Common Insurance Terms

Allowed Amount - The maximum amount that the provider is allowed to be paid for a service. This includes the insurance payment and any money collected from the patient/family.

Balance Billing - When a provider bills the patient/family the remaining balance after the insurance has made a payment. Balance billing is not allowed by in-network providers for covered services.

Benefit/Plan Year - The health plan benefits run for 12 months from the plan effective date.

Billed Amount - The full visit amount the provider bills the insurance. The write off/adjustment will be deducted from this amount.

Birthday Rule - When both parents have health insurance to cover a child, the primary insurance is determined by the parent's birthday that falls first in the year. For example, if the mom's birthday is July 7th and the dad's birthday is February 3rd, the dads insurance would be primary and the moms would be secondary. The year they were born does not matter.

Calendar Year Benefits - The health plan benefits run from January 1st of the year to December 31st of the same year.

Capitation - The insurance company has a specific provider that the therapy services must be performed by.

Claim - A bill from the provider to the insurance company that lists the services performed and other details included the billed amount.

COBRA Policy - Temporary health insurance coverage that a patient/family pays for after employment health coverage has ended.

Co-Insurance - A percentage of the allowed amount that is due by the patient/family for each therapy visit. For example, if the insurance allowed amount is $100 for the therapy visit and the patient has a 20% co-insurance, they will pay 20% of $100, which is $20.

Co-Pay (Co-Payment) - A fixed amount due by the patient/family for each therapy visit.

Coordination of Benefits - When a health plan will verify with the patient/family if there is any other health coverage for the patient/family.

Cost Share - Either a percentage or a flat rate of the allowed amount that is due by the patient/family for each therapy visit.

Covered Expenses - Healthcare services that would be reimbursable under the patient/family health plan.

Date of Service Rate - The fee for therapy services when they are paid in full on or before the date they are performed.

Deductible - This dollar amount must be paid in full by the patient/family before the insurance will make any payments. There is usually an individual and a family deductible amount. Under some plans, therapy services are not subject to the deductible. Each plan is different. Deductibles are usually based on a calendar year; however they could also be based on a benefit/plan year.

Effective Date - The start date that the patient became eligible on the insurance policy. The eligibility may change from month to month.

EPO (Exclusive Provider Organization) - An insurance company or health plan that offers care that has requirements that must be followed for services to be covered. These plans are generally not as restrictive as HMO or MCO. For example, a patient must see an in-network provider, but no referrals are required to see a specialist.

Exclusion/Excluded Services - Healthcare services, specific conditions, or circumstances that the insurance company or health plan do not cover.

Flexible Spending/Health Savings Account - An account that the patient/family adds money to and can use to pay for certain health care expenses.

HMO (Health Maintenance Organization) - An insurance company or health plan that offers care that has requirements that must be followed for services to be covered. For

example, a patient must see an in-network provider and referrals are required to see a specialist.

In-Network Provider - The rendering provider is contracted with the insurance plan network. The provider will have a set allowed amount and can only bill the patient for certain items.

In-Patient - When a patient receives treatment/services in a hospital or skilled nursing facility.

Insured - The primary person on the insurance policy.

Lifetime Max - The maximum amount (dollars or visits) that an insurance company will pay for a covered service for the entire time the plan is in effect.

MCO (Managed Care Organization) - An insurance company or health plan that offers care that has requirements that must be followed for services to be covered. For example, a patient must see an in-network provider and referrals are required to see a specialist.

Medicaid - A healthcare insurance program that is run by the state. There are different types of plans including fee for service (standard), waiver programs (including Katie Beckett) and the MCO's (HPN, Silver Summit, Anthem, and Molina).

Medicare - A government health insurance program. Patients can qualify for Medicare coverage if they are 65 years old or above or if they have certain disabilities. The four common coverages to Medicare are Part A (hospitals), Part B (Doctors and Outpatient Services), Part C (Medicare Advantage), and Part D (Prescription Drugs).

Medicare Advantage Plan - A health plan offered by private insurance companies to replace Medicare coverage. They generally have more benefits covered than a standard Medicare plan.

Medigap - A term used to describe a Medicare supplemental insurance plan that covers costs that are not covered by Medicare.

Medically Necessary - Refers to the decision made by a health plan if a medical treatment, test, or procedure is necessary to maintain or restore the patients' health or to treat a diagnosed medical problem. For example, if the insurance feels therapy is not medically necessary, they will not pay for the service.

Open Enrollment - The only period of time when a patient/family can purchase or make changes to their healthcare plan. If changes are not made during open enrollment, then there must be a qualifying event to make changes at a different time in the year.

Out-Patient - When a patient receives treatment/services and can come and leave on the same day.

Out of Network Provider - The rendering provider is not contracted with the insurance plan network. The provider can bill the patient/family any remaining balance after the insurance payment has been made.

Out of Pocket Max - The highest dollar amount that a patient will have to pay in a plan year. This usually includes deductibles, co-pays, and co-insurance. Most plans have an individual and a family out of pocket max amount. Once an out-of-pocket amount is met, the insurance will cover 100% of the cost of the covered service.

PPO (Preferred Provider Organization) - An insurance company or health plan that offers care with the least requirements for covered services. For example, a patient can see an in-network or out-of-network provider and specialists without a referral.

Premium - The amount of money the patient/family pays monthly or annually for their insurance policy.

Primary Insurance - This term is used for the first insurance payer when the patient has multiple insurance policies.

Qualifying Event - A change in life circumstances that will allow a patient/family to alter their current health insurance plan outside of the open enrollment time period. For example, moving to a different state, losing health insurance, or having a baby.

Rehabilitation Services - Healthcare services that help a patient keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology.

Reimbursement - The payment made to a provider for the services that the patient received.

Secondary Insurance - This term is used for the second insurance payer when a patient has multiple insurance policies.

Termination/Expiration Date - The last date the patient will be covered on the insurance plan.

Tertiary Insurance - This term is used for the third insurance payer when a patient has multiple insurance policies.

Verification of Benefits - When a provider's office will contact a patient's insurance company to confirm the coverage and benefits.

Write Off/Adjustment Amount - Any dollar amount that is above the contracted allowed amount. This amount is not due by the patient/family.