

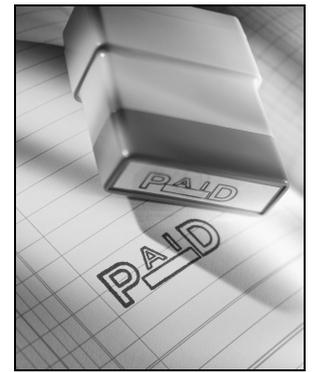
Patient Education

Patient Care Services



Money Matters

*Managing your health care bills from
University of Washington Medical Center
(UWMC)*





Patient and Family Centered Care *at University of Washington Medical Center*

University of Washington Medical Center (UWMC) provides health care through an approach called patient and family centered care (PFCC). PFCC invites patients to be as involved in their own health care as they want to be.

PFCC also actively involves patients, families, and staff as partners who all have a voice in developing programs and policies and influencing day-to-day interactions at the medical center. Some of its core concepts are communication, information sharing, choices, respect, partnership, and the understanding that the presence of family is a strength, not an inconvenience.

Patient and family centered care leads to better health outcomes, wiser allocation of resources, and greater employee, patient, and family satisfaction. It is simply the right thing to do.

Without UWMC's practice of patient and family centered care, *Money Matters* would not have been written. A dedicated team of patients, family members, and staff produced this resource. All are members of the Inpatient Oncology Advisory Council, and all added valuable insights, information, and input based on their own expertise and experience.

For more information about the Inpatient Oncology Advisory Council, other Patient and Family Advisory activities and councils, or patient and family centered care at UWMC, please contact:

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Patient and Family Centered Care, UWMC
206-598-2697
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Money Matters

*Managing your health care bills from
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This handbook provides information and tips from patients and families to help you understand, organize, and manage your bills for health care services. Most of the information is based on how billing works at University of Washington Medical Center (UWMC). However, many of the tips may help you organize and manage bills from other health care providers as well.

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We understand that this may be a stressful time for you and your loved ones. Managing money and health care bills may be your main concern or it may be the last thing on your mind. For many people, dealing with money issues, health care bills, and complicated systems is overwhelming.

We hope this handout is helpful. It includes:

- General information about health care bills.
- Suggestions about how to organize your records.
- Tips on how to read the bills from UWMC.
- Answers to common questions about patient billing.
- Resources and contact information for departments, agencies, and organizations related to this topic.
- Definitions of terms used in health care billing matters.

About Your Health Care Bills

After your hospital stay or clinic visit, you are likely to receive at least 2 separate bills, depending on what services were provided. Here are explanations of the different types of bills you may receive:

Facility Fees

Patient Financial Services (PFS) bills for services provided to patients of UWMC. Services billed by PFS are called *facility fees*. These include hospital stays, clinic visits, and other services such as X-rays, lab tests, and therapies. You will receive a separate bill for these medical center services.

Professional Fees

You may also receive a bill from UW Physicians (UWP) for *professional fees*. These fees are for services provided by individual doctors.

Provider-based Services

For *provider-based services* at UWMC clinics, you will be charged both a facility fee and a professional fee. The facility fee may be as much as, or more than, the professional fee, depending on services provided. Provider-based clinics include UWMC Pacific Clinics, UWMC Roosevelt Clinics, Eastside Specialty Center, UW Medicine Regional Heart Center-Alderwood, UWMC Prosthetics and Orthotics Clinic, and the Center on Human Development and Disability.

Other Providers and Facilities

Patients may also receive bills for visits and services involving other providers, including Seattle Cancer Care Alliance, Children's University Medical Group, ambulance companies such as Airlift Northwest, and Certified Registered Nurse Anesthetists (billed by Support Med). For information about bills from providers at other facilities not mentioned above, please contact them directly.

How to Organize Your Health Care Financial Records

Organizing your bills may be the last thing you are thinking about when facing a surgery, hospital stay, chronic health problem, or other health care issues. But in most cases, keeping your records organized will help lower your overall stress.

You may want to ask someone you trust to help keep your records organized. With a system in place, you will be able to find information when you need it, you'll be able to keep track of information, and it will be easier to spot errors if they occur.

All of us have different ways to organize records. It may help to start by deciding:

- How you want to organize – whether you will use:
 - A computer-based system, including what technology to use and how to name electronic folders and files.
 - A paper system, including using binders, files, and color coding.
 - A combination of computer and paper system.
- What papers to keep and what can be thrown away.
- What papers to copy and where to keep the copies.
- What order to put bills in – by date received, by provider, or by billing number or date.

Here are some helpful tips on organizing bills and other information, shared by current and former patients and family members:

- **In my binders, I have sections for EOBs (explanation of benefits), professional charges, facility charges, related expenses (such as occupational therapy, physical therapy, prescriptions, and parking fees), and other medical expenses (such as dentist or eye doctor visits).**
- **Make copies of the front and back of your insurance cards – your plan number may change from year to year and it's great to be able to reference the correct group number if the charges are not paid in a timely manner.**
- **I find it easiest to arrange EOBs and bills by the date of service. I keep all of these folders in a big zip-lock bag. This way they are all in one place and if I drop it in the rain, they are protected and won't go flying everywhere. I keep bills from different facilities in separate folders.**
- **You may want to keep the document that explains your insurance benefits with your health care financial records. It is in your best interest to know what your benefits are.**
- **You may want to consider dedicating one credit card for all medical charges. Keep the monthly statements in your files. At the end of the year, if you itemize your tax return and your expenses are over a certain percent of your income, you can deduct part of the money you paid out. Just add up the 12 statements and you are ready to figure out this portion of your taxes.**

Sample Bills from UWMC

Here are copies of actual bills from UWMC. The balance due is listed on the back of the statement (see next page).

<p>University of Washington Medical Center PO Box C-9715 Federal Way WA 98063</p>	<p>UNIVERSITY OF WASHINGTON MEDICAL CENTER UW Medicine</p>																																	
<p>03/27/08</p> <p style="text-align: right; font-size: small;">9203-6</p>	<p>Questions</p> <p>Billing questions or changes in insurance coverage?</p> <p>Toll Free: 866-298-2825 Fax: 888-945-0537 Or visit our website at www.uwmedicine.org</p> <p>Hours of Operation, 8:00am - 5:00pm Monday - Friday</p>																																	
<p>First Request For Payment</p>																																		
<p>Account Summary</p>																																		
<p>Balance due from patient: \$960.25</p> <p>Please see the reverse side of this statement for your account activity and listing of accounts.</p>																																		
<p>Important Message</p>																																		
<p>Thank you for selecting University of Washington Medical Center for your healthcare needs. We value your use of our services and facilities.</p> <p>The remaining balance is your responsibility. If you have any questions regarding the amount paid by your insurance, please contact them directly.</p> <p>Please mail your check or money order in the enclosed envelope. For your convenience, we also accept payment by credit card. If you choose to pay by credit card, please complete the appropriate information at the bottom of this statement.</p> <p>Please pay Balance Due within 30 days of statement date. If you are unable to pay in full, please call us to set up a payment plan. Thank you.</p>																																		
<p>Please Return Lower Portion With Your Payment In The Enclosed Envelope</p>																																		
<p style="text-align: center; font-size: x-small;">IF PAYING BY CREDIT CARD COMPLETE BELOW</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"> </td> <td style="width: 20%; text-align: center;">EXP DATE</td> <td style="width: 20%; text-align: center;">AMOUNT</td> </tr> <tr> <td colspan="3">CARDHOLDERS NUMBER</td> </tr> <tr> <td colspan="3">CARDHOLDERS NAME</td> </tr> <tr> <td colspan="2">CARDHOLDER ADDRESS</td> <td>ZIP CODE</td> </tr> <tr> <td colspan="3">CARDHOLDER SIGNATURE</td> </tr> </table>		EXP DATE	AMOUNT	CARDHOLDERS NUMBER			CARDHOLDERS NAME			CARDHOLDER ADDRESS		ZIP CODE	CARDHOLDER SIGNATURE			<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Name</td> <td style="width: 30%;">Account #</td> <td style="width: 40%;">Balance</td> </tr> <tr> <td style="background-color: #cccccc;"> </td> <td style="background-color: #cccccc;"> </td> <td>\$960.25</td> </tr> <tr> <td colspan="3" style="padding-top: 10px;">Statement Date: 03/27/08</td> </tr> <tr> <td colspan="3" style="padding-top: 10px;">Amount Paid: _____</td> </tr> <tr> <td colspan="3" style="padding-top: 20px;">Remit This Payment Stub To: University of Washington Medical Center PO Box 24366 Seattle WA 98124-0366</td> </tr> <tr> <td colspan="3" style="text-align: center; padding-top: 5px;"> </td> </tr> </table>	Name	Account #	Balance			\$960.25	Statement Date: 03/27/08			Amount Paid: _____			Remit This Payment Stub To: University of Washington Medical Center PO Box 24366 Seattle WA 98124-0366					
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Sample of billing statement (front)

For Your Information

If you are able to document financial hardship, you may be eligible for our Financial Assistance Program. For more information or to make payment arrangements, contact us at 1-866-298-2825.

Please Note: This statement does not include professional fees billed by UW Physicians.

We invite you to visit us on-line at www.uwmedicine.org

Account Activity

Name	Account #	Service	Charges	Payments	Adjustments	Balance
		07/18/07	497.50	93.33	0.00	404.17
		11/05/07	4521.00	3151.14	813.78	556.08

Balance Due From Patient: \$960.25

HAS YOUR INSURANCE OR ADDRESS INFORMATION CHANGED?

If you have new health insurance information or a new address, please complete the below portion.

PATIENT NAME		NEW PHONE #	
NEW ADDRESS	CITY	STATE	ZIP CODE
POLICY HOLDER'S NAME (IF PATIENT IS DEPENDENT)		GROUP NAME/EMPLOYER	
ID #	GROUP #	EFFECTIVE DATE	INSURANCE PHONE #
INSURANCE COMPANY NAME		INSURANCE ADDRESS	
EMPLOYER		EMPLOYER ADDRESS	

Sample of billing statement (back)

Common Questions About Health Care Bills

Why did I receive more than 1 bill for the same date of service?

In most cases, you will receive at least 2 bills. Most times, the bills are from:

1. The hospital (*facility fees*).
2. The doctor or other professional services provider (*professional fees*).
3. Patient Financial Services (*facility fees* for patients of UWMC for services such as hospital stays, clinic visits, X-rays, lab tests, and therapies).

See pages 2 and 3 of this handbook for more information about kinds of bills.

What is an Explanation of Benefits (EOB)? Do I need to pay any amounts shown on this statement?

An Explanation of Benefits, also called an EOB, may be sent to you by your health insurance company after you or your family receives services from a doctor, specialist, hospital, or other medical facility. This statement is NOT a bill that you need to pay. If you owe money, you will receive a bill from the doctor or facility whose services you used.

The EOB lets you know that your health plan has received your claim. It explains the services provided, the fees involved, how much you may have already paid as co-payment, deductible amounts, how much your insurance paid, and what amount you must pay.

In most cases, you will receive an EOB only when there are fees you need to pay. The total you owe is listed under “Patient Responsibility.” This amount may include fees such as co-pays that you already paid. Some insurance companies send an EOB even if you do not owe anything.

Every insurance company uses its own form for their EOB. If you have questions about an EOB you receive, contact the insurance company listed on the statement.

What if I don't have health insurance?

If you do not have health insurance coverage, you must pay your bill within 30 days of receiving it – unless you have applied for financial assistance and are waiting for a decision, or you have made other payment arrangements with UWMC Patient Financial Services (206-598-1950 or toll-free: 877-780-1121). See “What do I do if I can't pay part or all of my bill?” on page 9.

Why didn't my insurance pay my entire hospital bill?

Some charges may not be covered by your insurance. If this is the case, paying for them is your responsibility. These charges are listed on your insurance statement under "Patient Responsibility." (See question on page 7 about Explanation of Benefits statements).

Fees that may not be covered by your insurance include:

- Deductibles.
- Co-insurance and/or co-pays.
- Benefit limitations such as items or services not covered under your insurance plan.
- Medicare program exclusions. (See your Medicare Handbook for a complete listing.)

Check your Explanation of Benefits (EOB) or contact your insurance company with specific questions. Make sure to have your EOB handy when you call.

Whom do I contact to update my insurance or other billing information?

If any of your insurance information has changed since you registered, you must notify **2 offices** as soon as possible:

1. UWMC Financial Services/Financial Counseling

- Weekdays, 8 a.m. to 5 p.m.: 206-598-4320
- After hours, weekends, and holidays, call Admitting: 206-598-4310

2. UW Physicians (UWP)

206-543-8606 or 888-234-5467 (toll-free)

What if I think my claim was denied because of missing or incorrect information?

Insurance claims may be denied because of missing or incorrect information on the claim. If you believe your claim was denied for this reason, call Patient Financial Services right away at 206-598-1950 (toll-free: 877-780-1121). They will take your corrected information, update your account, and/or bill your insurance again.

What do I do if I need more information to bill my Medical Savings or my Healthcare Reimbursement Account?

The information you need to submit an insurance claim to a Medical Savings Account (MSA) or a Healthcare Reimbursement Account will vary. You may need to supply information that is not listed on your bill, such as your doctor's name or the diagnosis. If you need that information, call Patient Financial Services at 206-598-1950 (toll-free: 877-780-1121) weekdays, 8 a.m. to 5 p.m.

You can also go online to the Patient Financial Services Customer Service Web site and request a Charge Details report. This report gives more information than your bill. Go to:

<http://uwmedicine.washington.edu/PatientCare/PatientAndVisitorInfo/HospitalBill/Contact+Us.htm> and click on “Contact us or submit your billing question online.”

What do I do if I can't pay part or all of my bill?

You may be able to work out a payment plan for your medical bills. To learn more, call UWMC Patient Financial Services (206-598-1950 or toll-free: 877-780-1121).

Charity care is available to Washington state residents only for services that are medically appropriate. *Elective* medical care – care that is not needed for the patient's physical health – is not covered by charity care. To be eligible for charity care, patients must meet federal income guidelines and have the required supporting documentation.

To apply for charity care, patients must:

- Ask for a Charity Application before, during, or after receiving services at UWMC.
- Submit their fully completed application within 14 days of their original request.
- Include income verification and supporting documents such as bank statements with their completed application.

Billing Your Insurance

If you gave the medical center your insurance information, you do not need to do anything after receiving your itemized statement. We will bill the insurance or other health plan.

If your health coverage has changed, see “Whom do I contact to update my insurance or other billing information?” on page 8.

Summarized Statement of Charges

There are many steps to the billing process. First, the person listed as the “guarantor” on the patient's account will receive a *summarized statement of charges* from Patient Financial Services. This statement lists the services received at UWMC. This statement does not include professional services billed by UW Physicians or other billing providers.

Explanation of Benefits (EOB)

After processing your claim, most insurers, including Medicare, will send you an *Explanation of Benefits* (EOB). This form describes what services were covered by your insurance and what your balance or “Patient Responsibility” is. (See pages 7 and 16 for more information on EOBs.)

If you have questions about your EOB, contact your health plan or Patient Financial Services. Have your EOB handy when you call, write, or e-mail.

Patient Responsibility

Remember: Fees listed under “Patient Responsibility” are due within 30 days from the date you receive the bill from your doctor or medical facility.

Charges that may not be paid by your insurance that you must pay include:

- Deductibles.
- Co-insurance and/or co-pays.
- Benefit limitations – items or services not covered by your insurance plan.
- Medicare program exclusions. (See your Medicare Handbook for a complete listing.)
- Claims your health insurance denies due to missing or incorrect subscriber information.

Please note that in third-party liability cases, such as automobile accidents, you are responsible for payment. We will not hold open accounts until settlement is reached in these cases.

Tips for Working with Customer Service

Here are some tips from current and former patients and their family members that may be helpful:

- **If you call customer service at your insurance company or a health care provider, it is very helpful to write down the date, the time, and the name of the person you spoke with, especially if they quote benefits.**
- **Try to build a relationship with one customer service representative and get their direct number. That way you will not have to repeat your story to a new person each time you call.**

- For an emotionally charged issue, or if you are really frustrated, you may want to authorize a caregiver to call or intervene on your behalf. Please note that you may need to give consent for this. Talk with your insurance company to find out how to authorize someone to be your spokesperson.
- If your claims have not been paid correctly, do not hesitate to call and have them reprocessed. You will need to know what your benefits are and make sure they are paid correctly.
- Bills from UWMC and Seattle Cancer Care Alliance (SCCA) use the same numbering system, but that's about all they have in common. You must call SCCA for SCCA questions and UWMC for UWMC questions. It helps to organize bills by their number because then they are already in chronological order. You can also tell if you are missing any because you will have gaps in the numbering sequence. UW Physicians bills are totally different in that they list multiple dates of service for each physician on the same bill.
- If there is any kind of problem with insurance, be persistent and don't give up.

Where to Find Help

UWMC Departments

- **Financial Counseling** – A financial counselor can come to your room to talk with you while you are in the hospital. Or, you can visit their office next to Admitting on the 3rd floor. To schedule a visit, call 206-598-4320 weekdays between 8 a.m. and 5 p.m. Financial counselors can help you and your family:
 - Understand your hospital bills and payment options for your hospital stay.
 - Work with insurance companies, DSHS, and Medicare.
 - Apply for Medicaid and other financial assistance.
- **Patient Financial Services** – Weekdays, 8 a.m. to 5 p.m., call 206-598-1950 or 877-780-1121 (toll-free). Or, visit <http://uwmedicine.washington.edu/PatientCare/PatientAndVisitorInfo/HospitalBill/Contact+Us.htm>.

- **UW Physicians (UWP)**
206-543-8606 or 888-234-5467 (toll-free)
<http://uwmedicine.washington.edu/PatientCare/PatientAndVisitorInfo/UWPhysicians>

Other Agencies/Organizations

- **Airlift Northwest**
206-521-1616 or 866-245-4373 (toll-free)
<http://airliftnw.org>
- **Basic Health Plan**
800-660-9840 (toll-free)
www.basichealth.hca.wa.gov
Basic Health is a health insurance plan sponsored by the State of Washington. You cannot enroll in this plan if you qualify for Medicare.
- **Certified Registered Nurse Anesthetists (CRNAs)**
425-353-2840
- **Children’s University Medical Group (CUMG)**
206-987-8450 or 888-675-2864 (toll-free)
- **Disability Income Insurance** (Short-term disability, SSD, SSI)
Social Security Disability
800-772-1213 (toll-free)
www.socialsecurity.gov
- **Medicaid**
In King County: 206-341-7750, 800-346-9257 (toll-free), or TTY 800-833-6384
Other Washington counties: call your local Home and Community Services (HCS) office
www.adsa.dshs.wa.gov/pubinfo/benefits/medicaid.htm
Medicaid is a health insurance plan managed by the State of Washington for people who have a very low income and are medically disabled. It will pay 100% of covered medical expenses. Talk with your financial counselor or social worker to see if you qualify. Other states offer similar plans.
- **Medicare**
800-633-4227 (800-MEDICARE) 24 hours a day, 7 days a week
www.medicare.gov
Medicare is a health insurance plan managed by the federal government. It is for persons who are at least 65 years old, are on dialysis, have had a kidney transplant, or have been on Social Security Disability for at least 2 years. Medicare has a number of deductibles and co-pays.

There are 2 parts to Medicare:

- Part A covers hospital stays.
- Part B covers doctor fees for their inpatient and outpatient services, plus all approved outpatient expenses.

- **Seattle Cancer Care Alliance (SCCA)**
206-288-1109 or 877-849-8368 (toll-free)
www.seattlecca.org
- **Washington State Assistance – Department of Social and Health Services (DSHS)**
206-341-7424
www1.dshs.wa.gov
- **Veterans Benefits Administration**
800-827-1000 (toll-free)
www.vba.va.gov
- **Washington State Health Insurance Pool (WSHIP)**
800-877-5187 (toll-free)
www.wship.org

WSHIP is a health insurance plan sponsored by the State of Washington. You must be rejected by another insurance plan before you can enroll in this coverage. Costs can be high for people who are not on Medicare. If you are on Medicare, the cost is reduced.

Financial Planning Resources

- **Patient Advocate Foundation**
800-532-5274 (toll-free)
www.patientadvocate.org
Provides help for patients who have experienced employment discrimination or denial of insurance benefits.
- **Patient Assistance Programs**
 - **RxAssist**
www.rxassist.org
Web site sponsored by an organization called Volunteers in Health Care offers searchable database with application forms.
 - **Partnership for Prescription Assistance**
www.pparx.org
 - **RxHelp**
877-923-6779 (toll-free)
www.rxhelpforwa.org
A program for Washington state residents.
- **Washington State Insurance Commissioner**
206-464-6263 or 800-562-6900 (toll-free)
www.insurance.wa.gov
Provides information and investigates consumer complaints.

Terms Used in Health Care Billing

<p>Allowed Amount</p>	<p>Determined by your insurance to be the amount your provider is due for a particular service. This amount is usually less than the amount billed by the provider and is determined by pre-negotiated contracts or regulations. The combined total paid by you and your insurance to a provider should not exceed the allowed amount.</p>
<p>Benefit Contract</p>	<p>The legal agreement between a health plan and its members. This contract establishes the full range of benefits available to the members through their health care plan. Also called <i>a certificate of coverage</i> or <i>evidence of coverage</i>.</p>
<p>Benefits</p>	<p>The extent to which your insurance coverage will pay for services provided to you. Benefits may describe what portion of the allowed amount may be due from you, the level to which they will pay for services provided by various providers, and what types of services they will or will not cover.</p>
<p>Brand-Name Drug</p>	<p>Drugs made and sold by a major drug company. Brand-name drugs may or may not be listed on a <i>formulary</i> (see “Formulary,” page 17). For any health need, there may be competing drugs from different companies. Your health plan formulary may list a specific brand-name drug if a price agreement has been made with that company. This brand-name drug will cost more than the generic version, but cost less than other brand-name drugs that are not on the formulary. If you buy brand-name drugs that are not on the formulary, you often pay more because your health plan pays more.</p>
<p>Clinical Trial or Research Study (Also see “Experimental or Investigational Treatments” on page 16.)</p>	<p>A treatment that is being studied that involves both patient care costs and research costs. Patient care costs that may be covered by insurance are doctor visits, hospital stays, tests, and other procedures, whether a person is part of the experiment or is in the control group that receives traditional care. Special tests that are part of the research study may not be covered by your insurance, but they may be paid for by the study. Check with your insurance plan or state insurance board.</p> <p>In 2000, Medicare began covering some clinical trials. To be covered, the trials must meet specific criteria. In eligible trials, Medicare will cover treatments and services such as tests, procedures, and doctor visits. Some items may not be covered, including the experimental drug or items that are used only for data collection in the clinical trial. Some clinical trials provide the investigational drug at no charge.</p>

COBRA (Consolidated Omnibus Budget Reconciliation Act)	<p>A federal law that protects employees and their families in certain situations by allowing them to keep their existing health insurance for a specified amount of time. COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. The individual must pay the premium cost to keep their insurance plan, but the costs are usually less expensive than individual health coverage. COBRA applies only under certain conditions, such as job loss, death, divorce, or similar events. COBRA usually applies to group health plans offered by companies with more than 20 employees. Some states require employers to offer continued health care coverage to people who do not qualify for COBRA. Call your state's insurance board for more information. There may be a small fee (for example, 2%) for processing COBRA payments.</p>
Co-insurance	<p>The amount you must pay after insurance has paid their portion, according to your insurance plan. In many health plans, patients must pay for a portion of the allowed amount. For instance, if the plan pays 70% of the allowed amount, the patient pays the remaining 30%. If your plan is a <i>preferred provider organization</i> (see "Preferred Provider Organization (PPO)," page 19), your co-insurance costs will be lower if you use the services of an <i>in-network</i> provider on the plan's <i>preferred provider list</i>. (See "In-Network," page 18.) Call your insurance company for more information.</p>
Co-payment (Co-pay)	<p>A set fee that the patient pays at the time of service or when they fill a prescription. Co-payment amounts vary by service and may vary depending on which provider (in-network or out-of-network) you see. For prescriptions, co-payment amounts may vary depending on name-brand versus generic drugs.</p>
Coordination of Benefits	<p>How insurance companies work together when you have more than one insurance plan. Some people are covered by more than one commercial insurance plan, such as through their employer as well as their spouse's or domestic partner's employer. If you have more than one insurance plan, check with the secondary policy to find out how it covers expenses left over after your primary coverage has paid its part. (See "Secondary Insurance," page 19.)</p>
CPT Code (Current Procedural Terminology Code)	<p>A 5-digit numbering system that helps standardize billing. There is a CPT code for certain types of medical services. Using this code allows health care providers and insurance companies to communicate and track billing more efficiently.</p>

<p>Deductibles</p>	<p>The amount a patient pays before the insurance plan pays anything. In most cases, deductibles apply per person per calendar year. And, in most cases, the higher your deductible, the lower your premium. With preferred provider organizations (PPOs), deductibles usually apply to all services, including lab tests, hospital stays, and clinic or doctor’s office visits. Some insurance plans waive the deductible for office visits. Some health maintenance organizations (HMOs) have service-specific deductibles.</p>
<p>Disability Income Insurance</p>	<p>A type of insurance carried by employers to cover part of a disabled worker’s regular income. If you were working before having your health problem, your employer might provide disability income insurance. There are 2 types of income insurance – short-term and long-term.</p> <ul style="list-style-type: none"> • <i>Short-term disability insurance</i> pays a portion of your salary, often around 60%, while you are off work for a medical reason. Short-term disability insurance usually pays a portion of your salary for 3 to 6 months. • <i>Long-term disability insurance</i> pays a portion of your salary, often 60%, as long as you are considered disabled and unable to work. However, you will usually need to be disabled for a minimum length of time, such as 90 days, before benefits will begin.
<p>Effective Date</p>	<p>The date on which a contract for coverage begins.</p>
<p>Eligibility</p>	<p>A determination of whether or not a person meets the requirements to participate in the plan.</p>
<p>Experimental or Investigational Treatments (Also see “Clinical Trial or Research Study” on page 14.)</p>	<p>Treatments not yet medically proven to be effective. These treatments may or may not be covered by health insurance. Some states require that investigational treatments be covered. Check with your insurance plan and state insurance board to see if coverage is available.</p>
<p>Explanation of Benefits (EOB)</p>	<p>A statement sent to you by your insurance after they process a claim sent to them by a provider. The EOB lists the amount billed, the allowed amount, the amount paid to the provider and any co-payment, deductibles, or coinsurance due from you. The EOB may detail the medical benefits activity of an individual or family. Also see pages 7 and 10.</p>

Flexible Spending Account (FSA or Flex Account)	An employee benefit that allows a fixed amount of pre-tax wages to be set aside for qualified expenses. Qualified expenses may include child care or uncovered medical expenses. The amount set aside must be decided in advance, and employees lose any unused dollars in the account at the end of the year.
Formulary	A list of preferred prescription medicines. The formulary sorts drugs into groups, or tiers, based on how much of the costs your health plan will pay and how much the patient has to pay.
Generic Drug	Drugs with proven benefits that cost less because they are not made by major drug companies and do not carry brand names. In almost all cases, you pay the least out of pocket for drugs in this group. Not all drugs have generic options.
Health Maintenance Organization (HMO)	A type of managed care with a prepaid plan. Individuals enrolled in an HMO pay a premium, usually every month, for their health care services such as doctor visits, hospital care, lab work, and emergency services. They also pay a small fee called a <i>co-payment</i> at the time of service. The HMO has arrangements with providers and hospitals and the co-payment applies only to those providers and facilities affiliated with the HMO. A person may receive care outside of the HMO with prior approval from the HMO and payment for those services may be at a reduced benefit. Check with your plan for specific benefit information.
Health Plan	When a person is part of a health plan, the plan pays for all or part of a person's health care costs. The types of health insurance are group health plans, individual plans, workers' compensation, and government health plans such as Medicare and Medicaid. Health insurance can be further classified into fee-for-service (traditional insurance) and managed care. Both group and individual insurance plans can be either fee-for-service or managed care plans.
Health Savings Account (HSA)	An account that uses pretax dollars to pay part of the costs of medical care. HSAs have tax benefits for everyone. Contributions are made into the account by the individual or the individual's employer and are limited to a maximum amount each year. The contributions are invested over time and can be used to pay for qualified medical expenses, including most medical care such as dental, vision, and over-the-counter drugs. Unlike a flexible spending account, funds roll over and accumulate year after year if not spent.

Individual Insurance	Health insurance purchased by an individual, not as part of a group plan.
In-Network	A group of doctors, hospitals, and other health care providers preferred and contracted with your insurance company. Depending on your insurance plan, you may not have coverage for services from providers that are not in-network, or your benefits may be reduced. You will receive the highest level of coverage from your insurance plan by receiving services from in-network providers.
Lifetime Maximum Coverage	A cap or limit on what insurance will cover. This amount varies based on the insurance plan. Some specific benefits have limits, and they are charged against the overall limit of the plan.
Lifetime Transplant Maximum	The total amount an insurance plan will pay for services related to a particular transplant in a patient’s lifetime.
Medicaid	A health insurance plan through your state for people who have very low income and are medically disabled. Medicaid will pay for 100% of covered medical expenses. To see if you qualify, contact your local health department or social services office for an application.
Medicare	A health insurance plan administered through the federal government. Medicare is for people who have been on Social Security Disability for at least 2 years, or are at least 65 years old. There are 2 parts of Medicare – Part A and Part B. Part A covers hospital stays. Part B covers inpatient and outpatient doctor fees, and approved outpatient expenses. Medicare has a number of deductibles and co-pays.
Medicare Supplements or “Medigap” Policies	Policies that supplement Medicare coverage. Most times, these policies pay the Medicare co-pays and deductibles, but nothing extra. Check with your supplemental insurance to find out how it coordinates benefits with Medicare.
Out-of-Network	In PPO programs, care given by a provider who is not on their preferred provider list. For HMO programs this term refers to covered services that are not provided or authorized by the primary care provider.

Out-of-Pocket Maximum	The most money you will have to pay before your insurance company covers all costs. Each plan sets a dollar limit for the calendar year. Once that limit is reached, the plan will pay 100% of the allowed amount for eligible charges for the rest of the calendar year. Some insurance companies do not include certain costs in this limit, such as fertility treatments or prescription drugs. Other insurance companies increase the out-of-pocket maximum for care provided by out-of-network providers.
Point of Service (POS)	A type of health plan that allows members to choose to receive services from a participating or non-participating network provider. There are usually higher costs to the patient if they receive services from an out-of-network provider.
Pre-existing Condition	A medical condition for which the patient has received treatment during a specific period of time prior to enrolling in a new insurance plan. This period (such as 30, 60, 90 days, 6 months, etc.) before enrollment is called the “look-back” period. “Treatment” is defined as receiving medical advice, recommendations, prescription drugs, diagnosis, or treatment. <i>A pre-existing condition might not be included in the new coverage.</i> Check with your insurance plan and/or state insurance board to determine pre-existing condition rules. For most group health plans, if you have continuous, verified coverage and no gaps in coverage, pre-existing conditions are covered by the new insurance plan.
Preferred Provider Organization (PPO)	A health care organization that covers a greater amount of the health care costs if a patient uses the services of a provider on their preferred provider list. Some PPOs require people to choose a primary care doctor who will coordinate care and arrange referrals to specialists when needed. Other PPOs allow patients to choose specialists on their own. A PPO may offer lower levels of coverage for care given by doctors and other health care professionals not affiliated with the PPO.
Secondary Insurance	For people who are covered by more than one insurance plan, the secondary policy covers expenses after the primary insurance has paid their part of the health care bill. (See “Coordination of Benefits,” page 15.)

Questions?

See “Where to Find Help,” pages 11 through 13 of this handbook.

<p>Self-Insured Health Plan</p>	<p>A group health plan in which the employer assumes the risk for providing health care benefits to their employees. The cost for paying claims is paid by the employer. Employers will often purchase stop-loss insurance to reduce their risk in the event of a high-cost, catastrophic claim.</p>
<p>Social Security Disability (SSD) Insurance</p>	<p>An income assistance program administered by the federal government for those with disabilities. The Social Security Administration (SSA) has its own definition of disability for various illnesses, such as kidney disease or diabetes. The application process can take many months. If approved, the monthly amount you receive is based on how much money you have paid into Social Security through payroll taxes.</p> <p>To be eligible for SSD, your disability must meet 1 of these conditions:</p> <ul style="list-style-type: none"> • Have lasted or be expected to last at least 1 year. • Be permanent. • Be expected to result in death. <p>SSA must consider you disabled for at least 5 months before you start receiving benefits.</p>
<p>Social Security Income (SSI)</p>	<p>A disability income program through SSA for disabled people who have not worked enough to pay much into the Social Security System and so are not eligible for SSD. The disability rules are the same as for SSD. However, SSI has strict income and financial limits.</p>
<p>Third-Party Payer</p>	<p>An organization other than the patient (first party) or health care provider (second party) involved in paying health care claims.</p>
<p>Usual, Customary, and Reasonable (UCR)</p>	<p>In general terms, the price charged by the provider. Specifically, a charge for a particular service is considered to be “usual and customary” if it falls within the range of prices charged for the same service by other providers in the same geographical area.</p>
<p>Waiting Period</p>	<p>The amount of time members must wait after enrolling in an insurance plan before they are eligible for certain benefits.</p>

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