What's the difference between a deductible and a co-pay?

What's an HMO? What's a PPO? What's my "out-of-pocket?"

Are you confused by health insurance lingo? You're not alone!

Terms to know:

- **Coinsurance:** The percentage of the cost you pay for a service after meeting the deductible.
- **Deductible:** The amount of covered expenses that a member or family must pay out-of-pocket each calendar year before the plan starts paying.
- **Out-of-pocket maximum:** The maximum you'll have to pay for covered expenses each year before the plan pays at 100%.
- **Premiums/Rates:** The cost of coverage you pay.
- **Preventive Care:** Care intended to help you maintain good health and detect potential health conditions early on when they are more easily treatable and to help reduce the risk of a condition becoming a chronic disease or critical illness.
- **Chronic Condition:** Unlike acute illnesses (like a cold or the flu), chronic conditions are long-lasting and even though the symptoms may get better with medical care, you usually still have the underlying condition. Examples include asthma, diabetes and arthritis. If you have been diagnosed with a chronic condition, it is important that you learn how to manage your condition and develop a strong relationship with your care team.

Here are more in-depth health insurance Terms and Definitions

One of the biggest problems for most people is simply understanding the health insurance benefits that they have. For the most part, health insurance policies try to be user-friendly in their wording, but many people are just not familiar with medical and insurance terminology.

Most health insurance policies also provide something similar to a cheat sheet which gives the basic outline of policy coverage and covers the most common medical services. However, you need to be sure that you understand the different things that are excluded under your plan. Many health insurance plans provide limited benefits for services such as mental health, chiropractic services, and occupational health. Even physical therapy and home health care are often limited to a certain number of visits per year.

Co-payment or Co-pay

A co-payment is a pre-determined amount that you must pay a medical provider for a particular type of service. For example, you may be required to pay a $15 co-payment when you visit your doctor. In this instance, you must pay $15 to the doctor's office at the time of the visit. Normally, you are not required to pay any additional fees -- your health insurance company will pay the rest. However, in some cases, if your health insurance policy specifies it, you may be responsible for a co-payment and then a percentage of the remaining balance.

Deductible

A deductible is the amount of your medical expenses you must pay for before the health insurance company will begin to pay benefits. Most health insurance plans have a calendar-year deductible which means that in January of every new year the deductible requirement starts over again. So, if your calendar year deductible is $1500, as long as your medical

expenses for the current year do not exceed $1500 the insurance company pays nothing for that year. Once January of the new year starts, you have to begin again to pay for $1500 of your own medical expenses.

Coinsurance

Coinsurance (or out-of-pocket expense) is the amount or percentage of each medical charge that you are required to pay. For example, you may have a $100 medical charge. Your health insurance company will pay 80% of the charge and you are responsible for the additional 20%. The 20% is your coinsurance amount.

Coinsurance accrues throughout the year. If you have a large number of medical charges in one year, you may meet the coinsurance maximum requirement for your policy. At that point, any covered charges will be paid at 100% for the remainder of the calendar year.

Stop loss or out-of-pocket expense limit

Sometimes you will hear the out-of-pocket expense limit referred to as your stop loss or coinsurance amount. Basically, this is the amount you will need to pay out of your own pocket per calendar year before the health insurance company pays everything at 100%.

You will need to check your policy because many policies that require co-payments do not allow these co-payments to go toward the out-of-pocket amount. For example, you may have reached your out-of-pocket maximum for the year, so if you are admitted to the hospital you may pay nothing. However, since you have to pay a $15 co-payment every time you visit the doctor, you will still have to make this co-payment.

Lifetime maximum benefit

This is the maximum amount that the health insurance company will pay toward your medical expenses for the lifetime of your policy. Generally, this amount is in the millions of dollars. Unless you have a very severe condition, you will not likely exhaust this amount.

Preferred Provider Organization

A Preferred Provider Organization (also known as a PPO) is a group of participating medical providers who have agreed to work with the health insurance company at a discounted rate. It's a win-win situation for each side. The insurance company has to pay less money and the providers receive automatic referrals.

In most health insurance policies, you will see different benefit levels depending on whether you visit a participating or nonparticipating provider. A PPO plan provides more flexibility for the insured person because they can visit either a participating or nonparticipating provider. They just receive a better price if they use a participating one.

Health Maintenance Organization

A Health Maintenance Organization (also known as an HMO) is a health insurance plan which restricts you to only using specified medical providers. Generally, unless you are out of the area of their network, no benefits are payable if you go to a nonparticipating physician. Typically, you are required to select one main doctor who will be your Primary Care Physician (PCP). Any time you have a health problem, you must visit this doctor first. If they feel that you need it, they will refer you to another network provider. However, you cannot just decide on your own to visit a specialist; you must go through your PCP.

Medically necessary

You will see this term in all health insurance policies, and it is a frequent cause of denied claims. Most insurance companies will not cover any expenses that they do not consider medically necessary. Just because you and/or your doctor consider something medically necessary, your health insurance company may not. For this reason, you always need to verify that any costly procedures you are considering will be covered.

Routine treatment

Routine treatment is generally defined as preventive services. For example, a yearly physical examination that you have on a regular basis is generally considered to be routine. Many of the immunizations that children and adults receive fall under this classification. Some insurance companies provide limited coverage for routine treatment; others provide no benefits at all.

Pre-existing condition
A pre-existing condition is a condition that you acquired and/or received treatment for prior to the effective date of your current health insurance policy. Health insurance companies vary on how they treat pre-existing conditions. Some companies will not give you coverage at all if you have certain chronic pre-existing conditions. Others will give you coverage but will not provide any benefits for a period of time -- usually from 12-24 months. Still, other health insurance companies will specifically exclude a pre-existing condition from a policy and will never provide any benefits for that condition.

Be sure that you are very clear on the pre-existing limitations of your policy so that you are not unpleasantly surprised when you visit your doctor.

Explanation of Benefits
This is the form that the health insurance company sends you after they complete the handling of your claim. It details the bill they received and how they processed it. It is commonly called an EOB.

Coordination of Benefits
If you are eligible for benefits under more than one health insurance plan, your various health insurance companies will need to coordinate benefits. This insures that no more than 100% of the total charge is paid. There are many variations on how this situation can occur. In general, the primary company makes their payment first. Then you file a copy of the charges with the secondary company along with a copy of the Explanation of Benefits (EOB) from the primary company. The secondary company usually picks up the remainder of the bill.

Participating provider
A participating provider is a medical provider who has signed a contract with a health insurance company or health insurance network to charge pre-determined rates to patients who are in the network.

Nonparticipating provider
A nonparticipating provider is a medical provider who does not have a contract with a particular health insurance company or network. If you use a nonparticipating provider, you will generally pay a larger portion of the bill. In some cases, you may be responsible for the entire bill.

Limited benefit plans
These are not considered to be comprehensive medical insurance plans. Instead, they provide very specific, limited benefits for different types of services. For example, they may provide a flat rate for each day you stay in the hospital or pay a limited amount for each surgical procedure that you have.

Typically, they are marketed toward people who cannot afford or are unable to obtain more comprehensive coverage due to pre-existing health conditions. Or, they may be geared toward people who have high-deductible plans. The good thing about these plans is that they generally pay in addition to any other coverage you may have. Therefore, no coordination of benefits is required.

If this is your only coverage, be aware that you will usually have to pay a large portion of any bill as these limited plans do not usually pay large amounts per day. For example, it may actually cost you $1000 a day to stay in the hospital. If your limited benefit plan pays you $200 a day for each day you spend in the hospital, you will be personally responsible for the remaining $800 per day.

Medicare supplement plans
People who have Medicare often choose to purchase a Medicare supplement plan as Medicare does not usually cover medical charges in full. Medicare continues to change and add new options but, in general, a supplemental plan pays the balance of the medical charges after Medicare pays its portion. For example, most Medicare supplements will pick up the Medicare deductible.

Some policies also pay for some of the charges that Medicare may not cover. There are many different policy variations. If you are not sure what you are purchasing, consider contacting a broker that assists senior citizens.

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