I. **Copay** – A copayment or copay is defined as the fixed amount a patient pays directly to a provider for a product or service. Please note that this terminology specifically applies to US practices.

II. **Deductible** – The deductible is the amount that a patient must pay "out-of-pocket" before the insurance will pay for any expenses.

III. **Co-insurance** – Co-insurance refers to the portion or percentage of the "allowable charge" that the patient must pay to the provider after they meet their deductible for any services rendered.

IV. **Out-of-Pocket Maximum** - The out-of-pocket maximum is the set amount of money that a patient or insured individual must pay in covered medical costs in a given year. After this maximum amount is met, in most cases, the insured will not pay any copays once this is met. It is important to note that the "health insurance out-of-pocket maximum" does not apply to any services or materials billed to a vision plan.

V. **Contracted Allowable** – Otherwise known as the allowed amount, is the amount agreed upon by the provider that they will accept as payment from a particular insurer as signified on the fee schedule and is typically less than the provider's usual and customary charges for a given service.

VI. **Fee Schedule** – The fee schedule is the list of all professional services and products for which an insurer will allow a provider to bill, along with the corresponding maximum allowed amount that they have agreed to pay the provider for those services.

VII. **Coordination of Benefits** – Coordination of benefits (COB) is the process of coordinating benefits between two or more payors. Patient will need to inform you of which insurance is primary, secondary, tertiary, or you will need to research this information as you check benefits, to ensure you bill to the primary payor first. To coordinate benefits, you must send the primary payor explanation of benefits with a new claim form to the secondary payor, and then again to the tertiary payor, if applicable.

VIII. **Types of Insurers**
   a. Primary – The primary insurer is the company to which the initial charges for services will be billed to first, and is usually responsible for the largest amount of payment to the provider
   b. Secondary – The secondary insurer is the company that receives the remainder of the "allowed amount" of charges after the primary insurer pays their contracted portion. After the secondary pays the remainder of charges owed, if any, are billed to any tertiary insurers or directly to the patient.

c. Tertiary – A tertiary insurer is defined as any remaining insurers or payors that have agreed to pay remaining charge amounts, prior to the patient being billed, after both the primary and secondary insurers have paid their allowed amounts.

IX. **Health/Medical Insurance** – Health insurance is defined as the insurance that allows for a provider to bill for health or medically-related reasons or diagnoses. In eye care, health diagnoses may include, but aren't limited to, Cataracts, Diabetic Retinopathy, Glaucoma, Macular Degeneration, and Dry Eye Syndrome.

X. **Vision Insurance/Plans** – A vision plan or insurance is one that is billed for non-medically related conditions of the eye such as Hyperopia, Myopia, Astigmatism, and Presbyopia. In most cases a vision plan is also who a provider bills for a portion of materials, such as glasses or contact lenses and contact lens services.

XI. **Electronic Remittance Advice (ERA)** - The ERA is an explanation from a health plan to a provider regarding a claim payment that explains, in detail, how a health plan has adjusted claim charges based on specific factors, including contractual agreements, benefit coverage and patient responsibility.

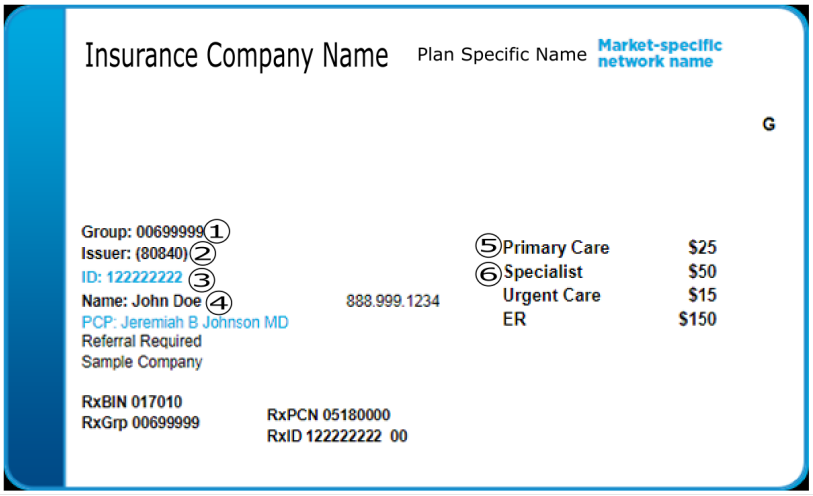
XII. **Explanation of Benefits (EOB**) – The EOB is a statement sent to the provider by the insurer detailing what services or materials were paid for on their behalf along with any applicable reasoning for why a particular charge may have been denied or not paid.

XIII. **Current Procedural Terminology (CPT) Code** – A CPT code is the medical billing code used to represent a particular service or product offered by a provider, in order to bill to a particular insurer/payor.

XIV. **Diagnosis Code** – This is signified as International Classification of Disease, better known as ICD or ICD-10 currently. The ICD-10 code is used as a tool to most commonly identify disease, disorders, or symptoms that could indicate the reason for a particular patient being seen or charges being billed.

XV. **CPT Modifiers** – Modifiers are used to provide additional information about a procedure, service, or product being billed. The most common modifiers added to CPT codes in ophthalmic practices are RT & LT to signify which eye the service or product was for, -24 used to signify an exam performed during the global billing period of a surgery yet is unrelated to the surgery.

## XVI. Insurance Card Breakdown




1. Group # - The group number signifies the company that the policy was issued to
2. Issuer # - If listed, represents the unique number that the provider will use to bill the correct insurer
3. ID # - Represents the unique member ID required to locate the member's benefits through the insurer
4. Name – This can be either the Primary Person on the insurance policy, followed by the name of the insured or just the name associated with the specified member ID.
5. Primary Care – This is the amount of copay reserved for the insured member's primary care physician for generic office visits only.
6. Specialist – this is the copay required for ALL other providers, including optometrists & ophthalmologists, for specialty services as deemed by the insurance benefit.