GLOSSARY

Coinsurance: The percentage of costs of a covered health care service you pay after you have paid your deductible.
Copayment: A fixed amount you pay for a covered health care service after you have paid your deductible.
Cost Sharing: The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost(s) of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.
Deductible: The amount you pay before your insurance plan starts to pay.
Fee for Service: A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.
Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
Inpatient Care: Health care that you get when you're admitted as an inpatient to a health care facility, like a hospital or skilled nursing facility.
Medicaid: Insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Many states have expanded their Medicaid programs to cover all people below certain income levels. You can apply anytime. If you qualify, your coverage can begin immediately, any time of year.
Medically Necessary: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Medicare: A federal health insurance program for people 65 and older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.
Primary Care: Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health related issues. They may also coordinate your care with specialists.
Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.
Premium: The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance. If you have a Marketplace health plan, you may be able to lower your costs with a premium tax credit.
Uncompensated Care: Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

Helpful resources:

McLaren offers financial assistance options. Detailed information is available online or by calling the Financial Counseling office at the subsidiary you are seen at:

McLaren Bay Region:	(989) 894-3815
McLaren Caro Region:	(989) 672-5121
McLaren Central Michigan:	(989) 772-6792
McLaren Flint:	(810) 342-2246
McLaren Lapeer Region:	(810) 667-5759
McLaren Greater Lansing:	(517) 975-3628
Karmanos Cancer Institute:	(313) 576-9032
McLaren Macomb:	(586) 493-8119
McLaren Northern Michigan:	(231) 487-4241
McLaren Oakland:	(248) 338-5403
McLaren Port Huron:	(810) 987-5000 Ext: 62958
McLaren Thumb Region:	(989) 269·8933 Ext 4579
McLaren Patient Accounts: Facility: 586-273-6048 Professional: 586-698-0150	(800) 591-8707

McLaren HEALTH CARE

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MHCC-510 (4.20)

YOUR GUIDE TO BILLING AND PAYMENT

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DOING WHAT'S BEST FOR TRANSPARENCY IN CARE

McLaren Health Care is a low-cost care provider that values its patients' rights to be involved in the financial discussions surrounding their care.

As the health care industry is ever changing and evolving, so is the process of payment.

McLaren Health Care is committed to transparency about the cost of care.

UNDERSTANDING POINT OF SERVICE (POS) COLLECTIONS

Point of Service (POS) collection is a national practice designed to inform the patient of their financial obligation prior to an elective or non-emergent procedure. POS reduces confusion about the complexity of billing and insurance explanation of benefits, and reduces the stress and surprise of financial obligation. In preparation for your upcoming test/procedure at a McLaren facility, we would like you to know what to expect and help ensure you understand your hospital financial obligations, minimize medical debt, and gain peace of mind before your treatment.

A few days in advance of your scheduled procedure, you will receive a phone call from our Financial Clearance Department. During this call we will review the financial responsibilities that you will need to meet before your test/procedure will be performed, including what you will need to pay for the HOSPITAL FEES and what arrangements need to be made for payment. Please keep in mind that any payment you will be making will be applied towards the hospital fees for the services you will have received at the McLaren facility, and you may still be receiving a separate bill from your physician(s) for the PROFESSIONAL FEES.

If you have previous outstanding balances and/or bad debt with McLaren Health Care, we will request payment for the amount owed before or at time of service. McLaren Health Care will work collaboratively with patients who are willing to take an initiative to be committed to their financial liability.

PROVIDER-BASED BILLING

McLaren takes an active role in the care delivered in physician offices which are owned by McLaren where most of our patients' day-to-day medical needs are met.

Physicians now have access to all your hospital and McLaren physician office medical records to better coordinate your care. Hospital-based outpatient clinics must meet the same stringent level of inspections, regulations, and accreditation standards as those of our full service hospitals.

This is a national model of practice for integrated delivery systems where the hospital operates the service and employees support personnel involved in patient care.

These requirements require additional resources. To partially cover the increased costs, Medicare and Medicaid allow the hospital to bill as a "hospital outpatient." This is known as "provider-based billing."

If you rely on Medicare, Medicaid, or another form of governmental health insurance, these changes will mean that you will receive two bills covering the care that you received:

- One bill is for hospital-based services such as x-rays, laboratory work, procedures, supplies, and medical assistant and other office staff (sometimes referred to as a "facility fee").
- The other bill is for care delivered by the physician, physician assistant, or nurse practitioner.

These statements will show any amount owed for the visit, as determined by your insurance plan's specific benefits.

COMMON QUESTIONS AND ANSWERS

Is the patient being double-billed?

No. There are two claims submitted to the insurance company for hospital-based services, work of the medical assistant and other office staff (sometimes referred to as a "facility fee"); and the other for physician services care delivered by the physician, physician assistant, or nurse practitioner. However, in total, the charge would be the same for a non-provider-based billing patient receiving the exact same services. In that case, the patient's insurance would only receive one claim.

Will patients have to pay more for services?

The amount a patient is required to pay by their insurance (through a copay, deductible, or coinsurance) is entirely based on the coverage the patient selected through their insurance carrier.

Patients may have a copay, deductible, and/or coinsurance applied by their insurance to both claims submitted to their insurance. Patients should review their insurance benefits or contact their insurance provider to determine what their policy will pay and what out-of-pocket expenses they may incur based on the locations of the services provided.

UNDERSTANDING YOUR BENEFITS AND PAYMENT POLICIES

Patients are responsible to contact their insurance plan to determine if McLaren is an in-network participating provider with their plan.

Patients should review their insurance benefits or contact their insurance provider to determine what their policies will pay and what out-of-pocket expenses they may incur based on the location of the services provided.

No patient will *ever* be denied access to care based on their ability to pay for any non-elective care or emergency care.

Elective testing and procedures will also proceed regardless of the ability to pay, as long as the patient agrees to work with McLaren to set up a payment plan to cover their financial responsibility associated with *their* care.

Additionally, the physician or other advanced practitioner who ordered the test or procedure will be the ultimate decision-maker for determining if any test or procedure can be rescheduled.

NON-HOSPITAL BILLS YOU MAY RECEIVE

Diagnostic Imaging Services (Radiology), Laboratory Services, Anesthesia Services, Professional Emergency Services & Inpatient Consulting Services performed at a McLaren facility are read/interpreted and/or performed by a McLaren or Non-McLaren employed physician/professional. Their charges for reading/interpreting tests and/or providing services and consultations are being provided by the McLaren Facility.

If you receive a separate bill for any of these services, please call the number on your bill for any billing questions and inquires.

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