Health Insurance

Plain and Simple

PROTECT YOURSELF
PROTECT YOUR MONEY

By John and Ann Gridley

515 SE Main, Roseburg, OR 97470
Published by Design Time Web Design & Development
1012 SE Oak Suite 303, Roseburg, OR 97470

Visit:
www.ehealthlink.com
www.healthinsurancesource.com
www.design-time.com

Acknowledgement

We would like to thank everyone who helped make this book a reality.

First, Roger Churchill of Design Time Web Design, our Webmaster and friend. He inspired us to write the book and published the book on the Internet.

Second, our clients. Through the years, they have shared their stories with us, taught us what is important to them to know about, and learned along with us.

Third, our agents. Without their hard work and loyalty, the Agency and this book would not be possible. They also provided invaluable feedback to make this book as complete and understandable as possible.

TABLE OF CONTENTS

We will refund your money if you don't learn something new about health insurance and you can keep the book, too.

Introduction

How does health insurance work?

Why don't they write insurance literature so that people can understand it?

How much will I have to pay in medical expenses with this plan?

HOW DO I CHOOSE THE RIGHT PLAN FOR ME?

Questions and more questions, and then came this book.

This book was written to demystify health insurance, help you understand it, and help you choose the right plan for you. Health insurance comes in several different plan designs. Just like with clothing, furniture, housing and food, each person has different tastes and desires. Once a person understands health insurance design, the choices are a lot easier to make.

You can read through this book all at once, you can use it as a reference guide, or you can do both while shopping for insurance or reviewing a policy you have already purchased.

As health insurance agents, we've been teaching people how to read, understand, and speak "insurancese" for over 12 years. With this knowledge, our clients are able to evaluate insurance plans, see what is covered and what is not, and make decisions with confidence. With this book, we hope you can, too.

The Super Smart Shopper

Know what to expect
and what to watch out for.

The Super Smart Shopper

What is health insurance?

What are the ramifications of a doctor or hospital bill if you do not have health insurance?

Why does health insurance cost as much as it costs?

How come some policies look so inexpensive and others look outrageous?

Should you have an agent?

What should you look for when choosing an agent?

This section of the book will answer these and other questions and give you some insight and direction as you begin to ponder, “Do I want health insurance? What insurance is right for me?”

What Is Health Insurance?

Health insurance is nothing more than a group of individuals, usually in a metropolitan area, county, geographic region, or state, who pool their money to cover a portion of the medical expenses of the group. The more of your medical expenses you want paid, the more money you contribute to the group each month in the form of a bill, called a premium. The insurance company manages the pool of money for the group and incurs administrative expenses on the group's behalf.

Health insurance is regulated at the state level, except for certain federal protections relative to information practices, portability of health insurance (your ability to take your insurance with you when you leave or lose your job, for example), and your privacy rights.

Except for these federal protections and rules, sometimes called provisions, insurance rules and practices vary considerably from state to state. Learn as much about the rules in your state as you can from an insurance agent or your state's insurance department.

Why Buy Health Insurance In the First Place

The examples you will read about are based on actual experiences of our clients.

For one of our clients, health Insurance was too expensive. Nothing ever happened to him. He never got sick. Why waste the money? Furthermore, his wife had always taken care of insurance issues until a divorce a few months earlier. He never took time to do anything about it.

Then, one day, OOPS! He fell off a ladder and broke his wrist. In the absence of health insurance, the doctors and the hospital could charge him whatever they chose. They charged $15,000. He came to see us after the incident, and wanted to make sure this didn't happen to him again in the future.

Just like you can't buy fire insurance for your house while it is burning or after it has burned down, you can't buy individual health insurance after an accident, while you pregnant, or after you are diagnosed with a catastrophic illness.

You need to buy health insurance BEFORE you need it.

Another client of ours lost their house because they did not have health insurance. The bill was $19,000. They could not pay the bill. They lost the house to the hospital. We met them when they moved to Roseburg, Oregon from California, in a motor home, to start their life over again. The unfortunate part was that the accident that caused the bill also disabled the client and took away his ability to earn an income to help pay the bill. The really unfortunate part was that they thought they had insurance, but the insurance company providing the group health insurance had gone bankrupt.

Health insurance may seem expensive, but not as expensive as the potential consequences of not having it.

Always purchase health insurance from reliable companies and agents. If you do not have health insurance, medical providers will see you as an opportunity to recoup some of their losses.

Note: The term “Insurance Agent” has recently been changed to “Insurance Producer” by regulating bodies governing insurance; however, we will continue to use the term agent throughout this book because of its current common acceptance by the public.

Why Buy Health Insurance in the First Place?

Costs of Medical Care May be Higher Than You Imagined

A Small Thing

A fall, a broken wrist and a surgery to insert a couple of pins

Can Turn Into A Big Thing

Combined bills for hospital, physicians and other medical services of **over $15,000**

Prices You Pay For Medical Care May Not be the Best Price

On Your Own

You

How successful are you in negotiating a significantly lower price?

$15,000 Bill

Physician

Pharmacy

With Insurance Co. Help

Insurance Company or Health Plan

You

Insurance Company negotiates for you

$8,500 Bill – Insurance Co. Pays Part

A $10 prescription without insurance may only cost $2 with insurance.

You May Want to Protect Any Property That You Own

Now Yours

~~Your House~~

~~Your Business~~

Large Hospital Bill That You Can't Pay

Could Be Theirs

Your House

Your Business

They can and have taken a house or a business to satisfy an unpaid hospital bill. The fine print on that hospital admission form even makes it easier for them to do

How to Shop For Health Insurance

The old adage "You get what you pay for" is very true in health insurance, as is, "There's no free lunch". Medical costs are what they are. You will find that the cost of medical care in your geographic area is about the same regardless of where you access service or which insurance company you have. Remember, an insurance company is in business to make a profit, or "excess income" if they are a non-profit health company. If you are evaluating a plan that looks inexpensive and is promising to cover everything, beware. Savings in premium, your monthly bill for the health insurance, usually results in more medical cost sharing when you use the insurance.

Before you begin shopping for health insurance, you may want to consider the following questions:

- What is the best value for my money?
- What am I getting for my money?
- Does my decision pass the "sleep test"?

The insurance you choose should provide you with a feeling of security, knowledge that you have covered potential risk to a level that you're comfortable with.

What is the sleep test?

Some of our clients determine that they want a $5000 deductible plan, the amount of medical bills they have to pay before the insurance starts paying, because of the low price relative to a low deductible plan. A good rule of thumb is: As the deductible goes up, the premium goes down. This relationship reflects the amount of risk you assume versus the amount of risk the insurance company assumes. This, however, is not a dollar for dollar trade off. The amount that the premium is reduced for taking on a higher deductible is not the same amount as the additional risk. In other words, you will save less in premium than you will spend if you have a large medical expense.

Don't worry if you don't know what a deductible is. In this example, it means you pay $5000 each year in medical bills before the insurance company starts paying.

So…the client decides he wants a $5000 deductible plan. I say, "That may be a fine choice, but I'd like you to go home and sleep on it. When you go to bed tonight, pretend that you have the $5000 deductible plan. If you wake up in the morning, refreshed and happy with your decision, then we'll go ahead. If, on the other hand, you wake up at 3:00 in the morning in a cold sweat thinking, 'Oh my gosh, what did I do?' we probably need to reconsider your decision."

People have used this sleep test. It works.

Why Would You Want an Insurance Agent or Insurance Producer?

An insurance agent and an insurance producer are the same thing. First, there are basically two kinds of agents: captive and independent. A captive agent is an individual who works for one insurance company either as an employee or a subcontractor. He or she will primarily be focused upon one company's products. He or she may be able to represent more than one company, but probably not. An independent agent or broker works for him or her self. He or she represents several different companies with no particular motive to choose one company over another.

In most states, you're paying for an agent whether or not you have one. Insurance premiums include the cost of paying an insurance agent a commission, which is usually 5 – 10 percent.

If you know which company you want, regardless of premium, a captive agent is a fine choice.

If you aren't sure which company you want, an independent agent can save you time. We recommend you choose one that either specializes in health insurance or has a large health insurance customer base. He or she knows the market, what's available, the rules, and has everything at his or her fingertips. Once the agent knows what you think you want, the agent can narrow down the choices to meet your parameters.

An agent can keep you out of trouble. Many times someone will come to us who has purchased something that wasn't what he or she thought it was. They are staring at a multi-thousand dollar hospital bill that they thought their health insurance was going to pay. People sometimes choose a plan in which they could have a large hospital bill, but they should know that at the time of purchase. It shouldn't be a surprise.

Insurance companies usually change (read "raise") their prices, or premiums, at least once every year. When premiums change, your agent can help you evaluate what's available in the market and make recommendations.

Every once in a while, you will see something on TV, hear about some great plan on the radio, get something in the mail, or have someone track you down in person. You can take whatever it is to an established insurance agent. A good, ethical agent will help you evaluate this opportunity.

An insurance agent fights for you. He or she will help you deal with the insurance company if you have a claims dispute. Many times, claims problems are simply a glitch in the system, a failure of a provider to submit a claim properly, or an insurance company employee who didn't get his or her fingers on the correct keyboard keys. Your agent usually will have several ideas about what may have happened and how to get it fixed.

An insurance agent will whine for you. From time to time, you may not be able to pay your bill or the bill and the check may fall under your car seat instead of into a mailbox. Your insurance agent can go to bat for you and sometimes get some leniency from the insurance company.

How to Shop for Health Insurance

Should You Shop Around for the Lowest Price?

You probably have a choice of insurance agents to buy from.

You

You may be able to buy directly from the insurance company.

Premium for a specific insurance policy from a particular insurance company in a given geographical area

Built-in Commission

Insurance Agent

You

You now have a third party to work for you if you have a problem with the company.

In most states you will find prices for health insurance policies are identical regardless of from whom you purchase them. In some states prices are filed with the state and it is illegal to change them. In most cases, if you purchase directly from the insurance company, you still pay the commission but don't get the third party representation.

You Should Shop for Value and Service

You

Insurance Agent

You can use a single insurance agent or broker with several companies and plans to choose from.

OR

Insurance Agent

You can use one or more agents who each represent a single insurance company or who have a limited number of selections.

Shop for Value

Health insurance is expensive because of the cost of medical care. Look for the best coverage that meets your needs based on how you will most likely access medical providers. Try to get the most out of each dollar you spend.

Shop for Service

Find an insurance agent you can trust and work with in the event you have a problem with the insurance company. They can't perform miracles; however, they usually know how to get in touch with the right people to resolve your problem. Remember the insurance company usually wants to keep their agents happy in order to continue to receive new business from them.

How Premiums Increase With Age

All else being equal, it may be contended that a person's age has the greatest impact upon the insurance premium. Insurance companies have determined that as people age, there is a good chance that health problems or the risk of health problems will also increase. They have based this decision on actual claims they have had to pay, research of health conditions, etc.

The second greatest impact may well be the insurance company's ability to choose whom they accept for health insurance. If, at the state government level, it is decided that an insurance company must take everyone regardless of health or if the insurance company can only request five years of medical history, this will drastically affect the premiums. In these examples, obviously the amount of risk that the insurance company may be assuming, that they can't see, is passed on to consumers in higher insurance premiums.

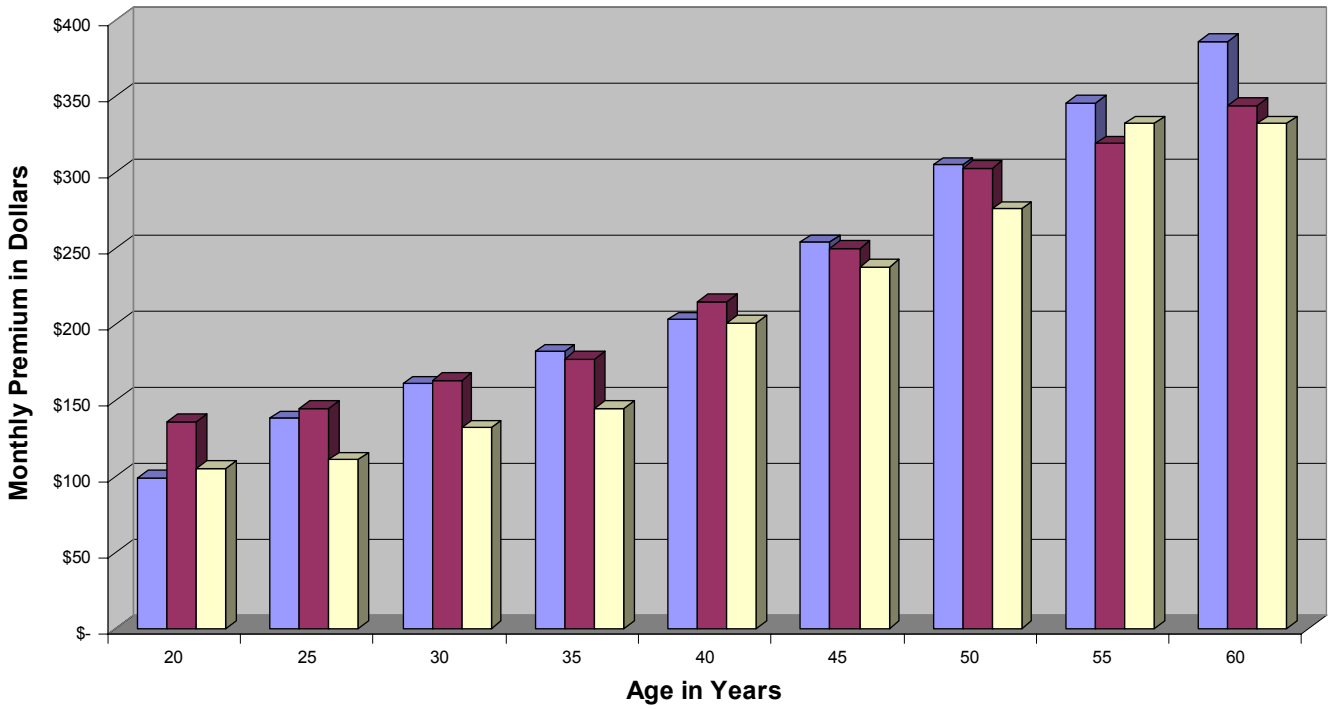
There are other factors that can affect health insurance premiums in some states. Some states include smoking and gender in their rating systems. Gender is often a premium factor because, while women tend to take better care of themselves, they go to the doctor more frequently than men. This frequency of using medical services is reflected in higher premiums for women than for men, if the state allows separate pricing for women and men.

In some states, everyone has to buy maternity coverage. Oregon is one such state. Not too long after the law went into effect, a 62-year-old man came into our office to look at his options for health insurance. As he was looking over the benefit summaries, he noted that maternity coverage was included and wanted a plan without it. The agent explained to him that all plans included maternity coverage. "I'll get a letter from my doctor to tell the insurance company that I can't get pregnant," the man exclaimed. The agent had to tell the man that the letter wouldn't matter. There weren't any plans in Oregon that did not include maternity.

How Premiums for Health Insurance Increase with Age

Rates for individual policies from 3 different companies are shown below.

Premiums Increasing with Age for Typical $500 Deductible Plans



Age, geographic area, and family makeup are among the most common significant factors affecting premium rates.

Insurance is regulated on the state level and many of the factors that can affect premium rates vary by state.

Among some of the other factors that may affect premium rates, are guaranteed issue, mandated benefits, occupation, sex, tobacco use, and weight guidelines.

Some states allow policy rating which can cause increased premiums due to anticipated high-risk health conditions.

Other states allow limitations or exclusions where certain health conditions are excluded from coverage altogether or coverage is otherwise limited. Certain health conditions may be waived from coverage for a certain period of time.

Copyright © 2003 – ehealthlink.com, LLC. All rights reserved.

How Do a Hospital Accident and Major Medical Policy Differ?

An insurance policy is a written contract between you and the insurance company that, among other things, tells you what the insurance company will and will not pay. For those medical bills that the company will pay, the contract tells you how much and when the company will pay. We believe that there is not necessarily a "bad" insurance policy. Where a policy becomes "bad" is when the consumer thinks it will do something that it will not. If you think that you have complete hospital coverage and will be covered when you leave the hospital, then find out after you have tried to use the coverage, that you have no coverage or are left with a large hospital bill, you will probably think that you bought a "bad" policy.

Know what you're buying.

Generally speaking, there are "hospital accident" policies and "major medical" policies.

The easiest way to remember a hospital accident policy is that it will generally cover you when you enter the hospital. It will not cover you when you walk out the door, unless you also purchase expensive supplemental benefits. For example: Oops! You break your leg…badly. You go to the hospital. All the work performed in the hospital is covered to the extent that the policy allows. You leave the hospital. Follow-up doctor visits; removal of the cast, and physical therapy may not be covered. You were outside of the hospital. So, inside - covered, outside - not.

Major medical policies will cover the major part of your medical expenses regardless of whether or not you are in the hospital. Again, this policy will cover to whatever limits exist in the policy and what deductible you choose.

You can well imagine that a hospital accident policy would be less expensive than a major medical policy. Again, the premium reflects who is assuming the risk for your potential medical bills.

Now, back to the idea of a "bad" policy. Whatever policy you are considering, know what it covers and what it does not. A policy only turns bad on you when you end up with a medical bill that you thought the insurance company was going to pay. This surprise will rear its ugly head at the very time you may not be able to afford a financial surprise, like when you're flat on your back in bed after a surgery or illness.

It is always wise to read you policy as soon as you receive it. You usually have at least a 10-day free look period during which you can return the policy for a full refund of premium.

Know How a Hospital Accident & Major Medical Policy Differ

Hospital Accident Policy

You Assume Major Risks

At some point you assume the risk for claims above the insurance company's specified payment, not the insurance company.

The insurance company pays at various percentages up to the limits specified in the policy usually for a narrower range of covered benefits.

Common Misconceptions

It doesn't cover all expenses. It is designed to cover hospital and accidents at a time when hospitals are trying to get you out the door.

It is not necessarily less expensive by the time you add all the supplementary benefits and discount card programs.

Common Characteristics

Deductibles are usually per occurrence meaning you could have more than one each year.

It may cover 100% of hospital room and board charges, but only up to $400 per day. If the actual cost in your community is $750, you are left with a $350 balance. What about next year when the hospital raises its price to $800?

All covered items have upper limits.

Have to add benefits to expand the coverage to other medical costs.

Often marketed to the self-employed.

Major Medical Policy

They Assume Major Risks

The insurance company assumes all the risk, with minor exceptions, up to a maximum lifetime limit of usually $1 million or more.

You pay a deductible plus your share of shared expenses, usually $1,000 to $2,000, after which point the insurance company pays 100%.

Common Misconceptions

Major Medical is not limited to just high deductible policies. It means any policy that takes over major risks even a $200 deductible plan.

There may not be as big a difference as you might think between high and low benefit plans due to state mandated benefits.

Common Characteristics

Deductibles are usually once a year and more medical expenses count toward the deductible.

After you pay your deductible and usually $1,000 to $2,000 of shared expenses, it does pay at the 100% rate for all covered medical expenses for the rest of the year.

Some internal policy limits exist.

Usually comes as a fairly complete package for medical care.

The Even Smarter Buyer

Know how the different kinds of plans work.

The Even Smarter Buyer

As insurance agents, we of course want you to come to us with all your insurance needs. You may be able to purchase insurance directly from the insurance company, however, part of your premium will be a waste of money in most cases.

Insurance agents work on commissions paid by the insurance companies. We get paid if we sell something. This "something" is a small percentage, usually 5-10 percent, of the premium. Commissions are intended to compensate agents for the time, cost, and effort it takes to make a sale, but more importantly to you, the commission is compensation to provide you with ongoing service. You may always contact the insurance company directly, however, your agent should be ready and willing to serve you, thus saving you time and aggravation. If you purchase directly from the insurance company, the insurance company keeps the commission and you have to rely on the insurance company for your service needs.

We believe that you deserve to know everything you want to know in your search for health insurance and decisions that you may make down the road about what to buy. You deserve to know all of the options, ups and downs, insides and outsides.

Heath insurance companies change their premiums usually at least once every year. Some companies also will change your premium when you have a birthday. Yep, you're right, they usually go up. Each year, you may want to reevaluate if your health insurance plan is still the best for you, given the premium changes. If you can read and understand "insurancese", you are empowered to pick up any insurance plan, digest it, evaluate it, and make a decision.

As insurance agents, the more you know as a consumer, the easier it is for you and us to have a productive, efficient conversation about what to do at premium change time.

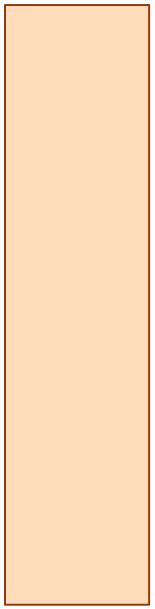
The Basic Health Insurance Plan Designs

There are only a handful of basic insurance plan designs. Once you understand the designs, you can evaluate any plan you look at. This section will explain the various plan designs.

Overview of the Three Basic Health Insurance Plan Designs with Common Variations

Traditional Indemnity Fee-for-Service

Freedom to Use Any Provider



Single Level of Benefits

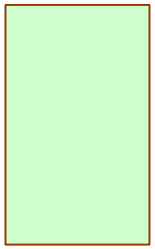
Shared expenses are typically based on an 80/20 coinsurance arrangement after first meeting an annual deductible. Payment at the 80% level by the insurance company is normally based on a percentile of usual, customary and reasonable (UCR) fees. The higher the percentile paid at by the insurance company, the higher the benefit and the less likely there would be any excess fees due over-and-above the 20% figure. Other coinsurance combinations such as 90/10, 70/30 and 50/50 are often available.

FFS – Fee For Service
PPO – Preferred Provider Organization
POS – Point Of Service
HMO – Health Maintenance Organization
EPO – Exclusive Provider Organization
UCR – Usual Customary and Reasonable Charges
PCP – Primary Care Physician
Indemnity – Compensation for damage, loss or injury suffered
Coinsurance - Percent sharing of expenses
Deductible – Amount insured pays first

Preferred Provider Variations

Choice of 2 Provider Network Options

Preferred Provider



Payment for services is usually based on a deductible that has to be met first followed by a coinsurance just like a traditional plan.

Deductible and coinsurance may be applied jointly or separately to in and out of network services resulting in a higher out-of-network penalty.

Non-Preferred Provider

May be based on UCR

May be based on contract rate

Usually requires a 20% higher coinsurance payment by the insured as a penalty.

May have a doctor visit copay

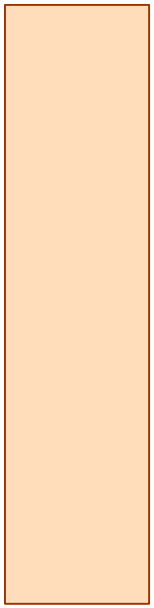
May have a doctor visit copay and require the use of a PCP

May be a Point-Of-Service POS plan with HMO benefits in the network & deductible out.

HMO & Exclusive Provider

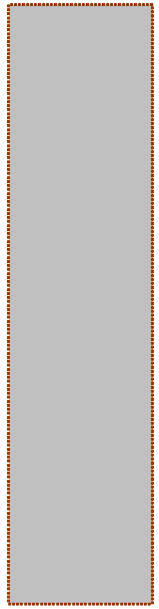
Limited to a Single Provider Network

HMO or EPO Network



Payment for services is usually based on copayments, but may include a deductible that has to be met first. Some benefits may be based on a percentage.

Non-Network Provider



There is no payment for services obtained outside the network except for any specified urgent or emergency care.

HMOs require selection of a PCP and referrals to specialists. EPOs may or may not require PCP selection and referrals.

Traditional Plan - Example of a $500 Deductible Plan

This type of plan is sometimes referred to as an “indemnity plan” or a “fee for service plan”. It is usually a plan which allows you complete freedom of choice in choosing where you want to go for health care.

You will want to determine, however, what this freedom to choose includes. At this time, most plans require you to go to a provider who provides “traditional” medical care in contrast to alternative medicines that naturopaths, acupuncturists or chiropractors may perform. Limited alternative care benefits are becoming more common.

This is a “you pay first, they pay second” type of plan. First you pay your deductible, second, you share some expenses, and then the insurance company takes over the rest.

The deductible is the amount that you agree to pay 100 percent of each year, and you agree to pay it before the insurance company shares any medical expenses with you. It is the amount you deduct from what the insurance company will pay. Your payment of the deductible, in most cases, is an annual event, not a per-expense event. The year usually will start in January (rather than at your annual renewal date).

This deductible is not due in January like a bill. It only represents the amount of money that you agree to pay before the insurance company pays IF you incur a medical bill. You aren’t going to magically get a bill the first of the year for the deductible amount.

After the deductible comes the “Stop Loss”. This is an amount of medical expenses that you agree to share the cost of with the insurance company. After you have paid your share of these expenses, your losses stop. You stop losing money out of your pocket and the insurance company takes over at the 100 percent level for the rest of the year. Your share may also be referred to as your out-of-pocket expense.

When you see, for example, a $5000 stop loss, this does not mean that you have to pay $5000. It means that you will share a percentage of the $5000 of medical bills with the insurance company. This sharing is expressed as a percentage of “you pay”, “they pay”.

More and more insurance companies are using the term “out of pocket”, which is nothing more than the dollar amount of your share of medical expenses, a much easier concept to get across and to understand.

After you pay your deductible and your share of the stop loss, the insurance company will take over at the 100 percent level for any additional medical bills up to a “Lifetime Maximum.” If you see a $5 million lifetime maximum, it means that the insurance company will pay up to this amount as long as you have the insurance policy. Payment at the 100 percent level is usually defined by “usual and customary charges”, or “usual, customary, and reasonable fees”, and may not be 100 percent of every bill you receive. Usual and customary is usually determined by what medical providers in a certain

geographic area charge for services. Each insurance company determines at what level they are willing to pay. This is discussed in more detail later.

When you are looking at a Traditional Plan or Indemnity Plan there are several parts of it you should scrutinize.

- How many family members have to meet the deductible?
- What expenses are included in the deductible and stop loss? Does the insurance company include prescriptions in this or do prescription have their own, separate deductible and stop loss?
- What is the lifetime maximum?
- Does the policy waive the deductible in case of an accident?
- Does the policy cover the kind of care and expenses that you want it to cover? If preventive coverage or alternative care is important to you, is it covered?
- What are the limitations and exclusions of the policy?
- Do specific medical expenses have limitations on them? A limitation, for example, could be that the insurance company will only pay up to $500 for an ambulance benefit.

Traditional Plan – Representative $500 Deductible Plan

This plan is referred to as an indemnity plan. Indemnity means compensation for damage, loss, or injury suffered. It is usually reserved for plans that allow you complete freedom of choice as to which physician, medical provider, hospital, or other medical facility to go to.

They Pay

100%
Up to a
$5 Million
Lifetime Maximum

3

← Covered Medical Expenses in Excess of the Deductible and the Stop Loss

Only covered expenses are considered eligible for payment. Know your policy's limitations and exclusions. Some policies have the further stipulation that expenses must be for medically necessary care. Other policies may include limited preventive care.

CAUTION: The 80% and the 100% values the insurance company pays are usually based on **usual, customary, and reasonable (UCR)** rates and UCR rates are further determined by percentile of payment. SEE later section on UCR and contracted rates.

You Share

You Pay 20%

They Pay 80%

2

← The Next **$5,000** of Covered Medical Expenses Each Year

Referred to as a $5,000 **Stop Loss** or that point at which your losses stop and the insurance company takes over.

Your total **out-of-pocket** expenses are equal to **20% of $5,000** or **$1,000** plus the **$500 deductible** for a total of **$1,500**. The deductible is usually limited to 2 or 3 per family while the coinsurance portion is usually per person, but could have a limit of 2 or 3 per family as well.

You Pay

100%

1

← The 1st **$500** of Covered Medical Expenses Each Year

Referred to as the **Deductible**

Prescription drugs may be included in the deductible, have a separate deductible, covered without having to meet the deductible or may be excluded.

The Deductible may be **waived** for treatment during the **1st 90 Days** following an accidental injury.

Preferred Provider - Example $500 Deductible Plan

This is a type of a managed care plan that typically requires that you access certain providers to get the most benefit from your policy. Preferred providers are those providers that have a contract with the insurance company. This contract states how much the provider will charge for services. This amount is less than the retail amount that you would pay if you did not have insurance.

If you go to a provider who is not contracted with the insurance company for the particular plan you have chosen, you will probably still have coverage, however, the amount that you pay will be greater.

The premiums for these plans are less than traditional plans because the amount that the insurance company will have to pay is more predictable and is less than the retail amount. Insurance companies negotiate with providers to accept less than retail for their services. Those providers who agree to the contract are those providers that you can go to get the best benefits from your policy.

We often hear, “I don’t want to do this. I want to go wherever I want to go.” Fine, you can do that. You will pay higher premiums, but you can do it.

The following description is the same as that in the Traditional Plan section. The differences between the traditional plan and the preferred plan are highlighted so that you can quickly read them and pass the redundant stuff.

The deductible is the amount that you agree to pay 100 percent of each year, and you agree to pay it before the insurance company shares any medical expenses with you. It is the amount you deduct from what the insurance company will pay. Your payment of the deductible is an annual event, not a per-expense event. The year usually will start in January (rather than at your annual renewal date).

Even though you have a deductible, you will immediately start reaping the benefits of having a preferred provider plan. You will see this with your first office visit. While the retail cost of an office visit may be $100, the provider has agreed to only charge $75. When you have a preferred provider plan, you will only be billed the $75, already saving $25 off the retail price, for example.

This deductible is not due in January like a bill. It only represents the amount of money that you agree to pay before the insurance company pays IF you incur a medical bill. You aren’t going to magically get a bill the first of the year for the deductible amount.

After the deductible comes the “Stop Loss”. This is an amount of medical expenses that you agree to share the cost of with the insurance company. After you have shared these expenses, you stop losing money out of your pocket and the insurance company takes over at the100 percent level for the rest of the year.

When you see, for example, a $5000 stop loss, this does not mean that you have to pay $5000. It means that you will share a percentage of the $5000 of medical bills with the insurance company. This sharing is expressed as a percentage of "you pay", "they pay".

Here again, your 20 percent is based upon the provider's agreed upon price, not the retail price.

The caution with Preferred Provider plans is…you MUST go to contracted providers to get the best benefits, the 80 percent or 90 percent benefit, for example. If you go outside of the panel and if your provider does not have a contract with the insurance company for your particular plan, you will pay a lot more. The typical percentage, if you go outside the plan, is an extra 10 percent – 30 percent.

It's worse than that! If the insurance pays 60 percent if you go outside of panel, this is not a true 60 percent. It is usually 60 percent of the contracted amount. So…assume that the retail price is $100 and the contracted price is $75. If you go to a preferred provider, and your plan pays 80 percent, you pay only $15.00. If your provider is not on panel, and your plan pays 60 percent, you would pay $30 (40 percent of $75) plus the $25 over the contracted amount for a total of $55.

After you pay your deductible and your share of the stop loss, the insurance company will take over 100 percent of the in-network medical bills up to a "Lifetime Maximum." If you see a $5 million lifetime maximum, it means that the insurance company will pay up to this amount as long as you have the insurance policy.

The caveat again is that the providers must be contracted with the insurance company for you to get this better benefit.

So, what do you need to consider when evaluating a preferred provider plan?

You need to consider all of the questions listed in the Traditional Plan section plus the following additional considerations:

- **Are your providers contracted with the insurance company for the plan you're considering? There are at least three ways to find this out.**
  - **Ask your insurance agent.**
  - **Ask your providers**
  - **Ask the insurance company. Use the phone or the Internet. Provider directories are usually accessible on the Internet.**
- **How much does the insurance pay if you do not use contracted providers? This percentage will vary by insurance company and plan.**

Make sure you understand that, if you do not use contracted-providers, the percentage that you see is based upon either UCR or the contracted amount, NOT the retail amount. You may end up paying MORE THAN the percentage listed.

Some people do not want to deal with the issue of having to use preferred providers; they want to go where they want without having to check anything. Remember that freedom has a price. Traditional plans may cost a lot more than preferred provider plans. It may be worth it to purchase a preferred provider plan, deal with the provider panel issues, and enjoy the lower premiums.

Preferred Provider – Representative $500 Deductible Plan

They Pay

100%
Up to a
$2 Million
Lifetime Maximum

3

← Covered Medical Expenses in Excess of the Deductible and the Stop Loss

Only covered expenses are considered eligible for payment. Know your policy's limitations and exclusions. Some policies have the further stipulation that expenses must be for medically necessary care. Other policies may include limited preventive care.

CAUTION: The 60% and the 100% values the insurance company pays could be based on billed rates, contracted rates, or usual, customary, and reasonable (UCR) rates and UCR rates are further determined by percentile of payment. SEE separate section on UCR and contracted rates.

You Share

If You Use **Non-Preferred Providers**

You Pay 40%	They Pay 60%

If You Use **Preferred Providers**

You Pay 20%	They Pay 80%

2

← The Next **$5,000** of Covered Medical Expenses Each Year

Referred to as a $5,000 **Stop Loss** or that point at which your losses stop and the insurance company takes over.

Office Visit Co-pays of $10, $15, or $20 may allow you to go to your physician without having to meet your deductible. They usually cover just the visit charge and may not cover all charges incurred at his office.

Prescription drugs may be included in the deductible, have a separate deductible, covered without having to meet the deductible or may be excluded.

You Pay

100%

1

← The 1st **$500** of Covered Medical Expenses Each Year

Referred to as the **Deductible**

The Deductible may be **waived** for treatment during the **1st 90 Days** following an accidental injury.

Preferred Provider Plans – A Twist

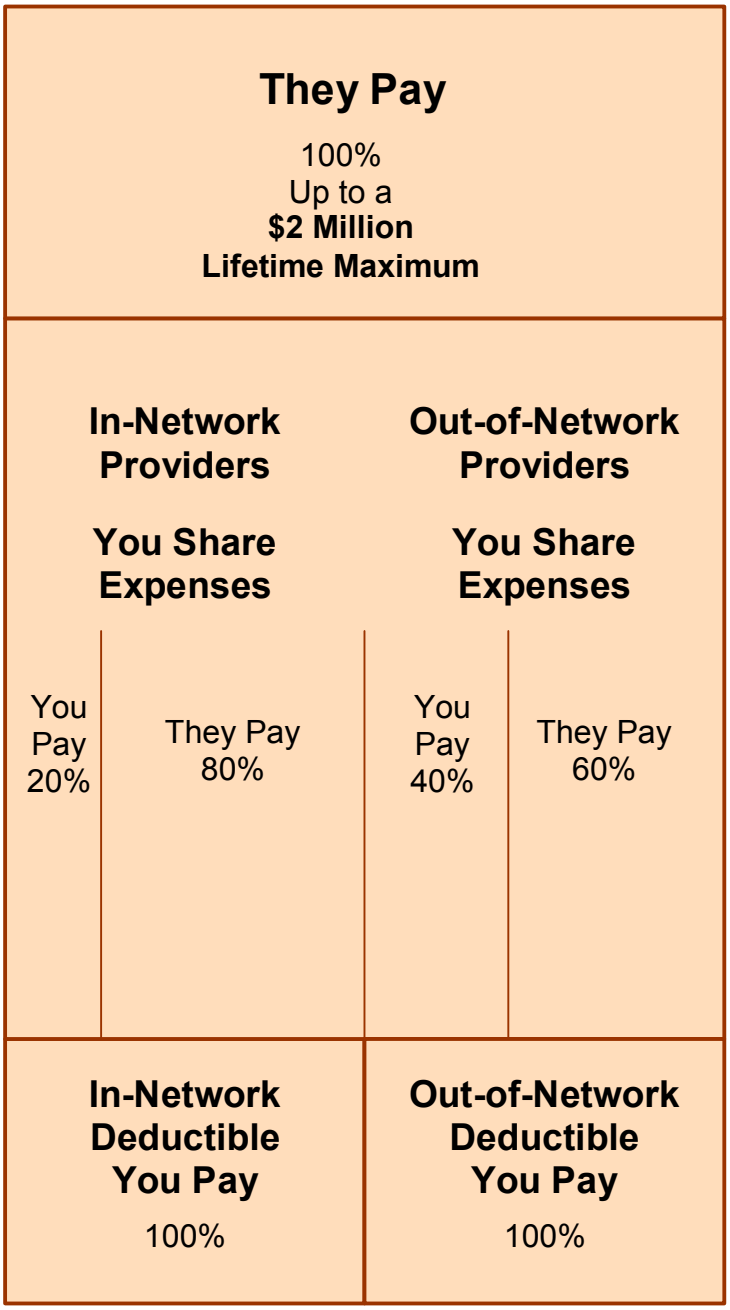
In an attempt to keep premiums affordable, while facing ever-increasing costs for medical care, some insurance companies have applied a new approach in providing coverage under a Preferred Provider Plan. This change shifts costs to you and provides an even stronger incentive to use the network of preferred providers.

The new approach applies both a separate deductible and a separate coinsurance amount (your percentage of those expenses you share with the insurance company). Under this approach, if you use both in-network and out-of-network service providers, you may end up paying two deductibles and reach separate out-of-pocket limits for each category. This significantly increases your risk exposure and worst-case out-of-pocket limits over a conventional Preferred Provider Plan.

It becomes more important to know whether the policy you have, or are considering, uses both a common deductible and coinsurance approach, a common deductible with a separately applied coinsurance for in and out of network services, or a separately applied deductible and coinsurance for both types of services.

PPO Plan - Separate Application of Deductibles & Coinsurance

CAUTION: The 60% and the 100% out-of-network values the insurance company pays could be based on billed rates, contracted rates, or usual, customary, and reasonable (UCR) rates and UCR rates are further determined by percentile of payment. SEE separate section on UCR and contracted rates.



3

Covered Medical Expenses in Excess of the Deductible and the Stop Loss

2

The Next **$20,000** of Covered Medical Expenses in this example is referred to as a $20,000 **Stop Loss**.

Separate coinsurance amounts (shared charges) are applied to In-Network Services and to Out-of-Network Services

In this example, you would pay 20% of In-Network expenses up to a maximum of $4,000. You could also pay 40% of any Out-of-Network expenses up to a maximum of an additional $8,000. Total shared costs could equal $12,000 in addition to the two $1,000 deductibles.

1

Separate Deductibles are applied to In-Network Services and to Out-of-Network Services

On a $1,000 deductible plan, you could pay two $1,000 deductibles if you exceed the deductible amount in and out of the network.

Health Maintenance Organization (HMO) Plan – Example

While HMO plans are the managed care plans that have the most restrictions regarding how you access care and which providers you may access, they typically offer richer benefits and lower premiums than traditional plans and preferred provider plans. Exclusive Provider Organization (EPO) plans operate like HMO plans without being a federally qualified HMO.

You typically pay copays, a relatively small dollar amount each time you access service, instead of deductibles and percentages. The most you pay in medical expenses in a year is expressed as "maximum out of pocket" expenses. These plans typically offer a first dollar benefit. For example, when you go to the doctor, you will usually pay a $10 or $15 copay. The insurance company pays the rest of the bill.

HMO plans typically cover preventive care and may even include a vision exam.

There are HMOs and HMOs. Yes, there are HMOs that require you to go to a specific group of providers and that can approve or decline certain treatments. There are HMOs in which the providers are employees of the HMO rather than independent practitioners. However, there are many HMOs that simply contract with providers. In these HMOs, you and your service provider decide your course of treatment. While the insurance company may require pre-authorization and may require justification for a procedure, the actual treatment will not necessarily be declined. What may be declined is the payment of a claim for the treatment. The providers are independent practitioners.

So, what's so bad about an HMO? Nothing. You just have to understand, accept, and play by the rules.

As long as you follow the rules, you receive the benefits your policy provides. If you do not follow the rules, you may not receive any benefits. You may have to pay the entire medical bill.

You will have to choose a Primary Care Provider (PCP), usually a general practitioner contracted with the HMO as a PCP. You may be pleasantly surprised to find that your family doctor is contracted as a PCP with the HMO you are considering. If you decide that you don't love your PCP anymore, and want to change, HMOs will allow this. They may only allow changing once a year. They will have a requirement that you notify them within a certain number of days before the change will go into affect.

You will have to go to your PCP for all your care unless he or she refers you to a specialist. The specialist also must be contracted with the HMO. If the HMO does not have a contract with a specific kind of specialist, the HMO may make special arrangements with a specialist so that you can receive care and have the HMO pay the claims. These special situations require prior authorization by the insurance company. There may be some services that you can obtain without a referral from your PCP. Look for these exceptions in the HMO plan's summary of benefits or contract, the policy.

As always, you will want to scrutinize the benefit summaries of the plan you are considering to determine what is covered, how it's covered, and what's not covered.

Health Maintenance Organization (HMO) Plan - Example

Some Exclusive Provider Organization (**EPO**) and Preferred Provider Organization (**PPO**) plans also use this same co-payment model with or without the requirement for a Primary Care Physician (**PCP**). The PPO plans provide for going out-of-network at additional cost.

Only covered expenses are considered eligible for payment.
Know your policy's limitations and exclusions.

HMO plans typically cover routine **preventive care** as well as medically necessary care.

3

HMO plans require that you select a **Primary Care Physician (PCP)**. Your PCP is the coordinator of all your care and must give you a **Referral** before you can go see a **Specialist**.

Unlimited Lifetime Maximum Benefit

2 **They pay the balance** after your Co-Payments add up to the **Out-of-Pocket Limit**.

$1,000 Out-of-Pocket Limit per Person

Until Your Co-Payments Reach Out-of-Pocket Limit

20% Durable Med	They pay the balance for each service after **your Co-Payment**.
$100/Day Hospital	
$50 Ambulance	
$50 Surgery	
$10 Physician Visit	

1

HMO plans require that you receive all your medical care from **member** physicians, hospitals, and other providers in most cases.

There is **no coverage** for care received from **non-member** providers.

You Pay Co-Payments for Services

Fixed Dollar or Percent Prescription Drug Benefit

As prescription costs have skyrocketed, insurance companies have scrambled to find ways to keep insurance premiums down. Someone has to pay for this stuff!

So…you will often see what's called a fixed dollar benefit, a percentage benefit, or a tiered prescription benefit that is expressed as a certain sum of money, or as a percentage, or as both. You may also see that you may be able to choose a plan with or without prescription coverage or purchase upgraded prescription coverage to complement your basic benefit.

Some plans will have a separate deductible for the prescription benefit.

The prescription benefits are fairly self-explanatory. A fixed dollar benefit and a percentage benefit are what they say they are. You pay either a certain sum of money for a prescription or you pay a certain percentage of the cost for a prescription.

Fixed Dollar or Percent Prescription Drug Benefit

Here are two examples of a **Fixed Dollar or Percent** Drug Benefit.

$10 or 20% whichever is Greater

If the price of a prescription drug is between $0 and $10	If the price of a prescription drug is between $10 and $50	If the price of a prescription drug is over $50
You only pay the **actual cost** of the prescription (Ex. $7)	You pay **$10**	You pay **20%** (Ex. An $85 Rx costs you $17)

$15 or 50% whichever is Greater

If the price of a prescription drug is between $0 and $15	If the price of a prescription drug is between $15 and $30	If the price of a prescription drug is over $30
You only pay the **actual cost** of the prescription (Ex. $12)	You pay **$15**	You pay **50%** (Ex. A $45 Rx costs you $22.50)

Some plans provide this benefit without having to meet a deductible first. Other plans may use a separate drug deductible or a combined deductible with drug + medical expenses.

Insurance companies negotiate prices with pharmacies on prescription drug prices. If you previously did not have insurance, you may find your costs for prescriptions are less with or without any other prescription benefit.

3-Tier Prescription Drug Benefit Example

If a plan has a tiered benefit, it means that you will pay different amounts for different prescriptions. A rule of thumb is that you will pay more for more expensive prescriptions. Makes sense, yes?

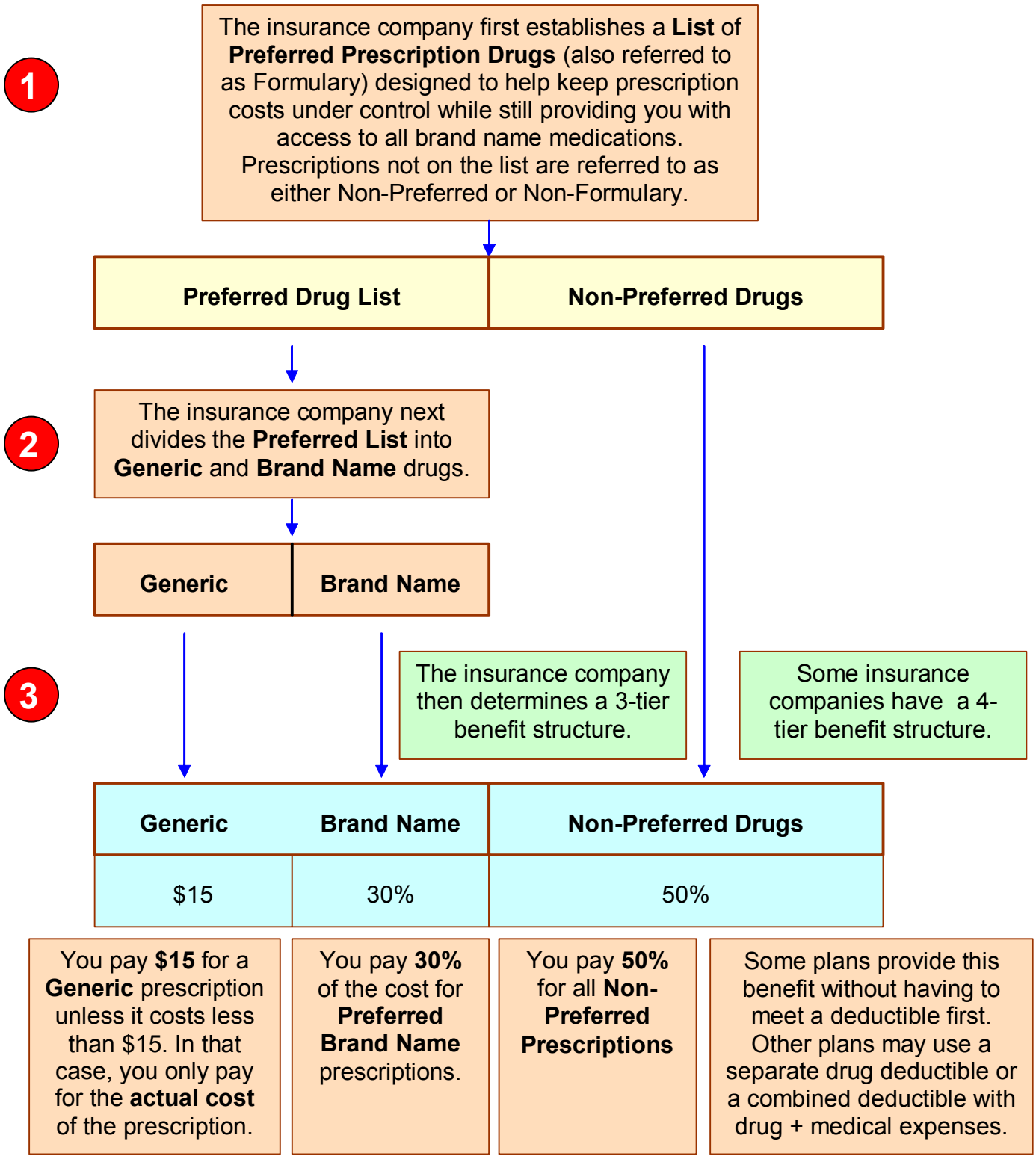
If you are taking prescriptions, and want to find out how much the insurance company would pay on them, there are several ways to find out this information.

- Contact your insurance agent
- Look up the prescription list on the insurance company's website
- Call the insurance company

Remember that each insurance company may treat a prescription differently. Do not assume that because one insurance company will cover all but $10 of the prescription that all insurance companies will do the same.

If a prescription benefit or an upgraded benefit is an option on the plan you're looking at, take some time to think about the future. The time to choose a prescription benefit is when you do not need it. When you need it, it will be too late. If you do not choose a prescription benefit, and want to add it later, you will have to apply for it the same as when you applied for the health insurance. The insurance company can decide whether to approve your request or not. This is why we say that, if you need it, it's too late. You will most likely be declined. As always, though, what you purchase is your decision because it's your money paying the premiums. We just try to bring up things you may want to consider as you make decisions.

3-Tier Prescription Drug Benefit Example



Using Tax Dollars to Help Pay the Costs

Know what tax advantaged plans do for you.

Health Savings Accounts or HSA Plans for Individuals and Employee Groups

Health Savings Accounts or HSA plans are new for 2004 and allow you to save money to pay for medical expenses on a tax-free basis. An HSA is similar to a Medical Savings Account (MSA) except any individual under age 65 can participate while an MSA is limited to self-employed individuals. An employer can also offer an HSA to his employees, through a Flexible Spending Account (FSA) commonly referred to as a cafeteria plan, and both the employer and employees can contribute to the savings account. An MSA is limited to one contributor or the other but not both.

An Insurance Policy and a Special Savings Account

An HSA is a combination of a health insurance policy meeting minimum deductible requirements and a separate savings account for medical expenses. Congress created the HSA as yet another way to cover your medical expenses, and it is subject to IRS regulations and guidelines. A health insurance company or an insurance plan usually provides the health insurance policy. A licensed HSA administrator and financial services company, such as a bank, usually administers the savings account portion of the HSA.

The Health Insurance Plan Must Meet Certain Design Requirements

A qualified HSA plan has a single deductible that applies to all medical expenses covered by the insurance policy whether you are insuring yourself or an entire family. This deductible must be satisfied each year before the insurance company pays on any medical claims. The single deductible for an individual must be a minimum of $1,000 and can be any deductible up to the maximum out-of-pocket limit of $5,000 and the single deductible for a family must be at least $2,000 up to the maximum out-of-pocket limit of $10,000 for the year 2004. Preventive care can be provided without having to meet the deductible first. The limits on maximum out-of-pocket expenses include both the deductible and any shared expenses you are obligated for. These limits are subject to annual cost-of-living adjustments determined by the IRS, which will cause these values to change over time. You can exceed the out-of-pocket limits, if you go outside the provider network on a preferred provider plan. The plan still qualifies.

Yearly Savings Allowed Based on Plan Deductible and Age

You can save up to 100% of the individual deductible not to exceed $2,600 and you can save up to 100% of the family deductible not to exceed $5,150 for 2004 in your HSA account. These limits are also subject to annual cost-of-living adjustments. Amounts are pro-rated if you start the plan mid-year. Individuals age 55 to age 65 can contribute an additional $500 over the above limits and the additional amount allowed increases by $100 each year until it reaches $1,000 in 2009. If both husband and wife are over 55, each can contribute the additional amount to the HSA.

Other Types of Supplemental Coverage Are Permitted

You can have a policy covering a specific disease such as cancer; one providing a fixed payment for hospital coverage such as a daily benefit, or you can have one that provides supplemental accident, disability, dental, vision or long-term care benefits.

Use of HSA Funds to Pay Medical Expenses

Funds in an HSA account can be used to pay both medical expenses incurred in meeting the deductible and any required shared expenses you are responsible for each year tax-free. These funds can also be used to cover qualified medical expenses not covered by the health insurance plan such as vision and dental expenses. See IRS Publication 502, "Medical and Dental Expenses".

Savings Account Money Belongs to You and Can Be Accumulated

You own the HSA funds in your account. If you have an HSA as part of an employer sponsored health plan, you still own the funds and can take them with you when you leave or retire. You can carry unused funds over from year to year until retirement, if you wish. Like an IRA, investment earnings accrue tax-free. If you withdraw funds prior to age 65 for non-medical expenses, you will be subject to a 10 percent income tax penalty in addition to any other income taxes you may owe on the accumulated funds. After age 65 you can continue to use the funds tax-free for medical expenses including premiums on health insurance and Medicare plans, except for Medicare Supplements, or you can withdraw the funds for other purposes subject to normal income taxes without a penalty. The 10 percent penalty is waived in the case of death or disability.

Other Important Contribution Considerations

If you also have an MSA Plan your total contribution to both plans cannot exceed the contribution limits discussed above for an HSA. Contributions are tax-deductible for the individual even if he does not itemize deductions on his tax return. Employer contributions are made on a pre-tax basis.

Transfer of Ownership to Spouse on the Death of An Individual

HSA ownership may transfer to an individual's spouse, upon death, on a tax-free basis.

Health Savings Accounts – HSA Plans for Individuals

Health Savings Account (HSA) funds can be used to pay for specified medical expenses on a tax-free basis or they can be left to accumulate to age 65 on a tax-deferred basis similar to a regular IRA. Withdrawals for other than medical expenses are subject to ordinary income tax and a 10% early withdrawal penalty. **Data shown here is based on plans meeting yearly requirements for 2004.**

4 **Separate HSA Savings Account**

You can **save** up to **100%** of your **individual deductible** before taxes every year in your HSA savings account up to **$2,600**.

3

The highest **Out-of-Pocket Maximum** allowed is **$5,000** including the deductible.

2

Plans will probably be available with some **sharing arrangement** of expenses after the deductible or one that pays 100% of the expenses after the deductible.

1

Deductible must be at least **$1,000**. (Example shows deductible equal to the maximum allowed HSA contribution for maximum savings.)

Lifetime Maximum

They pay
At 100 **%**
After you reach the **Out-of-Pocket** Maximum for the Plan

They Pay 100% or

You Share

You Pay 50% or 20%	They Pay 50% or 80%

You Pay

100% of the first $2,600 of expenses

Deductible

Individual Plan

Lifetime Maximum

They pay
At 100 **%**
After you reach the **Out-of-Pocket** Maximum for the Plan

They Pay 100% or

You Share

You Pay 50% or 20%	They Pay 50% or 80%

Depending on Plan

You Pay

100% of the first $5,150

Family Deductible

Family Plan

Separate HSA Savings Account

You can save up to **100%** of your **family deductible** before taxes every year in your HSA savings account up to **$5,150**.

Each person **age 55** can **add $500**/ Yr. more going to $**1,000 in 2009**

The highest **Out-of-Pocket Maximum** allowed is $**10,000** including the deductible and any shared expenses.

Plans will probably be available with some **sharing arrangement** of expenses after the deductible or one that pays 100% of the expenses after the deductible.

Coverage for preventive care, accidents, disability, dental care, vision and long-term care are not subject to the deductible

Income limits apply starting at $75,000.

Deductible must be at least **$2,000**.

Tax Deduction for Small Businesses and the Self-Employed

Until recently there have not been many options available to self-employed individuals and Subchapter S Corporations. They have now gained the availability of Medical Savings Accounts (MSA) followed by 100 percent deductibility of health insurance premiums and will soon have Health Savings Accounts (HSA).

The Importance of Tax Deductibility of Premiums

Money spent on premiums by self-employed business owners and other small businesses can generally be deducted at the 100 percent level from both state and federal tax returns. Money spent to pay for medical expenses can only be deducted if those expenses exceed 7.5 percent of Adjusted Gross Income and only to the extent that they exceed this figure. It is easily possible for state and federal income taxes and self-employment taxes to equal 50 percent. This would mean that for every $1 you spend on medical expenses you would have to earn $2 to pay for it. In contrast, you only have to earn $1 to pay for $1 worth of health insurance premiums.

The Impact of Government Mandates on the Cost of Health Insurance

States have added a significant number of mandated health benefits to health insurance policies sold in their states over the past ten years. In addition, the federal government has added protections and additional requirements such as privacy of health information and patients' bill of rights. These additional requirements all contribute to the rising cost of health insurance. This has had an interesting effect on premiums in another way. In the past, a person could choose a high-deductible policy and save a considerable amount of money making this option attractive to those who wanted to cover the up-front costs for health care themselves. Now the difference in price between a plan that has no deductible and covers the majority of medical costs and one with a $5,000 deductible is nowhere near as significant. The costly mandates are required to be in both policies. Perhaps this is one reason the sale of MSA plans has not been as great as were the expectations of many.

Using the Tax Deduction and Government Mandates to Your Advantage

You can convert almost all of your medical expenses to premiums by purchasing the best and most complete health insurance plan you can find, one that covers almost all of your possible medical expenses. You have now changed your situation so that you are only paying $1 for each $1 of medical expenses most of the time. It is true that you are giving up the savings as opposed to purchasing a high-deductible plan, but look at a typical example from our client base in the illustration that follows. Over time it would be difficult to beat this approach unless you never need medical care. Whether it works in your situation depends on your particular tax situation.

This Approach Has Merit for Small C Corporations As Well

Just like you, your employees' medical expenses have to exceed 7.5 percent of their Adjusted Gross Income before any of their medical expenses are tax deductible. They many only have to earn $1.50 or so to pay for each $1 of medical expenses they incur depending on their individual tax situations. What it means to you is that you pay only $1 for each $1 improvement in health care benefits. To afford them the equivalent value, you would have to give them a raise equivalent to $1.50. You would have to also pay FICA and FUTA taxes on this raise. In some cases, the cost of providing the best benefits over the ones currently provided is less than $1 per hour for all employees. Whether this is important in your situation depends on the competitiveness for good employees in the business you are in and how valuable these benefits would be to your employees perhaps in lieu of higher wages.

An Option for Small Businesses & the Self-Employed

This example is based on a small primarily family owned group consisting of three employees including the owner, his wife, and one other employee. The wife's coverage includes their two children. The employee is single with the employer paying his full premium. Oregon State Tax rates and premiums are used in this example.

High Cost Maximum Benefit Plan	Low Cost High Deductible Plan
$10 Physician Visit Copay $100 Hospital Visit Copay 100% Plan Annual Premium **$11,659**	$1,000 Deductible 30% Member Coinsurance $10,000 Stop Loss Annual Premium **$8,212**
	Annual Savings **$3,446**
Federal Income Tax Rate 27.0% Self-Employment Tax Rate 15.3% State Income Tax Rate 9.0% Total Tax Rate 51.3% Savings - Premium Deduction **$5,981**	Federal Income Tax Rate 27.0% Self-Employment Tax Rate 15.3% State Income Tax Rate 9.0% Total Tax Rate 51.3% Savings - Premium Deduction **$4,213**
	Net After Tax Savings **$1,678**
Good Year	
Assume the company pays 100% of the health insurance premium and everyone has a great year with absolutely no medical expenses.	Total after tax premium savings for the company would be **$1,678**.
Bad Year	
Assume that one of the owner's children had a broken wrist, required an operation to insert two pins and used network providers at a cost of $15,000. This would invoke the $1,000 deductible and 30% of the next $10,000 or $3,000 for a total out-of-pocket expense of $4,000. No other members had any expenses.	Total non tax-deductible out-of-pocket expenses would be **$4,000.** Total before tax cost of $4,000 income used to pay bill. **$8,008.** Time to recover costs is **4.8 years.**

Unless the group remains healthy and avoids accidents, a high deductible plan could actually cost you more money over time when you were really trying to save money. Think of the maximum benefit plan as a health reimbursement arrangement approach for a small business.

Medical Savings Accounts - MSA Plans for Small Groups And the Self-Employed

MSA plans work just like a Traditional Plan or a Preferred Provider Plan except that you can set aside a certain sum of money to pay for medical expenses and the plan design must conform to government standards to qualify as an MSA health insurance plan. Not all plans qualify.

High Deductible Insurance Policy and a Special Savings Account

A Medical Savings Account or MSA is a combination of a high deductible health insurance policy and a separate savings account. Congress created the MSA as another way to cover your medical expenses, and it is subject to IRS regulations and guidelines. A health insurance company or an insurance plan usually provides the high deductible health insurance policy. A licensed MSA administrator and financial services company, such as a bank, usually administers the savings account portion of the MSA.

Self-employed Business Owners and Groups of 2-50 Employees

The MSA is designed for self-employed business owners and companies employing from two to 50 employees. Qualified individual health insurance policies are used for self-employed plans and qualified group health insurance plans are used for companies of 2-50 employees. Availability of plans is limited to the qualified plans offered by insurance companies conducting business in the state.

Unique Single Deductible Health Insurance Plan Design

A qualified MSA plan has a single deductible that applies to all medical expenses covered by the insurance policy whether you are insuring yourself or an entire family. This deductible must be satisfied each year before the insurance company pays on any medical claims. The single deductible for an individual can range from $1700 to $2600 and the single deductible for a family can range from $3450 to $5150 for the year 2004. The maximum out-of-pocket expense cannot exceed $3,450 for an individual and $6,300 for a family. These deductible limits are subject to an annual cost-of-living adjustment determined by the IRS, which could cause the deductible on your plan to change over time. Supplemental medical benefits, such as a prescription drug benefit, do not pay until the plan deductible is met; however, prescription drug costs would count toward the deductible for the year and would be paid after the deductible is met provided that the benefit was either built-in or purchased as a separate option.

Yearly Savings Allowed Based on Plan Deductible

You can put aside money in your Medical Savings Account each year to pay for future medical expenses and deduct that amount from your income tax return for the year much like an IRA. An individual can contribute an amount equal to 65 percent of his or her individual policy deductible and a family can contribute an amount equal to 75 percent of the one family deductible. The employer or employee, but not both in the

same tax year, can make contributions. You are not required to contribute the maximum each year, but it would probably be in your best interest to do so for the long-term tax benefits. Premiums paid for the health insurance plan are also a tax-deductible item.

Allowable Expenses Include Items Not Covered by the Health Plan

Funds in the MSA account can be used to pay for medical expenses incurred in meeting the deductible each year tax-free. These funds can also be used to cover qualified medical expenses not covered by the health insurance plan such as vision and dental expenses.

Savings Account Money Belongs to You and Can Be Accumulated

You, as an employee, own the MSA funds and can take them with you when you leave or retire. You also don't lose them each year and can carry unused funds over from year to year until retirement, if you wish. If you withdraw funds prior to age 65 for non-medical expenses, you will be subject to a 15 percent income tax penalty in addition to any other income taxes you may owe. After age 65 you can continue to use the funds tax-free for medical expenses including premiums on some Medicare supplemental policies or you can withdraw the funds for other purposes subject to normal income taxes without a penalty.

MSA Plans for the Self-Employed & Small Groups

MSA Savings Account funds can be used to pay for specified medical expenses on a tax-free basis or they can be left to accumulate to age 65 on a tax-deferred basis similar to a regular IRA. Withdrawals for other than medical expenses are subject to ordinary income tax and a 15% early withdrawal penalty. **Data shown here is based on plans meeting yearly requirements for 2004.**

Separate MSA Savings Account

You can save up to 65% of your individual deductible before taxes every year in your MSA savings account or $1,300 in this example.

The highest Out-of-Pocket Maximum is $3,450. If you had a 100% plan with a $2,000 deductible, your Out-of-Pocket Maximum would be $2,000.

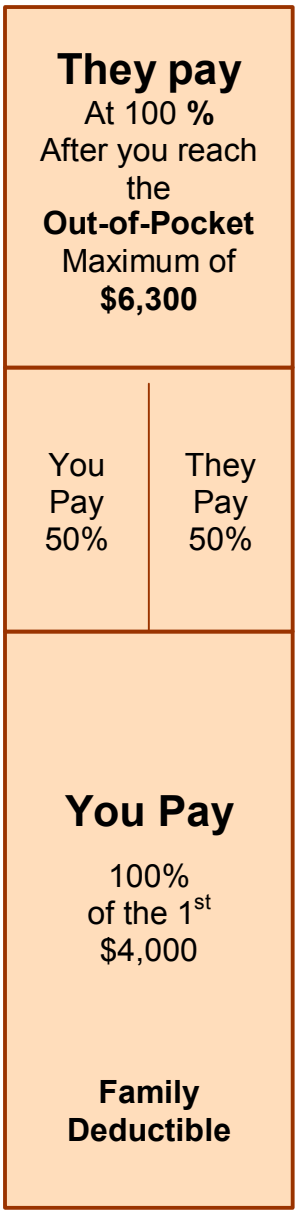
Plans are available with a 20% share for you and an 80% share for the insurance company. Plans are also available where the insurance company pays at 100%.

Available in deductibles from $1,700 to $2,600

Lifetime Maximum

Individual Plan

Lifetime Maximum



Family Plan

Separate MSA Savings Account

You can save up to 75% of your family deductible before taxes every year in your MSA savings account or $3,000 in this example.

The highest Out-of-Pocket Maximum is $6,350. If you had a 100% plan with a $4,000 deductible, your Out-of-Pocket Maximum would be $4,000.

Plans are available with a 20% share for you and an 80% share for the insurance company. Plans are also available where the insurance company pays at 100%.

Available in deductibles from $3,450 to $5,150. The full family deductible must be met before the insurance company pays any benefits even if only one family member has medical expenses.

Health Reimbursement Arrangements - HRA Plans for Employee Groups

Health Insurance Plan Plus an Arrangement to Pay Medical Expenses

A Health Reimbursement Arrangement or HRA is a combination of any health insurance policy approved by the state as an employee benefit plan and a separate arrangement to reimburse employees for all or a portion of the qualified medical expenses not paid by the health insurance policy. An HRA is quite often referred to as a Health Reimbursement Account (Accounts); however it does not require the establishment of a separate funding account, as does a Medical Savings Account (MSA) plan. It is an arrangement whereby an employer agrees to pay certain medical expenses. When a Third Party Administrator (TPA) is used, the TPA may establish a small account on behalf of the employer.

Congress created the HRA as a new consumer-directed plan designed to cover medical expenses and it is subject to IRS regulations and guidelines. While usually a high-deductible plan is chosen for the insurance portion, there is no requirement to do so, and any state approved plan can be used. The employer determines the reimbursement arrangement.

Uses All Employer Funds and Employer Makes All the Decisions

The HRA is designed for companies employing two or more employees, excluding sole-proprietors and owners of subchapter-S corporations from participation. Employer funds are used to reimburse employees for qualified medical expenses in accordance with the pre-established employer arrangement. IRS requirements for qualified medical expenses also apply. Employer payments are a tax-deductible business expense and reimbursements to employees are tax-free. Availability of plans is limited to the qualified plans offered by insurance companies conducting business in the state

Since only employer funds are involved, the employer determines the amount to reimburse each year, the amount that can be carried over each year, when to make reimbursements, whether the employee or the employer pays first, what happens when an employee leaves the company and what is the maximum an employee can accumulate. The employer may have other options available to him as well.

Reimburses Employees for Medical Expenses and Allows Carry-over

The arrangement specifies a dollar-limit for the amount of qualified expenses that will be reimbursed to an employee each year. The arrangement also usually specifies that any unused allocation of funds can be accumulated and carried over for use next year. Since the employer owns the funds until presented with valid receipts, there are no actual funds accumulated that employees own to rollover to a new employer or take with them if they leave the company. An employer could continue to reimburse a former employee if he chooses to do so.

Encourages Employee to Make Wise Health Care Choices

Let's say an employer provides a health plan with a $2,500 deductible and agrees to reimburse employees up to $1,000 per year for eligible expenses. If an employee uses this allocation wisely, he may have all or most of this allocation left to carryover for next year. In three to five years, the employee could have enough accumulated to pay 100% of the expenses for any major medical situation that occurs, including the deductible and coinsurance amounts. This is his reward for having stayed with the company that long and now becomes a consideration for him in evaluating other employment opportunities where he would loose this benefit. On the other hand an employee, who because of necessity or over-use spends $2,000 the first year, would receive $1,000 in reimbursements and would owe $1,000 to health care providers because the deductible hadn't been met for the year.

Account Administration by the Company or Third Party Administrator

A simple corporate board resolution can be used to establish the reimbursement arrangement and the company itself can administer it. Usually a TPA is chosen as the most cost-effective and convenient method of drafting and administering the arrangement when more than just a few employees are involved. The TPA collects all the claims for payment, sends a single monthly bill to the employer and then reimburses the employees with valid claims. This could save a considerable amount of time when a single physician visit with lab tests and x-rays could result in claims from up to three different healthcare providers all arriving at different times.

Health Reimbursement Arrangement (HRA) for Employer Groups

A Health Reimbursement Arrangement (HRA) is an arrangement or agreement between an employer and his or her employees. It is not an account. The employer usually provides a high-deductible group health insurance plan that covers employees for major expenses and then the employer reimburses employees for incurred medical expenses up to a certain limit each year. Any unused portion of the employer's allocation of funds each year may be carried over for and added to next year's allocation for use that year. It is 100% employer money provided only on an as needed basis for actual expenses.

Since all the money belongs to the Employer, the Employer makes all the decisions about how much to reimburse each year, who pays first, and if and how much can be carried over and used next year.

The insurance takes over for both you and your employer when your expenses reach this level.

The Group Health Plan pays 100 %

This shows a typical plan with a 20% share for you and an 80% share for the insurance company. You may be able to accumulate enough funds to pay your 20% over time.

You Share

You Pay 20%	The Group Plan Pays 80%

Usually a high-deductible plan is chosen. A $2,500 would be a typical choice.

You owe the balance of the Deductible, if you incur additional Medical Expenses

Employer arranges to reimburse a potion of your medical expenses each year.

Let's assume this is the first $1,000

1. **You incur Medical Expenses.**
2. **You Submit the Bill to your Employer or a Third Party Administrator (TPA) your Employer has contracted with.**
3. **You are reimbursed for covered Medical Expenses up to $1,000 in this example.**
4. **If you do not use this entire available dollar amount, you may be able to carry all or part of this amount over to next year and add it to next year's $1,000.**

Flexible Spending Accounts - FSA Plans for Employee Groups

Employer Sponsored Special Health Care Spending Account

A Flexible Spending Account or FSA is an account established by an employer that allows his employees to contribute a portion of their salary each month, income tax-free to them and salary tax-free to their employer, for the purpose of paying for their health care expenses and any portion of health insurance premiums they may be responsible for. It is not available for self-employed individuals or individual employees on their own. Congress authorized the FSA under the Revenue Act of 1978 and the FSA is subject to IRS regulations and guidelines. It is sometimes referred to as a Section 125 plan after the IRC section number. Any health insurance policy approved by the state as an employee benefit plan can be used in conjunction with an FSA plan.

Four Categories of Expenses Covered as FSA Eligible

1. That portion of an employee's health insurance premiums paid for by the employee each month.
2. Health care related expenses that are not reimbursed by the group health insurance plan.
3. Dependent day care expenses for children.
4. Other health related premiums paid by the employee such as vision coverage, dental insurance, a supplemental disability or accident policy offered through the employer.

Plan May be Established as a Premium Only Plan or POP

A Premium Only Plan (POP) can be established for categories 1 and 4 above covering that portion of group health insurance premiums paid by the employee and premiums on any other qualifying supplemental insurance policies offered through the employer on a payroll deduction basis. Including categories 2 and 3 involves the establishment of a special trust account for employee funds and invokes the use-it-or-lose-it-provision below. A plan covering all four categories is usually referred to as a Cafeteria Plan,

Annual Election and Dollar Commitment With a Use-It-or-Lose-It Provision

At the annual plan renewal date, each employee must decide whether he or she wants to participate in the plan for the coming year. An employee who decides to participate must also decide how much is to be withheld from his or her paycheck each month. This, at best, is an educated guess as to how much of the deductible and coinsurance amounts might be required, what other qualifying expenses such as dental and vision will be used, and what dependent day care costs will be. This amount cannot be changed during the year except for certain qualifying events. Any funds left in an employees' account at the end of the year are lost and belong to the employer. The employer can only use those funds for the benefit of all employees, as would be the case for an office party or dinner for all employees.

Employees Save on Income Taxes, Giving Them an Effective Pay Raise

An employee saves money by not having to pay income tax on the money withheld for the FSA. Let's say an employee is in the 30 percent tax bracket for payroll withholding tax purposes. That means the employee's paycheck would increase $30 for every $100 put in the FSA each month compared to spending the same $100 without an FSA plan in place. The $30 increase comes from savings on income taxes that would otherwise be paid.

Employers Save on Payroll Taxes by Reducing Taxable Payroll

An employer reduces his payroll for payroll tax purposes by the amount of employee contributions to the plan. This savings on FICA and FUTA taxes amounts to a 7.65 percent savings. The employer would reduce his tax bill by $76.50 for each $1,000 contributed to the plan by his employees.

Employers Must Meet Two Tests on a Yearly Basis

An employer must meet the Key Employee Concentration Test and the Highly Compensated Employee Average Benefit Test on a yearly basis. This is designed to prevent excessively benefiting a select few. A Third Part Administrator (TPA) usually handles these details.

Flexible Spending Account (FSA) Plan for Employer Groups

A Flexible Spending Account (FSA) is an account established by an employer that allows his employees to contribute a portion of their salary each month, income tax-free to them and salary tax-free to their employer, for the purpose of paying for their health care expenses and any portion of health insurance premiums they may be responsible for. It is subject to IRS regulations and guidelines and is sometimes referred to as a Section 125 plan after the IRC section number. It is also commonly called a Premium Only Plan (POP) and a Cafeteria Plan based on how it is set up by the employer.

Each employee decides on an annual basis at plan anniversary whether to participate in the plan or not and how much he or she wants to contribute for the upcoming year. Any funds not used at year-end are lost.

1 **Employer Establishes an FSA Account**

Two Types of Section 125 Accounts Can Be Established

Premium Only Plan	Cafeteria Plan
That portion of employee's health insurance premiums paid by employee.	That portion of employee's health insurance premiums paid by employee
Other related premiums paid by employee for voluntary or supplemental benefits.	Other related premiums paid by employee for voluntary or supplemental benefits.
	Qualified health care expenses not reimbursed by the group health plan.
	Dependent day care expenses for children.

2 A portion of an employee's paycheck is contributed to the account each payday. This occurs before taxes so that money normally used to pay taxes now helps pay for health insurance.

Employee Paycheck 019 $1,000

3 Employer has a reduced payroll saving on FICA & FUTA taxes. (7.65% of contributions)

Bill for health care expenses or day care

5 Claims Paid

4 Employee submits claims for eligible Cafeteria Plan expenses.

Employer or Third Party Administrator (TPA) pays claims.

FSA funds used to pay claims.

How Much Do They Really Pay

Know what to expect before you have a claim.

How Much Do They Really Pay?

Insurance companies pay claims according to different methodologies. In this next section, you'll read about UCR, percentiles, and contracted rates.

Does the insurance company pay claims based upon what providers usually charge or do they pay based upon a predetermined fixed amount.

Does the amount that the insurance company pays differ depending on which provider you use?

Percentile of Usual, Customary, and Reasonable (UCR) Fees

We've already covered a lot of ground about what you should look for when you're evaluating a plan for possible purchase. There's another animal to know about…"UCR", otherwise known as usual, customary, and reasonable.

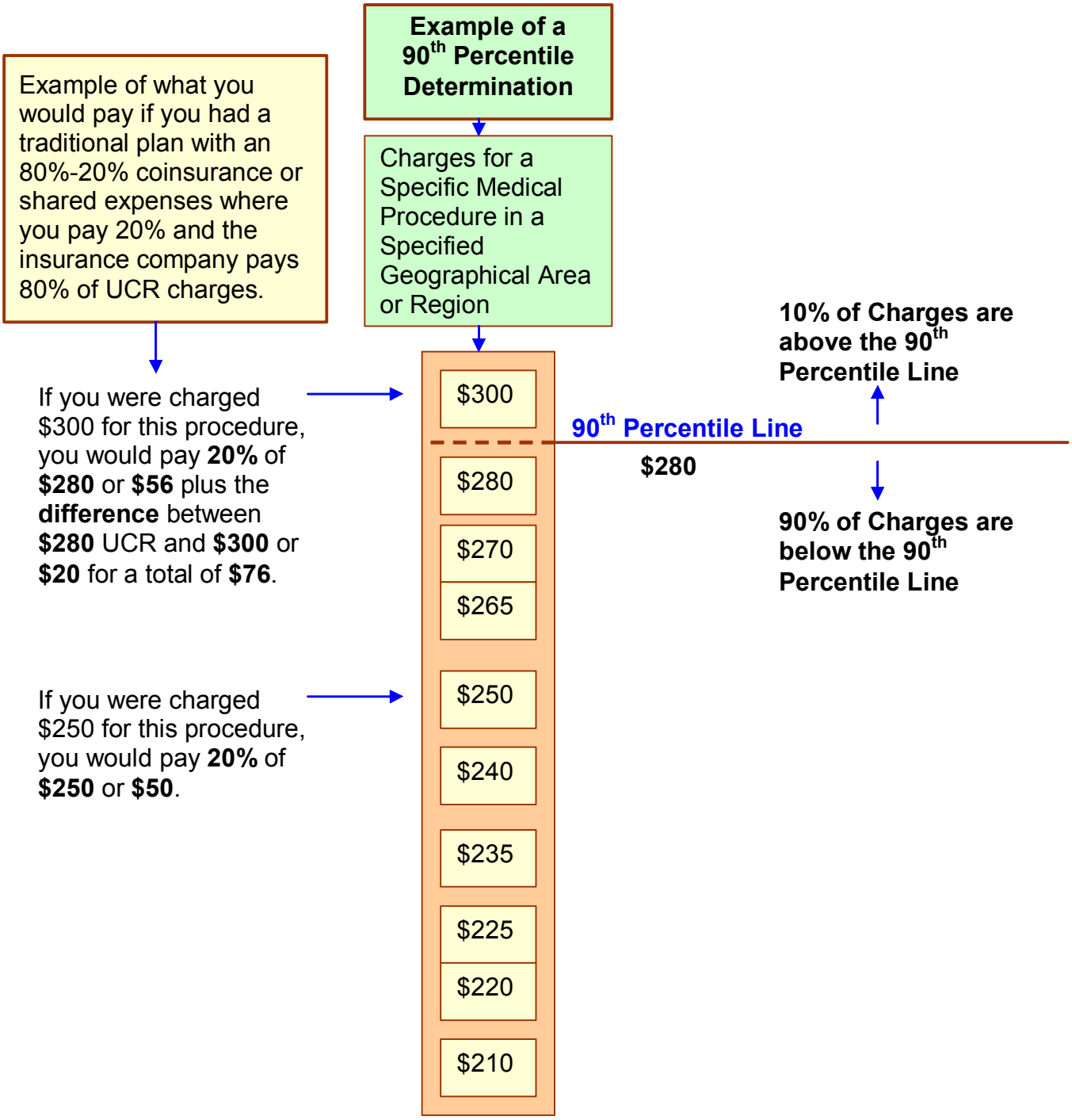
You will find that you're dealing with UCR when you're looking at traditional plans or when you're looking at some preferred provider plans in the event that you would choose to go away from the preferred provider doctor panel, those doctors that do not have contract with the insurance company for your plan.

The easiest way to understand UCR is to think about it as the dollar amount that a provider would usually and reasonably charge for a procedure or service. The insurance company will list what everybody charges for a procedure. Then, they will decide that they will pay up to the charge that is greater than 90 percent of the charges in the area, which means that some providers are charging more than the insurance company is willing to pay.

So, in the example, assume your bill is $300. The insurance company has decided that 90 percent of the doctors charge below $280 for this same procedure or service. All the insurance company will consider payment of is a billed amount up to the $280. You will be responsible for either your deductible or the percentage, depending on how much you've already incurred in medical expenses, plus the extra $20. It's up to you if you want to discuss the charges with the provider or not.

If you are considering a traditional plan, find an insurance company that is proud of their UCR. If you or your insurance agent cannot get this information, it may be because the insurance company is not competitive in this arena or they want the flexibility to change their UCR at will. Yes, they can do this.

Percentile of Usual, Customary, and Reasonable (UCR) Fees



The percentile at which an insurance company pays claims is usually not published in their literature. They often do not like to disclose these figures. This gives them the flexibility to arbitrarily change the percentile to adjust for actual claims experience. Companies that do publish these figures are usually proud of their rate of payment.

Percentage of Contracted Rates Payment Determination

If you see that an insurance company pays according to a “contracted rate” it means that the insurance company has negotiated with providers to accept a certain amount of money for procedures and services.

Think about contracted rate as being a discounted rate, in contrast to a full price retail rate. This contracted rate will be less than what you would pay if you did not have any health insurance.

You gain the benefit of the insurance company’s negotiations when you go to contracted providers. You will hear these providers referred to as “in network”, or “preferred providers”, or “member providers”.

What you really want to look at is what happens if you go to a provider who does not have a contract with the insurance company. These providers are usually called “out of network”, non-preferred providers”, or “non-member providers”. They can charge you whatever they choose. The insurance company, however, will most likely choose to pay a percentage of what they would have paid if the provider had been a contracted provider. The short of this is: if you see that an insurance company will pay 60 percent of a claim if you go to a non-contracted provider, this is most likely not going to be a true 60 percent. It will be 60 percent of the contracted amount. Some insurance policies will still pay out-of-network expenses on a UCR basis. This will usually result in a higher payout than for a contracted rate.

Percent of Contracted Rates Payment Determination

Example of what you would pay if you had a PPO plan where you are responsible for 20% of the shared expenses for member providers and 40% of the shared expenses for non-member providers.

Example of a Contracted Rate Negotiation with Providers

Various Charges for a Specific Medical Procedure in a Specified Geographical Area or Region

If you go to a **Non-Member Provider** and are charged $300 for this procedure, you would pay **40%** of **$265** or **$106** plus the **difference** between **$265** and **$300** or **$35** for a total of **$141**.

If you go to a **Member Provider** you would pay **20%** of **$265** or **$53**.

If you go to a **Non-Member Provider** and are charged $235 for this procedure, you would pay **40%** of **$235** or **$94.**

$300
$280
$270
$265
$250
$240
$235
$225
$220
$210

Non-Member Providers are free to charge fees above or below this amount.

Contracted Rate

$265

Member Providers have agreed to accept $265 as the payment for this procedure.

Considerable savings result from using member providers. This is also the reason a Preferred Provider Organization (PPO) plan is less expensive than a traditional plan where you are free to go to any doctor. If you use member providers in the PPO plan you will never be charged extra charges. A traditional plan, while giving you extra freedom, can have extra charges if your provider charges more than the UCR amount for services.

On some newer PPO plans, you can actually incur a second deductible and accumulate expenses toward a separate non-member out-of-pocket limit if you use non-members providers. This can dramatically increase your out-of-pocket costs for using non-members.

What Else Do You Need to Know

Are you really covered

What Else Do You Need to Know?

After you've learned how to read insurancese, have researched plans, talked with an agent if you choose, it's time to complete an individual health insurance application. There are some things you should know, like "pre-existing conditions", and full disclosure on the insurance application.

This section will also address COBRA, Continuation, and Portability, insurance coverage you may be eligible for if you are going to lose, or have lost coverage through your employer.

Pre-Existing Condition Exclusion

If you are accepted for health insurance without having prior health insurance, the insurance company may impose a 6-month exclusion period, for example, before they cover anything for which you were treated, diagnosed, or received advice for during the 6 months prior to your application. The pre-existing period varies among insurance companies and states. You will want to read the exact wording of this contract clause for the insurance company you are considering to determine how long the insurance company will exclude pre-existing conditions and how far back they will look to determine what would be considered a pre-existing condition. Short-term medical policies may have a longer pre-existing conditions period. Pregnancy cannot be considered a pre-existing condition on group plans meeting HIPAA requirements, but often has a one-year waiting period on individual health insurance plans.

An HMO can impose an affiliation period of two months in lieu of a pre-existing condition period. During this period you will not pay a premium or receive benefits. If you are a late enrollee this affiliation period could be three months in length.

The insurance companies will, in effect, shorten this exclusion period depending upon if you meet certain requirements for the length and type of prior coverage and how long ago the prior coverage ended. They will credit, month for month, the exclusion period. So in this example, if you had coverage for 3 months, you would only have a 3-month exclusion period. Your prior coverage is shown on a certificate of creditable coverage. Most companies send this automatically upon termination of coverage; however, you can also request one from your prior insurance company if not.

A pre-existing condition, by definition, is something that you have or have had within a certain period of time. This is sometimes called a look-back period and the length of this look-back period is determined by the insurance company. The insurance company will specifically state the condition or conditions that the insurance company will not cover during the pre-existing condition exclusion period. Any new medical conditions you experience, once covered by the new insurance, will be covered or not covered per the insurance contract.

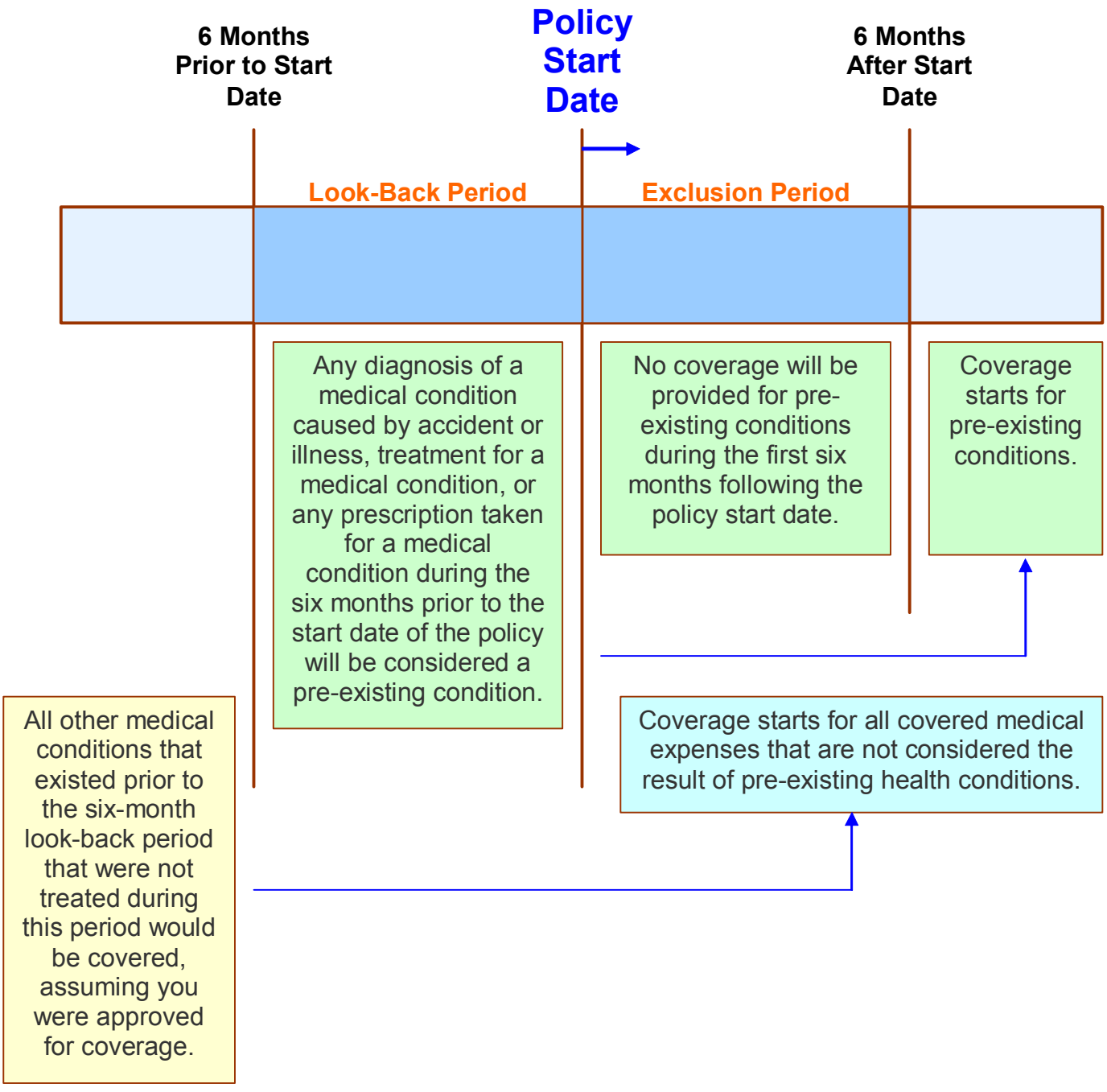
For example, you are currently taking, or have taken in the last six months, medication for an ear infection. You apply for insurance. You have not had insurance for over six months. The insurance company approves you for coverage. They may not cover your medication or treatment of the ear infection for six months. After that time, they will cover it if the contract includes this benefit. If you had coverage for three months, and applied for new coverage within a certain number of days of losing the coverage, the insurance company would give you three months credit toward the exclusion period. They would cover an ear infection or medication after three months if the contract included this benefit.

Depending on state regulations, insurance companies may be able to exclude or waive specific medical conditions on new policies. If an insurance company excludes a medical condition, it means that they will not cover it…period. If an insurance company waives coverage for a condition, it usually means that they will not cover it for a certain period of time. After that time, they will cover it per whatever the insurance policy states.

Short-term policies typically do not give credit. You will have whatever waiting period the policy states.

Pre-Existing Condition Exclusion – Typical 6-Month Example

This example is just one of many possible pre-existing condition exclusion periods. The look-back period and the exclusion period do not necessarily have to be the same length. Other common examples are 3-month and 1-year periods. One company uses a 5-year look-back period for their short-term medical policy.



The Dark Side of Trying to Hide Information

You MUST tell the complete truth on the insurance application. You do not need to write a book. You do need to be complete, concise, and factual. The insurance company needs to know the date of service or how long you've had the condition, what the condition is, how or if it was treated, the outcome of the treatment, and where the medical records would be, i.e., the doctor or hospital's name, address, and phone number. Failure to provide any of this information may cause delay in the insurance company processing your application, thus a delay in your opportunity to purchase the health insurance, if you are approved.

For example, four years ago, you broke your right arm. On the application, you would write down that, on May 23, 1999, you broke your right arm. A cast was put on it. You had a complete recovery. Dr. Jones, Medical Hospital, 123 SE Main, Anywhere, Anystate 97111, 541-111-1111 provided the treatment.

The easiest way to illustrate the importance of honest, complete disclosure is to relate an experience of one of our ex-clients…note ex-client.

The client completed an insurance application. The insurance company approved the client. Almost a year after the insurance went into affect, the client had a heart attack and heart surgery. The insurance company terminated the client's insurance clear back to the effective date. The client was responsible for paying the full price of all medical bills for everything that had happened to him since the effective date of the insurance.

Why? The client did not put down on the application that he had a heart condition. He did not want to risk being declined.

The insurance companies can request medical records. You give them this permission when you complete and sign the application. They may request records to determine if they will approve or decline you. They may request records if you receive medical treatments. They want to know what happened. They also want to know if it happened before. You might as well tell them everything up front and take your chances. The consequences of less than complete disclosure are serious.

The Dark Side of Trying to Hide Information from Insurers

You decide to just leave this information off the application to make sure you get approved.

Three years ago you were treated for a medical condition that hasn't been a real problem since, but conceivably could become one in the future.

Start Date of Policy

In the Past ← → **In the Future**

One year later you are treated for the same medical condition.

Here is what can happen and often does!

The insurance requests your medical records from your doctor and finds out that you were treated for the same condition before and did not include this information on your application.

Your policy is termed retroactively back to the original start date.

The insurance calculates how much money they have paid out in claims on your behalf less the amount you have paid in premiums.

Total benefits paid to medical providers on your behalf.

LESS

Total insurance premiums paid by you to date.

EQUALS

If they paid more than you did, you now owe them this difference. You could also get a refund.

If the insurance paid more on benefit claims than you paid in premiums, you now have to pay them back the difference. If you paid more in premiums, they will give you a refund. In either event, you **no longer have insurance coverage** at a time when you might really need it.

COBRA and Continuation

Nope, this COBRA is not a snake. It is health insurance. Continuation is also health insurance. The rules are complicated, but the concept is easy. If you have had health insurance through your employer for a specified length of time, and then lose this coverage, you are guaranteed to be able to continue to keep the health insurance for a certain amount of time. Your spouse and child or children also have rights to continue the insurance.

The exception to this right is if you are terminated from employment because of your gross misconduct.

The number of employees your employer has determines if you can keep your insurance through COBRA or any applicable state Continuation program.

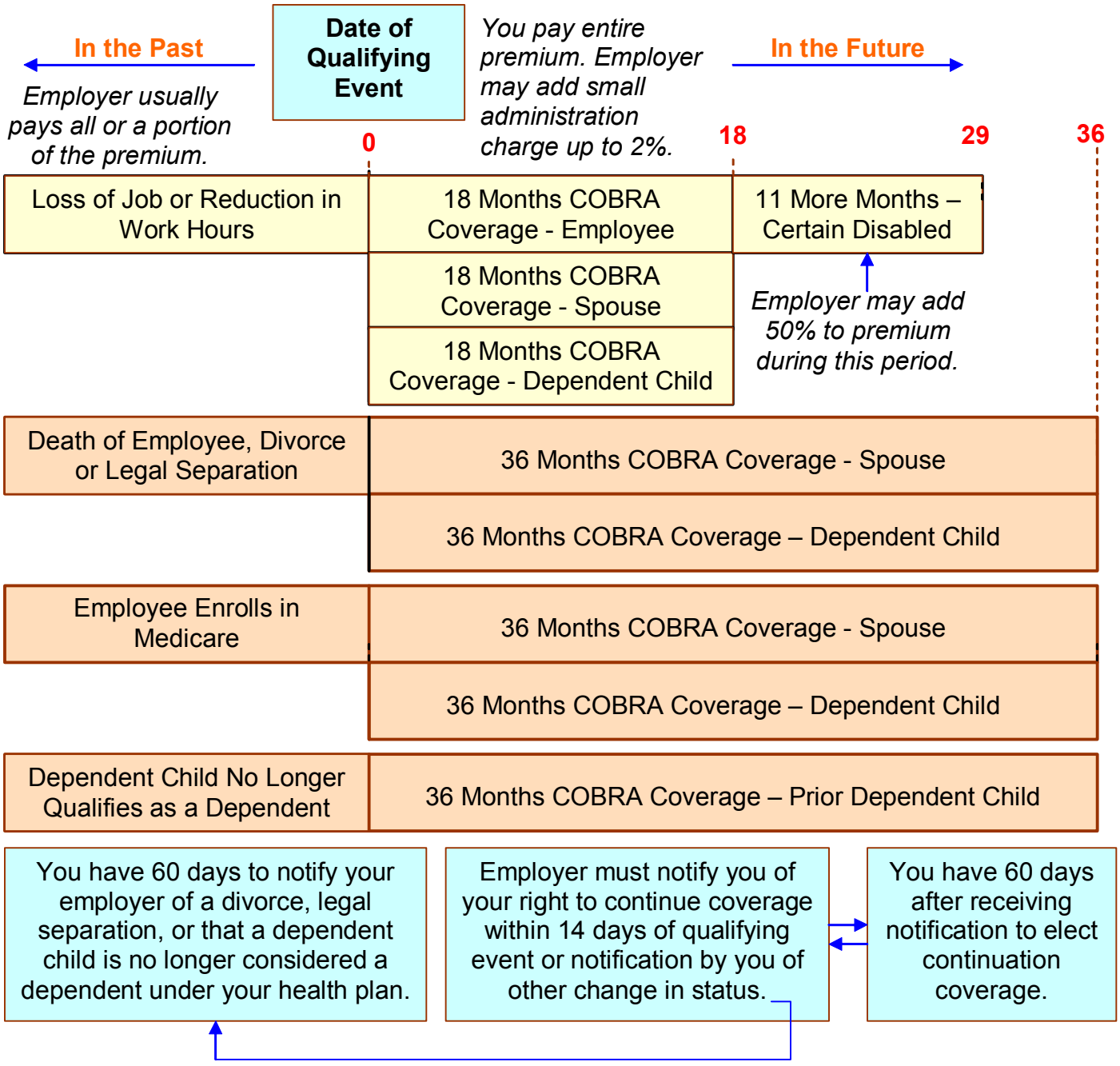
Your employer is responsible for notifying you of your COBRA or Continuation rights at the time you are terminated from employment or lose your insurance. You can learn about COBRA and Continuation by contacting your State Insurance Department by phone or over the Internet.

COBRA Overview and the Role of State Continuation

COBRA – Consolidated Omnibus Budget Reconciliation Act.

Employees, spouses, and dependent children who have been covered under the group health insurance plan of an employer having 20 or more employees may be eligible for COBRA coverage.

State Continuation coverage may be available in some states for employees of employers having fewer than 20 employees. State Continuation may only cover health benefits while COBRA may cover health, dental & other benefits that were a part of the plan.



Portability

If you meet certain requirements, you are eligible for an individual health insurance plan that you don't have to qualify for. It is "guaranteed issue"; you are guaranteed to get it if you meet Health Insurance Portability and Accountability Act (HIPAA) requirements. Unlike regular health insurance, you do not have to answer any health questions.

Portability rules and eligibility may vary from state to state since some states have enacted more favorable rules than the federal HIPAA minimum requirements. Check with a local agent or your state insurance department.

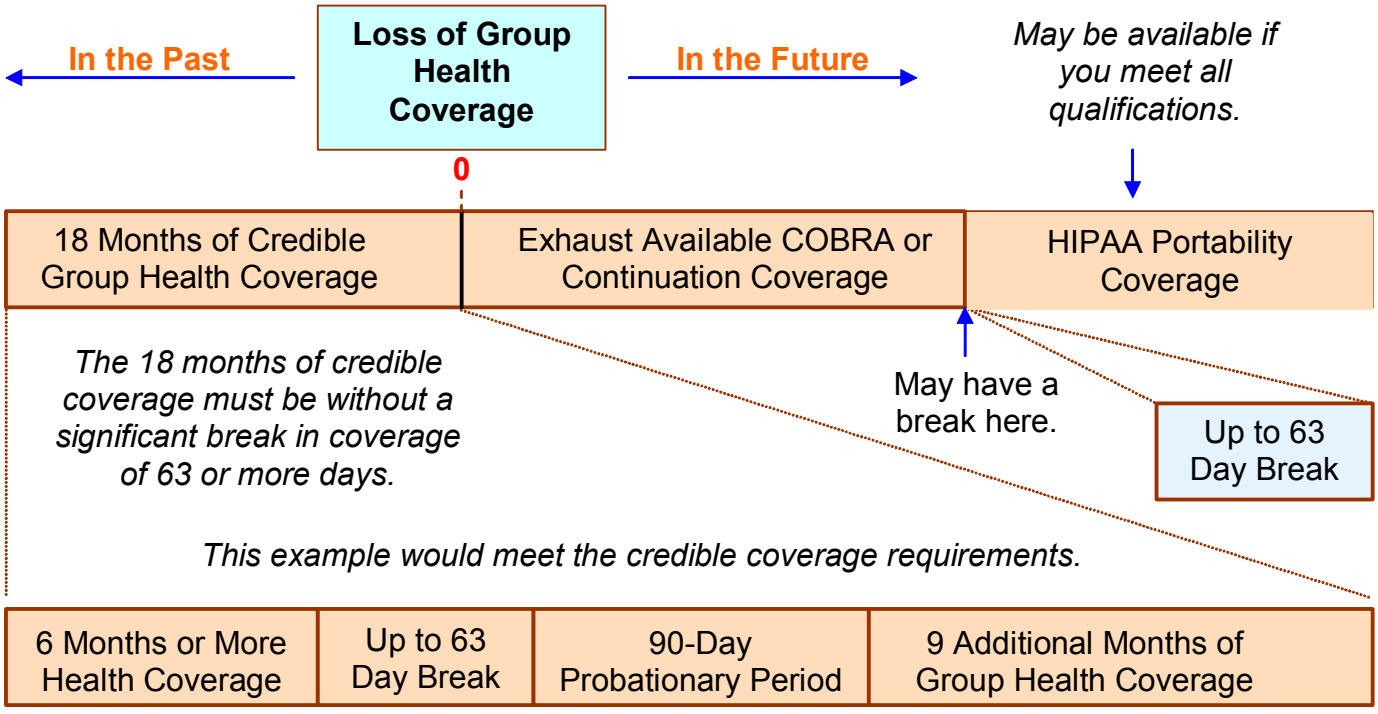
While Portability plans are usually more expensive that regular health insurance plans, if you are eligible for Portability, you should evaluate it as an alternative in case you get declined for regular insurance.

HIPAA Portability Coverage - Eligibility and Considerations

HIPAA – Health Insurance Portability and Accountability Act

If you meet **ALL** the HIPAA requirements, you are eligible to have HIPAA guarantee you the right to purchase individual health insurance coverage. In some states the coverage available to you may be through that state's high-risk pool.

Some states have their own portability regulations that offer you a greater level of protection in maintaining your portability of coverage when you loose group health insurance coverage. Check your state's regulations.



This shows the periods that count toward meeting credible coverage requirements.

This shows the periods where you are actually covered by the health insurance plan.

The other HIPAA requirements you must meet!

- Your most recent coverage must have been through a group health plan.
- You are not eligible for coverage under any other group health plan.
- You are not eligible for either Medicaid or Medicare coverage.
- You do not have any other health insurance coverage.
- You did not loose your coverage simply because you failed to pay the premium.
- You did not loose your coverage for committing fraud.
- You accepted and exhausted your COBRA continuation coverage or your state's continuation coverage if it was available and offered to you.

Glossary

Accumulating Deductible	The amount paid on individual deductibles is credited and accumulates toward a common family deductible. Once deductible charges add up to the family deductible, no further individual deductibles are due for the year.
Affiliation Period	A period that may be imposed by an HMO in lieu of a pre-existing condition exclusion period of up to two months (three months for a late-enrollee) where no payment is due and no coverage is provided.
Alternative Care	Treatment provided by a chiropractor, naturopath, acupuncturist, or massage therapist as an alternative to medical treatment performed by a physician.
Cafeteria Plan	A Flexible Spending Account (FSA) plan usually incorporating all four types of FSA expenses allowable by the IRS and invoking the use-it-or-lose-it provision.
Captive Agent	An insurance agent representing a single insurance company or health plan.
Carry-Over Deductible	Those expenses occurring in the last three months of the year, in a year where you have not met your current year's deductible, are carried over and applied to next year's deductible.
Certificate of Creditable Coverage	A certificate from your prior health insurance carrier describing how much creditable coverage you have and stating when your prior coverage ended.
COBRA	Consolidated Omnibus Budget reconciliation Act of 1986 giving certain employees and their dependents the right to continue their current coverage, at their expense and on a temporary basis, after their group health insurance would otherwise terminate.
Coinsurance	Those medical expenses covered on a shared basis between the insured and the insurance company or health plan usually expressed as a percentage as in 20%/80% where the insured pays a 20% share and the insurance company pays an 80% share.

Commission	A small percentage of the premium paid to an insurance agent or producer for assisting you in applying for coverage and providing continuing service after the purchase. Usually built into the premium and paid regardless of whether purchasing through an agent or directly from the company.
Common Application	Refers to the application of either the deductible, shared expenses coinsurance), or both in a preferred provider or point-of-service plan. Medical expenses are applied to a single deductible or coinsurance amount resulting in less potential out-of-pocket expenses than if applied separately.
Continuation	The right to continue health insurance after no longer eligible for coverage under a group plan if meeting certain conditions. Referred to as COBRA continuation for group of 20 or more employees. State continuation plans for smaller groups apply in some states.
Contracted Provider	A medical provider who has an agreement or contract with an insurance company or health plan to accept a set schedule of fees for specified medical services performed.
Contracted Rate	The rate providers have agreed to accept for providing a specified medical service in accordance with the terms of a contract. May be likened to a discounted price from a retail price for services.
Copay	A small dollar amount due at the time of service and based on a per-visit or per-occurrence basis. A typical example would be physician visit copay due when visiting his office.
Co-payment	See Copay
Creditable Coverage	Credit for recent prior coverage towards any pre-existing condition exclusion period imposed by a new plan. Credit is on a day-for-day basis and recent coverage must have been within 63 days unless a longer period is allowed by state regulations.

Deductible	The amount, usually on a per calendar year basis, that you pay for medical services in a year before the insurance company or health plan pays any claims on services subject to the deductible. After the deductible has been satisfied, the insurance company shares expenses with you until the out-of-pocket limit is reached for that year.
Durable Medical Equipment	Medical supplies or equipment such as wheelchairs, walkers, oxygen, artificial limb replacements, dentures, and mechanical devices used to assist in mobility or supplement the joints and limbs that may be covered by an insurance policy.
EPO	See Exclusive Provider Organization
Exclusion Period	That period of time, when starting coverage on a new health insurance policy, during which coverage for pre-existing conditions is not provided. Coverage for pre-existing conditions starts at the end of the exclusion period.
Exclusions	Services excluded from coverage.
Exclusive Provider Organization	A health plan that limits coverage to a single list of providers with no benefits for services performed by non-member providers except in emergencies. Similar to HMO coverage.
Fee-For-Service	The provision of a medical service in exchange for a fee. This is now commonly used to describe traditional insurance or indemnity plans where the insured has the freedom to go to any medical provider and the insurance company pays on a usual, customary and reasonable basis.
FICA Tax	Federal Insurance Contributions Act (FICA) tax consisting of a Social Security tax of 6.2% and a Medicare tax of 1.45%.
Flexible Spending Account	A Medical Savings Account or MSA is a combination of a high deductible health insurance policy and a separate savings account for paying for specified medical services on a tax-free basis. Unused funds can be carried forward to future or retirement much like an IRA. If used for medical expenses after age 65, use is also on a tax-free basis.

Formulary	A list of prescription drugs selected by an insurance company or health plan and considered "formulary", "preferred", or "approved" drugs. Prescription drugs are chosen based upon clinical information and price and the list is referred to as a formulary drug list.
FSA	See Flexible Spending Account
FUTA	Federal Unemployment Tax Act (FUTA) tax of 2.64% plus any surcharges in effect for the year. A contingency assessment of .06% is also added.
Gate-Keeper	A Primary Care Physician who is responsible for all your health care and controls your access to specialists through the use of a required referral system.
Health Insurance	A group of individuals, usually in a metropolitan area, county, geographic region, or state, who pool their money to cover a portion of the medical expenses of the group. The more of your medical expenses you want paid, the more money you contribute to the group each month in the form of a premium. The insurance company manages the pool of money for the group and incurs administrative expenses on the group's behalf.
Health Maintenance Organization	A Health Maintenance Organization (HMO) is a health plan that consists of a network of contracted doctors and hospitals to provide treatment to members of the HMO's plans. An HMO may consist of dedicated facilities where all care is received at the HMO's facilities or selected individual physicians, hospitals and other service providers contracted on an individual basis. An HMO uses the Primary Care Physician (PCP) concept to coordinate all your health care.
Health Plan	A health-care-service contractor or health-maintenance organization. Commonly used interchangeably with the term insurance company.

Health Reimbursement Arrangement	A Health Reimbursement Arrangement or HRA is a combination of any health insurance policy state approved as an employee benefit plan and a separate arrangement to reimburse employees for all or a portion of the qualified medical expenses not paid by the health insurance policy. An HRA is quite often referred to as a Health Reimbursement Account (Accounts); however it does not require the establishment of a separate funding account, as does a Medical Savings Account (MSA) plan.
Health Savings Account	Health Savings Accounts or HSA plans are new for 2004 and allow you to save money to pay for medical expenses on a tax-free basis. An HSA is similar to a Medical Savings Account (MSA) except any individual under age 65 can participate while an MSA is limited to self-employed individuals. An employer can also offer an HSA to his employees, through a Flexible Spending Account (FSA) commonly referred to as a cafeteria plan, and both the employer and employees can contribute to the savings account.
Highly Compensated Employee Average Benefit Test	An employee or owner who meets specific compensation and/or ownership criteria and are considered a group which generally cannot be discriminatorily favored under a qualified plan for coverage, participation, contributions or available benefits or rights.
HIPAA	Health Insurance Portability and Accountability Act of 1996 (HIPAA) best know for protecting health insurance coverage for workers and their families when they change or lose their jobs and privacy of information among other items.
HMO	See Health Maintenance Organization
Hospital Accident Policy	A policy that pay expenses incurred for hospitalization and surgical procedures due to sickness or accidental injuries, including procedures such as CT Scans and MRIs, and certain post hospitalization expenses. Also referred to as a Hospital Surgical policy.
HRA	See Health Reimbursement Arrangement
HSA	See Health Savings Account

Indemnity	Used to describe a policy that provides compensation for damage, loss or injury suffered. See also Fee-For Service.
Independent Agent	An insurance agent or insurance producer who is not an employee of an insurance company or health plan and is free to represent more than one company.
In-Network	Refers to services received within the insurance company's or health plan's network of approved or contracted providers.
Insurance Agent	A person required to be licensed under the laws of a state to sell, solicit or negotiate insurance. Now referred to as an Insurance Producer.
Insurance Broker	An insurance agent or insurance producer who is not an employee of an insurance company or health plan and represents several insurance companies.
Insurance Carrier	See Insurance Company
Insurance Company	A insurance company, insurance carrier or insurer licensed to conduct business in a state.
Insurance Producer	A person required to be licensed under the laws of a state to sell, solicit or negotiate insurance.
Key Employee Concentration Test	A test that demonstrates that no more than 25% of non-taxable benefits are provided to key employees including officers or owners who meets specific compensation and/or ownership criteria.
Late Enrollee	An employee eligible for coverage on a group health plan who failed to enroll when first eligible and during the time allocated for enrolling usually within 30 days after the eligibility date.
Lifetime Maximum	The maximum dollar amount an insurance company will pay in claims during the lifetime of an insurance policy. A policy may have provisions to credit back a portion on an annual basis.
Limitations	Refers to services that have a limited benefit either in terms of a dollar amount or a number of occurrences.

Look Back Period	That period of time, when determining a pre-existing condition exclusion period, used to define what is a pre-existing condition based on when it occurred.
Major Medical Policy	A comprehensive insurance policy that covers most medical expenses up to a maximum limit, usually after a deductible and coinsurance (shared expenses) have been met.
Managed Care	A system of delivering health care where care is delivered through a specified network of doctors and hospitals contracted with an HMO or Preferred Provider Organization.
Mandated Benefits	Benefits required to be included in a policy by virtue of state or federal insurance regulations.
Medical Providers	Persons or firms providing medical care including, but not limited to, physicians, hospitals, surgical centers, urgent care clinics, ambulance services, skilled nursing homes and durable medical equipment suppliers.
Medical Savings Account	A Medical Savings Account or MSA is a combination of a high deductible health insurance policy and a separate savings account for payment of medical expenses on a tax-free basis. It is limited to self-employed business owners and companies employing from two to 50 employees.
Medically Necessary	Considered necessary by a physician to treat a medical condition and not to include preventive care or elective services unless otherwise covered by an insurance policy.
Member Provider	A provider of medical services belonging to a network of providers contracted with a certain insurance company or health plan.
MSA	See Medical Savings Account
Network	An insurance company's group or list of approved or contracted providers from which you can obtain service at the plan's highest benefit level.
Non-Formulary	Not on an insurance company's approved drug list and usually only available at a highest cost (lower benefit level).

Out-Of-Network	Outside an insurance company's list or group of contracted providers where services received, if covered at all, are covered at a lower benefit level.
Out-Of-Pocket	The maximum dollar amount of shared expenses (coinsurance) you will pay in a year before the insurance company or health plan begins paying at the 100% level of benefits. This is usually in addition to a deductible you may have paid prior to sharing expenses.
PCP	See Primary Care Physician
Percentile	Expressed as a percentage that an insurance company will pay on a usual, customary and reasonable basis. A percentile of 90% means that an insurance company will pay up to the charge for a specified service that is greater than 90% of the charges in the area.
Point-Of Service	A managed care plan that provides maximum benefits through an HMO network and reduced benefits through a second list of participating or preferred providers.
Policy	The actual contract of insurance defining the coverage, terms and conditions between you and the insurance company or health plan.
POP	See Premium Only Plan
Portability	The right to purchase, from one of two plan choices, a guaranteed-issue individual policy within 63 days of losing your group health plan coverage provided you have been covered on the group health plan for a specified period of time.
POS	See Point-Of-Service
PPO	See Preferred Provider Organization
Pre-Authorization	A requirement by an insurance company or health plan that certain services must be approved in advance to be covered or to be covered without a penalty.

Pre-Existing Condition	A condition for which you were diagnosed with or received treatment for and, in some cases, for which a prudent person should have sought treatment that occurred in the look-back period established by an insurance company or state law.
Preferred Provider	A provider of medical services belonging to a network of providers contracted with a certain insurance company or health plan.
Preferred Provider Organization	A managed care company that uses a network of preferred or member providers, but allows for services from other providers at a higher utilization cost to you.
Premium	The monthly amount due to an insurance company or health plan to cover the cost of the policy. (Your share of the group's expenses - See Health Insurance)
Premium Only Plan	A Flexible Spending Account limited to covering an employees' share of group health plan premiums and that of any dependents and allowed supplemental insurance policy premiums.
Preventive Care	Care rendered in advance of a medical condition to prevent a condition from occurring or to detect a condition early enough to prevent it from becoming a serious condition.
Primary Care Physician	A personal physician selected by you to supervise and manage all of your health care services, referred to as a PCP and used by HMO plans and some PPO plans. Referral to specialists is usually required by HMO plans while not a requirement of PPO plans using a PCP to receive the best benefits for certain services.
Referrals	A written referral from your PCP authorizing you to visit a specified specialist.
Section 125 Plan	Refers to the Section of the IRS code (IRC) that establishes Cafeteria and Premium Only Flexible Spending Accounts.

Separate Application	Refers to the separate application of either the deductible, shared expenses coinsurance), or both in a preferred provider or point-of-service plan. Separate application means you have two sets of deductibles, out-of-pocket expenses or both resulting in an increased penalty for receiving treatment outside the network as compared to Common Application.
Short-Term Policies	A policy of short duration usually from 30 days to 185 days for the purpose of providing temporary coverage for short term needs such as between jobs.
Specialist	A physician who specializes in a certain area of medical care or treatment.
State Insurance Department	The department in each state that has the primary responsibility for regulating health insurance sold in that state and usually a great source of information available for you to access.
Stop Loss	The point at which your losses stop and the insurance company takes over at the 100% level, expressed as a dollar amount of covered medical expenses after first satisfying the deductible. It refers to the total amount of shared expenses after the deductible, not just your share. Your share of those expenses is your Out-Of-Pocket expense.
Third Party Administrator	An independent third party who administers a self-funded insurance plan, a flexible spending account, or a health reimbursement arrangement.
Tiered Benefit	Refers to more than one level of benefits as would be used in a 3-tier of 4-tier prescription drug benefit.
TPA	See Third Party Administrator
Traditional Plan	See Fee-For Service.
UCR	See Usual, Customary and Reasonable
Use-It-Or-Lose-It Provision	That provision in a FSA plan or Cafeteria plan whereby funds placed in you account during the year are lost if not used by plan year-end. These funds revert back to the employer who can only use them for the benefit of all employees.

Usual Customary and Reasonable	Those charges for medical services that are considered usual, customary and reasonable in the geographic area you are a part of by an insurance company or health plan.
Waiting Period	A probationary period established by an employer, within required limits, that must be satisfied prior to your becoming eligible for enrollment in the company's group health plan.
Waiver	You agreement with the insurance company, on an individual health insurance policy, to waive treatment for a specified medical condition as a pre-requisite for being approved for the policy applied for.

You Have Completed Your Initial Training

Keeping Up with Changes in Health Insurance is a Never Ending Quest.

The End