Out-of-pocket limits

Need-to-know details about out-of-pocket limits under the ACA

The Affordable Care Act established out-of-pocket limits to protect consumers from runaway medical costs. The limits include essential health benefits covered under nongrandfathered plans, but out-of-network procedures or treatments not covered under an individual's plan can still cost consumers more than the established limits. Here are the important details employers and employees need to know.

What are the out-of-pocket limits?
The limits reflect the most an individual or family will pay for covered essential health benefits before their plan begins to pay 100 percent of the costs. The limits are adjusted each year. For 2018, the limits include:

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<thead>
<tr>
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<th>Individual out-of-pocket maximum</th>
<th>Family out-of-pocket maximum</th>
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<tbody>
<tr>
<td>ACA compliant plans</td>
<td>$7,350</td>
<td>$14,700</td>
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<tr>
<td>High-deductible health plans</td>
<td>$6,650</td>
<td>$13,300</td>
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What counts toward the out-of-pocket limit?
Covered essential health benefits are included in the out-of-pocket maximum. This includes deductibles, coinsurance, copayments or similar charges, and any other expenditure required of an individual that is a qualified medical expense for essential health benefits, which includes items and services in the following 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care
Can actual out-of-pocket costs exceed these limits?
Yes. Out-of-pocket limits do not count premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing or spending for nonessential health benefits. That means patients can rack up bills for procedures, treatments or prescriptions not covered under their plan or outside of their network. These costs won’t count toward their out-of-pocket limit but can directly affect their wallet.

How are limits applied to individuals who are part of a family plan?
The individual limit is extended to each member of a family plan. This means that an individual’s out-of-pocket expenses covered under their plan will not exceed the individual limit, and a family’s out-of-pocket expenses covered under their plan will not exceed the family out-of-pocket maximum when they are added together.

How can voluntary insurance help?
Voluntary insurance is designed to complement an individual’s major medical plan. These benefits work hand in hand with major medical plans to help individuals who are sick or hurt have the funds they need to help with health-related costs their primary insurance might not cover, such as daily living expenses, like bills and groceries, as well as medical deductibles and insurance copayments, expenses major medical insurance isn’t designed to cover.

This material is intended to provide general information about an evolving topic and does not constitute legal, tax or accounting advice regarding any specific situation. Aflac cannot anticipate all the facts that a particular employer or individual will have to consider in their benefits decision-making process. We strongly encourage readers to discuss their HCR situations with their advisors to determine the actions they need to take or to visit healthcare.gov (which may also be contacted at 1-800-318-2596) for additional information.

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Aflac herein means American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York.