Mahube-Otwa Family Health FEE SCHEDULE 2023

		Code 4	Code 3	Code 2	Code 1
Office Visits					
99384-99386	New Patient-Complete Exam	$110.00	$165.00	$220.00	$275.00
99394-99396	Established Patient-Complete Exam	$92.00	$138.00	$184.00	$230.00
99202	New Patient Visit 15-29 min.	$62.00	$93.00	$124.00	$155.00
99203	New Patient Visit 30-44 min.	$86.00	$129.00	$172.00	$215.00
99204	New Patient Visit 45-59 min.	$116.00	$174.00	$232.00	$290.00
99205	New Patient Visit 60-74 min.	$150.00	$225.00	$300.00	$375.00
99417	Prolonged Services, 75+ min.	$10.00	$15.00	$20.00	$25.00
99211	RN Visit	$16.00	$24.00	$32.00	$40.00
99212	Established Patient Visit 10-19 min.	$38.00	$57.00	$76.00	$95.00
99213	Established Patient Visit 20-29 min.	$60.00	$90.00	$120.00	$150.00
99214	Established Patient Visit 30-39 min.	$82.00	$123.00	$164.00	$205.00
99215	Established Patient Visit 40-54 min.	$106.00	$159.00	$212.00	$265.00
99417	Prolonged Services, 55+ min.	$10.00	$15.00	$20.00	$25.00
99401	Prev.Med. Counsel 15 min	$28.00	$42.00	$56.00	$70.00
99402	Prev.Med. Counsel 30 min	$48.00	$72.00	$96.00	$120.00
99403	Prev.Med. Counsel 45 min	$66.00	$99.00	$132.00	$165.00
99404	Prev.Med. Counsel 60 min	$82.00	$123.00	$164.00	$205.00
99406	Substance Smoking Cessation (3-10 min)	$10.80	$16.20	$21.60	$27.00
99407	Substance Smoking Cessation (10+ min)	$21.60	$32.40	$43.20	$54.00
99408	Alcohol/Subst Counseling 15-30 min.	$26.00	$39.00	$52.00	$65.00
99409	Alcohol/Subst Counseling >30 min.	$52.00	$78.00	$104.00	$130.00
99411	Group Counsel/Educ 30 min	$14.00	$21.00	$28.00	$35.00
99412	Group Counsel/Educ 60 min	$18.80	$28.20	$37.60	$47.00
Lab Tests					
36416	Finger Stick	$2.40	$3.60	$4.80	$6.00
85018	HGB	$2.60	$3.90	$5.20	$6.50
88142	Pap Smear	$16.00	$24.00	$32.00	$40.00
88142	Repeat Pap	$16.00	$24.00	$32.00	$40.00
Q0091	Pap Collection	$28.00	$42.00	$56.00	$70.00
87624	HPV Screening	$30.00	$45.00	$60.00	$75.00
81002	Urinalysis	$2.80	$4.20	$5.60	$7.00
87491	Chlamydia	$30.00	$45.00	$60.00	$75.00
87591	GC Test	$30.00	$45.00	$60.00	$75.00
86703	HIV-1/2 rapid test	$10.00	$15.00	$20.00	$25.00
81025	Pregnancy Test - Pos, Neg, Undeterm.	$5.20	$7.80	$10.40	$13.00
82120	Vag Panel	$2.80	$4.20	$5.60	$7.00
87252	Herpes Culture	$20.00	$30.00	$40.00	$50.00
86780	Syphilis Screening	$8.00	$12.00	$16.00	$20.00
86803	Hepatitis C Screening	$10.00	$15.00	$20.00	$25.00
87661	Trich Screening	$28.00	$42.00	$56.00	$70.00
87563	Mycoplasma Genitalium	$20.00	$30.00	$40.00	$50.00
99000	Lab Handling Fee	$2.40	$3.60	$4.80	$6.00
Vaccine					
90460	Inj. Fee <19 with provider counseling	$21.22	$21.22	$21.22	$21.22
90471	Inj. Fee any age without counseling	$21.22	$21.22	$21.22	$21.22
90651	UUAV & MNVFC Gardasil Vaccine	$0.00	$0.00	$0.00	$0.00
90651	Private Gardasil Vaccine	$260.00	$260.00	$260.00	$260.00

Mahube-Otwa Family Health FEE SCHEDULE 2023		Code 4	Code 3	Code 2	Code 1
Birth Control Supplies					
S4993	Orals	$20.00	$30.00	$40.00	$50.00
S4993	Seasonique (3 mo. Supply)	$60.00	$90.00	$120.00	$150.00
S4993	ECP: Plan B/ My Way	$20.00	$30.00	$40.00	$50.00
J7295	Nuva Ring	$64.00	$96.00	$128.00	$160.00
J7304	Xulane Patch (1 month = 3 patches)	$64.00	$96.00	$128.00	$160.00
Birth Control Supplies Cont.					
J1050	Depo/Medroxy	$46.00	$69.00	$92.00	$115.00
96372	Injection Fee	$15.20	$22.80	$30.40	$38.00
J7307	Nexplanon	$480.00	$720.00	$960.00	$1,200.00
J7298	IUD Mirena	$440.00	$660.00	$880.00	$1,100.00
J7300	IUD Paragard	$440.00	$660.00	$880.00	$1,100.00
J7301	IUD Skyla	$440.00	$660.00	$880.00	$1,100.00
J7296	Kyleena	$440.00	$660.00	$880.00	$1,100.00
A4267	Condom-Male (each)	$0.24	$0.36	$0.48	$0.60
A4267	Condom-Male latex free (each)	$0.24	$0.36	$0.48	$0.60
A4268	Condom-Female	$4.80	$7.20	$9.60	$12.00
Treatments/ Medications					
J8499	Acyclovir 15	$16.80	$25.20	$33.60	$42.00
J8499	Aldara/Imuquimod	$28.00	$42.00	$56.00	$70.00
J8499	Azithromycin/Zithromax 1 GM	$14.80	$22.20	$29.60	$37.00
J0696	Ceftriaxone 500 mg vial	$2.80	$4.20	$5.60	$7.00
96372	Injection Fee	$15.20	$22.80	$30.40	$38.00
J8499	Doxycycline	$8.00	$12.00	$16.00	$20.00
J8499	Fluconazole 150 mg	$16.80	$25.20	$33.60	$42.00
J8499	Metronidazole 500 mg #14	$16.80	$25.20	$33.60	$42.00
J8499	Sulfamethox	$8.40	$12.60	$16.80	$21.00
Other Medical Services					
56501	Destroy vulva lesion, <14	$70.00	$105.00	$140.00	$175.00
56515	Destroy vulva lesion, >15	$112.00	$168.00	$224.00	$280.00
57061	Destroy Vaginal lesion, <14	$60.00	$90.00	$120.00	$150.00
54050	Destroy penis lesion, chemical, <14	$64.00	$96.00	$128.00	$160.00
54060	Destroy penis lesion, surgical, <14	$90.00	$135.00	$180.00	$225.00
54065	Destroy penis lesion, >15	$108.00	$162.00	$216.00	$270.00
54056	Destroy Penis lesion, cryo, <14	$68.00	$102.00	$136.00	$170.00
17110	Wart Destruction (use if not listed above)	$52.00	$78.00	$104.00	$130.00
11200	Removal Skin Tag	$60.00	$90.00	$120.00	$150.00
58300	IUD Insertion	$62.00	$93.00	$124.00	$155.00
58301	IUD Removal	$74.00	$111.00	$148.00	$185.00
58300	IUD Remove/Re-Insert- use both	$62.00	$93.00	$124.00	$155.00
58301	IUD Remove/Re-Insert- use both	$74.00	$111.00	$148.00	$185.00
11981	Implant Insertion	$108.00	$162.00	$216.00	$270.00
11982	Implant Removal	$112.00	$168.00	$224.00	$280.00
11983	Implant Remove/Re-Insert	$180.00	$270.00	$360.00	$450.00
	Prenatal Visit	$16.00	$24.00	$32.00	$40.00
	Prenatal Vitamins	$1.20	$1.80	$2.40	$3.00

Steps on the Sliding Fee Scale by Income Range ($)						
2023 Poverty Level		**<100%** Code 5	**101-150%** Code 4	**151-200%** Code 3	**201-250%** Code 2	**>250%** Code 1
Family Size						
1	Yearly	0.00 - 14580	14581 - 21870	21871 - 29160	29161 - 36450	> 36451
	Weekly	0- 280.38	280.39 420.58	420.59 560.77	560.78 700.96	> 700.98
2	Yearly	0.00 - 19720	19721 - 29580	29581 - 39440	39441 - 49300	> 49301
	Weekly	0- 379.23	379.24 568.85	568.86 758.46	758.47 948.08	> 948.10
3	Yearly	0.00 - 24860	24861 - 37290	37291 - 49720	49721 - 62150	> 62151
	Weekly	0- 478.08	478.09 717.12	717.13 956.15	956.16 1195.19	> 1195.21
4	Yearly	0.00 - 30000	30001 - 45000	45001 - 60000	60001 - 75000	> 75001
	Weekly	0- 576.92	576.93 865.38	865.39 1153.85	1153.86 1442.31	> 1442.33
5	Yearly	0.00 - 35140	35141 - 52710	52711 - 70280	70281 - 87850	> 87851
	Weekly	0- 675.77	675.78 1013.65	1013.66 1351.54	1351.55 1689.42	> 1689.44
6	Yearly	0.00 - 40280	40281 - 60420	60421 - 80560	80561 - 100700	> 100701
	Weekly	0- 774.62	774.63 1161.92	1161.93 1549.23	1549.24 1936.54	> 1936.56
7	Yearly	0.00 - 45420	45421 - 68130	68131 - 90840	90841 - 113550	> 113551
	Weekly	0- 873.46	873.47 1310.19	1310.20 1746.92	1746.93 2183.65	> 2183.67
8	Yearly	0.00 - 50560	50561 - 75840	75841 - 101120	101121 - 126400	> 126401
	Weekly	0- 972.31	972.32 1458.46	1458.47 1944.62	1944.63 2430.77	> 2430.79
9	Yearly	0.00 - 55700	55701 - 83550	83551 - 111400	111401 - 139250	> 139251
	Weekly	0- 1071.15	1071.16 1606.73	1606.74 2142.31	2142.32 2677.88	> 2677.90
10	Yearly	0.00 - 60840	60841 - 91260	91261 - 121680	121681 - 152100	> 152101
	Weekly	0- 1170.00	1170.01 1755.00	1755.01 2340.00	2340.01 2925.00	> 2925.02
11	Yearly	0.00 - 65980	65981 - 98970	98971 - 131960	131961 - 164950	> 164951
	Weekly	0- 1268.85	1268.86 1903.27	1903.28 2537.69	2537.70 3172.12	> 3172.13

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs (see https://www.healthcare.gov/glossary/out-of-pocket-costs/), like a copayment (see https://www.healthcare.gov/glossary/co-payment/), coinsurance (see https://www.healthcare.gov/glossary/co-insurance/), or deductible (see https://www.healthcare.gov/glossary/deductible/). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are <u>never</u> required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have these protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.