Takeda Insurance - Terminology

**Premiums**

To make comparison easier, plans sold to individuals are grouped in standardized “metal tiers” with various combinations of premiums and cost sharing:

* **Bronze** plans cover 60 percent of the average member's total health care costs and thus have the lowest premiums but the highest out-of-pocket costs. Individual deductibles for Bronze plans in 2014 average $5,081, according to [an analysis by HealthPocket, a private health insurance data-crunching firm](http://www.healthpocket.com/healthcare-research/infostat/2014-obamacare-deductible-out-of-pocket-costs/#.UyidUlzLtCN).
* **Silver** plans cover 70 percent and have higher premiums and lower out-of-pocket costs than Bronze plans, with an average individual deductible of $2,907.
* **Gold** plans cover 80 percent and have higher premiums and lower out-of-pocket costs than Silver plans, with an average individual deductible of $1,277.
* **Platinum** plans will cover 90 percent and have the highest premiums and lowest out-of-pocket costs, with an average individual deductible of $347.

**Which of those plans is right for you depends on your health and your financial situation:**

* If you already know you have an expensive medical condition, consider a plan with a higher premium that covers more of your costs.
* If you are generally healthy you might come out ahead paying a lower premium and a bigger share of your health costs, because those costs are most likely not going to be that high. Of course, you need to be prepared to pay more if you do unexpectedly become sick or injured.

**Out-of-pocket expenses**

The terms “cost sharing” or “out-of-pocket costs” refer to the proportion of your medical bills you will be responsible for paying when you actually receive health care. Cost sharing does not include your monthly premium.

Unfortunately cost sharing is not standardized from plan to plan and provisions can sometimes be complicated.

If you buy insurance through your state marketplace, you’ll be able to see and compare the cost-sharing structure of plans before you buy. If you get insurance through a job, the information will be on the [Summary of Benefits and Coverage](http://www.consumerreports.org/health/resources/pdf/SBCinfo.pdf) form.

These are the four cost-sharing terms you will see.

**DEDUCTIBLE.**The amount you pay every year before the insurance company starts paying its share of the costs. If the deductible is $2,000, then you would pay cash for the first $2,000 in health care you receive each year, after which the insurance company would start paying its share. In every plan you can buy, preventive services will be covered in full even if you haven’t used up your deductible for the year. **Some plans will also pay a portion of your costs for a few other services, usually doctor visits and prescription drugs, even before your deductible has been met.** This is more common with Gold and Platinum plans but some Silver and Bronze plans also cover some services before the deductible has been met. The only way to figure out whether a plan covers some services "not subject to the deductible" is to study its provisions very carefully.

**COPAY.**A fixed dollar amount you pay for certain types of care. You might pay $30 for a doctor visit and the insurance company will pick up the rest. Plans with higher premiums generally have lower copays, and vice versa. And some plans do not have copays at all. They use other methods of cost sharing.

**COINSURANCE.**The percentage of the cost of your medical care that you have to pay. For an MRI that costs $1,000, you might pay 20 percent ($200). Your insurance company will pay the other 80 percent ($800). Plans with higher premiums generally pick up a larger portion of the bill.

**OUT-OF-POCKET LIMIT.**The most cost-sharing you will ever have to pay in a year. It is the total of your deductible, copays, and coinsurance (but does not include your premiums). Once you hit this limit, the insurance company will pick up 100 percent of your costs for the remainder of the year. Most people never pay enough cost-sharing to hit the out-of-pocket limit but it can happen if you require a lot of costly treatment. Plans with higher premiums generally have lower out-of-pocket limits.

In 2014, the out-of-pocket limit for plans sold to a person and to small groups cannot be more than $6,350 per person or $12,700 for a family. But most Silver, Gold, and Platinum plans have lower out-of-pocket limits than that. In 2015, the maximum out-of-pocket limits allowed will increase slightly. They will be $6,450 for an individual and $12,900 for a family.