



Stretch Your Benefits Vocabulary for the Plano ISD health plan

Admission (being admitted to the hospital)

When a registered patient is admitted for at least 24 hours to a hospital, skilled nursing facility, or other health care facility.

Calendar Year (in relation to benefits)

The period of time from January 1 through December 31 of the same year, during which time the deductibles, annual maximums, and out-of-pocket expenses accumulate. The Calendar Year is also called the Plan Year or Benefit Year.

Centers of Excellence

A network of credentialed health care facilities selected for specific services based on stringent criteria including outcomes and efficiency. For example, an organ transplant managed care program may require members to access transplant services through a centers of excellence network.

Co-insurance

The amount for which the patient is responsible after the plan has paid its portion of the expense. This amount is usually a percentage of the eligible expense. The patient and the plan share the total cost of the service. For example, if the plan pays 80 percent of a service and the patient pays 20 percent, then the 20 percent is the co-insurance amount.

Coordination of Benefits

The process of determining benefit payments when more than one health insurance carrier may be responsible for payment.

Current Procedural Terminology (CPT Code)

Every medical procedure (e.g., surgery, office visit, lab work, etc.) has a five-digit code called a CPT code or procedure code. The first digit of a CPT code represents the type of service rendered:

- 1, 2, 3, 4, 5, or 6: surgery
- 7: radiology
- 8: pathology
- 9: medical
- 0: anesthesia

Though not common, CPT codes starting with 9 may also be for surgery, X-ray, or lab charges. For example, the CPT code for a cardiac catheterization is 93501. Although the procedure begins with a 9, which ordinarily represents a medical service, cardiac catheterization is a surgery charge.

Date of Service

The date a covered employee or dependent received a medical or dental service. For example, if a covered employee visited the doctor on 5/8/2007, the date of service would be 5/8/2007.

Deductible

The amount of expenses the patient must pay before the plan will begin to provide benefits for certain services. For example, if a benefit is subject to a \$250 deductible and the expense for a medical service is \$300, the patient is responsible for \$250 of the charge and the plan would consider the remaining \$50. Deductibles apply to one benefit year only. When a new benefit year begins, the accumulation begins again with \$0 for the new benefit year.

Diagnosis

What the medical professional determines as the cause of an illness or injury of a patient. An example of a diagnosis would be measles, hepatitis, etc.

Diagnosis Code (ICD-9 Code)

The International Classification of Diseases. The universal coding method used to indicate a diagnosis or medical condition.

Durable Medical Equipment (DME)

Medical equipment which can withstand repeated use; is not disposable; is used to serve a medical purpose; is generally not useful in the absence of a sickness or injury; and is appropriate for home use. Examples of DME are hospital beds, wheelchairs, and oxygen equipment.

Eligible Expense

Qualified or acceptable. When referring to a medical expense or charge, the word eligible means that the expense is qualified or acceptable to be paid under the plan.

Exclusions

Benefits, conditions, or expenses not covered by the plan. Exclusions are listed in the Plan Document.

Explanation of Benefits (EOB)

A statement that explains how a claim was processed and where the dollars submitted on the claim were applied (e.g., PPO discounts, deductibles, co-insurance).

Facility

Usually refers to a hospital as the provider of medical services.

Flexible Spending Account

The two types of flexible spending accounts are 1) medical and 2) dependent care. A medical flexible spending account allows employees to pay for un-reimbursed healthcare expenses such as deductibles and co-insurance payments with pre-tax dollars. A dependent care flexible spending account allows employees to pay for child care with pre-tax dollars.

Incurred Date

The beginning date of a medical or dental service. For instance, if a patient entered a hospital on 2/18/2007 and left the hospital on 2/20/2007, then 2/18/2007 would be the incurred date.

Inpatient

A hospital service rendered while a patient is in a hospital for 24 hours or more.

Itemized Bill

A form that includes all information from a provider that is necessary to process a claim. Information on an itemized bill includes the ICD-9 code, charges, CPT code, description of services, date of service, employee's name, patient's name, patient's account number, provider's tax identification number, and the provider's name and address.

Lifetime maximum

Applies to the entire time a person is covered under the plan. When that person reaches his lifetime maximum, the plan will no longer pay benefits for the applicable service. Sometimes plans will set lifetime maximums for all services, rather than for each service individually.

Out-of-Pocket (OOP)

The amount a patient has paid from his own pocket during the benefit year. A plan may have an out-of-pocket maximum. When that maximum has been met, the plan may pay benefits at 100 percent for some services. An out-of-pocket maximum applies to one benefit year only. When a new benefit year begins, the accumulation begins again with \$0 for the new benefit year.

Outpatient

When a patient visits a provider and the visit is less than 24 hours, the services he or she receives during that time are generally considered outpatient services.

Preferred Provider Organization (PPO)

A network of physicians and facilities with which an organization has contracted to offer medical care at reduced rates.

Provider (Provider of Service)

A person or facility that provides medical, dental, mental, substance abuse, or vision services to an individual. Generally, the plan specifies certain types of providers whose services are not covered, or specifies requirements to which a provider must adhere in order for that provider's services to be covered.

Subrogation

A procedure where the health plan recovers money from a third party when a medical expense was another person's fault. An example may be an auto accident injury.

UB 92

The current Uniform Billing form that hospitals use.

Upcoding

Use of a more complex CPT code to describe a medical service and fee than the service warrants.