1 each ear every 3 benefit years and $1,500 per aid) • Non-emergency care when traveling outside the U.S.	• Private-Duty Nursing (Home Health only) • Routine Eye Care – limited to 1 exam including refraction/benefit year

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: ValueHealth Benefit Administrators, PO Box 1090, Great Bend, KS 67530, (800) 290-1368; or the Department of Labor, Employee benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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 on how 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: ValueHealth Benefit Administrators, PO Box 1090, Great Bend, KS 67530, (800) 290-1368; Additionally, a consumer assistance program can help you file your appeal. Contact the Kansas Insurance Department, Consumer Assistance Division, 420 SW 9th St, Topeka, KS 66612 (800) 432-2484, www.ksinsurance.org or CAP@ksinsurance.org.

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 (800) 290-1368.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 290-1368.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 290-1368.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 290-1368.

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	$700
Primary care cost sharing	$0
Hospital (facility) cost sharing	20%
Other cost sharing	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,760**

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

The plan's overall deductible	$700
Specialist cost sharing	$0
Hospital (facility) cost sharing	20%
Other cost sharing	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$700
Specialist cost sharing	$0
Hospital (facility) cost sharing	20%
Other cost sharing	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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