

Cost-Sharing: Know What You May Owe

Health insurance protects you from paying the full cost of your care. But you will likely still have to pay some money out of your pocket. Almost all plans call for “cost sharing.” That means your insurer pays for part of your care, and you pay for part. The costs may include:

Premium. A payment to buy and keep up your coverage, often made on a monthly basis. If you have coverage through your job, your employer may pay part or all of your premium.

Deductible. A set dollar amount you must pay out of pocket each year before your plan starts paying for services. Plans may have separate deductibles for individuals and families, or for types of coverage like medical care or prescription drugs.

Copay (or copayment). A fixed dollar amount for each doctor visit or service, such as \$20 to visit your primary care physician (PCP). Copays may be higher for some services. For instance, you may pay \$20 to visit your family doctor, but \$30 for a specialist. Some preventive services, like yearly health exams, flu shots and mammograms, may not need a copay.

Coinsurance. A percentage of the cost of a service (for example, you pay 20 percent, your plan pays 80 percent).

Other things may affect your costs:

Out-of-network providers do not have a contract with your plan. They may charge more than your plan will pay (the plan’s “allowed charge”) for a particular service or type of care. Or, your plan may not pay, or may pay less, for out-of-network care. You will have to pay the difference.

Covered services are treatments your plan covers. Most plans do not cover services like over-the-counter drugs or cosmetic services, or services they believe are unproven or “experimental.”

The out-of-pocket limit is the most money that your insurer requires you to pay over a certain period, usually a year. After you reach this limit, your plan will pay the full cost of covered services. But they will only pay up to the dollar amount of the allowed charge for that service. Your limit may differ for in-network and out-of-network services.

Having health insurance can help protect you from paying for the full cost of your care. But it doesn’t mean you won’t have to pay anything out of your pocket when you go to the doctor. Almost every plan involves “cost-sharing,” which means that your insurer pays for a portion of your care, and you pay a portion.

The amount you will have to pay out of your pocket depends on the type of plan that you have, and whether or not you use a provider who is contracted with your plan’s network. If you go “out-of-network,” you may have a greater number of providers to choose from, but your costs will likely be higher. It’s important to remember that providers aren’t just doctors. Your plan also contracts with hospitals, labs, radiology facilities and pharmacies – they are providers too. When

you need care, it's important to know if each of these providers is in your plan's network or not, in order to anticipate what you may be required to pay.

Types of Costs

Most health plans require a premium payment. This is the amount that you pay to purchase and maintain your policy. If you have health coverage through your job, your employer may pay most or all of the cost of the premium. Once your premium is paid, the types of cost-sharing that you may have are:

- Co-payments
- Deductibles
- Co-insurance
- Limits
- Allowed Charges- this is the amount your insurer will agree to pay for a service, including any amounts you have to pay. For in-network providers, it is based on contracts with the providers. For out-of-network providers, the allowed charges may be:
 - the same as for in-network providers,
 - based on the amounts that Medicare would pay for the same services, or a set multiple of that amount, or
 - Usual, Customary and Reasonable (UCR) charges, an amount that your plan determines is reasonable for that service in your local area.
- If you use an out-of-network provider who charges more than your insurer's allowed charge, you will have to pay the difference in addition to deductibles, co-payments and co-insurance.
- Out-of-Pocket Limit– Many plans have out-of-pocket limits. This limit is the most that your insurer can require you to pay over a certain period. The out-of-pocket limit may be different for in-network and out-of-network services. After you reach the out-of-pocket limit, your plan will pay 100% of the amount allowed for covered services up to the allowed charges for that service. Out-of-pocket expenses for non-covered services do not count toward the limit.
- Limits on Services – Your plan may limit you to a certain number of services, like 10 chiropractic visits per year. You will have to pay the full cost of any visits above that limit. If you exceed the number of visits in your plan, the extra visits would not be covered expenses, so that expense wouldn't count toward the out-of-pocket limit if your plan offers one.
- Non-covered services– Your plan may not cover some types of treatments, like cosmetic surgery, or over-the-counter medications. You will have to pay the full cost of those services. Because these would not be covered services, these expenses do not count toward the out-of-pocket limit.

Type of Plan	What does it mean?	Co-payments	Deductible	Co-insurance
Health Maintenance Organization (HMO)	Your primary care physician coordinates your care and refers you to a specialist if needed. You must use in-network providers, except for emergency care.	Yes	Sometimes, such as special services like hospital stays	Sometimes
Preferred Provider Organization (PPO)	You can visit any provider without a referral, either in or out of your network, but you may pay more for out-of-network care.	Sometimes	Yes	Yes
Point-of-Service Plan (POS)	Your primary care physician coordinates your care and refers you to a network specialist if needed. You can choose to go to an out-of-network specialist, but costs for out-of-network care may be higher.	Yes	Yes, higher for out-of-network providers	Yes, higher for out-of-network providers
Exclusive Provider Organization (EPO)	You can get a referral from your PCP or you can go to a network specialist without a referral. You must use in-network providers, except for emergency care.	Sometimes	Yes	Yes