Glossary of Terms

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expenses, payment allowance, or negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference.

Annual Open Enrollment: The annual period during which you may choose to change your medical and/or dental coverage level or switch plans for the next plan year.

Annual Out–of–Pocket Maximum: The maximum amount of coinsurance and deductible you pay for covered medical expenses in any single calendar year. Once you have paid the out-of-pocket maximum, the Plan pays 100% of expenses (except for plan copayments, which are still required). Prescription copayments and monthly premiums do not count toward your out-of-pocket maximum.

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Beneficiary: Person(s) named by the employee or retiree in an insurance policy to receive any benefits provided by the plan if the participant dies.

Brand-name drugs: Prescription drugs that carry a trademark or brand name. Brand-name drugs may be significantly higher in cost than generic drugs, even though, by law, both must have the equivalent active ingredients.

Coinsurance: The percent (for example, 10%) you pay of the allowed amount for covered health care services to providers. Network coinsurance usually costs less than non-network coinsurance. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your

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Coordination of Benefits: Typically, coordination of benefits is the insurance industry standard practice used to share the cost of care between two or more carriers when a member is covered by more than one benefit plan. When someone is covered under two plans at the same time, the benefits received under those plans will be coordinated so that the participant will receive a benefit that is not greater than either one of the plans would pay under its own terms. In order to accomplish this, one plan is designated as "primary" and the other is designated as "secondary".

If you are covering your spouse as a dependent, and he or she also receives coverage elsewhere, for your spouse the City's benefit plan will always be secondary and the other plan will always be primary. Likewise, if you cover yourself as a retiree on our plan, and your spouse covers you under his or her plan, our plan is primary and his or her plan would be secondary with respect to your benefits.

Copayment: A fixed amount (for example, $15) you pay for a covered health care services to providers, usually when you receive the service. Network copayments are usually less than non-network copayments.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance begins to pay. For example, if your deductible is $1,250, your plan won't pay anything until you've met your $1,250 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

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Formulary Drugs: Listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to covered enrollees. Formularies are subject to change without notice.

Grievance: A compliant that you communicate to your health insurer or plan.

Generic Drugs: Prescription drugs that meet the standards for safety, purity, strength, and quality as their brand-name counterparts. These drugs, however, bear only a chemical or general-classification name — not a brand name.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient services.

Health Insurance Plan: An individual or group plan that provides or pays some or all of your eligible health care costs in exchange for a premium.

Health Maintenance Organization (HMO): A pre-paid medical plan that provides a comprehensive predetermined medical care benefit package.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Inpatient: A hospital stay (usually 24 hours or more) for which a room and board charge is made by the hospital.

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Medicare: The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD). Part A, Hospital Insurance, pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care. Part B, Supplementary Medical Insurance, helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A. Enrollment in Part B is voluntary and available for a small premium. (You are required to be enrolled in Part B if you are enrolled in any of the City's health plans.)

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Formulary Drugs: Prescription medications not on a plan-approved list.

Non-Network Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Open Formulary: A relatively unrestricted listing of drug medications and sufficient information about them to enable health practitioners to prescribe treatment that is medically appropriate.

Outpatient (Hospital) Care: Care in a hospital, clinic, or health facility that usually doesn't require an overnight stay.

Physician Services: Health care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

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Primary Care Provider: A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Qualifying Event: An event entitling an employee/retiree to add and/or drop an eligible dependent or drop coverage in the middle of a plan year. A qualifying event may include, but is not limited to, marriage, divorce or legal separation, birth, adoption, court order, legal guardianship, or a dependent child's loss of dependent status.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Summary Plan Descriptions (SPD): A document that provides explains fundamental features about your benefits, including eligibility requirements.

Subrogation: The right of the employer or insurance company to recoup benefits paid to participants through legal suit, if the action causing the injuries and subsequent