**What is Max Visits?:**

When the patient has used their approved number of visits for the plan year.

**What is a Calendar Plan?:**

Meaning the patient's insurance plan runs from 01/01-12/31

**What is a Fiscal Plan?:**

Meaning the patient's insurance plan from month to month. (06/01-05/30 or 07/01-06/30)

**What is a Self-Funded Plan?:**

A self-funded plan provided through employment or an association plan means that there's no insurance company, HMO or other organization paying the premiums for the plan, it is funded by the employer.

**What are Combined Visits?:**

This means if they get a total of 30 combined visits, those 30 visits can be used for PT, OT or ST, or combination of all. If they are not combined this means they can only be used for that specific discipline.

**What is a Benefit Exclusion?:**

A health insurance exclusion refers to anything the insurance company will not cover, ranging from a type of drug to a type of surgery. These exclusions can vary from plan to plan, and it's essential that you get to know your plan's exclusions.

**What Is Co-Pay?**

A co-pay is a fixed out-of-pocket amount paid by an insured for covered services. It is a standard part of many health insurance plans. Insurance providers often charge co-pays for services such as doctor visits or prescriptions drugs. Co-pays are a specified dollar amount rather than a percentage of the bill, and they are usually paid at the time of service.

**What is a Deductible?**

The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself at your insurance company's contracted rate, then your insurance will start to issue payments excluding any copays or coinsurance after you have met your deductible.

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

**What is Maximum Out of Pocket?**

What you pay toward your plan's coinsurance and copays are all applied to your out-of-pocket max, if your plan has a maximum. This is designed to limit your out-of-pocket costs through the year.

Once you reach your out-of-pocket max, your plan pays 100 percent of the allowed amount for covered services.

Some insurance plans will include your deductible amount in the Out-of-Pocket Max, and some will not.

**What is Coinsurance?**

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

Let's say your health insurance plan's allowed amount for an 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 the full allowed amount, $100.

## 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'd pay all of the first $3,000 (your deductible).

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

So 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'd pay only that amount, including your deductible and coinsurance (if your deductible applies to the Out-of-Pocket Max. The insurance company would pay for all covered services for the rest of your plan year.

Generally speaking, plans with low monthly premiums have higher coinsurance, and plans with higher monthly premiums have lower coinsurance.