



THE STATE
of **ALASKA**
MICHAEL J. DUNLEAVY
GOVERNOR

**Department of Commerce, Community,
and Economic Development**

DIVISION OF INSURANCE

P.O. Box 110805
Juneau, AK 99811-0805
Main: 907.465.2515
Fax: 907.465.3422

CONSUMER NOTICE REGARDING OUT-OF-POCKET COSTS

Brief Description

The Alaska Division of Insurance invites consumers to learn more about how their health insurance company pays claims, and the out of pocket costs for which consumers are responsible.

In addition to premiums, consumers may also be obligated to pay deductibles, copays, coinsurance, and amounts in excess of the allowed amount. Descriptions of the out-of-pocket costs to consumers can be found below.

We encourage all consumers to review their insurance plan policy or certificate to view plan benefit levels and the cost sharing structure in order to understand what charges your insurer pays, and which charges consumers pay. Consumers should consider all of the health care costs they will have, not just the premium they pay to their insurance company every month. Please note that a health care provider who fails to bill for or collect consumer portions of the cost sharing may be committing insurance fraud under AS 21.36.360(b).

Premium

The premium is the amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

Deductible

The deductible is the amount you must pay for covered health care services each plan year before your insurance plan starts to pay. With a \$2,000 deductible, you pay the first \$2,000 of covered services yourself.

After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

- Many plans pay for certain services, like a checkup or disease management programs, before you've met your deductible. Check your plan details.
- All comprehensive health plans newly issued after January 1, 2014 pay the full cost of certain preventive benefits received from network providers even before you meet your deductible.
- Some plans have separate deductibles for certain services, like prescription drugs.
- Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

Generally, plans with lower monthly premiums have higher deductibles. Plans with higher monthly premiums usually have lower deductibles.

Copayment

A copayment is a fixed amount (\$20, for example) you pay for a covered health care service after you've paid your deductible.

For example, if your allowable cost for a doctor's office visit is \$100 and your copayment for a doctor visit is \$20:

- If you've already paid your deductible, you pay \$20, usually at the time of the visit.
- If you haven't met your deductible, you pay \$100, the full allowable cost for the visit.

Copayments, also called copays, can vary for different services, such as drugs, lab tests, and visits to specialists.

Generally, plans with lower monthly premiums have higher copayments.

Coinsurance

The coinsurance is a percentage you pay (20%, for example) of the costs for a covered health care service after you've paid your deductible.

For example, if your health insurance plan's allowable cost for a doctor's office visit is \$100 and your coinsurance is 20%:

- If you've paid your deductible, you pay 20% of \$100, or \$20. The insurance company pays the rest.
- If you haven't met your deductible, you pay \$100, the full allowable amount for the visit.

Generally, plans with low monthly premiums have higher coinsurance.

Example of Coinsurance with High Medical Costs

Let's say the following amounts apply to your plan and you need a lot of treatment for a serious condition. Allowable costs are \$12,000.

- Deductible: \$3,000
- Coinsurance: 20%
- Out-of-pocket maximum: \$6,850

You would pay all of the first \$3,000 (your deductible).

You would pay 20% of the remaining \$9,000, or \$1,800 (your coinsurance).

Your total out-of-pocket costs would be \$4,800 (your \$3,000 deductible plus your \$1,800 coinsurance).

If your total out-of-pocket costs reach \$6,850, you would pay only that amount, including your deductible and coinsurance. The insurance company would pay for all covered services for the rest of your plan year.

Out-of-Pocket Limit

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you may spend for services your plan doesn't cover.

The maximum out-of-pocket limit for any 2019 Marketplace plan is \$7,900 for an individual plan and \$15,800 for a family plan for in-network expenses. Some insurers have unlimited out-of-pocket amounts for out-of-network services.

Generally, plans with lower monthly premiums have higher out-of-pocket limits.

Example of Out-of-Pocket Maximum with High Medical Costs

Let's say you need surgery with allowable charge of \$20,000 and the following figures apply to your health insurance plan.

- Deductible: \$1,300
- Coinsurance: 20%
- Out-of-pocket maximum: \$4,400

You would pay the first \$1,300 of covered medical expenses (your deductible).

Your 20% coinsurance on the rest of the costs (\$18,700) comes to \$3,740.

Your total costs would be \$5,040. That's \$1,300 (your deductible) plus \$3,740 (coinsurance).

However, your out-of-pocket maximum is \$4,400 for in-network services. Your insurance company pays all covered costs above \$4,400; for this surgery and for any covered care you get for the rest of the plan year.

Allowed Amount

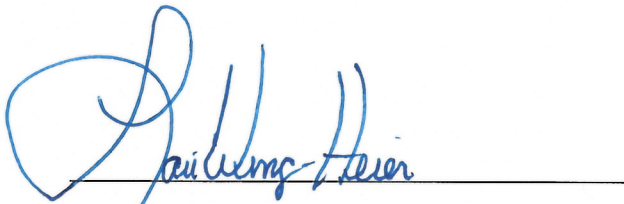
The allowed amount is the maximum amount a plan will pay or base payment on for a covered health care service. The allowed amount may also be called eligible expense, payment allowance, or negotiated rate.

For network providers, the allowed amount is the contracted rate that the network provider has agreed to accept. For non-network providers the payment must be based on the billed amount or the 80th percentile of charges for geographic area in which the services are received.

In compliance with regulation 3 AAC 26.110(a)(5) and your insurance contract, if your provider charges more than the plan's allowed amount, you may be responsible for those payments. Your provider will send you a bill and you will need to pay the difference between the allowed amount and the billed amount.

Providers who fail to balance bill consumers and fail to make good faith efforts to collect outstanding debt may be committing insurance fraud as described in AS 21.36.360(b), since the bill submitted by providers to insurers could be considered inflated.

Date: February 27, 2019



Lori Wing-Heier
Director of Insurance