FIRST DOLLAR PLAN FREQUENTLY ASKED QUESTIONS

What Is The First Dollar Plan?

The First Dollar Plan (FDP) is underwritten by Companion Life Insurance Company, Columbia, South Carolina. It is administered by Special Insurance Services, Inc. SIS is located in Plano, Texas and administers all aspects of the First Dollar Plan for Companion Life, including policy/certificate issuance, premium collection and claims administration.

The benefits provided by The First Dollar Plan will help you pay for out-of-pocket expenses you may be responsible for due to a hospital confinement or due to most out-patient procedures. For an expense to be eligible, it must meet three criteria:

1. First, it **must be medically necessary for the treatment of an injury or a sickness.** Expenses resulting from voluntary or elective surgeries, procedures or expenses due to wellness or preventive care, and those expenses designated as physician office visit expenses are not covered.
2. Second, the expense must be covered by your major medical plan and must have been applied towards your deductible or coinsurance provision under that plan. If an expense or procedure is not covered by your major medical plan, it will not be an eligible expense under the First Dollar Plan.
3. Third, the expense must be incurred while the First Dollar Plan is in force.

What constitutes a Major Medical Plan?

A major medical plan must be a group or individual medical plan (whether fully insured plan or an employer sponsored self-funded plan) that provides benefits for hospital confinements and requires you to pay a deductible and/or portion of coinsurance. A major medical plan does not include Medicare, Medicaid or government sponsored programs not typically considered major medical coverage (such as, but not limited to, CHAMPUS, TRICARE, veterans benefits, etc.).

How does the FDP Out-Patient Benefit Work?

In today's healthcare system, many procedures such as MRI's, CAT Scans, laboratory tests, X-Rays, chemo-therapies, surgical procedures, and many others are routinely performed on an "Out-Patient" basis that does not require the patient to be admitted to a hospital for an overnight stay. These procedures are routinely covered under most Major Medical Plans and are subject to the same deductibles, co-insurance requirements and co-pays as those for "In-Patient" charges. The First Dollar Plan "Out-Patient" benefit can help reduce your out-of-pocket costs for these charges.

Each covered person has a maximum out-patient benefit per calendar year, subject to a maximum benefit for all covered persons within a family unit, equal to two (2) times the individual out-patient benefit maximum. This family maximum applies to the entire family unit regardless of the number of covered persons within the family unit. However, in no event will the maximum calendar year out-patient benefit for any one person exceed the individual maximum.

For example, if your FDP has a maximum individual out-patient benefit of $2,000 and you elect Family Coverage, the total out-patient benefit available to your entire family unit is $4,000. In this example, if one family member accrues $2,500 in eligible out-patient expenses in a calendar year, the FDP Out-Patient Benefit would be capped for that individual at $2,000 and any out-of-pocket expenses for that individual above that cap would be your responsibility for the remainder of that calendar year. However, your remaining family members would still have $2,000 available for eligible out-patient expenses which could be applied to charges for one specific dependent or applied to charges incurred by several dependents.

Why are Physician Office Visit charges and expenses related to Wellness Visits not covered under the FDP Out-Patient Benefit?

Most major medical plans offer reasonably low co-pays for physician office visits and some wellness benefits are now available with no deductible or coinsurance under the Affordable Care Act.

Will I receive an ID card or some other proof of insurance with the FDP?

Upon receipt of your initial premium payment and processing of your enrollment form via the Benefit Alliance Plan, SIS will issue you a certificate of insurance, outlining the plan benefits, terms, conditions and limitations along with an ID card that you can present to providers at the time of service. You should receive your ID card within 10 days of your effective date of coverage.

Should you need to see a doctor before receiving your ID card, you may contact the SIS Customer Service Department with your provider's name, address and phone number. The SIS representative will contact the provider on your behalf to explain the First Dollar Plan coverage.

How Do I File A Claim?

When you enroll in the First Dollar Plan, you will receive a certificate of insurance, an ID card, and a claim form, along with specific instructions on how to file a claim. These instructions outline the procedures you should follow and where you should send your claim. Simply stated, you will need to submit a completed claim form, itemized bills (NOT balance due statements), and the EOB's (Explanation of Benefits) you have received from your major medical plan that correspond to the itemized bills. Claims may be filed at any time, but must be filed no longer than 12 months from the date of service in order to be eligible for coverage.

Upon receipt of all required documentation, claims processing takes approximately 10 business days. If you have any questions about this process, you can call the Customer Service Department at Special Insurance Services and representatives will be happy to assist you.

What is the difference between an itemized provider bill and an EOB (Explanation of Benefits)?

An itemized provider bill from the medical provider details the procedures performed and the dates of service of those procedures. This bill (unless it is the patient's copy) should include the dates of service for each procedure performed, a CPT code (standardized code used by physicians and other providers to denote the type of service(s) performed. Hospitals do not use CPT codes) for each procedure performed, a diagnosis code, and the charge for each procedure. Sometimes a provider will send you a recapped statement or a "balance due" statement. These types of statements do not contain the itemization the insurance company requires in order to process your claim. An "Explanation of Benefits" or EOB as it is commonly referred to, is a statement from your major medical insurance company outlining the charges they have processed, detailing what expenses were filed, the dates of service, how much may have been discounted due to PPO repricing, what expenses were not covered and why, what was applied to the deductible, how much they paid to the provider, and what the claimant's out-of-pocket responsibility is. The EOB, along with the itemized bill, provides the information necessary to process your claim under the First Dollar Plan.

When can I enroll in the First Dollar Plan?

Enrollment in the First Dollar Plan is limited to designated annual open enrollment periods or within the 60 day period following your original hire date. If you do not enroll during one of these times, you will be required to wait until the next open enrollment period unless you qualify by law as a "special enrollee" due to certain qualifying life events such marriage, divorce, or such as the loss of an employer-sponsored major medical insurance plan thereby making it necessary to purchase replacement major medical coverage. If you apply under the "special enrollee" provision, your new qualifying major medical coverage effective date must be within the 60 day period prior to FDP enrollment.

First Dollar Plan Claim Examples

***Major Medical Plan**: $3,000 Calendar Year Deductible; Co-Insurance = 80%/20%; Maximum Out-of- Pocket - $6,350*

A. The insured is admitted as in-patient to hospital. Total charges for the hospital, tests, physician's fees, etc. equal $30,000.

B. The insured has an out-patient MRI. Total billed MRI charges including facility, radiologist read/consult equal $6,000.

A). In-Patient Without First Dollar Plan	
Major Medical Deductible	*$3,000*
*Co-Insurance Costs**	*$3.350*
Total Out-of-Pocket Responsibility	***$6,350***
First Dollar Plan Pays	*N/A*
Major Medical Plan Pays	*$23.650*
You Pay	***$6,350***

A). In-Patient With First Dollar Plan – Plan D ($6000/$3,000)	
Major Medical Plan Deductible	*$3,000*
Co-Insurance Costs	*$3,350*
Total Out-of-Pocket Responsibility	***$6,350***
First Dollar Plan Pays	*$6,000*
Major Medical Plan Pays	*$23,650*
You Pay	***$350***

*A) *$30,000 minus $3,0000 deductible = $27,000. Co-insurance requires you to pay 20% of the $27,000 up to the total Out-of-Pocket policy maximum of $6,350, which includes the $3,000 deductible.*

B). Out-Patient Without First Dollar Plan	
Major Medical Deductible	*$3,000*
*Co-Insurance Costs***	*$ 600*
Total Out-of-Pocket Responsibility	***$3,600***
First Dollar Plan Pays	*N/A*
Major Medical Plan Pays	*$2.400*
You Pay	***$3,600***

B). Out-Patient With First Dollar Plan – Plan D ($6000/$3,000)	
Major Medical Plan Deductible	*$3,000*
*Co-Insurance Costs***	*$ 600*
Total Out-of-Pocket Responsibility	***$3,600***
First Dollar Plan Pays	*$3,000*
Major Medical Plan Pays	*$2,400*
You Pay	***$ 600***

*B) **$6,000 minus $3,0000 deductible = $3,000. Co-insurance requires you to pay 20% of the $3,000 up to the total Out-of-Pocket policy maximum of $6,350, which includes the $3,000 deductible*

***The total calendar year "per person" maximum benefit payable, whether paid as In-Patient or Out-Patient benefits, shall not exceed the total In-Patient benefit for the plan selected**. Claims examples are for illustrative purposes only. Each insured person's coverage may be different based on the plan design and specific situation. All benefits are subject to the exclusions and limitations outlined in both the major medical plan and First Dollar Plan policy and riders. The example listed herein assumes that all incurred charges are covered under both policies, no incurred charges are excluded, and no limitations have been applied.*