Cost Sharing and Out-of-Pocket Costs for Medical Services

Quick Facts and Information for Granite Staters

Quick facts about cost sharing and out-of-pocket costs:

In addition to your monthly premium, you may be responsible for other costs when you seek medical care.

While your health insurance will pay for most costs associated with the medical services covered by your insurance plan, you will likely still incur some expenses that you're responsible for paying. These costs are known as "cost sharing," since you're sharing a portion of the costs with your insurance company.

Preventive services are usually covered by your insurance plan without any cost sharing.

Preventive services, like annual wellness visits and immunizations, are designed to keep you healthy and to prevent you from needing more serious medical care. That's why the law requires most insurance plans to fully cover the costs of preventive services—as long as you've paid your premium!

Copayments usually apply to medical services and prescription drugs.

When you go to a doctor or the emergency room, you may be required to pay a flat fee, known as a copayment, for the service. The amount of your copayment for different medical services is determined by your insurance plan. You'll also have to pay a copayment for prescription drugs, and it varies depending on the type of medication you're buying. For example, brand-name drugs frequently have a higher copayment than generic drugs.

For 2019, qualified health plans require your out-of-pocket limit to be equal to or less than $7,350 for individuals or $14,700 for families.

Your plan may have a lower out-of-pocket limit than is required by the law, so make sure you check your plan! Once you reach your out-of-pocket limit, you are no longer responsible for any additional cost-sharing expenses.

GLOSSARY OF TERMS:

Cost Sharing: The portion of costs for health care services that you must pay when you seek medical services, including copays, deductibles and coinsurance.

Copayments (Copays): Flat payment amounts that you're responsible for at the time of service. They usually range from $10 – $75 for an office visit and up to several hundred dollars for an emergency room visit.

Coinsurance: The percentage of the total cost of a medical service that you're responsible for paying. For example, if the coinsurance through your health insurance plan is 20%, you're responsible to pay 20% of the cost, while your health insurance company will pay the remaining 80%.

Deductible: The amount you owe for health care services before your health insurance plan pays for most services. For example, if your deductible is $500, you'll have to pay $500 before your health insurance begins paying for services. However, your deductible doesn't apply to some services, like preventive care services.

Out-of-Pocket Limit: The most amount of money you'll be required to pay in a plan year. Once you reach this limit, your health insurance plan begins to pay 100% of the costs for covered medical services. Amounts paid for coinsurance, deductible and copays accumulate against the out-of-pocket limit.

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GLOSSARY OF TERMS CONTINUED:

Premium: The amount of money paid each month to have your health insurance plan.

Preventive Services: Health care services that promote good health, such as annual wellness and well-child visits, immunizations, and women's wellness visits. Most insurance plans are required to cover preventive services without cost sharing.

I have more questions.

Who can help me?

TO COMPARE HEALTH PLAN COSTS, VISIT THE NH HEALTHCOST WEBSITE.

www.NHHealthCost.HN.gov

CONTACT YOUR HEALTH INSURANCE COMPANY.

You'll find their phone number on the back of your insurance card or visit their website.

CONTACT THE NH INSURANCE DEPARTMENT CONSUMER SERVICES DEPARTMENT.

- (603) 271-2261
- (800) 852-3416
- (800) 735-2964 (TYY/RDD Relay Services)
- consumerservices@ins.nh.gov
- www.NH.gov/insurance

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