

Planning Your Costs Based on Where You Get Care

Your plan may have different rules and costs for different healthcare settings. In any setting, you may have to pay a copay, and in some cases, coinsurance. But, these may be waived for preventive services like flu shots and mammograms.

Doctor's office.

Day-to-day care at your family doctor's office is usually covered by health plans. Your plan may require a referral from your primary care physician (PCP) to see a specialist.

Outpatient settings (same-day care)

- Hospital outpatient centers—for services like physical therapy and chemotherapy. You may need preauthorization, or approval from your insurer before you go.
- Imaging centers—for radiology procedures like CT scans and ultrasounds. You may need preauthorization.
- Labs—for blood tests.
- Ambulatory surgery centers (ASCs)—for surgeries and tests, like colonoscopies, that don't need an overnight stay. You may need preauthorization.
- Hospital emergency rooms (ERs)—for treating a sudden, serious sickness or injury. The copay is usually higher than for other settings. But, it may be waived if you are admitted to the hospital. Most plans only cover visits to the ER for "true" emergencies. If you visit the ER for routine care, you may have high out-of-pocket costs.

Inpatient settings (need an overnight stay)

- Hospitals—for short-term care for a serious sickness or injury. You may need preauthorization.
- Rehabilitation (rehab) centers—for care after sickness or injury. For instance, you may get physical therapy for a hip replacement, before you're well enough to go home. Or, you may get therapy for substance abuse. You may need preauthorization.
- Your home—for help recovering from surgery or treating a serious sickness. You might get visits from physical or occupational therapists or home health aides. You may need preauthorization.

Other settings

- Urgent care centers—for when you don't have an emergency but you need care quickly. Costs are most often lower than for an ER visit.
- Retail clinics—for basic medical care if your regular doctor isn't on hand. Most, but not all, take insurance.
- Community health clinics and federally qualified health centers (FQHCs)—for low-cost care. If you are not insured, they may offer a sliding fee scale based on your income and family size.

When you need care, the first stop is usually your family doctor's office. But your health plan may have rules about where to go for certain services or medical procedures. Your health plan

contracts with a wide range of doctors and providers across different settings, such as primary care physicians, nurse practitioners and specialists to urgent care centers, hospitals, labs and radiology facilities. Before you go, find out what your plan requires, and if the office or facility you plan to visit is in your plan's network. Otherwise, you may have higher out-of-pocket costs.

Types of Settings

Your doctor's office is typically the first place to go when you need care. Health plans generally cover doctor visits for check-ups, flu shots, diagnoses, and other day-to-day care. But, you may need to go somewhere else if you need more complicated tests, like a CT scan. Your plan may also require a referral from your primary care doctor to see a specialist, such as a cardiologist or rheumatologist.

There also are several other types of healthcare settings. Outpatient settings, like hospital clinics and ambulatory surgery centers, provide basic services and tests where you can be treated in a single day. Inpatient settings, like hospitals or rehabilitation centers, are for treating more serious illnesses or injuries that may require an overnight stay.

Where You Get Care May Affect Your Costs

Different healthcare settings may bill differently. For instance, when you see a doctor, you'll receive a bill with a "**professional**" fee for the visit. But if you receive a test at a lab, have surgery in a hospital, an x-ray at an imaging center or sometimes when you visit a doctor's office that is owned by a hospital system, there may also be a "**facility**" fee for the use of that location. In some cases, the fees may be lumped together into a single charge, so it won't be clear on your bill. Some insurers may require you to have certain services in certain settings, so make sure to check with your plan before deciding where to go for care.

Common Outpatient Settings

Hospital Outpatient Centers perform medical procedures that do not require an overnight stay at the hospital. Examples include behavioral health counseling, physical therapy, same day surgery, hospital lab tests, chemotherapy and x-rays.

Imaging Centers perform radiology (imaging) procedures like CT scans, ultrasounds, MRIs and mammograms. Often, your insurer will need to approve payment for these tests before your visit. You may also have a copay or a deductible, although there is generally no cost to you for preventive screenings like mammograms.

Labs draw and test your blood to diagnose certain conditions. You may have a copay for these services.

Ambulatory Surgery Centers (ASCs) perform procedures that may be too complex for a doctor's office, but are simple enough for you to be treated and released in the same day without being admitted to a hospital, like colonoscopies or arthroscopies. Your insurer may require preauthorization, which means your insurer must approve payment for these procedures in advance.

Hospital Emergency Departments are for treating a sudden, serious illness or injury. By law, any patient who comes to the emergency department requesting examination or treatment for a medical condition must be provided with an appropriate medical examination to screen for an emergency medical condition. If you have an emergency medical condition, then the hospital is obligated to either provide you with treatment until you are stable or to transfer you to another hospital. Many plans cover some portion of emergency care, no matter where you are – even outside the plan’s provider network. Once your emergency medical condition has been resolved and you are stable, you will generally be moved to a provider in your network for follow-up care.

You will usually pay a higher copayment, which is sometimes waived if you are admitted to the hospital. Keep in mind that most plans only cover visits to the emergency room for “true” emergencies. If you visit the ER for non-emergency care, you could have higher out-of-pocket costs.

Common Inpatient Settings

Hospitals provide short-term treatment for serious illnesses or injuries, surgeries and often emergency and obstetric care. If you are planning a surgery or other hospital service in advance, like a joint replacement, your insurer will usually need to approve coverage and payment before you have the surgery. You will generally pay coinsurance for these procedures. In an emergency, many plans will cover some portion of your care whether you are in the network or not. If you are outside the network, you may be moved to an in-network hospital once your condition is stable.

Rehabilitation (Rehab) Centers are for ongoing therapy after an illness or injury, when you are stable enough to be moved from the hospital but may not be healthy enough to go home. These centers provide physical and occupational therapy if you are recovering from a complex problem, like a hip replacement or a broken bone. Other types of rehabilitation centers treat patients with substance abuse. You generally need your insurer to pre-authorize these services, and will need to go to a rehab within your network. Your hospital will usually work with your insurer to coordinate your move from the hospital to rehab. Some rehab centers also offer outpatient services.

Your home can also be a healthcare setting if you are recovering from a complex operation, like a joint replacement, or have a serious illness. You might receive visits from physical and occupational therapists, home aides or social workers. These services generally need to be pre-authorized by your insurer, and your plan may assign you a care coordinator to make sure you get the treatment and services that you need, including any home medical equipment like an oxygen tank or a walker.

Other Types of Healthcare Settings

Urgent Care Centers are for times that you don’t have an emergency, but need care quickly and your primary care doctor isn’t available. Urgent care centers often offer care after hours and on weekends. However, most are not equipped to deal with major medical traumas or conditions. Most health plans include urgent care centers in their networks. You will generally have a copay or coinsurance for an urgent care visit, but it is usually lower than the cost for an ER visit.

Retail Clinics offer basic, drop-in medical care. Services may include treating sore throats, flu shots and checks for conditions such as high blood pressure and diabetes. In many cases, they are open seven days a week. Retail clinics are often located in drugstores, groceries and chain stores. Most, but not all, retail clinics accept insurance; check with the clinic and with your insurer before getting care.

Community Health Clinics and Federally Qualified Health Centers (FQHCs) are clinics that provide low-cost care in communities that have limited access to healthcare services. These centers are located in both cities and rural areas. They provide primary care and preventive services like check-ups, screenings and lab tests, prenatal care, vaccinations and in some cases basic dental services. Many accept Medicaid. If you do not have insurance, they may offer a sliding fee scale based on your income and family size.

Your Action Plan: Know Where to Go

- Know your plan's rules before you get care. For instance, your doctor might offer to give you an X-ray or scan at their office, but your plan may only pay if that test is authorized in advance, and you have it at an imaging center.
- Before you receive a service, ask your doctor what charges you can expect. Will there just be a professional fee, or will a facility fee be added? Will the two be combined? Will you have one copay or two?
- Ask your plan whether your service or procedure will cover the costs of the procedure and whether it needs to be pre-authorized.
- Make sure the doctors and facilities you visit are in your plan's network by checking your plan's website, or calling a representative. Double-check with your provider, too, since this information can change.
- If you choose a healthcare setting outside your network, check with your plan first and see if it will pay for out-of-network care, and if so, how much it will cover. If it does not cover any out-of-network care, ask the provider how much the charge will be, and if you would be able to negotiate a lower rate or sign up for a payment plan.
- If you are not insured, you may be able to get care through a low-cost community health center. You can find a clinic or FQHC near you by visiting <http://findahealthcenter.hrsa.gov/>