



Understanding Cost-Sharing with a Qualified High Deductible Health Plan

How you share in the costs of your health plan

Every health plan is unique. Your specific benefits and costs depend on which plan you choose. But before choosing a health plan, make sure you look beyond the monthly premium to see the real costs. And find out what your share of those costs will be.

To learn more about the specifics of HAP coverage, check the Summary of Benefits and Coverage (SBC). To find the SBC, visit chooseHAP.org, shop for a plan and click on the plan name. Members can log in at hap.org and select “Benefits” under the “My Plan” tab.

What is cost-sharing?

Cost-sharing is the amount you pay for covered services, medications and medical supplies. These expenses are also known as out-of-pocket costs. They do not include your monthly premium (i.e., the amount you pay each month for health insurance). Your cost-sharing responsibilities reset at the beginning of the next benefit period (which is January 1 in most cases).

● COPAY*

A set amount you pay each time for a covered service, or the purchase of prescriptions or other medical supplies. The copay amount can vary by the type of covered health care service.

● DEDUCTIBLE

The amount you owe for certain covered services before your health plan begins to pay for them. There are per person (individual) deductible amounts and family deductible amounts. (See “more about deductibles” on page 7.)

● COINSURANCE

The percentage of charges for certain covered services that you pay after your deductible has been met. (Coinsurance can vary by plan and some plans don't have it at all.)

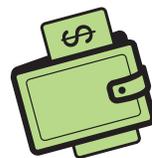
● OUT-OF-POCKET LIMIT**

The most you will pay for the combined total of all copays, coinsurance and deductibles for covered services in a benefit period (usually a calendar year). Once you meet your out-of-pocket limit, HAP pays all of the allowed amount for covered services.

NOTE: These symbols will be used throughout to help illustrate cost-sharing.

* Copays do not count toward the deductible. They apply after the deductible is met for a Qualified High Deductible Health Plan. You will continue to pay copays after you have met your deductible, until reaching your out-of-pocket limit. Does not apply to grandfathered health plans.

** The out-of-pocket limit never includes your monthly premium or non-covered services, non-covered prescriptions, or non-covered medical services and devices.



A cost-sharing example

In the following scenario, John and his family have a Qualified High Deductible Health Plan (QHDHP) with a health savings account (HSA). An HSA is a bank account that John puts money into from his paycheck. He can then draw money from the account to help pay for qualified medical expenses (copays, coinsurance, deductibles, vision and dental services). John's benefit period is from January 1 through December 31. His plan includes:

- \$20 generic drug copay
- \$2,000 per person/\$4,000 family in-network* deductible
- 20 percent coinsurance
- \$4,500 per person/\$9,000 family in-network out-of-pocket limit

It is important to know that a QHDHP works differently than traditional health plans. This includes how deductibles work. With a QHDHP, you pay the full cost of covered services (except preventive care) until meeting your deductible. At that point, other cost-sharing amounts – such as coinsurance and copays – would apply. In other words, once you meet the deductible, you pay only part of the cost of covered services. Your plan would then pay the rest.

If there is only one person in the plan, the “per person” deductible amount would apply. If there is more than one person, only the “family” deductible amount applies. See “more about deductibles” on page 7 for more information.

The following is only an example of cost-sharing. Your situation may be different.

January

John goes to his doctor for an annual check-up. The doctor asks about John's overall health, checks his weight and blood pressure and does other routine screenings. He already had his flu shot in November of last year and is up-to-date on immunizations. There is no cost to John for this preventive care visit.

Later in the month, John hurts his knee playing hockey. Because he's in a lot of pain, John goes to his doctor. John has not met his \$4,000 family deductible yet, so he pays for the entire doctor's office visit – a total of \$200.

John's doctor also writes a prescription for a drug to help with the pain and swelling in his injured leg. John fills the prescription at a local HAP-affiliated pharmacy. Since he has not met his deductible, John pays the full \$100 for this prescription. That's \$300 total toward John's family deductible.



\$300 toward John's Family Out-of-Pocket Limit • • • •

*If your plan has benefit coverage for out-of-network providers – those who do not contract with your health plan – your cost may be two to three times higher than in-network services.

February

The pain in John's knee isn't getting any better. John's doctor orders a test called an MRI, which costs \$1,500. John pays the full \$1,500 for this service since he hasn't met his \$4,000 family deductible yet. John uses money from his HSA to help pay for the MRI. John has now accumulated \$1,800 toward the family deductible.

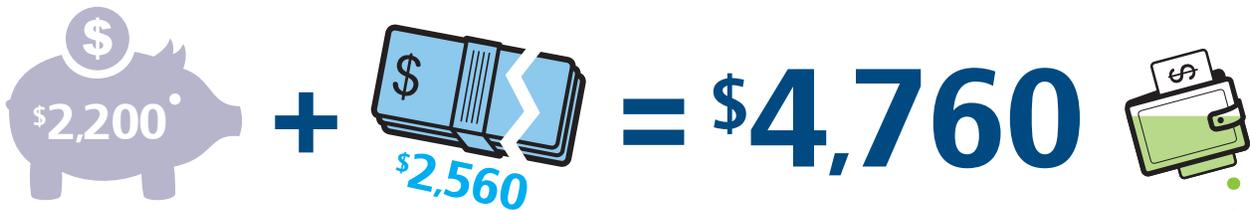


\$1,800 toward John's Family Out-of-Pocket Limit

March

John's MRI results showed that he needs surgery on his knee. The surgery will require John to stay in the hospital overnight. The total bill for the surgery and hospital stay is \$15,000. Of this, John pays \$2,200 that he has left before meeting the family deductible. John uses funds from his HSA to make this payment. He has now met the entire family deductible for the rest of the year. This means that ALL of John's family members have met the family deductible.

Since John paid the first \$2,200 of the bill to meet the deductible, the balance of the surgery is \$12,800. Since John's plan has 20 percent coinsurance on certain covered services, he will pay an additional \$2,560 (20 percent of \$12,800). This coinsurance counts toward John's family out-of-pocket limit. HAP will pay the rest of the bill (\$10,240). John's total cost for this surgery is \$4,760.



\$6,560 toward John's Family Out-of-Pocket Limit

After the surgery, John's doctor also writes him prescriptions for two drugs to help with the pain and swelling. Since he already met the family deductible, John only pays his copay of \$20 for each prescription.



\$6,600 toward John's Family Out-of-Pocket Limit

April–June

John's doctor orders 15 weeks (one visit per week) of physical therapy to help him regain full strength in his knee. Although John has met his deductible, he still has to pay coinsurance for each of his 15 visits. The total cost of each visit is \$150. Since John has 20 percent coinsurance, he pays \$30 at each visit (20 percent of \$150).



$$\$30 \times 15 \text{ visits} = \$450$$



\$7,050 toward John's Family Out-of-Pocket Limit • • • • •

July

John's daughter Jenna and son Trevor are playing on the monkey bars and both fall. Jenna breaks her arm in the fall and Trevor breaks his ankle. They go to the emergency room where the doctor takes a set of X-rays on each of the kids. John must pay coinsurance for the X-rays and the cast that was put on Trevor's ankle. The total bill for Trevor is \$1,250, so John pays \$250 in coinsurance (20 percent of \$1,250).

Jenna's X-rays showed that the break is bad enough to admit her for surgery the same day, using pins to hold the bones together while they heal. The surgery costs \$8,500. Because John met the entire family's deductible earlier in the year, he does not need to pay the deductible. Since his plan has 20 percent coinsurance, John pays \$1,700 for Jenna's surgery (20 percent of \$8,500).

The total of \$1,950 John spent covers the family out-of-pocket limit. This means that John and his family will not have any more out-of-pocket costs for covered services for the rest of their benefit period.



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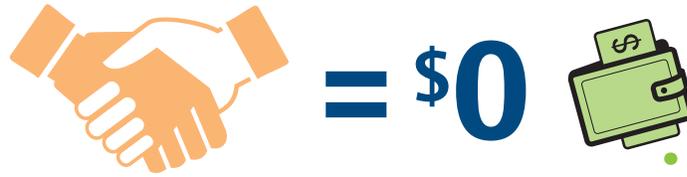
$$= \$1,950$$



\$9,000 Out-of-Pocket Limit Has Been Met • • • • •

October

John's wife Debbie has a very sore throat and goes to her doctor. The doctor runs some tests that show she has strep throat. He writes Debbie a prescription for an antibiotic. Debbie gets it filled at a local HAP-affiliated pharmacy. Because the family has now met the out-of-pocket limit, Debbie does not pay for her doctor's visit or the prescription. HAP pays the full amount.



\$9,000 Out-of-Pocket Limit Has Been Met • • • • •

How does it all work together?

Copays, coinsurance and deductibles all add up to out-of-pocket limits. John and his family met their out-of-pocket limit in July.

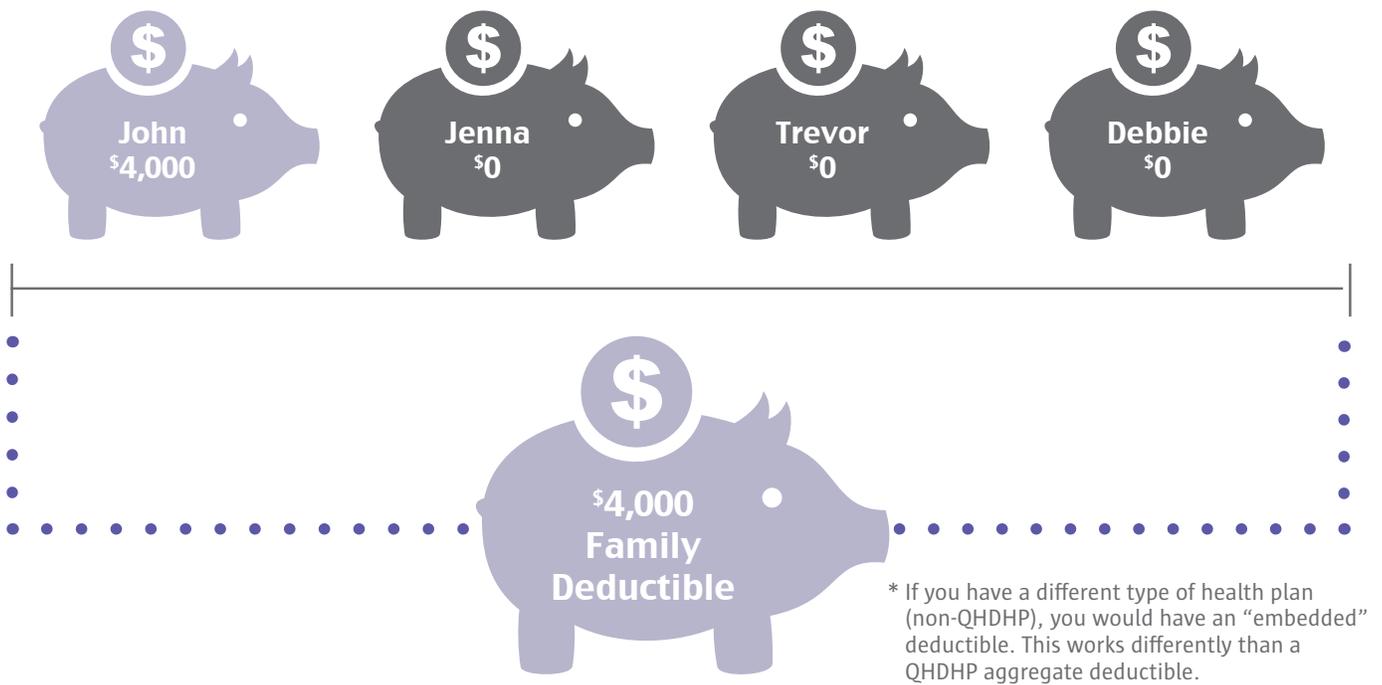
Summary of John's family costs:

Amount John and Family Have Paid																												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec															
	DEDUCTIBLE								Out-of-Pocket Limit Met HAP pays 100% of all covered services																			
	- Doctor's Visit	\$200																										
	- Prescription	\$100																										
	- MRI		\$1,500																									
	COPAYS													Out-of-Pocket Limit Met HAP pays 100% of all covered services														
	- Prescription			\$40																								
	COINSURANCE																		Out-of-Pocket Limit Met HAP pays 100% of all covered services									
	- Surgery			\$2,560				\$1,700																				
	- Physical Therapy					\$450																						
	- ER visit							\$250																				
	OUT-OF-POCKET LIMIT \$9,000	\$300	\$1,500	\$4,800		\$450		\$1,950																Out-of-Pocket Limit Met HAP pays 100% of all covered services				
		\$9,000 Total																										

More about deductibles

The above scenario is based on a health plan that covers John and his family, with a \$4,000 family deductible*. Since John has a QHDHP, each person in his family works together to meet their deductible. You may hear this called an “aggregate” or “umbrella” deductible.

When a family collectively meets their deductible, all members are considered to have met the deductible. For example, John met the family deductible of \$4,000 after his surgery, so everyone in his family is considered to have met the deductible.



Family out-of-pocket limit

In our example, John and his family met the deductible with John’s surgery in March. The family also met their \$9,000 out-of-pocket limit in July. In doing so, they do not have any more out-of-pocket costs for covered services for the rest of their benefit period. If John and his family did not meet the out-of-pocket limit, they would continue to pay copays and coinsurance until they reach a total of \$9,000.



For more information about our health plans, please visit [chooseHAP.org](https://www.chooseHAP.org).



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Health Alliance Plan

Subsidiaries:

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hap.org



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YEARS