Glossary of Financial Terms and Definitions

Ambulatory Surgery
Surgery done in the doctor's office or at a surgical center that does not require an overnight stay.

Ancillary Providers
Services over and above physician services, including laboratory, radiology, home health and skilled nursing facilities.

Authorization
Approval of care required before a service is provided; pre-authorization may be necessary before hospital admission, or before care is given by non-HMO providers.

Balance Billing
Billing a patient for charges not paid by their insurance plan because the charges are above the Usual and Customary Rate or because procedure was not covered by their plan.

Carve-out Policy
A contracted agreement between an insurance company and another company which provides special services to its members, such as prescription drugs or cancer treatment.

Claim
A record of medical services provided to a patient and submitted by the provider to the insurance company for payment.

Co-insurance
A policy provision by which the insured individual shares in the cost of certain expenses.

Co-pay
A co-pay is the amount that a patient is responsible for at the time they visit a physician or hospital.

COBRA (Consolidated Omnibus Budget Reconciliation Act)
COBRA allows for employees and their dependents to continue to receive insurance coverage after the loss of a job or reduction in hours. COBRA insurance is more expensive than group insurance, but is still usually less expensive than individual coverage.

Deductible
The amount that an insurance policy holder must pay out-of-pocket before the insurance company will cover any other expenses.

eCheck
An exchange of funds in which money is electronically transferred from the bank account of one party into the bank account of the other party. The checking account routing number and account number are used to draw funds from the account. eChecks can clear much faster than written checks.

EOB (Explanation of Benefits) or EOP (Explanation of Payment)
An insurance statement describing medical benefits including detailed explanation of why certain charges may or may not have been paid, as well as patient responsibility.

Exclusion/Non Covered
Services or supplies not covered under a health plan.

Flexible Spending Account (FSA)
Allows an employee to set aside a portion of earnings to pay for qualified expenses, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in a substantial payroll tax savings.

Health Insurance Portability and Accountability Act (HIPAA)
Passed in 1996, this act helps to ensure that privacy is maintained regarding patients' medical records. It also created a set of standards to which all electronic medical records must adhere.

Health Savings Account (HSA)
A partially self-funded account in which an employer pays a predetermined portion of medical claims up to a cap.

Inpatient
A patient who is admitted to a hospital and receives medical services from a physician during a period of at least 24 hours.

Insurance Cap
An insurance cap is the total lifetime dollar amount that an insurance company will pay on a policy.

In-Network Provider
Physicians and other service providers who are contracted with an insurance company.

Observation
Type of service used by doctors and hospitals to decide whether you need inpatient hospital care or whether you can recover at home or in an outpatient area. Observation is usually charged by the hour.

Out-of-Network
Provider Physicians who are not contracted with an insurance company.

Outpatient
A patient who receives health care services but is not admitted to a hospital.

Payer
An entity that assumes the risk of paying for medical treatments. This can be a self-insured employer, a health plan, an HMO, a PPO or a government agency. Payment is typically made in accordance with a contract between the health plan and the member and/or the health plan and the provider.

Pre-certification
Also known as pre-admission certification, this is the process of obtaining authorization from insurance company for routine inpatient and outpatient admissions. Failure to obtain pre-certification may result in penalty to the provider or the subscriber.

Primary Care Physician
A physician, usually a general practitioner, family practitioner or internist, who delivers general health care, and is most often the first doctor a patient sees. This physician treats patients directly, refers them to a specialist (or secondary care physician), and/or admits them to the hospital.

Provider
A physician, hospital, laboratory, pharmacy, or other organization that provides health care, goods or services.

Referral Authorization
Approval for a member to see a physician or access services outside of the participating medical group.

Referring Physician
A physician who sends a patient to another doctor for specialty care or services.

Subscriber
A person who enrolls in a health care plan and agrees to pay for premiums, co-payments, and deductibles that are part of the plan.

Third-party Administrator (TPA)
An entity that processes health care claims and performs related business functions to a health plan.

Treating Physician
A physician who provides care to the patient.