Glossary of Billing Terms

Copley understands that the billing terminology used in our industry can be confusing. We have provided the following glossary of billing terms to assist you in understanding the terms used in your health care bills. The definitions below are courtesy of the Healthcare Financial Management Association (HFMA) and healthcare.gov.

Advance Beneficiary Notice (ABN) - A notice the hospital or doctor gives you before you're treated, telling you that Medicare will not pay for some treatment or services. The notice is given to you so that you may decide whether to have the treatment and how to pay for it.

Advance Directive (Healthcare) - Written ahead of time, a health care advance directive is a written document that says how you want medical decisions to be made if you lose the ability to make decisions for yourself. A health care advance directive may include a Living Will and a Durable Power of Attorney for health care.

Appeal - A process by which you, your doctor, or your hospital can object to your health plan when you disagree with the health plan's decision to not pay for your care.

Assignment of Benefits - When insurance payments are sent directly to your doctor or hospital.

Authorization Number - A number stating that your treatment has been approved by your insurance plan. Also called a Certification Number or Prior-Authorization Number.

Balance Bill - How much doctors and hospitals charge you after your health plan, insurance company, or Medicare have paid its approved amount.

Beneficiary - Person covered by health insurance.

Benefit - The amount your insurance company pays for medical services.

Bill / Invoice / Statement - Printed summary of your medical bill.

Charge - The amount of money a doctor or supplier charges for a certain medical service or supply.

Charity Care - Free or reduced-fee care for patients who have financial hardship.

Claim - Your medical bill that is sent to an insurance company for processing.

Need Help?

Copley Hospital understands that medical bills can sometimes be confusing and difficult to understand. Our Patient Financial Services staff is happy to answer your questions or provide more information about your bill. Call us or stop by.

Hours: Monday – Friday
8:00am - 4:30pm

Telephone: 802-888-8338

Location:
2nd Floor Health Center Building
Suite 2400
530 Washington Highway,
Morrisville, VT 05661

Pay or View a Bill Online

For your convenience, Copley offers the ability to view or pay your Hospital bill online securely. Go to www.copleyvt.org.

Financial Assistance

If paying your hospital bill will be a financial hardship, Copley offers a financial assistance program and can help connect you to other state-based assistance programs.

Learn more by contacting a Patient Financial Counselor at 802-888-8336 or go online to copleyvt.org.

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Coding of Claims - Translating diagnoses and procedures in your medical record into numbers that computers can understand.

Coinsurance – Coinsurance is a percentage of the health care bill that you pay. For example, you pay 20% and your insurance company pays 80%. Your out-of-pocket cost is based on the total amount that your insurance has allowed for the visit, NOT on the hospital charges.

Contractual Adjustment - A part of your bill that your doctor or hospital must write off (not charge you) because of billing agreements with your insurance company.

Coordination of Benefits (COB) - A way to decide which insurance company is responsible for payment if you have more than one insurance plan.

Copayment/Copay - Copayments are set amounts you pay when you go to a health care provider. Providers usually collect copayments at the visit. Copayment amounts are listed on your health insurance card. For example, ER copay = $50.

Covered Benefit - A health service or item that is included in your health plan, paid for either partially or fully. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

CPT Codes - A coding system used to describe what treatment or services were given to you by your doctor.

Deductible - Deductibles are the yearly expenses you pay before your health insurance pays anything. For example, each year you pay the first $1,000 of your health care bills before your health insurance pays anything. Your out-of-pocket cost is based on the total amount that your insurance has allowed for the visit, NOT on the hospital charges.

Diagnosis Code- A code used for billing that describes your illness.

Diagnosis-Related Groups (DRGs) - A payment system for hospital bills. This system categorizes illnesses and medical procedures into groups for which hospitals are paid a fixed amount for each admission.

Discount - Dollar amount taken off your bill, usually because of a contract with your hospital or doctor and your insurance company.

Emergency Care - Care given for a medical emergency when you believe that your health is in serious danger, when every second counts.

Excluded Services - Health care services that your health insurance or plan does not pay for or cover. Excluded Services and Covered Benefits are defined in the health insurance plan's coverage documents.

Explanation of Benefits (EOB) - The notice you receive from your insurance company after getting medical services from a doctor or hospital. It tells you what was billed, the payment amount approved by your insurance, the amount paid, and what you have to pay.

Explanation of Medicare Benefits (EOMB) - The notice you receive from Medicare after getting services from your doctor or hospital. It tells you what was billed to Medicare, Medicare's approved payment, the amount Medicare paid, and what you have to pay. Also called a Medicare Summary Notice (MSN).

Federal Poverty Level (FPL) - A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

Financial Responsibility - How much of your bill you have to pay.

Guarantor - Someone who has agreed to pay the bill.

HIPAA - Health Insurance Portability and Accountability Act. This federal act sets standards for protecting the privacy of your health information.

Inpatient (IP) - Patients who stay overnight in the hospital.

Medicaid - A state administered, federal and state funded insurance plan for low-income people who have limited or no insurance. The Medicaid program in Vermont is Green Mountain Care.

Medicare - A health insurance program for people age 65 and older. Medicare covers some people under age 65 who have disabilities or end-stage renal disease (ESRD).

Medicare Part A - Also referred to as Hospital Insurance, it helps pay for inpatient care in hospitals and hospices, as well as some skilled nursing costs.

Medicare Part B - Helps pay for doctor services, outpatient care, and other medical services not paid for by Medicare Part A.

Medicare Part C (Medicare Advantage) - A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits.

Medicare Summary Notice (MSN) - The notice you receive from Medicare after getting services from your doctor or hospital. It tells you what was billed to Medicare, Medicare's approved payment, the amount Medicare paid, and what you have to pay. Also called an Explanation of Medicare Benefits (EOMB).

Network - A group of doctors, hospitals, pharmacies, and other health care experts contracted by a health plan to take care of its members.

Non-Covered Charges - Charges for medical services denied or excluded by your insurance. You may be billed for these charges.

Non-Participating Provider - A doctor, hospital, or other health care provider that is not part of an insurance plan's doctor or hospital network. Also called a non-preferred provider.

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. Usually charged by the hour.

Out-of-Network Provider - A doctor or other health care provider who is not part of an insurance plan's doctor or hospital network. Same as non-participating provider.

Out-of-Pocket Costs - Your expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered.

Out-of-Pocket Maximum/limit - The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits.

Outpatient (OP) - Patient who does not need to stay overnight in a hospital. Outpatient services include lab tests, x-rays, and some surgeries.

Participating Provider - A doctor or hospital that agrees to accept your insurance payment for covered services as payment in full, minus your deductibles, copayments and coinsurance amounts.

Premiums - Set amounts that you and/or your employer must pay to the insurance company for your health insurance, usually on a monthly basis.

Primary Insurance Company - The insurance company responsible for paying your claim first. If you have another insurance company, it is referred to as the Secondary Insurance Company.

Referral - Approval needed for care beyond that provided by your primary care doctor or hospital. For example, managed care plans usually require referrals from your primary care doctor to see specialists or for special procedures.

Secondary Insurance - Extra insurance that may pay some charges not paid by your primary insurance company. Whether payment is made depends on your insurance benefits, your coverage, and your benefit coordination.