# Winholt Equipment Group

As of October 1, 2020, Winholt Equipment Group has a custom partially self-funded health plan. While Winholt Equipment Group is the ultimate payer, the Plan is facilitated by the Third Party Administrator, American Plan Administrators (APA). This is an open-access plan type, similar to an indemnity plan, giving the members the freedom to visit any facility they choose without reduced benefits for out-of-network providers.

## How does this work?

The process is actually very simple.  As a provider, you treat the patient and collect any applicable co-pay at the time of service.  Medical claims are then submitted to Claimsbridge and then repriced and submitted to APA for payment.

Claims may be submitted to:

Claimsbridge under the Payer ID: 95606

Claims unable to be submitted electronically can be mailed to:

American Plan Administrators

PO Box 477

Arnold, MD 21012

# How will providers be reimbursed?

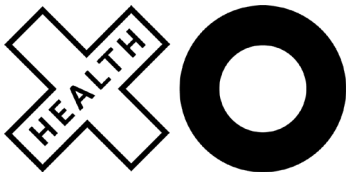
Facility providers will be reimbursed at the Allowable Charge, as described below.

***Allowable Charge***

"Allowable Charge" for a treatment, supply or other services rendered is determined by the Plan, at the Plan's discretion, by determining the amount established by a negotiated arrangement if one exists, or the lesser of:

- Specified Benefit Amount;
- Gross billed charge made by the provider;
- Usual, Customary and Reasonable payment for the same treatment, service, or supply;
- Prevailing fee charged in an area large enough to obtain a representative cross-section of providers rendering such treatment, supply or services for which the charge is made by Providers of similar skill and experience.

For Covered Charges rendered by a Physician or other professional provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charge.



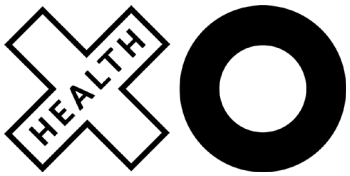

The Allowable Charges shall not include:

- Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS;
- Charges for billing errors including, but not limited to, upcoding, duplicate charges, and charges for services not performed;
- Charges relating to clearly identifiable errors in medical care;
- Charges the Plan cannot identify or understand the item(s) being billed; or,
- Charges identified based upon a medical record review and audit, which determines that a different treatment or different quantity of a drug or supply was provided.

Nothing in this section shall be construed to limit the Plan's discretion to deem a greater amount payable than the lesser of any of the above-referenced amounts. Furthermore, the Plan is not obligated to consider all factors. In the event that the Plan determines that insufficient information is available to identify the Allowable Charge for a specific service or supply using the listed guidelines above, the Plan reserves the right, in its sole discretion, to determine any Allowable Charge amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

***Specified Benefit Amount***

"Specified Benefit Amount" means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically




Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees do not exceed the Specified Benefit Amount. The determination that a charge does not exceed the Specified Benefit Amount include, but are not limited to, the following guidelines:

- 1.40 times the Medicare allowed amount for a Hospital facility, facility which is owned and operated by a Hospital, or an Ambulatory Surgery Centers;
- 1.15 times the Average Wholesale Price for pharmacy charges;
- 100% of the Organ Procurement Organization's invoice cost; and,
- 100% of the National Marrow Donor Program's invoice cost.

***Usual, Customary and Reasonable***

"Usual, Customary and Reasonable" means the common paid amount for the same or comparable service in the geographic area in which the service or supply is furnished. Usual, Customary and Reasonable payment is based upon:

- Amount of resources expended to deliver the treatment;
- Complexity of the treatment rendered;
- Generally accepted billing practices for unbundling or multiple procedures;
- Medicare reimbursement rates for comparable services or supplies;
- Costs of provider for providing the service or supply;
- Charging protocols and billing practices generally accepted by the medical community; and
- Amounts paid after discounts under government and private plans.

Nothing in this section shall be construed to limit the discretion of the Plan. The Plan is not obligated to consider all factors listed above.

If you have questions regarding the plan benefit, or want an estimate of the expected reimbursement, you can call:

American Plan Administrators (718) 625-6300 x315