Quadax
Revenue Cycle Optimizers

Your Guide to

Understanding Healthcare Billing

Allowed Amount
The highest amount your insurance company will cover (pay) for a service.

Benefit Period
The time period when services are covered under your plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date. It is often one calendar year for health insurance plans.
Example: You may have a plan with a benefit period of January 1 through December 31 that covers 10 physical therapy visits. The 11th or more session will not be covered.

Billed Amount / Amount Billed
The full amount billed by your provider to your insurance company. The amount paid by your insurance company (the allowed amount) is the amount the provider agreed to accept for the services provided.

Coinsurance
A certain percent you must pay each benefit period after you have paid your deductible. This payment is for covered services only. You may still have to pay a copay.
Example: Your plan might cover 80 percent of your medical bill. You will have to pay the other 20 percent. The 20 percent is the coinsurance.

Coinsurance Limit (or Maximum)
The most you will pay in coinsurance costs during a benefit period.

Copayment (Copay)
The amount you pay to a healthcare provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Covered Charges
Charges for covered services that your health plan paid for. There may be a limit on covered charges if you receive services from providers outside your plan's network of providers.

Deductible
The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time).
Example: If your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your healthcare services. After you reach $2,000, your health insurer will cover the rest of the costs.

Emergency Medical Condition
A medical problem with sudden and severe symptoms that must be treated quickly. In an emergency, a person with no medical training and an average knowledge of health/medicine could reasonably expect the problem could:

- Put a person's health at serious risk.
- Put an unborn child's health at serious risk.
- Result in serious damage to the person's body and how his or her body works.
- Result in serious damage of a person's organ or any part of the person.

FSA (Flexible Spending Account)

An FSA is often set up through an employer plan. It lets you set aside pre-tax money for common medical costs and dependent care. FSA funds must be used by the end of the term-year. It will be sent back to the employer if you don't use it. Check with your employer's Human Resources team. The can provide a list of FSA-qualified costs that you can purchase directly or be reimbursed for. A few common FSA-qualified costs include:

- Copays for doctors' visits, chiropractor and psychological sessions
- Hospital fees, medical tests and services (like X-rays and screenings)
- Physical rehabilitation
- Dental and orthodontic expenses (like cleaning, fillings and braces)
- Inpatient treatment for alcohol or drug addiction
- Vaccines (immunizations) and flu shots

High-Deductible Health Plan (HDHP)

A health plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible). A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

HMO (Health Maintenance Organization)

Offers healthcare services only with specific HMO providers. Under an HMO plan, you might have to choose a primary care doctor. This doctor will be your main healthcare provider. The doctor will refer you to other HMO specialists when needed. Services from providers outside the HMO plan are hardly ever covered except for emergencies.

HRA (Health Reimbursement Account)

An account that lets an employer set aside funds for healthcare costs. These funds go to reimburse Covered Services paid for by employees who take part. An HRA has tax benefits for employer and employees.

HSA (Health Savings Account)

An account that lets you save for future medical costs. Money put in the account is not subject to federal income tax when deposited. Funds can build up and be used year to year. They are not required to be spent in a single year. HSAs must be paired with certain high-deductible health insurance plans (HDHP).

Medicare

A federal government program that provides healthcare coverage for individuals 65+, under 65 and receiving Social Security Disability Insurance for a certain amount of time, or under 65 with end-stage renal disease.

Medicare Advantage

Also called Medicare Part C – are insurance plans through private insurers who pay the claims instead of Medicare. Most Medicare Advantage plans combine medical and Part D prescription drug coverage. Most also coordinate the delivery of added benefits, like vision, dental and hearing care.

Medigap

An extra health insurance plan purchased through a private insurance company to pay for costs not covered by original Medicare, such as copays, deductibles and healthcare if you travel outside of the United States. Medigap policies do not cover long-term care, dental or vision care, hearing aids, eyeglasses or private-duty nursing. Most plans don't cover prescription drugs.

Medically Necessary (or Medical Necessity)
Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:

- Accepted as standard practice. It can't be experimental or investigational.
- Not just for your convenience or the convenience of a provider.
- The right amount or level of service that can be given to you.

Example: Inpatient care is medically necessary if your condition can't be treated properly as an outpatient service.

Network Provider/In-network Provider
A healthcare provider who is part of a plan's network.

Non-covered Charges
Charges for services and supplies that are not covered under the health plan. Examples of non-covered charges may include things like acupuncture, weight loss surgery or marriage counseling. Consult your plan for more information.

Non-network Provider/Out-of-network Provider
A healthcare provider who is not part of a plan's network. Costs associated with out-of-network providers may be higher or not covered by your plan. Consult your plan for more information.

Outpatient Services
v]Services that do not need an overnight stay in a hospital. These services are often provided in a doctor's office, hospital or clinic.

Out-of-pocket Cost
Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum out of pocket (MOOP) cost. Consult your plan for more information.

PPO (Preferred Provider Organization)
A type of insurance plan that offers more extensive coverage for the services of healthcare providers who are part of the plan's network, but still offers some coverage for providers who are not part of the plan's network. PPO plans generally offer more flexibility than HMO plans, but premiums tend to be higher.

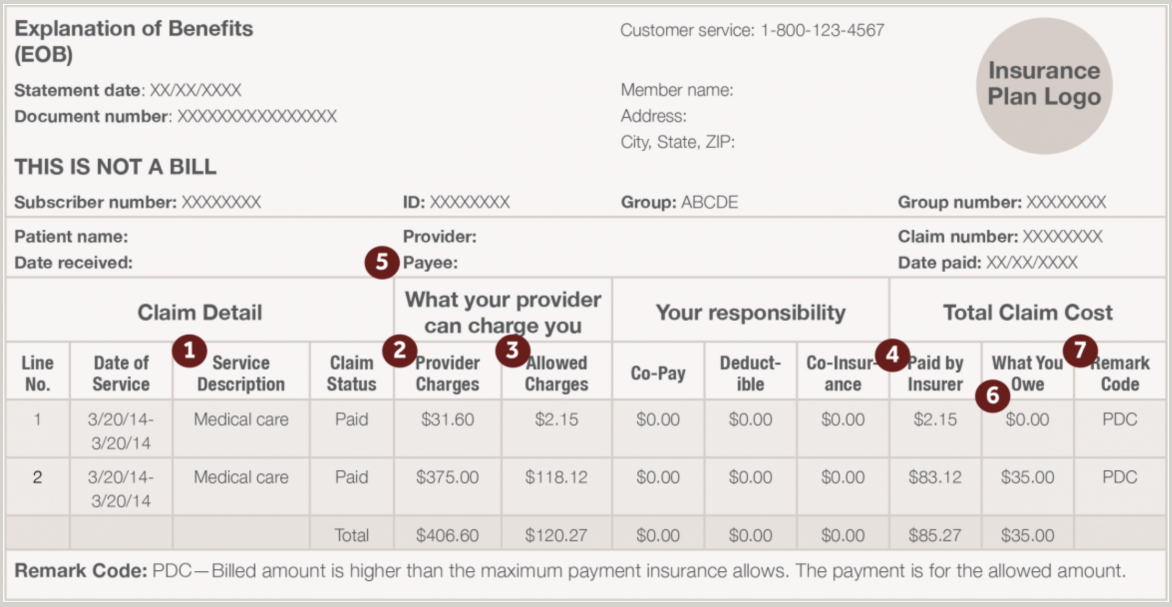
Prior Authorization
A requirement that your physician receive approval from your health insurance company to prescribe a specific service, treatment or medication for you.

Predetermination
A written request by a provider to determine if a proposed treatment or service is covered under your health insurance plan before you receive the service.

Premium
Payments you make to your insurance provider to keep your coverage. The payments are due at certain times.

Utilization Review
A critical evaluation by your insurance company of healthcare services provided to you to confirm the plan covers the service.

SAMPLE EOB



Explanation of Benefits (EOB)

Customer service: 1-800-123-4567

Insurance Plan Logo

Statement date: XX/XX/XXXX
Document number: XXXXXXXXXXXXXXX

Member name:
Address:
City, State, ZIP:

THIS IS NOT A BILL

Subscriber number: XXXXXXXX | **ID:** XXXXXXXX | **Group:** ABCDE | **Group number:** XXXXXXXX

Patient name:
Date received:

Provider:
Payee: 5

Claim number: XXXXXXXX
Date paid: XX/XX/XXXX

Claim Detail				What your provider can charge you		Your responsibility			Total Claim Cost		
Line No.	Date of Service	1 Service Description	Claim Status	2 Provider Charges	3 Allowed Charges	Co-Pay	Deduct-ible	4 Co-Insur-ance	Paid by Insurer	6 What You Owe	7 Remark Code
1	3/20/14-3/20/14	Medical care	Paid	$31.60	$2.15	$0.00	$0.00	$0.00	$2.15	$0.00	PDC
2	3/20/14-3/20/14	Medical care	Paid	$375.00	$118.12	$0.00	$0.00	$0.00	$83.12	$35.00	PDC
			Total	$406.60	$120.27	$0.00	$0.00	$0.00	$85.27	$35.00	

Remark Code: PDC—Billed amount is higher than the maximum payment insurance allows. The payment is for the allowed amount.

Depicted in EOB statement example above, are these points for reference:

1- SERVICE DESCRIPTION is a description of the health care services you received, like a medical visit, lab tests, screenings, surgery or lab tests.

2- PROVIDER CHARGES is the amount your provider bills for your visit.

3- ALLOWED CHARGES is the amount that your provider will be reimbursed, negotiated between the carrier and the provider (this may not be the same as the Provider Charges).

4- PAID BY INSURER is the amount your insurance plan will pay to your provider.

5- PAYEE is the person who will receive any reimbursement for over-paying the claim.

6- WHAT YOU OWE is the amount the patient or insurance plan member owes after your insurer has paid. You may have already paid part of this amount, and payments made directly to your provider may not be subtracted from this amount. Wait to receive a bill from your provider before paying for the services.

7- REMARK CODE is a note from the insurance plan that explains more about the costs, charges, and paid amounts for your visit.