Money Matters – Chinese

病人教育

病人护理服务部

有关收费的事项

如何管理华大医疗中心 (UWMC)的账单

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine

此小册是华大医疗中心
肿瘤病房咨询理事会发行

以病人及家属为主的医护

华大医疗中心

华盛顿大学医疗中心 (UWMC) 采用以病人及家属为主(PFCC)的途径提供医疗服务。病人及家属为主的医护(PFCC) 是邀请病者依照自身的意愿参与医疗。

病人及家属为主的医护中心（PFCC）需要病人、家属、及职员成为组员；积极地参与制定方案及政策、及与医疗中心日常交流时有发言权。其核心概念是在沟通、共享信息、选择、尊重、建立一个有互动的合作伙伴关系、并了解家庭的参与是一种力量、而非妨碍。

以病人及家属为中心的医护中心（PFCC）可加强康复效果、明智的资源分配、及提高员工、病人、家属的满意度。简单的来说、这是一个正确的途径。

若非华盛顿大学医疗中心 UWMC 采取以病人及家属为主的医护政策、即不可能撰写此*有关收费事项*'的小册。它是由一组很负责的病人、家属、及员工撰写了的资讯。他们都属住院病人肿瘤咨询委员会成员、每一位基于他们自己的专业知识及经验提供了此有价值的见解及资讯。

如您需要取得有关住院病人肿瘤咨询委员会、其他病人及家庭咨询活动及议会、病人及家属为主的医护中心的详细信息请联系：

Hollis Guill Ryan
Patient and Family Centered Care, UWMC
206-598-2697
hollisr@u.washington.edu

病人教育

病人护理服务部

有关收费的事项

如何管理华大医疗中心 (UWMC)的账单

此小册是为病人及家属提供一些有关如何理解、分档及管理医疗账单的资讯及建议。大多数的资讯是有关华大医疗中心（**UWMC**） 如何计费。但很多建议可能有助于您分档及管理其他医疗单位的账单。

内容

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我们知道此时可能是您及您所爱的家人会有压力的时候。管理财务及医疗的账单可能是当前的要务、但亦可能是最不考虑的事项。对大多数的人来说要处理财务、医疗账单、及复杂的系统是一种负担。

我们希望这小册对您有帮助；它的内容包括：

- 有关医疗账单的一般资讯。
- 就如何整理您的医疗账单的一些建议。
- 就如何了解华大医疗中心 UWMC 账单的小贴士。
- 回答病人对账单的一般疑问。
- 有关收费事项的部门、机构、组织的资源及联系资讯。
- 医疗账单上经常使用术语的栓释。

有关医疗的账单

住院或看门诊后、基于您接受过的服务项目最少会收到 2 份不同的账单。 下面为您解释可能会收到的各种不同账单：

设备费

病人财务服务部 (PFS) 会开出华大医疗中心 UWMC 为病人服务的账单。由病人财务服务部 (PFS)开的账单称为设备费。包括住院、门诊及其他服务如 X 光、检验及其他治疗。您会收到个别的账单。

专业收费

您亦可能收到由华大医生(UWP)专业收费的账单。此费用是每位医生的服务费。

基本医护服务费

华大医疗中心诊所的基本医护服务费是包括专业收费及设备费。因服务不同设备费与专业收费可能一样或更高。基本医护服务的诊所包括东区专科中心、华大爱德沃德心脏中心。华大医疗中心义肢及整型科及人类发展/残疾科。

其他医疗及设备费

病人亦可能收到在其他地方看病或接受服务的账单、他们包括西雅图癌症中心、儿童医院华大医疗集团、救护车公司；如西北空运、认证注册护士麻醉师（账单由辅助医疗部开出）。至于其他未列出的机构之账单、请直接与该机构联系。

如何整理您的医疗财务记录

在您面临手术、住院、常期的病痛或其他医疗问题时、如何整理您的医疗财务记录可能是您最不作考虑的事。 但在大多数的情况下、将账单整理好有助于减轻您身心的压力。

您亦可请一位亲信来为您整理账单。将系统设置后在需要时就很容易找到您需要的资讯、亦有助于查询资讯、当有错误时亦较容易发现。

每个人都有不同的方式来整理档案、下面的建议可能帮助您来开始着手：

- 您希望如何整理—无论您用何种方式：
  - 以电脑为主的系统、包括使用何种软件、档案夹及档案名称。
  - 使用纸张的系统、包括使用书夹、文件夹、颜色编码。
  - 电脑及纸张的综合系统。
- 那些文件需要保存那些可丢弃。
- 那些文件需要影印、影印本存放那里 。
- 如何将账单归档—以收到的日期、医生、或账单编号或开账单的日期。

下面是由现在的或过去的病人及家人提供的一些有助于整理账单及其他资讯的建议。

- 在我的文件夹内、我有一栏是保险涵盖的注解单（**EOBs** ）、医生的收费、设备费、相关费用（如职能 **/** 生活自理理疗、体能理疗、处方药及停车费）、及其他医疗费（如看牙医或眼科）。

- 复印保险正面及背面 – 您的保险计划编号可能每年不同、如不是及时付费可以用正确的分组号码做参考。

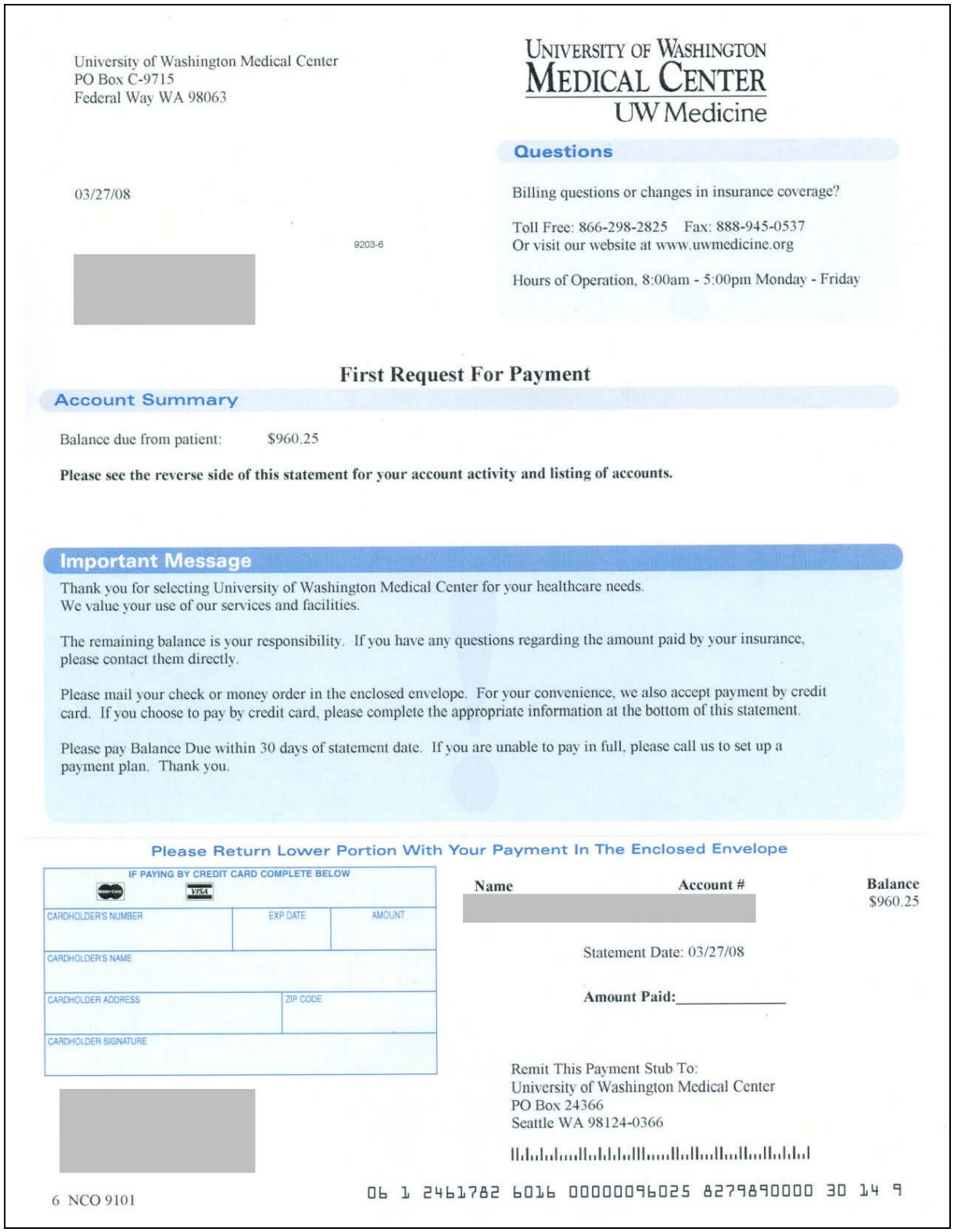
- 我发现以看医生的日期来归档是最简便。我将所有此类的账单放在一个大的朔胶封套里。如此它们都在一处、万一雨天掉在地上它们也有保护且不会四处飞散。我将不同诊所的账单放在不同的封套里。

- 您可以将保险涵盖的注解说明与您的医疗账单放在一起。如此您就能知道保险涵盖些什么、这样对您会有帮助。

- 您可仅用一张信用卡专来支付所有的医疗账单。将月结单放在档案夹里。在年终时如您采用列出开支的明细表来报税、一但您的开支如超过收入之某个百分率、可依据支付的款项减 免部分税金。将 **12** 个月结单加起来、即可算出您这部分的税金。

华大医疗中心 UWMC 账单的样本

这是华大医疗中心 UWMC 正式的账单。应付的款项是在此账单的背面（请
看下页



University of Washington Medical Center
PO Box C-9715
Federal Way WA 98063

UNIVERSITY OF WASHINGTON MEDICAL CENTER
UW Medicine

Questions

Billing questions or changes in insurance coverage?

Toll Free: 866-298-2825 Fax: 888-945-0537
Or visit our website at www.uwmedicine.org

Hours of Operation, 8:00am - 5:00pm Monday - Friday

03/27/08

9203-6

[redacted]

First Request For Payment

Account Summary

Balance due from patient: $960.25

Please see the reverse side of this statement for your account activity and listing of accounts.

Important Message

Thank you for selecting University of Washington Medical Center for your healthcare needs.
We value your use of our services and facilities.

The remaining balance is your responsibility. If you have any questions regarding the amount paid by your insurance, please contact them directly.

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.

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.

Please Return Lower Portion With Your Payment In The Enclosed Envelope

IF PAYING BY CREDIT CARD COMPLETE BELOW

CARDHOLDER'S NUMBER	EXP DATE	AMOUNT
CARDHOLDER'S NAME		
CARDHOLDER ADDRESS	ZIP CODE	
CARDHOLDER SIGNATURE		

Name **Account #** **Balance** $960.25

[redacted]

Statement Date: 03/27/08

Amount Paid:_____

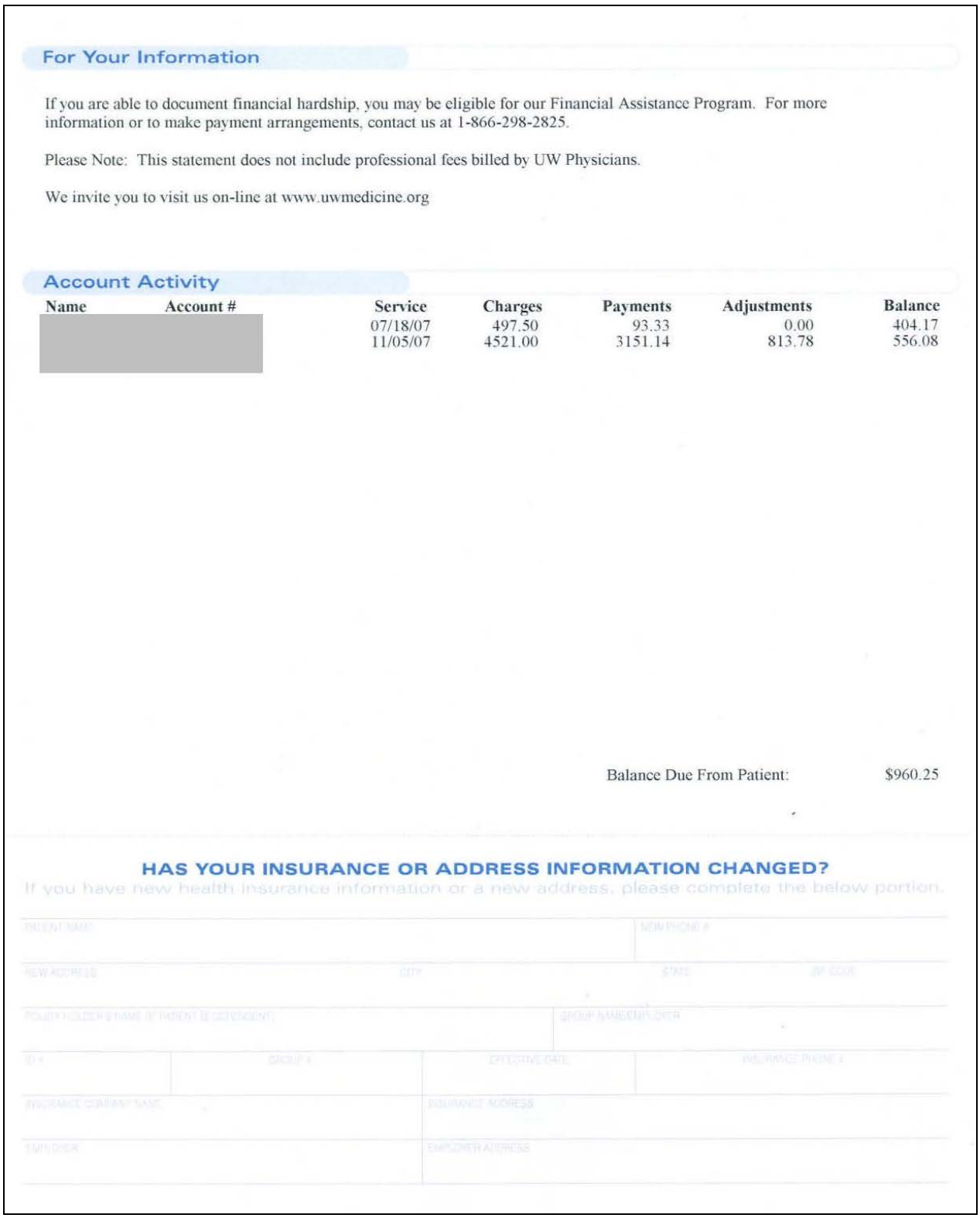
Remit This Payment Stub To:
University of Washington Medical Center
PO Box 24366
Seattle WA 98124-0366

[redacted]

6 NCO 9101

06 1 2461782 6016 00000096025 8279890000 30 14 9

账单样本（前面）



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.

账单样本（背面）

有关医疗账单最常见的疑问

为何同一天看病却有数份账单？

在多数情况下您最少会收到 2 份账单。大部分是由下列部门发出的：

1. 医院（*设备费*）。
2. 医生或其他专业人员的服务部（*专业收费的账单*）。
3. 病人财务部（*设备费* 是华大医疗中心为病人服务的费用如住院、门诊、X-光、实验室检测、及治疗）。

如需要有关此类收费的详情、请参看第 2 页及第 3 页。

保险涵盖注解是什么 (EOB)? 我需要付此结账单显示的数额吗？

保险涵盖注解单又称为 EOB, 可能在您或您家人看医生、专科、医院或其它医疗单位后保险公司寄给您的。此**并非**您需要付款的账单。如您需要付款、您会收到由您就诊的医生或医疗单位发出的账单。

保险涵盖注解单是让您知道您的保险公司已收到您的索赔。它为您解释已为您服务的项目、所须费用、已收到的病人固定付额、扣除额、保险公司已付额、及您必须付的金额。

一般情况下、仅在您需要付款时才会收到保险涵盖注解。您需要付的总金额是列在“病人负责”（Patient Responsibility） 一栏。此金额可能包括您已付的自付款部分。某些保险公司即使您不欠任何费用他们还是会寄保险涵盖注解单。

每一保险公司有其专用的保险涵盖注解表格。如您对保险涵盖注解有疑问、可与表格上所显示的保险公司联系。

如我没有健康保险？

如您没有健康保险、您必须在收到账单后 30 天内付清—除非您已申请经济辅助、且在等待判决、或您与华大医疗中心 UWMC 病人财务部已安排了其他付款的方式。 (206-598-1950 或免费电话电话 877-780-1121)。请看第 9 页“如不能付部分或全部的账单时我应该怎么办”。

为什么我的保险公司不付我全部的账单？

有些收费是您的保险不涵盖的。在这情况下付此款项是您的责任。此类收款项目是列在您保险公司账单的“病人负责”（Patient Responsibility）一栏。（请参看第 7 页有关保险涵盖的说明）。

您保险公司可能不涵盖的收费：

- 扣除款
- 共同保险费及/共同付额
- 涵盖的设限如项目或服务是不包括在您保险计划内的。
- 联邦医疗保险不保的项目(请参考联邦医疗保险手册的详细清单)。

核对保险涵盖注解单 EOB 或当有特别的疑问需要与保险公司联系时先将保险涵盖注解单 EOB 放在容易取得的地方。

更新保险或其它付款资讯我应该与谁联系？

您在注册后如保险有更改、请尽快通知下面 **2 个**单位：

1. **华大医疗中心 UWMC 病人 财务服务部/财务顾问**
   - 上班时间、上午 8 点至下午 5 点:：206-598-4320
   - 下班后、 周末、假日联系住院组：206-598-4310
2. **华大医生 UW Physicians (UWP)**
   206-543-8606 或 888-234-5467 (免费电话)

如我认为我的索赔被拒是因为资料不全或有误时应该如何处理？

保险公司可因为资料不全或有误而拒绝索赔。如您认为拒绝索赔是因此原因、请即刻致电病人 财务服务部：206-598-1950 (免费电话: 877-780-1121)。他们会更正您的资讯、更新您的账户、及/或再发账单给您的保险公司。

如我需要更多资讯以便动用我的医疗储蓄或医保报销账户、我需要如何处理？

送交医疗储蓄 (MSA) 或医保报销账户索赔所要的资讯各有不同。您可能需要送交其他不在您账单上的资讯如医生的姓名或诊断结果。如您需要这些资讯请致电病人财务部： 206-598-1950 (免费电话电话: 877-780-1121) 上班时间上午 8 点至下午 5 点。

您亦可上病人财务部的网站查看收费的细节、它会提供比您账单更详尽的资讯：
http://uwmedicine.washington.edu/PatientCare/PatientAndVisitorInfo/HospitalBill/Contact+Us.htm 然后按 “联系我们或在网上提问收费问题”（Contact us or submit your billing question online）。

如不能付全部或部分的账单时我应该怎么办?

您可与病人财务部设立一分期付款的方案来付您所欠的医疗款额。如您需要这些资讯请致电病人财务部： 206-598-1950 (免费电话电话: 877-780-1121) 。

华州的居民可以申请慈善基金的医护、但仅限于必要的医疗。“选择性的医疗”—即对病人身体健康没必要的医护—慈善金是不受理的。病人必须符合联邦收入标准且有需要的文件才合格接受慈善基金的医护。

申请慈善基金的医护、病人必须：

- 须在华大医疗中心接受医疗前、接受医疗期间、或医疗后提出申请。
- 在申请后 14 天内必须呈递全部的申请文件。
- 填妥的申请单内须包括收入核实及其他证明如银行月结单。

向保险公司报账

如您已将保险资讯交给医疗中心：您在收到账单的明细表后不必采取任何行动。我们会联系您的保险公司或其他医疗计划。

如您的保险有变动：**请看第 8 页 “**我应与谁联系来更新我的保险或其他付费资讯？”

收费总结单

计费有很多步骤。首先、病人的“担保人”会收到由病人财务部发送的*收费总结单*。此结账单列出您在华大医疗中心 UWMC 接受的服务。此结账单并不包括华大医生或其他医疗单位的服务。

保险涵盖注解单 (EOB)

在处理您的索赔后、大部分的保险公司包括联邦医疗保险、会寄保*险涵盖注解单* (EOB) 给您。此表格为您栓释那些是保险涵盖的服务、您的结余额或“病人负责款项”等项目。（有关保险涵盖注解单 (EOB)的详情请看第 7 页及 16 页)。

如您对您的保险涵盖注解单 (EOB) 有疑问；请联系您的健保单位或病人财务部，有此资料在手可使您很方便地以电话、信件或电子邮件联系。

病人的责任（病人负责款项）

提示：“病人负责款项”此款项须在收到医生或医疗单位账单后 30 天内要付款。

收费中保险不涵盖、您需自付的部分包括：

- 扣除款。
- 共同保险额及/或共同付额。
- 涵盖的设限—不包括在您保险涵盖的项目或服务。
- 联邦医保不涵盖的项目。（请参考您医保的完整列表手册）
- 因为遗漏或不正确的投保人资讯而被保险公司拒付。

请注意；如属第三方的赔偿责任的情况下、如汽车事故中、您应负责支付所有款项。我们不会等到案件解决后才结帐。

与客户服务部联系的小贴士

下列是现时或过去的病人及其家属所提供的小贴士、这可能对其他病人有帮助：

- **如与保险公司或医疗单位的客户服务部打电话；记录下日期、时间及通话者的姓名是很有帮助的特别是引述涵盖时。**
- **与某一客户服务员建立良好关系并取得他们的专线号码。如此您就不必每次对着一位新的服务员重复您的事由。**

- **对某些会触发情绪的事项或您已经为此事很烦恼、病人可以授权给照顾者协助打电话或介入处理此事件。请注意；病人可能需要先签同意书。请与保险公司联系查询如何授权他人作您的代言人。**
- **如病人没有得到正确的利益、不要犹豫并与他们联系要求他们再重新处理。病人需要知道他的福利、确定健保会给予正确的利益。**
- **华大医疗中心 UWMC 及西雅图癌症中心 SCCA 的账单是使用同一的编号系统、此外就无其他共同点了。如对西雅图癌症中心 SCCA 有疑问、须与西雅图癌症中心 SCCA 联系，对华大医疗中心 UWMC 有疑问、则须与华大医疗中心 UWMC 联系。以编号来归档较易因为它们已按照日期安排。以账单编号来归档有它的优点、因为从有无缺号您就知道有无账单遗漏。华大医生 UW Physicians 的账单又全然不同了、它们会将病人多次看多位医生的合并在一账单上。**
- **如病人与健保公司有任何问题、就务必坚持不要放弃。**

如何得到协助

华大医疗中心 UWMC 各单位

- **财务辅导** – 在住院期间财务辅导员可到病房间来与病人晤谈。或者、病人可到他们的办公室位于 3 楼住院部的隔壁。请在办公时间上午 8 点到下午 5 点致电 206-598-4320 以安排约谈时间。财务辅导员可协助病人及其家属。
  - 了解住院的账单及付款的选项。
  - 与保险公司、州政府福利局及联邦健保共同商讨。
  - 申请州政府医疗辅助及其他财务补助。
- **病人财务服务部–**办公时间上午 8 点到下午 5 点致电 206-598-1950 或 877-780-1121 (免费电话). 或上网：*http://uwmedicine.washington.edu/PatientCare/PatientAndVisitorInfo/HospitalBill/Contact+Us.htm.*

- **华大医生 UW Physicians (UWP)**
  206-543-8606 或 888-234-5467 (免费电话)
  http://uwmedicine.washington.edu/PatientCare/PatientAndVisitorInfo/UWPhysicians

其他 机构/ 组织

- **西北空运 Airlift Northwest**
  206-521-1616 或 866-245-4373 (免费电话)
  http://airliftnw.org
- **基本健保 Basic Health Plan**
  800-660-9840 (免费电话)
  www.basichealth.hca.wa.gov

  基本健保是华盛顿州政府赞助的健保。如您已符合申请联邦健保、即不可再加入此健保。
- **认证注册护士麻醉师 (CRNAs)**
  425-353-2840
- **华大儿童医疗组 Children's University Medical Group (CUMG)**
  206-987-8450 或 888-675-2864 (免费电话)
- **残障收入保险** (短期残障, SSD, SSI)
  社会安全残障保险 Social Security Disability
  800-772-1213 (toll-free)
  www.socialsecurity.gov
- **州政府医疗福利 Medicaid**
  在金县 King County: 206-341-7750, 800-346-9257 (免费电话), or 或 TTY 800-833-6384
  其他华州县: 请电您当地的家庭及社区服务处(HCS)
  www.adsa.dshs.wa.gov/pubinfo/benefits/medicaid.htm

  州政府医疗福利是华盛顿州政府为低收入的残障者提供的健保。它支付 100% 的医疗费用。请与您的财务辅导员或社工晤谈您是否符合条件。其他州政府亦有类似的福利。

  联邦健保 Medicare

  800-633-4227 (800-MEDICARE) 24 小时, 每周 7 天
  www.medicare.gov

  联邦健保是由联邦政府提供的健保。是专为 65 岁以上、肾透析者、肾移植者、或已接受社会安全残障保险辅助 2 年以上者。联邦健保有数种扣除金及共同付款部分。

联邦健保 Medicare 包括 2 部分：

- 部分 A 涵盖住院部分。.
- 部分 B 涵盖住院或门诊医生的费用及全部批准的门诊费用。

- **西雅图癌症中心(SCCA)**
  206-288-1109 or 877-849-8368 (免费电话)
  www.seattlecca.org
- **华盛顿州补助– 福利局 (DSHS)**
  206-341-7424
  www1.dshs.wa.gov
- **退伍军人福利部**
  800-827-1000 (免费电话)
  www.vba.va.gov
- **华盛顿州联营健保 Washington State Health Insurance Pool (WSHIP)**
  800-877-5187 (免费电话)
  www.wship.org

  WSHIP 是华盛顿州资助的健保。您必须被其他健保拒保后才可加入。对没有联邦健保的人其费用可能较高。如您有联邦健保就可打折。

财务计划资源

- **病人代言基金**
  800-532-5274 (免费电话)
  www.patientadvocate.org
  协助被雇主歧视、或拒绝保险福利的病人。
- **协助病人的项目**
  - **协助处方药 RxAssist**
    www.rxassist.org
    由卫生保健义工组织赞助的一个网站、提供可搜索的申请表格的资料库。
  - **协助处方药的合作 社**
    www.pparx.org
  - **处方药支助 处**
    877-923-6779 (免费电话)
    www.rxhelpforwa.org
    为华盛顿州居民提供的项目
- **华盛顿州保险专员**
  206-464-6263 或 800-562-6900 (免费电话)
  www.insurance.wa.gov
  提供资讯及调查客户的投诉。

医疗帐单的常用语

Allowed Amount **特定额**	**由您的保险公司拟定医生提供服务所定的收费额。**此额数通常是低于医生账单上的金额、它是由保险公司事先依合同或规章达到协定。保险公司及病人付款的总额不应超过特定额。
Benefit Contract **利益合约**	**健康保险及成员之间的法律合约。**此合约规定全部提供给成员的健康护理计划之利益。也称为涵盖范围证书或覆盖的证据。
Benefits **利益**	**医保将为您提供服务的范围。**但需根据不同的医护人员所提供不同的医疗服务而断定这些服务项目是否涵盖。
Brand-Name Drug **品牌药**	**由主要的药物公司生产及销售的药物。**品牌药可能或不可能列入“*配方药名册*”上（请参阅第 17 页“配方药名册”）对任何健康上的需要、可能都有其他药厂生产的竞争药。您的健保如与某药厂达到价位协议、其配方药即可能列入指定的品牌药。此品牌药可能比非品牌药要贵一些、但低于其他不列入药物名册的品牌药。如购买非属配方药名册的品牌药、病人一般要付更多、因为健保支付较多。
Clinical Trial or Research Study **(Also see “Experimental or Investigational Treatments” on page 16.)** **临床试验或研究项目（亦请参阅见第 16 页实验或调查研究疗法。）**	**现正研究的治疗法、涉及病人医疗费及研究费。**健保可能涵盖病人看医生、住院、测试、及其他程序无论病人是属于实验的一部分或传统治疗法控制组的部分。健保可能不涵盖属于试验项目内的特殊测试。但可能由试验项目涵盖。请参看健保计划或与华州保险委员会联系。 自 2000 年起、联邦健保开始涵盖某些试验项目。试验项目必须符合特定的要求才取得涵盖。凡合格的试验项目，健保会将涵盖治疗及服务如测试、程序、及看医生。有些事项可能不涵盖；包括实验药物或仅用于数据收集在临床试验中的项目。一些临床试验提供免费的调查研究中的药物。

COBRA (Consolidated Omnibus Budget Reconciliation Act) **（统一综合预算协调法案）**	**在某些情况下联邦法律保护职员及其家属、在指定的时间内容许他们继续享有现有的健保。**统一综合预算协调法案 COBRA 提供给某些前雇员、 退休人员、 配偶、 前配偶及子女在给予集体优惠的健保权利。个人必须缴付保费以保持他们的保险计划，但其费用一般低于个人健保。但统一综合预算协调法案 COBRA 仅适用于某些情况：如失业、死亡、离婚或其他类似情况。统一综合预算协调法案 COBRA 一般适用于公司有 20 位员工以上的集体健保。有些州政府要求雇主对不符合统一综合预算协调法案者继续提供健保。如需更多资讯请致电州政府保险委员会。需付少额的收费（如 2%）以处理统一综合预算协调法案 COBRA 的付款 。
Co-insurance **共同保险（自付部分）**	**根据您的健保计划、在保险公司支付他们的部分后、 您必须付的款额。**在大多数健保计划内、病人必须付一部分的特定额。例如，健保支付 70%的特定额，病人需付剩余的 30%。如您的健保是有*特约医生*、(请参阅“特约医生组织 (PPO)”第 19 页)。如采*用特约医生连网*内的医生；您的自付额就会较低。 (请参阅“连网”第 18 页) 请与您的保险公司联系以取得更多的资讯。
Co-payment (Co-pay) **共同付款（固定的自付额）**	**病人在看病或拿处方药时病人需付的款额。**自付额因医生及看病部门而不同，（属特约医生联网或非特约医生联网）至于处方药自付额因品牌药或非品牌药而异。
Coordination of Benefits **利益的协调**	**当您有多个健保时、保险公司之间的协调。**某些人参加一个以上的商业健保、如本人工作单位提供的健保、同时又有配偶或同居伴侣工作单位提供的健保。如您有一个以上的商业健保时、需查询辅助健保条例如何支付您主要健保付款后的剩余部分。 (请参阅第 19 页 “辅助健保”)
CPT Code (Current Procedural Terminology Code) **代码（当前程序术语代码）**	**是一 5 位数的统一账单代码。**某些医疗服务采用统一账单代码。此代码可协助医生及保险公司更有效地交流及追查账单。

Deductibles **预付额**	**在保险公司付任何利益之前病人需付的款额。**一般来说、扣除额是以每人每年来计算的。而且、大多数是预付额越高、保险费越低。特约医生单位 (PPOs), 预付额通常适用于所有服务、包括实验室测试、住院、到诊所或看医生。有些健保对看医生是免预付额的。有些维护健康单位(HMOs) 对某些服务有特定的预付额。
Disability Income Insurance **残疾收入保险**	**一种由公司为员工在残疾时、可以涵盖部分收入的保险。**如病人在健康有问题前已在工作、他的单位可能提供残疾收入保险。他们有短期及长期两种收入保险。 • *短期残疾保险*—当病人因健康的原因不能工作时、它会付病人一部分的薪金、短期残疾保险一般是 60%、为期 3-6 个月。 • *长期残疾保险* 付病人一部分的薪金。凡被考虑为残疾不能工作者、一般是支付薪金的 60% 。但一般必须因残疾不能工作 90 天以上才开始生效。
Effective Date **生效日期**	**保险涵盖合约生效之日。**
Eligibility **合格**	**决定某人是否合资格参与某保险计划。**
Experimental or Investigational Treatments **实验或研究性的疗法** **（Also see "Clinical Trial or Research Study" on page 14.)** **请参看第 14 页临床测试或研究项目)**	**尚未被确认医疗上是否有效的治疗法**。这类治疗可能或不可能由健保承担。一些州规定健保涵盖此类研究中的疗法。病人需与个人的保险计划及州政府保险委员会，查询可否覆盖。
Explanation of Benefits (EOB) **健保利益的栓释 (EOB)**	**保险公司在处理医生的账单后发给病人的报告。**利益的栓释（EOB）列出帐单上所有的款项、付给医生的数额、及任何自付额、预付额、或您应付的共保额。利益的栓释（ EOB） 也可能列出个人或家人的福利报表。请参阅第 7 页及第 10 页。

Flexible Spending Account (FSA or Flex Account) **有弹性的消费账户**	**是一员工福利容许在扣除所得税前拨出固定的金额来支付合格的医疗开支。**合格的开支可能包括幼儿照顾、及不涵盖的医疗支出。拨出的金额必须在事先决定、在会计年度结束时员工将损失尚未动用的金额。
Formulary **配方药的名册**	**首选的配方药名册。**此名册将药物基于健保将付的费用及病人自付费用来分类、或分层次。
Generic Drug **非名牌药**	**药物具实有效、因为不是大制药厂的产品、且不采用名牌的药名、因此其价位较廉。**几乎在所有情况下、此类的药物的自付款也低。但不是所有的药物都有这选择。
Health Maintenance Organization (HMO) **维护健康机构**	**是需要预先付款、管理式的医疗健保(HMO)。**个人加入HMO通常是按月付保费、健保包括看医生、住院、化验、及急诊。每次要付少量的自付额。HMO有特约医生及医院、自付款部分仅适于HMO的特约医生及医疗设施。病人如事先取得HMO批准、亦可看特约以外的医生及医院但利益可能降低。具体的利益请参考健保有关的资讯。
Health Plan **健保计划**	**个人加入健保后、健保即支付全部或部分的医疗费用。**健保可分为团体健保、个人健保、工伤偿赔、政府的健保如联邦健保Medicare及援助医保等（Medicaid）。健保又可进一步的分为服务费用（传统保险）及托管式保险。团体健保或个人健保两者均可为健保服务式（传统保险）及托管式保险。
Health Savings Account (HSA) **健康储蓄账户**	**在扣除所得税前拨出金额来支付部分医疗开支的账户。**是政府给每个人的税务福利。此保险可由个人或雇主设立账户。每年存入的款项是有最高限额。所投入的金额可以累积、用来支付必要的医疗费用‘包括牙科、视力、及非处方药。与弹性消费账户不同；未动用的余款可以经年累积。

Individual Insurance **个人保险**	**个人自己购买的健康保险、不属任何团体的计划。**
In-Network **特约医生**	**健保公司特约的一组医生、医院、及医疗人员，他们与保险公司有签合约。**因病人的保险计划而异；如看非特约医生时、健保不涵盖或利益会减少。如看特约医生、即可由保险公司得到最高额的涵盖及利益。
Lifetime Maximum Coverage **终生涵盖的限额**	**保险公司承保的终顶或限额。**此限额因保险计划而异。某些特殊的利益是有限额的、且计算在计划的总限额内。
Lifetime Transplant Maximum **终生有关移植之限额**	**保险公司对病者终生有关特定移植付款的限额。**
Medicaid **州政府医疗福利**	**州政府为低收入或残疾者提供的健保。**它付 100%涵盖的医疗费。可与当地的健康署或社会服务处联系索取申请表格查询是否符合资格。
Medicare **联邦健保**	**由联邦政府辖管的健保。**它为领取社会安全残疾金至少 2 年以上者、或 65 岁以上提供的健保。 它分为 2 部分–计划 A 及计划 B。计划 A 涵盖住院部分。计划 B 涵盖住院及门诊医生的费用、及核准的门诊费用。联邦健保 Medicare 亦有数种预付额及病人共付费。
Medicare Supplements or “Medigap” Policies **补助联邦健保或“Medigap”保险**	**补助联邦保险(Medicare) 的保险计划。**大部分此类的保险支付联邦健保 Medicare 病人的共付费及预付额、此外不再付其他任何费用。可洽询此类补助保险它们如何与联邦健保(Medicare)的福利搭配。
Out-of-Network **非特约医生**	**属 PPO 保险的受保人、 到不在特约医生名单上的医生看病。**维护健康保险 HMO 计划对此情况的栓释是：是属其服务的项目、但未经由家庭医生提供或批准的项目。

Out-of-Pocket Maximum **最高自付额**	**在保险公司付您全部的费用前、您必须自付的最高额。**每一健保计划设有每年度自付款的限额。当自付额达到其限额后、在余下的年度内健保对凡合格的账单、在允许收款的金额内会付 100% 。某些健保公司将某些费用不包括在最高自付额内例如；生育的治疗或处方药。其他的健保公司提高看非特约医生的最高自付金额。
Point of Service (POS) **服务点**	**健保计划容许病人选择看特约医生或非特约医生。**但您若看非特约医生时您自付款额就较高。
Pre-existing Condition **已存在的情况**	**在加入一个新的健保计划前已因病症接受过一时段的治疗。**加入一新健保前 (可为 30、60、90 天、6 个月等等) 被称为“回顾期”。“ 治疗”之定义为听取医生的专业意见 、提议、处方药、诊断、或治疗。对之前已存在的情况可能不被涵盖在新的健保计划内。务必与您的健保计划或政府保险局确认已存在情况之规条。大多数团体保险计划；如您能提出证明、确有持续的健保、其间没有空档的时段、则已存在情况是可以被新的健保计划接纳的。
Preferred Provider Organization (PPO) **特约医疗机构**	**一医疗机构；病人如能在他们特约医生名单内看病、则大部分医院服务费用都会被涵盖。**某些特约医疗机构 PPOs 要求病人选择一家庭医生、在需要时由家庭医生来协调医疗、安排转医到专科。病人亦可看非特约专科医生但健保涵盖较少。
Secondary Insurance **辅助保险**	**有些病人有一个以上的健保、辅助保险是在主要保险支付他们涵盖的部分后、其他剩余部分即由辅助保险涵盖**。（请参看第 15 页“福利的规划）。

您有疑问吗?

请看 此小册第 11 页到第 13 页

Self-Insured Health Plan **自保健保**	**是一种团体健保、公司给员工的福利，由公司承担健保的风险。**索赔是由公司支付。通常公司会购买停止损失保险、以减少高成本的灾难性索赔事故的风险。
Social Security Disability (SSD) Insurance **社会安全残疾保险(SSD)**	**残疾人士收入补助金是由联邦政府辖管。**社会安全局 (SSA) 对各种疾病、如糖尿病或肾脏疾病的残疾情况有其自己的定义。其申请过程可能需时数月。如获批准、您每月将收到的金额是根据您过去缴纳的工资税、已经纳入社会保障的金额而定。 您必须符合下列条件之一才可有资格领取社会安全残疾保险金（SSD）： • 已延续了或预期持续至少 1 年。 • 成为永久性的。 • 预期会导致死亡。 您必须在残疾 5 个月后、社会安全局（SSA）才考虑给您残疾保险福利。
Social Security Income (SSI) **社会安全收入（SSI）**	**当残疾者工作点数还不足、尚不能取得社会安全残疾保险金（SSD）时由社会安全局（SSA）发的一种残疾收入。**残疾规则与社会安全残疾保险（SSD）相同，但 SSI 有收入及经济情况的限制。
Third-Party Payer **第三者支付**	**是一单位（公司）性的团体组织、而非病人本人（第一方）或医疗人员（第二方）参与支付医疗索赔。**
Usual, Customary, and Reasonable (UCR) **惯常例及合理的(UCR)**	**总体来说，是指医生的收费。**具体来说，当一项特定的服务收费额被认为是"惯常合理的"、即意指它与同一地区其他医生所收取的相同的服务的价格相差不远。
Waiting Period **等待期**	**成员在加入保险计划后必须等待的时段、其后才符合某种福利资格。**

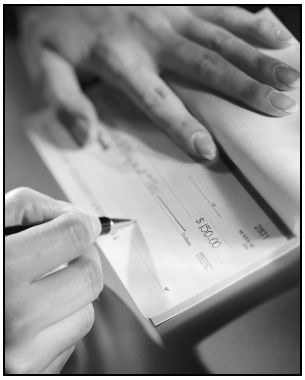
UNIVERSITY OF WASHINGTON MEDICAL CENTER
UW Medicine

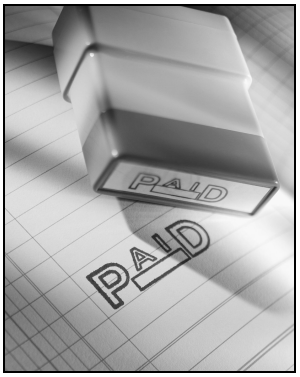
Patient Care Services
Box 359420
1959 N.E. Pacific St. Seattle, WA 98195

Money Matters - Chinese
05/2009
Translation by UWMC Interpreter Services
Reprints: Health Online

Money Matters

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





University of Washington Medical Center
UW Medicine

This handbook was created by UWMC's Inpatient Oncology Advisory Council.

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 UMWC, please contact:

Hollis Guill Ryan
Patient and Family Centered Care, UWMC
206-598-2697
hollisr@u.washington.edu

Money Matters

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

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.

Contents

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine

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:

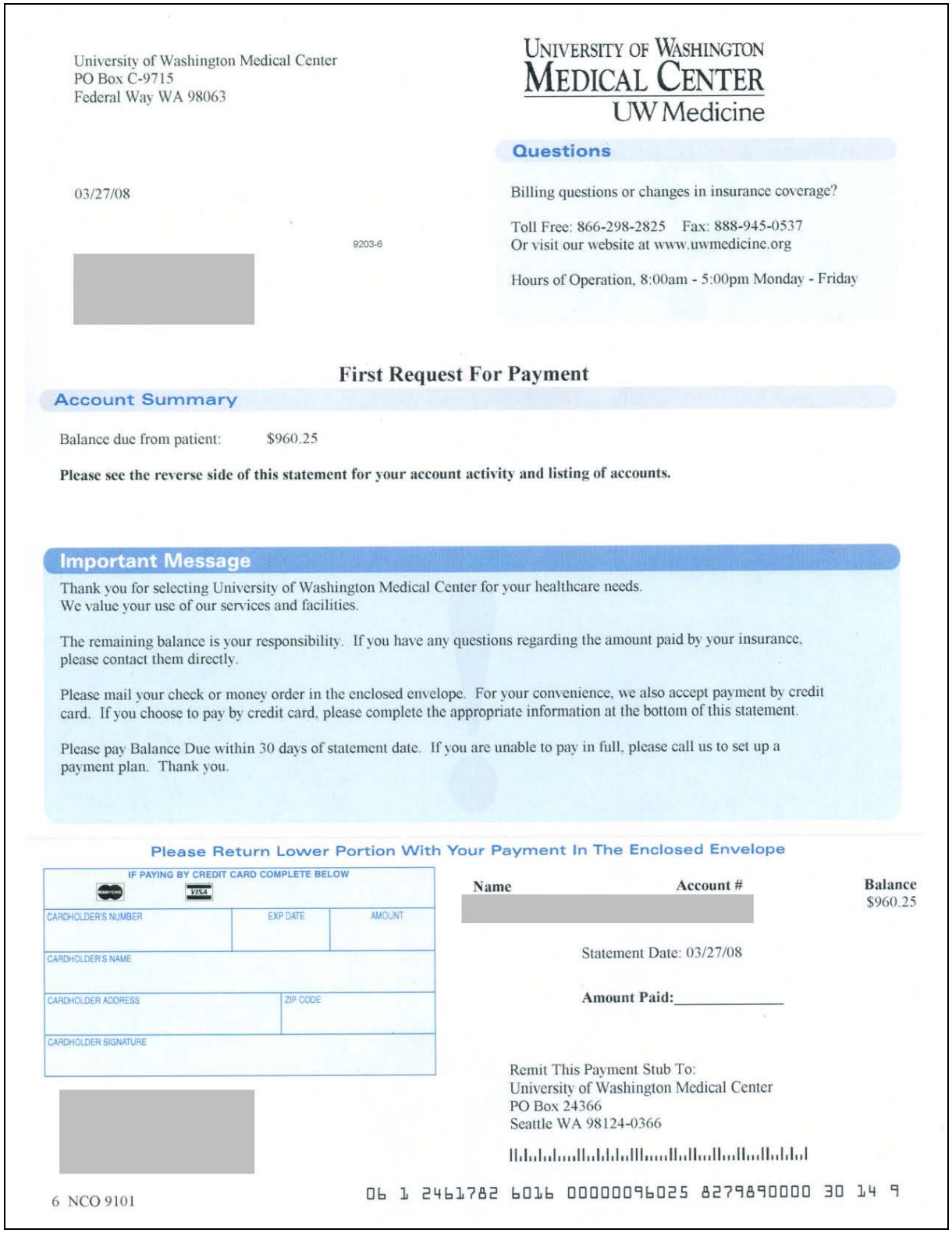
- How you want to organize – whether you will use:
  - A computer-based system, including what technology to use and how to name electronic folders and files.
  - A paper system, including using binders, files, and color coding.
  - A combination of computer and paper system.
- What papers to keep and 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).



University of Washington Medical Center
PO Box C-9715
Federal Way WA 98063

UNIVERSITY OF WASHINGTON MEDICAL CENTER
UW Medicine

03/27/08

9203-6

[redacted]

Questions

Billing questions or changes in insurance coverage?

Toll Free: 866-298-2825 Fax: 888-945-0537
Or visit our website at www.uwmedicine.org

Hours of Operation, 8:00am - 5:00pm Monday - Friday

First Request For Payment

Account Summary

Balance due from patient: $960.25

Please see the reverse side of this statement for your account activity and listing of accounts.

Important Message

Thank you for selecting University of Washington Medical Center for your healthcare needs.
We value your use of our services and facilities.

The remaining balance is your responsibility. If you have any questions regarding the amount paid by your insurance, please contact them directly.

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.

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.

Please Return Lower Portion With Your Payment In The Enclosed Envelope

IF PAYING BY CREDIT CARD COMPLETE BELOW

CARDHOLDER'S NUMBER	EXP DATE	AMOUNT
CARDHOLDER'S NAME		
CARDHOLDER ADDRESS	ZIP CODE	
CARDHOLDER SIGNATURE		

Name **Account #** **Balance** $960.25

[redacted]

Statement Date: 03/27/08

Amount Paid:_____

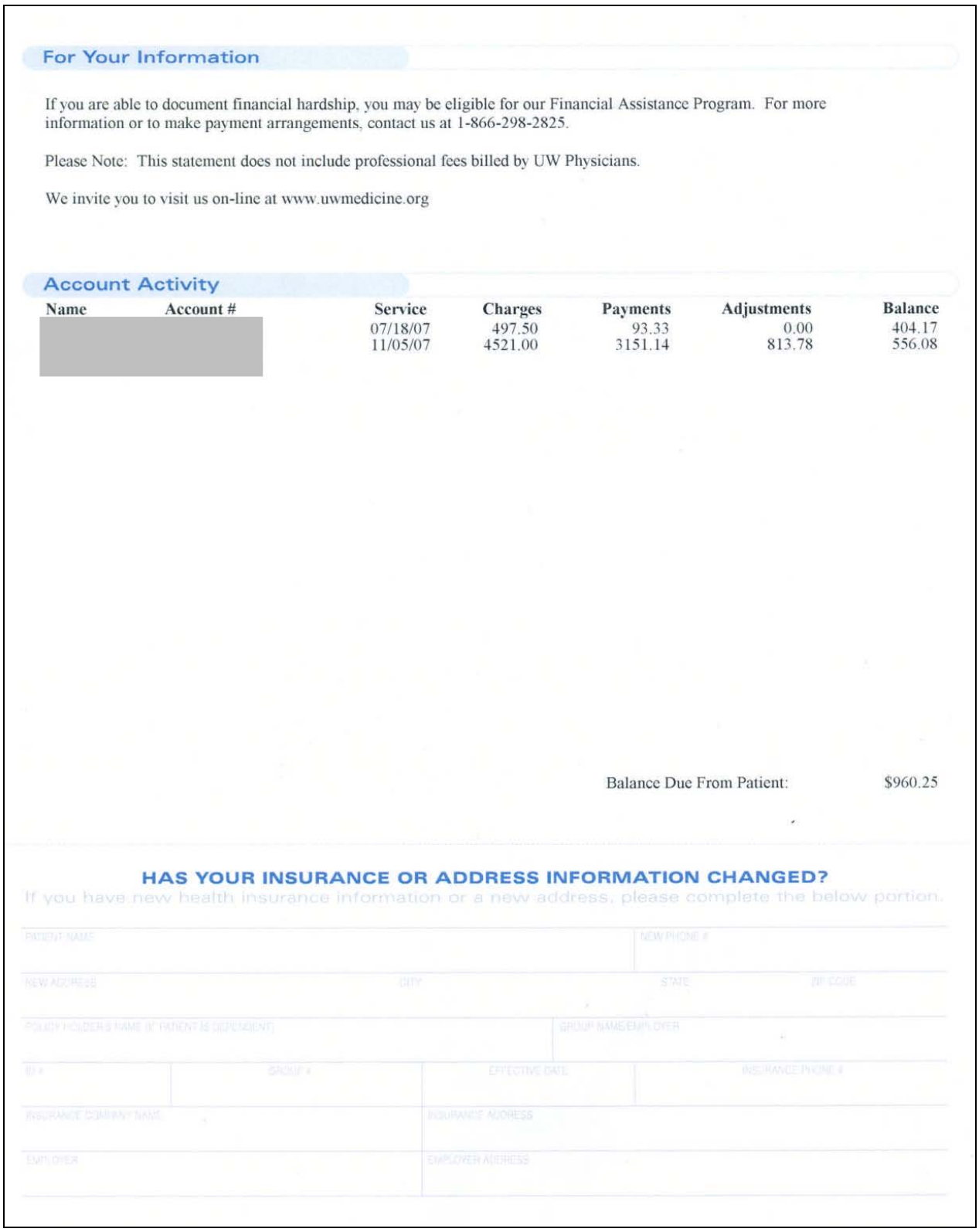
Remit This Payment Stub To:
University of Washington Medical Center
PO Box 24366
Seattle WA 98124-0366

[redacted]

6 NCO 9101

06 1 2461782 6016 00000096025 8279890000 30 14 9

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

Allowed Amount	**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.
Benefit Contract	**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 *a certificate of coverage* or *evidence of coverage*.
Benefits	**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.
Brand-Name Drug	**Drugs made and sold by a major drug company.** Brand-name drugs may or may not be listed on a *formulary* (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.
Clinical Trial or Research Study **(Also see "Experimental or Investigational Treatments" on page 16.)**	**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. 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.

COBRA (Consolidated Omnibus Budget Reconciliation Act)	**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.
Co-insurance	**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 *preferred provider organization* (see "Preferred Provider Organization (PPO)," page 19), your co-insurance costs will be lower if you use the services of an *in-network* provider on the plan's *preferred provider list*. (See "In-Network," page 18.) Call your insurance company for more information.
Co-payment (Co-pay)	**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.
Coordination of Benefits	**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.)
CPT Code (Current Procedural Terminology Code)	**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.

Deductibles	**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.
Disability Income Insurance	**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. • *Short-term disability insurance* 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. • *Long-term disability insurance* 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.
Effective Date	**The date on which a contract for coverage begins.**
Eligibility	**A determination of whether or not a person meets the requirements to participate in the plan.**
Experimental or Investigational Treatments **(Also see "Clinical Trial or Research Study" on page 14.)**	**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.
Explanation of Benefits (EOB)	**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.

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 *co-payment* 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. *A pre-existing condition might not be included in the new coverage.* 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.

Self-Insured Health Plan	**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**.**
Social Security Disability (SSD) Insurance	**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. To be eligible for SSD, your disability must meet 1 of these conditions: • Have lasted or be expected to last at least 1 year. • Be permanent. • Be expected to result in death. SSA must consider you disabled for at least 5 months before you start receiving benefits.
Social Security Income (SSI)	**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.
Third-Party Payer	**An organization other than the patient (first party) or health care provider (second party) involved in paying health care claims.**
Usual, Customary, and Reasonable (UCR)	**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.
Waiting Period	**The amount of time members must wait after enrolling in an insurance plan before they are eligible for certain benefits.**

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