Coinsurance vs. Copays: What's the Difference?

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No matter which type of health insurance policy you have, it's essential to know the difference between a copay and coinsurance. These and other out-of-pocket costs affect how much you'll pay for the healthcare you and your family receive.

KEY TAKEAWAYS

- A copay is a set rate you pay for prescriptions, doctor visits, and other types of care.
- Coinsurance is the percentage of costs you pay after you've met your deductible.
- A deductible is the set amount you pay for medical services and prescriptions before your coinsurance kicks in.

What Is a Deductible?

First, to understand the difference between coinsurance and copays, it helps to know about deductibles.

A deductible is a set amount you pay each year for your healthcare before your plan starts to share the costs of covered services. For example, if you have a $3,000 deductible, you have to pay $3,000 before your insurance kicks in fully.

If you have any dependents on your policy, you'll have an individual deductible and a different (higher) amount for the family.

If you have a high-deductible health plan, you may be eligible to set aside money in a tax-advantaged Health Savings Account.

What Are Copays?

Copays (or copayments) are set amounts you pay to your medical provider when you receive services. Copays typically start at $10 and go up from there, depending on the type of care you receive. Different copays usually apply to office visits, specialist visits, urgent care, emergency room visits, and prescriptions.

Your copay applies even if you haven't met your deductible yet. For example, if you have a $50 specialist copay, that's what you'll pay to see a specialist—whether or not you've met your deductible.

Most plans cover preventive services at 100%, meaning, you won't owe anything.

In general, copays don't count toward your deductible, but they do count toward your maximum out-of-pocket limit for the year.

What Is Coinsurance?

Coinsurance is the percentage of covered medical expenses you pay after you've met your deductible. Your health insurance plan pays the rest. For example, if you have an "80/20" plan, it means your plan covers 80% and you pay 20%—up until you reach your maximum out-of-pocket limit.

Still, coinsurance only applies to covered services. If you have expenses for services that the plan doesn't cover, you'll be responsible for the entire bill. If you're not sure what your plan covers, review your benefits booklet or call your plan provider.

What Are Out-of-Pocket Maximums?

Once you reach your out-of-pocket maximum, your health insurance plan covers 100% of all covered services for the rest of the year. Any money you spend on deductibles, copays, and coinsurance counts toward your out-of-pocket maximum. However, premiums don't count, and neither does anything you spend on services that your plan doesn't cover.

Like deductibles, you might have two out-of-pocket limits—an individual one and a family one.

In-Network vs. Out-of-Network

Some plans have two sets of deductibles, copays, coinsurance, and out-of-pocket maximums: one for in-network providers and one for out-of-network providers.

In-network providers are doctors or medical facilities that your plan has negotiated special rates with. Out-of-network providers are everything else—and they are generally much more expensive.

Keep in mind that in-network doesn't necessarily mean close to where you live. You could have a North Carolina plan and see an in-network provider at the Cleveland Clinic in Ohio.

Whenever possible, be sure you're using in-network providers for all of your healthcare needs. If you have certain doctors and facilities that you'd like to use, be sure they're part of your plan's network. If not, it might make financial sense to switch plans during the next open enrollment period.

Copay and Coinsurance Example

To help explain copays and coinsurance, here's a simplified example.

Say you have an individual plan (no dependents) with a $3,000 deductible, $50 specialist copays, 80/20 coinsurance, and a maximum out-of-pocket limit of $6,000.

You go for your annual checkup (free, since it's a preventive service) and you mention that your shoulder has been hurting. Your doctor sends you to an orthopedic specialist ($50 copay) to take a closer look.

That specialist recommends an MRI to find out what's going on. The MRI costs $1,500. You pay the entire amount since you haven't met your deductible yet.

As it turns out, you have a torn rotator cuff and need surgery to fix it. The surgery costs $7,000. You've already paid $1,500 for the MRI, so you need to pay $1,500 of the surgery bills to meet your deductible and have the coinsurance kick in. After that, your share is 20%—which, in this example, is $1,100. All in, your torn rotator cuff costs you $4,100.

The Bottom Line

When you shop for a health insurance plan, the plan descriptions always specify the premiums (the amount you pay each month to have the plan), deductibles, copays, coinsurance, and out-of-pocket limits. In general, premiums are higher for plans that offer more favorable cost-sharing benefits.

If you're generally a healthy and careful person, a low-cost plan with higher limits may work for you. However, if you expect to have significant healthcare expenses, it might be worth it to spend more on premiums each month to have a plan that will cover more of your costs.