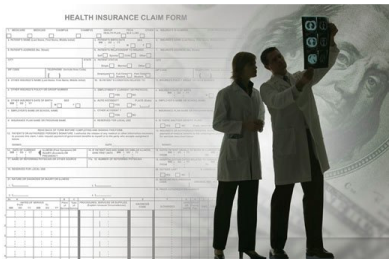
Do You Understand Your Health Insurance?

Most health insurance plans can be described with one word, "confusing." And generally people don't worry about it until they need it, and then it's too late! That will all change today! Below is a simple guide that we hope will help you better understand health insurance.



Let's use this sample <u>In-Network</u> benefit plan……

Deductible	$1,000 per person per calendar year
Coinsurance	80%
Out-of-Pocket Maximum *Includes deductible*	$3,000 per person per calendar year

And now let's assume that you just went into the emergency room, which is a benefit that is subject to your deductible then 80% coinsurance…..

Emergency Room Charge Billed to Carrier	**$2,000**
Carrier's Reasonable & Customary Charge	**$1,750**
Deductible *Member Responsibility and for the purpose of this example member has not met deductible*	**$1,000**
Subtotal amount subject to coinsurance	**$ 750**
80% Coinsurance *Carrier pays*	**$ 600**
20% Coinsurance *Member Responsibility*	**$ 150**
Total Deductible & Coinsurance Member Responsibility	**$1,150**

A Carrier's Reasonable & Customary (R&C) charge is the amount that a participating provider has agreed to accept with the carrier as payment in full for a particular benefit. Please see next page for definition of R&C.

Out-of-Pocket Maximum the individual must reach for the year in this example is $3,000 and the member just paid $1,150.

$3,000
-$1,150
$1, 850 Amount remaining for member to satisfy for the calendar year.

Now let's assume you are later admitted to the hospital, which is a benefit that is also subject to your deductible then 80% coinsurance……

Hospital Care Charge Billed to Carrier	**$15,000**
Carrier's Reasonable & Customary Charge	**$10,000**
Deductible *Member Responsibility and at this time the member has met deductible for the ER Claim above*	**$ 0**
Subtotal amount subject to coinsurance	**$10,000**
80% Coinsurance *Carrier pays*	**$ 8,000**
20% Coinsurance *Member Responsibility*	**$ 2,000**
Total Coinsurance for Hospital stay Member Responsibility	**$ 2,000**
Since the Out-of-Pocket Maximum is $3,000 per calendar year and the member reached $1,150 already the amount due will be $1,850 (see breakdown on right)	**$ 1,850**

Out-of-Pocket Maximum

$3,000
-$1,150 ER Visit
-$1,850 Hospital Visit
$ 0

At this point the out-of-pocket (OOP) maximum for the year was satisfied, therefore if the member requires any other services that would normally be subject to the deductible and/or coinsurance they would now be covered at 100% by the carrier.

It's also good to note that benefits, such as office visit copays are generally not included in the OOP, therefore the member would still have copays to pay even though the OOP was reached. You will want to refer to your plan for those details.

Still Have Questions?
Here Are Some Common Definitions.

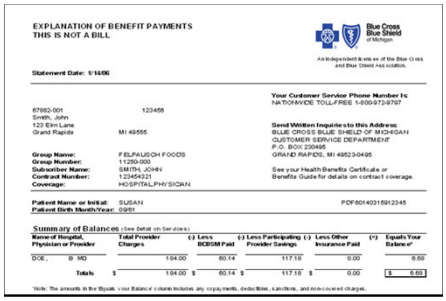
Copayment – A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. Example - $20 copay for an office visit to your primary care doctor.

Coinsurance – A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.

> Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges.
>
> Coinsurance rates may also differ if services are received from an in-network provider (i.e., a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by out-of-network providers.

Deductible – A fixed dollar amount during the benefit period - usually Jan 1 thru December 31 - that an insured person is responsible for before the insurer starts to make payments for covered medical services. Plans may require deductibles on a per individual or per family basis.

Explanation of Benefits (EOB) – A written statement the carrier sends to the insured after a claim has been reported, indicating the benefits and charges covered or not covered by the benefit plan.



EXPLANATION OF BENEFIT PAYMENTS
THIS IS NOT A BILL

Blue Cross Blue Shield of Michigan

An Independent licensee of the Blue Cross and Blue Shield Association.

Statement Date: 1/14/06

Your Customer Service Phone Number Is:
NATIONWIDE TOLL-FREE 1-800-972-9797

67982-001 123456
Smith, John
123 Elm Lane
Grand Rapids MI 49556

Send Written Inquiries to this Address:
BLUE CROSS BLUE SHIELD OF MICHIGAN
CUSTOMER SERVICE DEPARTMENT
P.O. BOX 230495
GRAND RAPIDS, MI 49523-0495

Group Name: FELPAUSCH FOODS
Group Number: 11250-000
Subscriber Name: SMITH, JOHN
Contract Number: 12345321
Coverage: HOSPITAL/PHYSICIAN

See your Health Benefits Certificate or Benefits Guide for details on contract coverage.

Patient Name or Initial: SUSAN
Patient Birth Month/Year: 09/81

PDF5014031912345

Summary of Balances (See Detail on Services)

Name of Hospital, Physician or Provider	Total Provider Charges	(-) Less BCBSM Paid	(-) Less Participating Provider Savings	(-) Less Other Insurance Paid	(=) Equals Your Balance*
DOE, B MD	194.00	60.14	117.18	0.00	6.68
Totals	$ 194.00	$ 60.14	$ 117.18	$ 0.00	$ 6.68

*Note: The amounts in the Equals Your Balance column includes any copayments, deductibles, sanctions, and non-covered charges.

In-Network Provider – A facility provider or professional provider that is licensed where required and performing within the scope of its license who participates in a specific network of providers (i.e. HMO or PPO Network) with a specific carrier.

Maximum Out-of-Pocket Expense – The maximum dollar amount an insured member is responsible for paying out-of-pocket during a year. Until this maximum is met, the plan and insured member share in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, for the remainder of the year subject to the lifetime maximum.

Reasonable and Customary Charges – The allowances or payment that the carrier has determined as reasonable for covered services provided to the member based on the type of services. The charge is also determined based on the location of the provider. In-Network providers must accept this agreed charge as payment in full. Out-of-Network providers, or those who do not belong to that carrier's network, do not have to accept the reasonable and customary charges as payment in full. Therefore out-of-network providers may balance bill the member for any difference between the provider's billed charge and the carrier's payment.

For more information or if you have questions contact MCC!

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