Billing & Insurance Glossary of Terms

Here are some common terms you will encounter when dealing with billing and insurance issues.

Allowed Expenses
The maximum amount a plan pays for a covered service

Benefits
These are medical services for which your insurance plan will pay, in full or in part.

Beneficiary
This is someone who is eligible for or receiving benefits under an insurance policy or plan.

Claim
This is a notice to the insurance company that a person received care. A claim is also a request for payment.

Coding
How physician's services are identified and defined.

Co-insurance
A type of cost sharing where the beneficiary and insurance provider share payment of the approved charge for covered services.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A federal law that requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance has been terminated. Cobra makes coverage available for up to 18 to 36 months. COBRA enrollees may be required to pay 100 percent of the premium.

Coordination of Benefits (COB)
A provision that applies when a person is covered under more that one group medical program.

Co-insurance
This is a term that describes a shared payment between an insurance company and an insured individual. It's usually described in percentages: for example, the insurance company agrees to pay 80% of covered charges and the individual picks up 20%.

Co-payment
A set fee the member pays to providers at the time services are provided. Co-pays are applied to emergency room visits, hospital admissions, office visits, etc. The patient should be aware of the co-payment amounts prior to services being rendered.

Coverage
What services the health plan does or does not pay for.

Covered Expenses
What the insurance company will consider paying for as defined in the contract.

Date of Service (DOS)
The date(s) healthcare services were provided to the beneficiary.

Deductible
A portion of the covered expenses (typically $100, $200 or $500) that an insured individual must pay before insurance coverage with co-insurance goes into effect. Deductibles are standard in my policies, and are usually based on a calendar year.

Enrollee
This is the person who is covered by health insurance.

Explanation of Benefits (EOB)
The coverage statement sent to covered persons listing services rendered, amount billed and payment made. This normally would include any amounts due from the patient, as described in "Beneficiary Liability," "Co-insurance," "Deductible" and "Co-payment"

Health Care Provider
An individual or institution that provides medical services (e.g. a physician, hospital or laboratory).

Health Insurance
Health Insurance coverage provides for the payment of benefits as a result of sickness or injury.

Health Insurance Portability and Accountability Act (HIPPA)
HIPPA is federal legislation to provide easier portability of medical information by standardizing electronic transaction and code sets, and enacting additional patient privacy provisions.

Health Maintenance Organization (HMO)
This is an entity which provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium.

Managed Care
Managed care is a system of managing medical care to ensure a certain standard of care, measure performance, and control costs.

Maximum Out of Pocket
The most money you can expect to pay for covered expenses. The maximum limit varies from plan to plan. Once the maximum out-of-pocket has been met, the health plan will pay 100% of certain covered expenses.

Medicaid
Medicaid is a jointly-funded, Federal-State health insurance program for certain low-income and need people. It covers many individuals including children, the aged, blind, and/or disabled.

Medicare
Medicare is a federal insurance program for people age 65 and older and certain disabled individuals. The Medicare program consists of two parts, Medicare Part A (hospital insurance) and Medicare Part B (supplemental medical insurance).

Medicare Advantage Plans
Medicare Advantage Plans are health plan options that are part of the Medicare program. If you join one of these plans, you generally get all your Medicare-covered heath care through that plan. Medicare Advantage plans include:

- Medicare Health Maintenance Organizations (HMO's)
- Preferred Provider Organizations (PPO)
- Private Fee-for Service Plans

Medicare Part A (Hospital Insurance)
Medicare part A pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

Medicare Part B (Medical Insurance)
Medicare part B covers doctors' services and outpatient hospital care.

Medicare Supplement Policy (Medsupp)
The insurer which pays a policyholder's Medicare co-insurance, deductible and co-payments for Medicare Part A and B and may provide additional supplement benefits according to the supplement policy selected.

Medigap Insurance
Medigap is individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, co-insurance and balance bills, as well as payment for services not covered by Medicare.

Network
Physicians, hospitals, and other health care providers that an HMO, PPO or other managed care network has selected to provide care for its members.

Non-Participating Provider
A non-participating provider is also known as an out-of-network provider. This is a healthcare provider who has not contracted with the carrier of a health plan to be a participating provider of health care.

Out of Network
Out of network coverage is for treatment obtained from a non-participating provider. Usually, it requires payment of a deductible and higher co-payments and co-insurance than for treatment provided by a participating provider. The insurer may also deny the entire bill.

Out-of-Pocket-Costs
This is the portion of payments for covered health care services required to be paid by the patient, including co-payments, co-insurance and deductibles.

Participating Provider
This is a provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility or a physician who has contractually accepted the terms and conditions as stipulated by the health plan.

Point-of-Service Plan
Managed care product that offers their enrollees a choice when they need medical services, rather than when they enroll in the plan. Enrollees may use providers outside the managed care network, but usually at a higher cost.

Preauthorization
Preauthorization is a plan requirement in which you or your primary care physician need to notify your insurance company in advance about certain medical procedures in order for those procedures to be considered a covered expense.

Pre-certification
This is authorization given by a health plan for a member to obtain services from a health care provider, usually required for hospital services.

Preferred Provider Organization (PPO)
This is a program that establishes contracts with providers of medical care. Providers under such contracts are known as preferred providers. The benefit of using a PPO is that it lowers member costs for services received for preferred providers; this encourages enrollees to use these providers.

Primary Care Physician (PCP)
This is a physician who practice is devoted to internal medicine, family/general practice and pediatrics. An obstetrician/gynecologist sometimes is considered a primary care physician, depending of coverage.

Referral
Consent from a primary care physician for a patient referral to ancillary services and specialists.

Secondary Insurance
This is an insurance policy, plan, or program that pays second on a claim for medical care.

Specialist
This is a physician who specializes in a specific are of medicine.

Subscriber
Subscriber is the person responsible for payment of premiums or whose employment is the source for eligibility in a health plan.

Usual, Customary and Reasonable
This is a term used to refer to commonly charged fees for health care services within a geographic area.