

Member Cost Sharing

An important component of a health care benefit plan involves the use of cost-sharing amounts. The information below explains some of the common questions you may have regarding deductibles, copayments and coinsurance and how they impact you.

What are cost-sharing amounts?

Cost-sharing amounts are the dollar amounts an eligible member is responsible for paying each year when covered services are received from a health care provider or pharmacy. There are five (5) types of cost-sharing amounts:

- **Copayment** – a specified dollar amount a member must pay for certain covered services.
- **Coinsurance** – a defined percentage of the charges a member must pay for certain covered services.
- **Deductible (or annual deductible)** – the amount a member must pay for certain covered services each calendar year of coverage before the Plan will begin to pay benefits. For example, if a member has a \$250 deductible, he/she would have to pay \$250 out of his/her pocket before Health Tradition begins to pay for eligible benefits.
- **Above Usual and Customary (U&C)** – applies when a member is receiving services at a non-network provider, with or without a referral, and the member is held responsible for costs that exceed our maximum allowed (usual and customary) fee.
- **Confinement Fee** – the amount a member must pay for inpatient hospitalization in addition to the deductible.

What are eligible services?

Eligible services are services covered under your plan's benefits. Please see your Certificate of Coverage and Summary of Benefits for a listing of eligible services.

When does deductible calculate?

Deductible calculation is based on your policy design. If your policy does **not** have an office copayment but has a deductible, your deductible calculates on:

- All clinic-based services
- All hospital-based services including physical, occupational and speech therapy
- All Emergency Department services

However, if your policy has an office copayment **and** a deductible, the deductible calculates on:

- Certain laboratory (lab) and pathology services in the clinic
- Certain radiology services in the clinic
- All hospital-based services including physical, occupational and speech therapy
- All Emergency Department services

Are there times when a copayment and deductible both apply?

Yes. If your policy has an office copayment, the copayment generally covers your cost-sharing amount for services that happen on the same day in the clinic. For example, if a member visits a provider for a sore throat and has a throat culture performed at the same time **and** the clinic's lab processes the culture, the claim will be covered at 100 percent less the member's office copayment.

However, if your office visit has additional services performed by hospital staff or departments, the deductible may also calculate. For example, if a member visited a provider in the clinic to have a mole removed, and the mole was sent to the pathology department in the hospital to be examined, the member would be charged the office copayment for the clinic visit and deductible for the hospital's pathology service. The pathology department is a hospital-based service and all eligible hospital-based services can calculate deductible.

The same process applies for Emergency Department (ED) visits. If there is a copayment for ED services in your policy, a copayment and deductible will both apply since the service is hospital-based.

How will I know if a service related to my clinic visit would calculate deductible?

Unfortunately, you may not know at the time the service is being rendered. Providers are most interested in getting you to the right care at the right time from the facility that you need. Only after you receive the bills may you realize where the service was provided.

What is deductible rollover credit?

Your deductible is calculated annually (January 1 to December 31), which means it starts all over again in January of every year. The in-network deductible earned on services used in the months of October, November and December is applied towards the following year's deductible.

For example, if you earn \$59.50 of in-network deductible on a November 15th visit, \$59.50 is reported as used when you start your deductible again in January of the next calendar year. For a person who has a \$250 annual/per member deductible, you now have \$190.50 of in-network deductible eligible to calculate on services for the new year. *For Premiere Plus members, the deductible rollover credit does **not** apply to the out-of-network deductible.*

What does the "maximum out of pocket" mean?

For members who have a deductible, or deductible and coinsurance as part of their benefits, there is an annual maximum for out of pocket cost-sharing amounts. This annual maximum may apply for both individual and family coverage. Only deductible and coinsurance amounts contribute toward this maximum; copayments, confinement fees and above usual and customary costs do not apply toward the members' maximum out of pocket cost-sharing amounts. Please see your Certificate of Coverage for more information.

Do preventive health services calculate cost-sharing amounts?

Health Tradition offers the following annual preventive health services with no cost-sharing amount when provided by an in-network provider:

- Physical exams
- Hearing exam
- Well-baby visits
- Pap smears
- Vision exam
- Immunizations
- Mammography

When these services are filed as routine or preventive services, Health Tradition pays in full. Certain Premier Plus members have out-of-network preventive coverage with cost sharing. Please see your Summary of Benefits or Certificate of Coverage for more information.

Who can I call if I have questions?

First, refer to your Summary of Benefits, Member Handbook and Certificate of Coverage to understand **your** policy provisions. For additional questions about member's cost-sharing amounts, call either Health Tradition Customer Service at 1-877-832-1823 (toll-free) or your Member Advocate at 1-888-459-3020 (toll-free) for further assistance.

Health Tradition Health Plan

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