Billing: Glossary

- **Adjustment/Discount**
  The portion of your bill that is adjusted in accordance with the contract between UCDHS and your insurance company.

- **Amount Not Covered**
  The amount your insurance company will not pay, for example: deductibles, co-insurance, co-payments, and other charges for services determined to be non-covered as part of you benefit package.

- **Ancillary Services as Defined by the No Surprises Act**
  Ancillary services are defined under the No Surprises Act to include care related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; care provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services (including radiology and laboratory services). This means these types of providers—or, in some instances, the providers that offer these types of care—can never ask a patient to sign a consent waiver to be balance billed for services covered by the No Surprises Act.

- **Applied to Deductible**
  The portion of your bill, as agreed with your insurance company, that you owe your medical provider.

- **Authorization**
  Permission to provide referred or requested a service that is granted by one or more of the following:
  Health insurance plan, or medical group or the hospital depending upon who is financially responsible for the requested or referred services that are to be performed.

- **Authorization Number**
  A number your insurance company issues that indicates your treatment has been approved.

- **Balance Billing**
  When a provider bills for the difference between the provider's charge and the payment received from the patient's insurance. For example, if the provider's charge is $100 and the insurance payment is $70, the provider may bill the patient for the remaining $30.

- **Benefit**
  The services that are covered under your insurance plan.

- **Bill/Statement**

  A printed summary of the medical services you received.

- **Birthday Rule**

- Used to determine primary and secondary coverage for children. The word "birthday" refers only to the month and day in a calendar year, not the year in which the person was born.
- If the parents are not separated or divorced, the insurance of the parent whose birthday occurs first in a calendar year is considered the primary insurance while the other parent's benefits are considered the secondary coverage.
- If the parents have the same birthday, the insurance plan that has covered the parent for the longest time is considered the primary insurance.
- In situations where the parents are separated or divorced and there is more than one insurance plan covering the child, the benefits are determined in the following order. **
- The insurance plan of the parent with legal custody of the child.
- The plan of the spouse of the parent with legal custody of the child.
- Last is the plan of the parent who does not have legal custody of the child.

  ** There can be some discrepancy, depending on a court decree, if there are no specific terms on a court decree (stating only that the parents share joint custody), the benefit determination would be the same as the first bullet above where if the parents are not separated or divorced, the insurance of the parent whose birthday occurs first in a calendar year is considered the primary insurance while the other parent's benefits are considered the secondary coverage.

- **Claim**

  The bill for your services that the hospital and/or physician sends to your insurance company for payment.

- **Co-insurance**

  The portion of your covered services that your insurance company requires you to pay after meeting your deductible.

- **Co-payment**

  A set fee established by your insurance company for a specific type of visit.

- **Coordination of Benefits (COB)**

  A group policy provision which helps determine the primary carrier in situations where an insured is covered by more than one policy.

- **Covered Services**
  A health care service, your insurance company agrees to pay a pre-established rate and/or percentage for.

- **Date of Service (DOS)**
  The date you were provided healthcare services.

- **Deductible (DED**)
  The amount of money, as determined by the benefit plan. A person must pay for authorized health care services before insurance payment commences. Deductibles are usually calculated on a calendar year basis but can also be based on the anniversary date of a patient's effective date with that plan or plan year of the named insured or subscriber.

- **Exclusive Provider Organization (EPO)**
  There are two types of EPO plans.
  - The current industry standard requires that a patient select a Primary Care Physician (PCP) (some patients may only have to choose a medical group) and when needed obtain authorization from that PCP to receive specialty services. A patient must stay within the contract network and only use preferred providers. There typically is a lifetime policy maximum with this type of plan. In the event a patient goes out of network (OON) they may be responsible for the entire balance that is not paid by the payer associated with the services provided.
  - The other type of EPO is one where the benefits are those of a PPO but the provider panel from which members obtain care is smaller than a PPO panel.

- **Explanation of Benefits (EOB)**
  The notice you receive from your insurance company explaining how your claim was processed and/or paid. It will indicate the amount billed, paid, denied, discounted, not covered, and the amount owed by the patient.

- **Guarantor**
  The person or entity who is financially responsible for payment on a patient's account. Usually the patient is financially responsible for medical charges. A parent or legal guardian/trustee is the guarantor for patient's 18 years of age and younger. This is also the case for patients with a decreased mental capacity.

- **Insured's Name (Beneficiary)**
  The name of the insured person.

- **In-Network Provider**
  Refers to providers or health care facilities that are part of a health plan's network of providers. They are also called participating providers. Health plan members (patients) usually pay less when accessing an in-network provider because in-networks providers have negotiated fees for the health plan's members' covered services.

- **Medi-Cal**
  A California state sponsored medical assistance program enabling eligible recipients to obtain essential medical care and services.

- **Medi-Cal Managed Care**
  The conversion of fee-for-service Medi-Cal to PCP governed care whereby eligible select a primary care physician who manages all care provided to the members via treatment or referrals for treatment by specialists. Patients who do not follow the prescribed guidelines are responsible for all charges associated with that episode of care and are not covered by the state of Medi-Cal program.

- **Medicare**

- Medicare is a federal insurance program which primarily serves those over 65 years old and younger, disabled people and dialysis patients. Medicare is divided into two parts:
- Medicare Part A covers inpatient hospital services, nursing home care, home health care and hospice care.
- Medicare Part B helps pay the cost of doctors' services, outpatient hospital services, medical equipment and supplies and other health services and supplies.
- Medicare Part C is called a "Medicare Risk" or "Medicare Advantage Plan"
- Medicare Supplement
  A supplemental private insurance policy to help cover the difference between approved medical charges and benefits paid by Medicare.

- **Network**
  A group of health care providers. It includes doctors, specialists, dentists, hospitals, surgical centers, and other facilities. These health care providers have a contract with the health insurance plan.

- **Non-Covered Services**
  A cost incurred by the patient when his/her insurance policy does not cover.

- **Out-of-Network (OON)/Non-Contracted Plan**
  Services rendered by a provider which does not have a contract to offer you care. Typically, managed care plans are contracted with a panel of providers. If a patient seeks care out-of-network, they may be financially responsible for some, or all the care provided. An exception to this rule is emergency medical care.

- **Out-of-Network Provider**
  Services rendered by a provider who is not a part of the health plan's contracted network of providers. If an individual seeks care out-of-network, he/she may be financially responsible for some, or all the care provided. An exception to this rule is emergency medical care.

- **Out-of-Pocket Costs**
  The amount that is paid by the patient or guarantor.

- **Out-of-Pocket Maximum**
  The maximum yearly amount that is paid by the patient or guarantor.

- **Point of Service (POS)/Tiered Plan**
  Health coverage that allows the patient to utilize a variety of benefits associated with different level/tiers of coverage. The following is an explanation of the common tiered POS coverage.
    - Tier 1 Level Benefits (HMO Coverage): members are assigned or chose a PCP; the PCP must manage the care. Stanford Health Care must obtain authorization for specialty services. Typically, patients are only responsible for their co-pays.
    - Tier 2 Level Benefits (PPO Coverage): the patient may self-refer to any in-network-contracted provider without obtaining authorization from their PCP but authorization is often required from the insurance company. Patients are responsible for a deductible and a percentage of their medical costs.
    - Tier 3 Level Benefits: coverage for medical care provided to POS members from non-contracted provider. Insurance payment amount is dependent on the benefit offered by the plan. Services may be denied by the insurance company as not covered and the patient is responsible for 100% of all charges. Typically, the patient is responsible for a larger share of the charges.
    - Care provided to POS members without the required authorization from their health plan will result in the patient being financially responsible for 100% of the charges.

- **Policy Number**
  A number your insurance company gives you to identify you and/or your coverage.

- **Pre-Certification Number**
  This number represents the agreement by the insurance company that the services has been approved. This is not a guarantee of payment.

- **Pre-Existing Condition**
  A health condition or a medical problem acknowledged by your insurance company as not covered as a benefit.

- **Preferred Provider Organization (PPO)**
  - Health coverage that allows the member to direct his/her own healthcare.
  - A patient may self-refer within a contracted network of physicians; after paying a deductible, a patient is commonly responsible for 10% or 20% of the allowable fee.
  - A patient may choose to receive treatment from a provider outside of the PPO network thereby increasing his/her deductible or out-of-pocket maximum.
  - The patient may be responsible for obtaining authorization from the health plan for some services such as physical therapy and MRI services.
  - There is typically a lifetime policy maximum associated with PPO coverage.

- **Primary Care Physician (PCP)**
  - The primary care physician (can be an internist, pediatrician, family physician, or OB/Gyn) is responsible for all general medical care of the patients and referrals to specialists for tertiary care when medically appropriate.
  - Most HMO, EPO and POS plans require members to choose or be assigned to a primary care physician.
  - The PCP is responsible for providing or authorizing all care (hospitalization, diagnostic, workups, and specialty referrals) for that patient
  - Depending on the type of insurance plan, a patient may not be covered for a visit to a specialist without prior approval of the primary care provider.

- **Primary Insurance Company**
  The insurance company responsible for paying your claim first.

- **Prior Authorization**
  - A utilization control measure employed by PPO, EPO, HMO and POS plans, whereby, elective hospital admissions or other expensive medical services or procedures must be approved by the insurance company, medical group, gatekeeper, or primary care physician in advance.
  - Such advance approval is known as prior authorization and is based on the insurance companies' determination of medical necessity, appropriateness, and other pertinent factors.
  - Generally, surgeries require prior authorization as do many procedures and tests done in the physician's office. A utilization review or prior authorization phone number is usually available from the insurance company to request authorization.
  - For all emergency surgeries and admissions, the provider must notify the insurance carrier of the patient's admission within 24 hours.

- **Provider**

  A hospital or physician who provides medical care to the patient.

- **Provider Charge**

  The amount of money the hospital or physician charges for a specific medical service.

- **Responsible Party/Guarantor**

  The person responsible to pay the bill.

- **Referral**

  A physician's medical order for services or consultations to be provided by a specialist.

- **Secondary Insurance**

  The insurance company responsible for paying the balance of your claim after the primary insurance company has determined benefits.

- **Self-Pay**

  If you do not have insurance, or if you are seeking care at Stanford Health Care and Lucile Packard Children's Hospital outside of your insurance plan benefits, you are considered a self-pay patient. The Stanford Health Care and Lucile Packard Children's Hospital self-pay policy requires full payment within 30 days of billing.

- **Share of Cost (SOC)**
  SOC may change when monthly income changes.

- **Subscriber**
  - A person who is enrolled for benefits with an insurance company. One subscriber may represent.
  - Health coverage that allows the member to direct his/her own healthcare.
  - A patient may self-refer within a contracted network of physicians; after paying a deductible, a patient is commonly responsible for 10% or 20% of the allowable fee.
  - A patient may choose to receive treatment from a provider outside of the PPO network thereby several members, such as dependents who are covered by their parents.

- **Surprise Billing**
  "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

- **Surprise Billing Protection Form**
  Refers to a form used as part of the notice and consent process (as mandated by the No Surprises Act) to provide a Good Faith Estimate on the charges for the services sought and allows a patient to waive their balance billing protections (agree to be balance billed for the out-of-network care).

- **Total Charges**
  The total price of your medical services.

- **Worker's Compensation**
  The cost for medical services that insurance companies believe are appropriate throughout the geographic area or community.