

Billing Terminology

What is an “allowed amount”?

This is the amount the insurance company is basing their payment on. This can be the contracted rate the provider has with your insurance carrier. This is not necessarily the billed amount.

What is the “billed amount”?

This is the fee the provider has billed to the insurance company. This is not necessarily the allowed amount, which can be less.

What is “coinsurance”?

This is a percentage of medical costs that you may be required to pay for covered services.

What is “coordination of benefits”?

Coordination of benefits, also referred to as COB, is used to establish the order in which health insurance plans pay claims when more than one plan exists.

What is a “copayment”?

This is a fixed dollar amount that you pay for some services when you receive care.

What is a “deductible”?

This is the amount you pay for covered services before your insurance begins to pay.

What an “EOB”?

This is an Explanation of Benefits. You receive an explanation of benefits from your insurance carrier, summarizing billed services.

Who is the “guarantor”?

The guarantor is the person responsible for the account balance. In most cases the patient is the guarantor unless the patient is a minor.

What is an “Out of Pocket Maximum”?

Certain benefits limit the amount you are required to pay. This is called your Out-of-Pocket Maximum. Once you reach this limit, you will have no additional out-of-pocket charges for services for the remainder of the year.

Who is the “policy holder” or “subscriber”?

The policy holder is the primary person on the policy, also referred to as the subscriber.

What is “pre-authorization”/“pre-certification”?

Certain services may require authorization before they are performed. These terms, pre-authorization and pre-certification, may be used interchangeably. Your insurance company will determine whether a scheduled service is permitted under your policy, at which time a pre-authorization or pre-certification number will be issued.