Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for your covered care:

Cost-share/Cost-sharing

Cost share or cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Note: You may have to pay the deductible, coinsurance, and/or copayment amount(s) that apply to your care at the time you receive the services.

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your Preferred professional provider for physical therapy, you pay a copayment of $25 for the visit, and we then pay the remainder of the amount we allow for the visit. (You may have to pay separately for other services you receive while in the provider's office.)

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible,

only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

The calendar year deductible is $500 per person. After the deductible amount is satisfied for an individual, covered services are payable for that individual. Under a Self Plus One enrollment, both family members must meet the individual deductible. Under a Self and Family enrollment, an individual may meet the individual deductible, or all family members' individual deductibles are considered to be satisfied when the family members' deductibles are combined and reach $1,000.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your $500 calendar year deductible has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. Coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 30% of the Plan allowance for durable medical equipment obtained from a Preferred provider, after meeting your $500 calendar year deductible.

If your provider routinely waives your cost

If your provider routinely waives (does not require you to pay) your applicable copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges $100 for a service but routinely waives your 30% coinsurance, the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

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