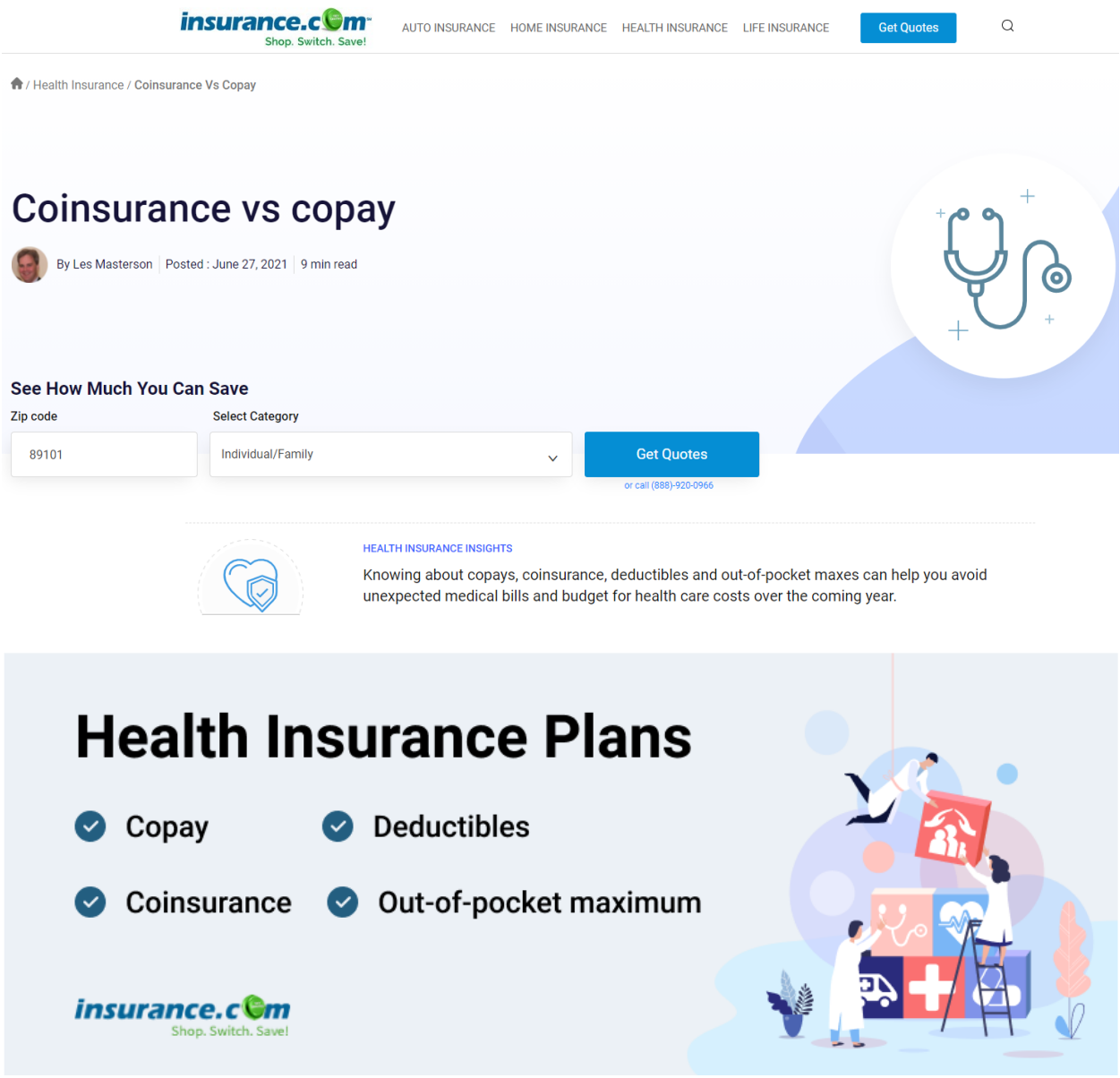

Premiums are what you pay to have health insurance, but out-of-pocket costs when you need health care services, including copays and coinsurance, can also reach into the thousands each year.

Understanding copays, coinsurance, deductibles and out-of-pocket maxes can help you avoid unexpected medical bills. It can also help you budget for health care costs over the coming year.

Let’s look at health insurance copays, deductibles, coinsurance and out-of-pocket maxes and how they work together.

KEY TAKEAWAYS

- Copay is the amount you have to pay for every visit, such as a doctor's office or pharmacy. Health insurance plans charge lower rates for primary care physician than a specialist visit.
- Coinsurance is the amount that you and your insurance plan pay for the covered medical expenses until you reach out-of-pocket maximum.
- When you’re deciding on the best health plan, make sure to think about all of your options. Don't just focus on copays. Also, consider deductibles, coinsurance and out-of-pocket maximums.

IN THIS ARTICLE

What is a copay?

A copay is what you pay at health care visits, such as a doctor's office or for prescription drugs. Health insurance plans usually charge lower rates for in-network primary care physician visits than specialists.

Both copays for primary care and specialists usually cost well under $100. Some plans even offer zero-dollar premiums, including nearly half of Medicare Advantage plans.

There aren't copays for annual wellness visits. However, you could still be charged a copay for a wellness visit if your doctor performs a service or requests a test that's deemed outside of a regular wellness visit.

Meanwhile, in-network emergency room visit copays can cost hundreds of dollars. Those copays may be waived if you're admitted to the hospital.

Plans often charge lower copays if you receive care at an urgent care center rather than a hospital emergency room. Urgent care centers have less overhead and cost health plans less, so health plans charge lower copays at urgent care centers than emergency rooms.

What is a deductible?

The deductible is what you have to pay for health care services before your health plan starts paying for care.

An annual deductible varies. Kaiser Family Foundation said the average employer-sponsored health insurance deductible for an individual in 2020 was:

- **Preferred provider organization (PPO) plans**: $1,204
- **Health maintenance organization (HMO) plans**: $1,201
- **High-deductible health plans (HDHPs)**: $2,303
- **Point of service (POS) health plans**: $1,714

The IRS defines an HDHP as a plan with a deductible of at least $1,400 for an individual and $2,800 for a family. However, HDHP deductibles can be much higher.

Meanwhile, the Affordable Care Act exchanges classify plans by metal level: Bronze, Silver, Gold and Platinum. The higher the metal type, the more you'll pay in premiums, but you'll pay fewer out-of-pocket costs.

A Bronze or Silver plan with higher out-of-pocket costs and lower premiums might be a wise choice if you're young, healthy, would rather pay lower premiums and don't expect to need many health care services over the next year. On the other hand, if you use many health care services and don't mind paying higher premiums with the understanding that you'll pay less for services, a Gold or Platinum plan may be a better selection.

What is coinsurance?

Once you reach your deductible, the health plan pays a portion of health care services. Coinsurance is the percentage that you and the plan pay for the covered medical expenses until you reach your out-of-pocket maximum. You can think of it as cost sharing between you and the health insurance plan.

Let's say your health plan has 20% coinsurance. That portion of the bill is your responsibility. The insurer pays the other 80% of the coinsurance. So, if you're hospitalized and the bill is $10,000, the health plan would pick up $8,000 and you'd be on the hook for $2,000.

What is an out-of-pocket maximum?

You pay your coinsurance portion until you reach your plan's in-network out-of-pocket maximum.

This annual out-of-pocket amount includes the amount you pay for:

- Premiums
- Anything you pay that the health plan doesn't cover

- Out-of-network care and services
- Out-of-pocket maxes vary by plan. Here are examples:
- A high-deductible plan can't exceed more than $6,900 out-of-pocket for an individual and $13,800 for a family.
- Affordable Care Act plans can't exceed $8,150 for an individual plan and $16,300 for a family plan.
- A Medicare Advantage plan can't exceed $6,700 for out-of-pocket maximums.
- Original Medicare, which is Part A and B, doesn't have out-of-pocket maximums. In that case, you may want to get a Medigap plan to help you pay for Medicare costs if you're concerned about out-of-pocket costs.

What does coinsurance after deductible mean?

Coinsurance is your portion of costs for health care services after you've met your deductible.

Once you reach the deductible, your health insurance plan will pick up a percentage of the health care costs and you'll pay for the rest.

An example is Affordable Care Act (ACA) plans**.** ACA plans are divided by metal tiers that take into account costs, including coinsurance.

Bronze plans have the highest coinsurance percentages. So, members of those plans pay the highest out-of-pocket costs. On the other hand, Platinum plans have the lowest coinsurance percentages, so people with those plans pay the lowest out-of-pocket costs.

Here are the coinsurance costs for each metal tier:

- Bronze -- **40% coinsurance; 60% insurer pays**
- Silver -- **30% coinsurance; 70% insurer pays**

- Gold -- **20% coinsurance; 80% insurer pays**
- Platinum -- **10% coinsurance; 90% insurer pays**

It's important to remember that ACA plan metals only take into account the costs. You also have to decide the type of benefit design you want. For instance, health maintenance organization (HMO) plans are quite different from **preferred provider organization (PPO) plans** regarding networks, whether the plans pay for out-of-network care and if you need referrals to see specialists. So, keep benefit design in mind when choosing an ACA plan, too.

How copays, deductibles, coinsurance and out-of-pocket maximum work together

Let's take a look at an example of how deductibles, copays and coinsurance work.

You go to the doctor for an aching back. Your primary care copay is $30, so you pay that before seeing the doctor.

Your doctor decides you need an MRI. You schedule an MRI, which costs $2,000.

Your deductible is $1,000 and your coinsurance responsibility is 20%. In that case, you'd pay the $1,000 for the deductible portion and you'd also be on the hook for the remaining 20% with the health plan picking up the other 80%.

In this case, you'd pay $1,200 for the MRI on top of the $30 copay.

Your back continues to give you problems and you have multiple doctor visits and tests that rack up costs. You wind up reaching your plan's $3,000 out-of-pocket max after the copays and the 20% coinsurance costs. At that point, your health plan picks up the health care costs for the year. One exemption is that some plans may still charge copays at doctor visits.

What does 40% coinsurance after a deductible mean?

If your plan has 40% coinsurance, that's the percentage of the costs you pay once you reach your deductible.

So, let's say you meet your deductible and you need a minor outpatient procedure. The costs total $1,000 and you have 40% coinsurance. In that case, you'd owe $400 and your insurance company would pick up the rest of the costs.

Bronze plans in the ACA marketplace have 40% coinsurance.

What does 100% coinsurance mean?

If you have 100% coinsurance, your insurance plan doesn't pick up any costs after reaching your deductible.

So, you'd be responsible for the $1,000 costs in the above example.

What does 50% coinsurance mean?

If you have 50% coinsurance, you cover half of the health care costs.

So, in that above example of a $1,000 bill, you'd be responsible for $500 -- or half.

What does 0% coinsurance mean?

Someone with 0% coinsurance doesn't have to pay any out-of-pocket costs once you reach the deductible.

A plan with 0% coinsurance likely has high premiums, deductible or copays to make up for not paying any coinsurance.

What does 30% coinsurance mean?

A plan member with a $1,000 medical bill would be responsible for $300 in the above example. The health insurance company would pick up the rest.

Silver plans in the ACA marketplace have 30% coinsurance.

What does 20% coinsurance mean?

A plan member with a $1,000 member bill would be responsible for $200 with the health insurance plan handling the rest.

Gold plans in the ACA marketplace have 20% coinsurance.

Importance of staying in-network

Getting care at an in-network facility or through an in-network provider is vital to keeping down health care costs.

Health plans have contracts with in-network providers. Those contracts dictate how much a health insurance company pays a provider or facility.

If you go to an out-of-network provider or facility, you'll have to pay all or more of the costs than you'd spend if you stayed in-network. An HMO doesn't allow members to see out-of-network providers, so you would have to pay for all of it. A PPO will let you visit an out-of-network provider, but you'll pay higher for that care than in-network costs.

Find out more about the different types of health plans.

Choosing a health insurance plan based on costs

When deciding on a health plan, you want to review all costs. Don't just look at copays. You'll want to also take into account a plan's deductibles, coinsurance and out-of-pocket maximum.

Also, think about how much health care you'll likely need over the next year. Some questions to ask yourself:

- Do you have a health issue that requires regular doctor visits?
- Do you need surgery over the next year?
- Do you have children or dependents who may need health care?
- Do you have a child on the way?

Answering the questions will help you compare health plans. All of those situations increase your out-of-pocket costs and will play a factor in choosing a health plan.

You'll want to run the numbers -- copays, deductibles and out-of-pocket costs. Once you do that, you can see if it would be better to go with higher premiums or higher out-of-pocket costs.

Costs are what people dislike most about health insurance

Not surprisingly, health insurance costs aren't popular. A recent Insurance.com survey of 1,000 people found that out-of-pocket costs, including deductibles, coinsurance and copays, barely edged out premiums as what they dislike most about their health insurance.

Out-of-pocket costs and premiums easily topped other health insurance headaches, such as surprise medical bills, prior authorizations, limited provider choices and referrals to see specialists.

Females and people under 55 dislike out-of-pocket costs the most; men and people 55 and over chose premiums.

Here's what people disliked most about their health insurance:

- Out-of-pocket costs -- 35.4%

- Premium costs -- 34.9%
- Surprise medical bills -- 11.1%
- Limited provider choices -- 7%
- Prior authorizations for procedures -- 6.8%
- Referral requirements to see specialists -- 4.5%