Benefit Beginning and End Date: October 1, 2016 through September 30, 2017
Plan Type: PPO Medical Plan / Plan C

Resource	Contact Information and Accessible Hours
TML MultiState Intergovernmental Employee Benefits Pool (IEBP)	**Physical:** 1821 Rutherford Lane, Suite 300 | Austin, Texas 78754 **Mailing:** PO Box 149190 | Austin, Texas 78714-9190
Customer Care Helpline	(800) 282-5385 | 8:30 AM - 5:00 PM Central
Secured Customer Care E-mail: Medical	Visit www.iebp.org ▸ click on the "Login" button ▸ click on "Online Customer Care" under the "My Tools" menu ▸ click on "Send a Secure Email" ▸ 8:30 AM - 5:00 PM Central
Secured Customer Care E-mail: Dental	dental-mail@iebp.org
Provider Benefit Information Portal: Provider information can be found under the Provider Services menu. Member specific information such as Eligibility, Claims, Summary of Benefits and Coverage, Provider Coding Guidelines, Medication Therapy Management Guide, Member Rights and Responsibilities, Provider/Member Appeal Rights and IEBP Quality Improvement Plan information is also available.	Visit www.iebp.org ▸ to register, click on the "Sign Up" link under the provider section ▸ to login, click on the "Login" button at the top right hand side of the screen
TML MultiState IEBP Internet Website	www.iebp.org | Twenty-four (24) hours
*My*IEBP Mobile Access	iPhone–App Store, Droid–Google Play, All other Phones–www.iebp.org | Twenty-four (24) hrs
Information on how IEBP evaluates new technology for inclusion as a covered benefit	Visit www.iebp.org ▸ click on "About Us" ▸ click on "Technology"
Medical Authorizations	(800) 847-1213 | 8:30 AM - 5:00 PM Central
Prescription Authorizations	RxResults | Toll Free: (855) 892-0936 | Local: (501) 686-7463 | Fax: (855) 851-5799 | 7:00 AM - 7:00 PM Central
Professional Health Coaches: Professional Health Coaches will answer basic health and medication questions and assist Covered Individuals with the Healthy Initiatives Incentive Program. Covered Individuals may enroll in professional health coaching.	(888) 818-2822 | 9:30 AM - 6:00 PM Central or Scheduled Appt.
Spanish Line	(800) 385-9952 | Spanish_cc@iebp.org *(There is an underscore between Spanish and cc.)*
Where to Mail Paper Medical Claims	TML MultiState IEBP | PO Box 149190 | Austin, Texas 78714-9190
Where to Mail Paper OptumRx Prescription Claims	OptumRx | PO Box 29044 | Hot Springs, AR 71903
OptumRx Prescription Member Customer Service	(888) 543-1369
OptumRx Prescription Pharmacist and Mail Service Customer Service: Register at optumrx.com to receive e-mail reminders when it is time to refill your prescription.	(800) 788-7871 (TTY 711) | www.optumrx.com
OptumRx Specialty/Biotech Pharmacy	(866) 218-5445 | Fax: (800) 491-7997
Telehealth	Healthiest You | (866) 703-1259 | www.healthiestyou.com
After Hours and/or Weekend Medical and Mental Healthcare Emergencies	Call 911 or immediately go to the emergency department.
IEBP Performance Improvement Plan	Visit www.iebp.org ▸ click on the "Login" button ▸ click on "My Tools" ▸ click on "Quality Improvement Program"
Cultural Sensitive Counties: Summary of Benefits and Coverage (SBC) and benefit declinations can be requested in Spanish in the following counties. County list may be updated midyear.	Visit www.iebp.org ▸ click on the "Login" button ▸ click on "Online Customer Care" under the "My Tools" menu ▸ click on "Send a Secure Email" ▸ 8:30 AM - 5:00 PM Central

Counties for 2016: Andrews | Atascosa | Bailey | Bastrop | Bexar | Briscoe | Brooks | Cameron | Camp | Castro | Cochran | Collingsworth | Concho | Crane | Crockett | Crosby | Culberson | Dallam | Dallas | Dawson | Deaf Smith | Dimmit | Duval | Ector | Edwards | El Paso | Frio | Gaines | Garza | Glasscock | Gonzales | Hale | Hansford | Harris | Haskell | Hemphill | Hidalgo | Howard | Hudspeth | Jeff Davis | Jim Hogg | Jim Wells | Karnes | Kenedy | King | Kinney | Kleberg | Knox | Lamb | La Salle | Limestone | Lipscomb | Martin | Matagorda | Maverick | McMullen | Menard | Midland | Moore | Navarro |

Resource	Contact Information and Accessible Hours
Nueces | Ochiltree | Parmer | Pecos | Presidio | Reagan | Reeves | San Saba | Sherman | Starr | Sterling | Sutton | Terry | Titus | Travis | Upton | Uvalde | Val Verde | Ward | Webb | Willacy | Winkler | Yoakum | Zapata | Zavala	

Common Medical Event	Network Benefit	Non Network Benefit	Limitations, Exceptions, and Exclusions
Maximum Lifetime Benefit	N/A	N/A	None
Maximum Lifetime Benefit for Substance Use Disorder	80% After Deductible	60% After Deductible	Three (3) Treatment Series per lifetime. Expenses for the treatment of Substance Use Disorder are paid the same as any other illness. Office visits are covered the same as any other illness and are covered under the copay.
Maximum Lifetime Benefit for Wigs *(oncology related)*	100% Deductible Waived	80% After Deductible	Limited to a $150 usual, reasonable and customary limit per lifetime.
Maximum Lifetime Benefit for Prosthetic Bra/Breast Prosthesis *(oncology related)*	100% Deductible Waived	80% After Deductible	Limited to a $150 usual, reasonable and customary limit per lifetime.
Maximum Lifetime Benefit for Sleep Studies	80% After Deductible	60% After Deductible	One (1) per sleep study per lifetime. Limited to Sleep Apnea and Narcolepsy
Maximum Lifetime Benefit for Morbid Obesity Treatment	50% After Deductible	N/A	Limited to $30,000 payable per lifetime. Never pays at 100% and expenses do not go towards the out of pocket.
Maximum Benefit for Hearing Appliances	80% After Deductible	60% After Deductible	Limited to a $3,500 usual, reasonable and customary limit per three (3) calendar years.
Maximum Benefit for Custom Molded Foot Orthotics	80% After Deductible	60% After Deductible	Limited to one (1) pair every thirty-six (36) months unless medically documented physiological changes.
Calendar Year Maximum for Inpatient Rehabilitation (excluding mental health and serious mental health)	80% After Deductible	60% After Deductible	Thirty (30) days per calendar year
Calendar Year Maximum for Inpatient Mental Health treatment	80% After Deductible	60% After Deductible	Fifteen (15) days per calendar year. Inpatient, Residential and Day treatment will all accumulate to the fifteen (15) day maximum. Day treatment will count 2:1. Expenses for the treatment of a Mental Health condition are paid the same as any other illness. Office visits are covered the same as any other illness and are covered under the copay.
Calendar Year Maximum for Outpatient Mental Health treatment	80% After Deductible	60% After Deductible	Twenty-six (26) visits per calendar year. Expenses for the treatment of a Mental Health condition are paid the same as any other illness. Office visits are covered the same as any other illness and are covered under the copay.
Calendar Year Maximum for Private Duty Nursing	80% After Deductible	60% After Deductible	Limited to one hundred (100) visits per calendar year; includes inpatient and outpatient private duty nursing.
Contraceptive Management	100% Deductible Waived	60% After Deductible	Physician charges for the insertion and/or removal of a physician inserted contraceptive device and the charges for the device. This benefit also includes charges for any associated labs or tests. Preferred Lab benefits are also available.
Allergy Injections	100% Deductible Waived after $20 copay	60% After Deductible	Includes charges for Allergy Serum and Allergy Testing. If an Allergy Injection is billed without an office visit, a copay will still apply. If an office visit is billed with a charge for an allergy injection, only one office visit copay will apply.
Diabetic Education	80% After Deductible	60% After Deductible	
Preadmission Testing	80% After Deductible	60% After Deductible	

Common Medical Event	Network Benefit	Non Network Benefit	Limitations, Exceptions, and Exclusions
Emergency Room Physician Charges –for Emergent/Immediate care Facility Charges –for Emergent/Immediate care Physician Charges – for Non Emergent/Immediate care Facility Charges – for Non Emergent/Immediate care	80% After Deductible 80% After Deductible 80% After Deductible 80% After Deductible	80% After Deductible 80% After Deductible 60% After Deductible 60% After Deductible	All emergency Room Facility charges are subject to a $100 facility access fee. The Emergency Room Access fee is waived if admitted. The access fee also applies to emergent/immediate care. Please refer to the definitions in the plan document for what is considered emergent/immediate care.
Second Surgical Opinions	100% Deductible Waived after $20 copay	60% After Deductible	
Preferred Lab Benefit	100% Deductible Waived	N/A	Includes laboratory expenses from a Preferred Lab Provider and Preferred Lab drawing site. Eligible network preventive/routine benefits and preferred lab benefits pay at no cost share to the covered individual. If services are not received at a Preferred Lab drawing site, any physician professional fees billed will be payable as a "physician all other service".
Non Preferred Lab	80% After Deductible	60% After Deductible	
Outpatient X-Rays and Major Imaging	80% After Deductible	60% After Deductible	
SpecialtyRx/Biotech Medications	100% Deductible Waived after a $80 copay	Not Covered	SpecialtyRx/Biotech medications are covered under the Medical plan when they are provided by a Network provider. SpecialtyRx/Biotech medications are also available under the prescription plan.
Durable Medical Equipment, Prosthetics and Related Supplies	80% After Deductible	60% After Deductible	Notification is required for charges in excess of $1,000 per durable medical equipment prior to purchase, lease or rental; limited to the U&R charges of standard models as determined by Medical Care Management.
Chiropractic Care	80% After Deductible	60% After Deductible	Ten (10) visits per calendar year. Limited to non-surgical treatments only. Never pays at 100% and expenses do not go towards the out of pocket.
Outpatient Cardiac Rehabilitation	80% After Deductible	60% After Deductible	
Home Health Care	80% After Deductible	60% After Deductible	One hundred (100) visits per calendar year
Temporomandibular Jaw Treatment (Non Surgical)	80% After Deductible	60% After Deductible	Single exam including history/physical, x-rays, muscle testing, range of motion, therapeutic injections, and psychological evaluation, as necessary. Includes Physical Therapy and a single Orthotic Appliance. See Medical Plan Document for complete coverage requirements.
Nutritional Counseling (Routine/Wellness)	100% Deductible Waived	60% After Deductible	Rendered by a Licensed Dietitian or Physician.
Nutritional Counseling (Diabetes Diagnosis)	80%	60%	Covered as part of the Diabetic Self-Management Training/Education benefit. Rendered by a Licensed Dietitian or Physician.
Nutritional Counseling (Morbid Obesity)	50%	N/A	Covered under the Morbid Obesity benefit. Must meet Morbid Obesity requirements.
Nutritional Counseling (All Other Diagnoses)	80%	60%	Based on Medical Necessity and rendered by a Licensed Dietitian or Physician. Services rendered as part of Home Health Care are subject to the Home Health Care benefit limits.

Common Medical Event	Network Benefit	Non Network Benefit	Limitations, Exceptions, and Exclusions
Other Eligible Major Medical Expenses	80% After Deductible	60% After Deductible	

Frequently Asked Questions	Network Benefit	Non Network Benefit	Limitations and Exceptions
Does this coverage provide minimum essential coverage?	Yes	Yes	The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**
Does this coverage meet the minimum value standard?	Yes	Yes	The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60 percent (60%; actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Filing Deadline

No benefits are payable for claims or additional information submitted by the employee, covered individual or a provider more than twelve (12) months after the date incurred (or within ninety (90) days after a non-compensable claims decision by Workers' Compensation)

Subrogation

The plan pursues subrogation pursuant to (1) Section 172.015 of the Texas Local Government Code, (2) contractual plan provisions, and (3) common law. The plan language grants to the plan a first lien on any accident-related reimbursements that the plan participant may receive from any source. These sources include, but are not limited to any responsible third parties, third party liability insurance, and the participant's own insurance, such as med-pay, personal injury protection, or uninsured/underinsured motorist coverage. The plan participant will be asked to complete an Accident/ Injury Questionnaire prescribed by the plan. Payment on any accident-related claims may be withheld pending the completion of the questionnaire.

Unproven Medical Procedures/Treatment

Experimental/Investigational/Unproven Services: medical, surgical, diagnostic, mental health, substance use disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Any drug not approved by the U.S. Food and Drug Administration (FDA) for marketing; any drug that is classified as IND (Investigational new drug) by the FDA;
- Determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials;
- Not consistent with the standards of good medical practice in the United States as evidenced by endorsement by national guidelines;
- Exceeds (in scope, duration, or intensity) that level of care which is needed - Given primarily for the personal comfort or convenience of the patient, family member(s) or the provider;
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered Experimental or Investigational.); or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 or 2 clinical trial, or is the experimental arm of a Phase 3 or 4 clinical trial as set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Medically Justified

A service that falls under the plan definition of UNPROVEN MEDICAL PROCEDURES/THERAPY, but that can be justified for an individual patient due to:

1. A rare/orphan disease (a rare/orphan disease is one that affects fewer than two hundred thousand (200,000) people, according to the U.S. Rare Disease Act of 2002).
2. A unique co-morbidity, or complication that precludes treatment with a proven medical procedure or therapy.
   a. No other treatment available due to co-morbidities
   b. Co-morbid Disease State Risk
3. Continuation and/or repeat of a previously approved successful treatment plan.
4. Concern for Complications due to treatment area.

5. Repeat of prior successful treatment intervention and disease state; disease state put in remission.
6. Treatment dose should be in compliance for best outcome.
7. Severity of illness defined as ongoing intensity and complication of disease state with lab value concerns.

Evidence Based Medicine (EBM)

Aims to apply the best available evidence gained from the scientific method to medical decision making. It seeks to assess the quality of evidence of the risks and benefits of treatments (including lack of treatment). EBM recognizes that many aspects of medical care depend on individual factors such as quality and value of life judgments, which are only partially subject to scientific methods. EBM, however, seeks to clarify those parts of medical practice that are in principle subject to scientific methods and to apply these methods to ensure the best prediction of outcomes in medical treatment, even as debate continues about which outcomes are desirable.

Usual and Reasonable (U&R)

Charges incurred using Non Network providers are subject to the usual and customary allowable amount.

Extenuating Circumstances

If a Covered Individual requires emergent/immediate care until stabilized or if a specialist care provider is required but there is not a Network specialist care provider within a seventy-five (75) mile radius from the employee's place of business, the provider would be paid at the Network benefit, subject to the Network deductible and Network Out of Pocket, subject to usual and customary allowable amounts.

Ancillary Provider Charges:

When a Covered Person uses a Network facility, all ancillary providers and specialists, including, but not limited to, anesthesiologist, pathologist, and radiologist will be paid at the Network benefit and subject to the Network out of pocket and Network deductible. Reasonable and Customary guidelines will still apply to Non Network Charges.

Population Health Engagement

Population Health Engagement supports members in all stages of health. This program provides information to the covered individual regarding healthy lifestyle choices and management of chronic disease states. The program offers personalized professional coaching to support the healthy lifestyle of change and plan of action. Online tools and educational material(s) are available to the covered individual. The population health engagement team consists of an interdisciplinary team of licensed professional nurses, licensed professional counselors and registered dietitians. **To contact a Professional Health Coach, call (888) 818-2822.** Para pedir servicios o la información en español, llame por favor (800) 385-9952.

Medical Intelligence Care Management

Medical Intelligence Care Management services help you use your benefits wisely during periods of treatment due to serious sickness or injury. This is done through early identification of the need for care management, followed by on-going work with you and your provider to plan health care alternatives to meet your needs. The Care Manager will try to conserve your benefits by making sure that your care is handled as efficiently as possible. Medical Intelligence Case Management is an option and is not a requirement of the plan.

The Care Management staff consists of licensed, professional nurses. The Nurses have years of experience in health care. They know the importance of not intruding in the doctor/patient relationship. The nurses add value by promoting health care alternatives that are acceptable to you, your doctors and your employer, Medical Intelligence Care Management helps to control health care costs and use your benefits wisely. The Medical Intelligence Care Management Team will coordinate care and document Notification communication.

What Happens on Inpatient Treatment?

The Covered Individual must notify Medical Intelligence Care Management per the Notification Requirements. Concurrent stay review requirements apply to all inpatient confinements. No benefits will be paid for any charges related to non-notified days or services.

Your Rights to Continue Coverage

Continuation of Coverage (COC)

The right to COC was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COC can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should review the Plan book or contact TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754, (800) 282-5385.

Self-Audit Reimbursement

Any Covered Person, who reviews eligible medical expenses and discovers an overcharge made by the medical facility or practitioner may provide the Benefits Administrator with a copy of the original billing, corrected billing and an explanation. The Covered Employee will be reimbursed 30% of the amount of savings generated. The reimbursement may not exceed the Covered Person's individual calendar year deductible and out of pocket amount. *This provision does not apply to duplicate billings or to charges in excess of the usual and customary charge, regardless of whether the charge is or is not reduced.*

Ombudsman Services

Availability of Consumer Assistance/Ombudsman Services: There may be other resources available to help you understand the appeals process. For questions about your appeal rights, an adverse benefit determination, or for assistance, you can contact the Employee Benefits Security Administration at (866) 444-EBSA (3272). Your state consumer assistance program may be able to assist you at the Texas Consumer Health Assistance Program Texas Department of Insurance (855) TEX-CHAP (839-2427).

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Title I:

- Refers to healthcare coverage reform and includes provisions for special enrollments and non-discrimination based on Health Status Factors;
- A self-funded, non-federal, governmental plan may exempt itself from HIPAA's provisions for standards relating to benefits for mothers and newborns, parity in the application of certain limits for mental health benefits, coverage for reconstructive surgery following mastectomy/lumpectomy and coverage of dependent students on medically necessary leave of absence. This Plan has opted out of and is exempt from these provisions. However, this Plan may comply voluntarily, in part or in whole, with some of the HIPAA requirements listed.

Title II:

- Effective April 14, 2003, Administrative Simplification guidelines were mandated. The administrative simplification process includes standards for electronic transactions and code sets, national identifiers (for employers, health plan and providers), Security and Electronic Signature Standards (Security Rule) and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);
- A self-funded, non-federal, governmental health plan cannot exempt itself from the Title II requirements.
- Notice of Breach

Privacy of Your Health Information

A Federal regulation, called the "Privacy Rule," requires TML Intergovernmental Employee Benefits Pool (IEBP)_to protect the privacy of each Covered Individual's identifiable health information. Under the Privacy Rule, IEBP may use and disclose a Covered Individual's identifiable health information only for certain permitted purposes, such as the payment of claims under the health plan. If IEBP needs to use or disclose a Covered Individual's health information for a purpose not permitted under the Privacy Rule, TML Intergovernmental Employee Benefits Pool must first obtain a written authorization signed by the Covered Individual.

In addition to restrictions on how IEBP may use and disclose a Covered Individual's identifiable health information, the Privacy Rule gives each Covered Individual certain rights. These include the right of a Covered Individual to access his or her health information, to amend his or her health information, and to receive an accounting of certain disclosures of his or her health information.

IEBP's Notice of Privacy Practices explains fully how IEBP may use and disclose a Covered Individual's identifiable health information and a Covered Individual's rights under the Privacy Rule. IEBP's Notice of Privacy Practices is included with each Covered Individual's enrollment information. IEBP's Notice of Privacy Practices also is available on IEBP's website at www.iebp.org, or an individual may request a paper copy of the notice by calling IEBP's customer service number at (800) 282-5385.

Security of Your Health Information

A Federal regulation, called the "Security Rule", requires IEBP to ensure the confidentiality, integrity and availability of a Covered Individual's identifiable health information that IEBP receives, creates, maintains or transmits electronically. IEBP has implemented administrative, physical and technical safeguards that meet both Federal requirements and industry standards for the security of electronic health information.

Important Disclaimer

The information presented in this Summary of Benefits and Coverage (SBC) **IS NOT** a guarantee of payment. The benefits described are subject to all plan limitations, pre-existing information, late entrants, filing deadlines, exclusions and eligibility requirements. All benefits are based on the plan document language.

If a Covered Individual is on continuation of coverage (COC), coverage could terminate retroactively if the individual's contribution is not made within the COC payment timeframe.

If a Covered Individual is receiving care or about to receive care and is identified as not actively at work, continuation of coverage benefits may be offered, but must be accepted and paid per the continuation of coverage time guidelines for provider services to be considered for eligible benefit payment.

Requests for reimbursement for a covered benefit should be sent to the Group Benefits Administrator within ninety (90) days of the date of service but not later than twelve (12) months.

All inpatient and outpatient facilities are required to be licensed and/or accredited by Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), Medicare, Texas Commission on Alcohol and Drug Abuse (TCADA), or Accreditation Association for Ambulatory Health Care (AAAHC) for the bill to be considered for payment.

You may be responsible for payment of all or part of any fees for healthcare services not covered by your Health Benefit Plan because the services received are provided by health care providers who are not members of the plan's provider network.

Glossary of Common Healthcare Terms

Actuarial Value: Underwriting and Benefit equivalency.
Allowed Amount: maximum amount on which payment is based for covered health care services; this may be called "eligible expense," "plan allowed amount," "plan eligible amount," "payment allowance" or "negotiated rate". If your provider charges more that the allowed amount, you may have to pay the difference. *See Balance Billing*.
Alphanumeric HCPCS: stands for alphanumeric Health Care Financing Administration Procedure Coding System, HCPCS has three levels.

1. Level 1, CPT, is developed and maintained by the American Medical Association (AMA) and captures physician services; The "D" codes in the HCPCS system are dental codes created by the ADA and published as CDT. The ADA is the sole source of the authoritative version of CDT.
2. Level 2, alphanumeric HCPCS, contains codes for products, supplies and services not included in CPT.
3. Level 3, local codes, includes all the codes developed by insurers and agencies to fulfill local needs. HHS states local codes will be eliminated once regulatory compliance begins.

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 for covered services.
Business Associate: means a person (not a member of a covered entity's workforce) who helps a covered entity with a function or activity involving the use or disclosure of individually identifiable health information.
Capitation: In the strictest sense, a stipulated dollar amount established to cover the average cost of health care delivered for a person. The term usually refers to a negotiated per person rate to be paid periodically, usually monthly, to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.
Care Management: A process whereby members at the highest risk are identified and a plan which effectively utilizes health care resources is formulated and implemented to achieve optimum patient outcome in the most cost effective manner.
Care Manager: An experienced professional (e.g., nurse, physician or social worker) who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.
Carve Out: A decision to purchase separately a service which is typically a part of an indemnity or HMO plan. Example: an HMO may "carve out" the behavioral health benefit and select a specialized vendor to supply these services on a stand-alone basis.
Case Mix: The relative frequency and intensity of hospital admissions or services reflecting different needs and uses of hospital resources. Case mix can be measured based on patients' diagnosis or the severity of their illnesses, the utilization of services and the characteristics of a hospital.
Claim: A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.
Coinsurance/Benefit Percentage: is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, you coinsurance/benefit percentage payment of 20% would be $200. This may change if you haven't met your deductible. The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount,** you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. This is called **balance billing**. The plan may encourage you to use network providers by charging you lower **deductibles, copayments and coinsurance** amounts.
CDS: Controlled dangerous substance
CHIP: Children's Health Insurance Program

CMS: Centers of Medicare & Medicaid Services

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not complications of pregnancy.

Concurrent Review: An assessment which determines medical necessity or appropriateness of services are they are being rendered.

Consumer-Driven Health Care/Consumer Centered Health Plan: An approach that encourages employees to take more control over their health care spending through such devices as a Health Reimbursement Arrangements (HRA) and/or Health savings accounts (H.S.A.)

Continuation of Coverage: COBRA Consolidated Omnibus Budget Reconciliation Act of 1985. This law includes the federal mandate that requires employers to offer continuation health coverage to certain former employees and their covered spouses and dependents.

Continuum of Care: A range of clinical services provided to an individual which may reflect treatment rendered during a single inpatient hospitalization, or care for multiple conditions over a lifetime, or care across settings (acute--skilled--home care--self care). The continuum provides a basis for analyzing quality, cost and utilization over the long term.

Copayments: are fixed dollar amounts (for example $15) you pay for covered health care usually when you received the services.

Cost-Sharing: Section 125, HRA, H.S.A Interface. The general term that refers to the share of costs for services covered by a plan or health insurance that you must pay out of you own pocket (sometimes called "out-of-pocket costs"). Some examples of types of cost-sharing include copayments, deductibles, and coinsurance/benefit percentage. Other costs, including your premiums/contributions, penalties you may have to pay or the cost of care not covered by a plan or policy are usually not considered cost-sharing.

Cost-Sharing Reductions: Discounts that lower cost-sharing for certain services covered by individual health insurance purchased through the Marketplace. You can get these discounts if your income is below a certain level, and you choose a Silver level health plan. If you are a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation, you can qualify for cost-sharing reductions on certain services covered by a Marketplace policy of any metal level and may qualify for additional cost-sharing reductions depending upon income.

Covered Services: Those professional medical, hospital, and related services which (i) have been determined to be appropriate for the patient, AND (ii) are considered covered by the applicable benefits plan. Health benefit payors do not consider every available service a covered service.

CPT: stands for Physician's Current Procedural. CPT is used by physicians and other health care professionals to code their services for administrative transactions. CPT is level one of the Health Care Financing Administration Procedure Coding System (HCPCS). CPT codes are updated annually by the AMA.

Credentialing Program: The goals, criteria, policies and procedures for credentialing physicians who desire to become or remain participating with a network or health plan.

DEA: Drug Enforcement Agency

Deductible: The amount you owe for health care services before your health benefit plan begins to pay. For example, if your deductible is $1,000, your plan will not pay anything until you have met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Diagnostic Test: Tests to detect what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Discharge Planning: The process, usually beginning upon admission which plans for the physical, social, emotional and medical needs of the patient upon discharge from an inpatient facility.

DOL: US Department of Labor

Drug Formulary: A listing of prescription medications which are preferred for use by a health plan and which will be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan. A plan that has adopted an "Open or voluntary" formulary allows coverage for both formulary and non-formulary medications. A plan that has adopted a "closed, select or mandatory" formulary limits coverage to those drugs in the formulary.

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.

EHB: Essential Health Benefits.

Emergency Medical Condition: The sudden and unexpected onset of an acute illness or accidental injury which is life threatening or likely to result in permanent disability if the patients fails to obtain medical treatment immediately or as soon as possible after the accident or injury.

Emergency Medical Transportation: Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan or health benefits payer may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care: Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Employee Assistance Program: An employer maintained program that provides counseling and referral services for the treatment of drug abuse, alcoholism, emotional, mental and physical problems and financial or legal difficulties that can affect job performance.

Encounter: A face-to-face meeting between a Covered Individual and a health care provider where services are provided.

Encounter Form: The method of reporting services rendered to patients which are eligible for reimbursement. An encounter form is the same format as a HCFA1500 and UB92.
Encounters per Member per Month: The number of encounters related to each Covered Individual on a monthly basis. The measurement is calculated as follows: Total # of encounters per month/total # of members per month.
ERISA: Employee Retirement Income Security Act of 1974. Federal law that sets minimum standards for most voluntarily established pension and health plans in the private sector to protect plan participants. ERISA sets requirements for individuals and employers that administer, supervise or mange pension plan funds.
Excluded Services: Healthcare services that your health benefit plan does not pay for or cover.
Family Medical Leave: Family Medical Leave Act of 1993. Requires covered employers to allow eligible employees to take up to 12 weeks of unpaid leave in a 12-month period for the birth or adoption of a child, or for a serious health condition of the employee or family member. FMLA applies to private employers with 50 or more employees for each working day of 20 or more weeks in the current or preceding calendar year, all public employers, and private elementary and secondary schools.
FDA: US Food and Drug Administration
FEDVIP: Federal Employee Dental and Vision Insurance Program
FEHBP: Federal Employees Health Benefits Program
Fee for Service Equivalency: A quantitative measure of the difference between the amount a physician and/or other provider receives from an alternative reimbursement system (e.g., capitation) compared to fee-for-service reimbursement.
Fee for Service Reimbursement: The traditional health care payment system, under which physicians and other providers receive a payment that does not exceed their billed charges for each unit of service provided.
Fee Schedule: A listing of codes and related services with pre-established payment amounts which could be percentage of billed charges, flat rates or maximum allowable amounts.
FICA: Federal Insurance Contributions Act
Formal Complaints: A patient problem presented for resolution which cannot be resolved immediately to the patient's satisfaction.
Formulary: A list of drugs your health benefit plan covers. A formulary may include how much you pay for each drug. If the plan uses "tiers", the formulary may list which drugs are in which tiers. For example, a formulary may include generic drug and brand name drug tiers.
Grievance: A written expression by a patient of a formal complaint which after being presented to the health plan has not been resolved to the patient's satisfaction and is presented for further investigation and resolution.
Group Model: A health care model involving contracts with physicians organized as a partnership, professional corporation or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and the group is responsible for compensation its physicians and contracting with hospitals for the care of their patients.
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 waling 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 settings.
HCFA 1500: A universal form, developed by the government agency known as the Health Care Financing Administration (HCFA) for providers of service to bill professional fees to health carriers.
HCFA Common Procedural Coding System (HCPCS): A listing of services, procedures and supplies as ordered by physicians and other providers. The national codes are developed by HCFA in order to supplement CPT4 codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy, and durable medical equipment. The local codes are developed by Medicare carriers in order to supplement the national codes. HCPCS codes are five digit codes, the first digit a letter followed by four numbers. HCPCS codes beginning with A through V are national and those beginning with W through Z are local.
Health Insurance: A contract that requires your health insurer/benefit carrier to pay some or all of your healthcare costs in exchange for a premium.
Health Insurance and Portability Act: Under Federal laws known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Health Care and Education Reconciliation Act of 2010, group health plans, , generally must comply with the eligible benefit and security requirements. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements if that plan is self-funded by the employer, rather than provided through a health insurance policy. HIPAA also will require HITECH compliance electronic healthcare transaction standardization from 4010 to 5010**.** This transition will impact the subscriber if separate ID numbers, Provider physical address, service type improvement
Health Maintenance Organization (HMO): An organization that provides a range of health care services for a specific group of individuals for a fixed periodic fee. A legal entity consisting of participating medical providers that provide or arrange for care to be furnished to a given population group for a per-person fixed fee. HMOs are used as alternatives to traditional indemnity plans as a way to manage costs and reduce health care expenses.
Health Plan Employer Data and Information set (HEDIS): A core set of performance measures to assist employers and other health purchasers in understanding the value of health care purchases and evaluating health plan performance.
HEDIS: Healthcare Effectiveness Data and Information Set

HHS: US Department of Health and Human Services
High Deductible Health Plan: A plan in which the annual deductible is at least $1,100 of individual coverage and at least $2,200 for family coverage, adjusted for inflation. Coverage under an HDHP is a requirement for creating a health savings account. (H.S.A.)
HIOS: Health Insurance Oversight System
Home Health Care: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
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.
Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.
HSA: Health Savings Account
HRA: Health Reimbursement Arrangement
Hybrid Entity: is a voluntary designation for a single covered entity that performs both covered and non-covered functions. A covered entity may designate itself a hybrid entity to avoid imposition of the privacy rules on its non-health care-related functions. A hybrid entity must ensure that an entity's health care component complies with applicable privacy provisions and the entity must have policies and procedures to ensure covered information is protected from inappropriate disclosure.
In-Area Services: Health care received within the authorized service area from a participating provider of care.
Incurred But Not Reported (IBNR): Costs associated with a medical service that has been provided, but for which a claim has yet to be received by the health plan. IBNR reserves are recorded by the carrier to account for estimated liability based on studies of prior lags in claims submissions.
Independent Medical Evaluation (IME): An examination carried out by an impartial health care provider generally board certified, for the purpose of resolving a dispute related to the nature and extent of an injury or illness.
Independent Practice Association (IPA): A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule or fee for service basis.
Independent Review Organization: Medical Plan external review organization to verify accuracy of benefit plan and clinical review adjudication process
Individual Responsibility Requirement: Sometimes called the "individual mandate". The duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you do not have minimum essential coverage, you may have to make a payment when you file your federal income tax return. You may not have to meet the requirement if no affordable coverage is available to you, or if you have a short gap in coverage during the year for less than three consecutive months, or qualify for a minimum essential coverage exemption.
***In-Network Coinsurance/Benefit Percentage*:** The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with the health benefit plan. In-network benefit percentage/coinsurance usually costs you less than out-of-network benefit percentage/co-insurance.
In-Network Copayment: A fixed amount (for example $15) you pay for covered health care services to providers who contract with your health benefit plan. In-network copayments usually are less than out-of-network co-payments.
Integrated Delivery System: A generic term referring to a joint effort of physician/hospital integration for a variety of purposes. Some models of integration include physician hospital organization (PHO), management services organization (MSO), group practice without walls, integrated provider organization and medical foundation.
International Classification of Diseases, 9th Edition (Clinical Modification) ICD-9-CM: A listing of diagnosis and identifying codes used by physicians for reporting diagnosis of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnosis and provide for reliable, consistent communication on claim forms.
International Classification of Diseases, 10th Edition (Clinical Modification) ICD-10-CM: Specificity and Manifestation ICD-9 transition to ICD-10. This will increase diagnosis specificity and allow manifestation to be identified. Clinical quality and coordinated care: 5X more diagnosis codes 69,000 (3-7 characters), 20x more injury codes, 15x more AMA professional procedure code (7 digits) 71,000 codes
IOM: Institute of Medicine
IRS: Internal Revenue Service
JCAHO: The Joint Commission on Accreditation of Healthcare Organizations.
JCI: The Joint Commission International.
Length of Stay: The number of days that a patient stayed in an inpatient facility.
Mandated Providers: Providers of medical care, such as psychologists, optometrists, podiatrists and chiropractors whose licensed services must under a State law or Federal law be included for coverage offered by a health plan.
Marketplace: A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace (**See** *Premium Tax Credits* and *Cost-Sharing Reductions*), and information about other

programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace is accessible through websites, call centers, and in-person assistance. In some states the Marketplace is run by the state. In others, it is run by the federal government.

Maximum Out-of-Pocket Limit: Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medical Loss Ratio: The cost of health benefits used, compared to revenue received.

Medically Necessary: Those medical treatments, supplies or services ordered by a physician to treat a patient's sickness, bodily injury or complication of pregnancy or pregnancy that are:

1. Consistent with symptoms, or diagnosis and treatment of the condition, disease, ailment or injury; and
2. Appropriate with regard to standards of good medical practice prevailing in the community where treatment occurs at the time such treatment is required; and
3. Not primarily for the convenience of the patient, patient's family or the treating physician.

Member Month: A count which records one Member for each month the Member is effective.

Minimum Essential Coverage: Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance that is available through the Marketplace or other individual market policies: Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Essential Coverage Exemption: A status that allows you to not have to make a payment for not having minimum essential coverage. You must meet certain eligibility requirements to get an exemption. Some exemptions require an application, while others may be available through the federal income tax filing process.

Minimum Value Standard: The Affordable Care Act generally establishes certain value standards for plans and health insurance. For example, "bronze level" individual insurance is designed to pay about 60% of the total cost of certain essential medical services, on average, for a standard population. Plans are subject to a minimum value standards that is similar to that 60% standard, although the benefits covered by the plan may differ from those covered under individual insurance.

NAIC: National Association of Insurance Commissioners

Network: An organization consisting of physicians and/or hospitals and/or ancillary providers formed through contractual relationships.

Network Coinsurance/Benefit Percentage: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health benefit plan. Network benefit percentage/co-insurance usually costs you less than out-of-network benefit percentage/co-insurance.

Network Copayment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health benefit plan. Network co-payments usually are less than out-of-network co-payments.

Network Provider/Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be a great, and you may have to pay more.

NCQA: The National Committee for Quality Assurance. NCQA is the accrediting body for managed care organizations with processes for auditing and reviewing similar to JCAHO.

NDC: National Drug Codes. NCS are used in reporting prescription drugs in retail pharmacy transactions, but, in February 2003, HHS eliminated the requirement for their use in other transactions. The 11-digit codes are assigned when the drugs are approved or repackaged and may be found on the packaging of drugs. The codes are established by the Food and Drug Administration.

Non-Covered Services: Those health care services that are not listed under the applicable benefit plan.

Non-Participating (Non-Par Non-Preferred) Provider: A term used to describe a provider of care that has not contracted with the health benefits carrier or a participating network.

NPDB: National Practitioner Databank which is a Federal entity that was established in 1986 to collect and release certain information relating to the professional competence and conduct of physicians, dentists, and other health care professionals.

OMB: Office of Management and Budget

OPM: US Office of Personnel Management

Open Access: A self-referral arrangement allowing Members to see participating providers of care without a referral from a Primary Care Physician. Typically found in IPA HMO. Also called open pan, self-referral programs.

ORT: Open Refill Transfers for prescriptions

Orthotics and Prosthetics: Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out of Area: Coverage for treatment obtained by a covered person outside of the network service area. If a Covered Person requires care from a specialist care provider, but there is not a Network specialist care provider within a seventy-five (75) mile radius from the employee's place of business, the provider would be paid at network benefits subject to U&R allowable amounts.

Out-of-Network Coinsurance/Benefit Percentage: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health benefit plan. Out-of-network benefit percentage/coinsurance payments usually are more than in-network copayments.

Out-of-Network Copayment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health benefit plan. Out-of-Network copayments usually are more than in-network copayments.

Out-of-Network Provider/Non-Preferred Provider: A provider who does not have a contract with your health plan to provide services. You will 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 plan or if your health plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Pocket Expenses: The portion of payments for health services required to be paid by the enrollee, including copayments, benefit percentage, and deductibles.

Out-of-Pocket Limit: The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium/contribution, balance-billed charges or health care your health insurance or plan does not cover. Some health insurance plans do not count all of your copayments, deductibles, coinsurance/benefit percentage payments, or other expenses toward this limit.

Outcome Measures: Assessments which gauge the effect or result of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life, and functional status, as well as objective measures of mortality, morbidity and health status.

Outcomes Research: Studies aimed at measuring the effect of a given product, procedure or medical technology on health or costs.

Outlier: An observation in a distribution that is outside a certain range, often defined as two or three standard deviations from the mean or exceeding a specific percentile. Frequently refers to a case of hospital stay that is unusually long or expensive for its type, or to a physician practice that uses an abnormally high or low volume of resources.

Patient Protection and Affordable Care Act of 2010 (PPACA): Is a federal statute that was signed into United States law by President Barack Obama on March 23, 2010. This Act and the Health Care and Education Reconciliation Act of 2010 (signed into law on March 30, 2010) made up the health care reform of 2010. The laws focus on reform of the private health insurance market, provide better coverage for those with pre-existing conditions, improve prescription drug coverage in Medicare and extend the life of the Medicare Trust fund by at least 12 years.

Partial Hospitalization Services: A mental health or substance abuse program operated by a hospital which provides clinical services as an alternative or follow-up to inpatient hospital care.

Payor: The purchaser of covered services which may include claims administrators, employers, insurance carriers, third party employee benefit plan administrators, self-funded plans and groups, and other similar arrangements.

Peer Review Organization (PRO): An entity established by the Tax Equity and Fiscal Responsibilities Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, re-admissions, and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates, and reducing lengths of stay while insuring against inadequate treatment. Also known as professional standards review organizations.

PHS Act: Public Health Service Act

Physician Hospital Organization (PHO): A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payor contracts and to further mutual interests. Physicians maintain ownership of their practices while agreeing to accept managed care patients under the terms of the PHO agreement. The PHO serves as a negotiating, contracting and marketing unit.

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

Plan: A benefit your employer, union or other group sponsor provides for your health care services.

Plan Allowed Amount: The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, *Usual and Reasonable (U&R)*, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. This is called balance billing.

Point of Service (POS): A health plan allowing the covered person the opportunity to choose to receive a service from a participating or a non-participating provider, with different benefit levels associated with the use of participating providers. Point of service can be provided in several ways:

1. An HMO may allow Member to obtain services from non-participating providers;
2. An HMO may provide non-participating benefits through a supplemental plan;
3. A PPO may be used to provide both participating and non-participating levels of coverage/access; or
4. Various combinations of the above.

Pool: A defined account (e.g. defined by size, geographic location, claim dollars that exceed X level per individual, etc.) to which revenue and expenses are posted. A risk pool attempts to define expected claims liabilities of a given defined account as well as required funding to support the claim liability.

PRA: Paperwork Reduction Act

Practice Guidelines: Systematically developed standards on medical practice that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions.

Preauthorization/Notification: A decision by the health plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. The benefit plan may require Preauthorization/Notification for certain services before you received the, except in an emergency situation. Preauthorization/Notification is not a promise the health benefit plan will cover the cost.

Preferred Provider Organization (PPO): A program in which contracts are established with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits (lower out of pocket responsibility) for services received from preferred providers, thus encouraging covered persons to use these providers.

Covered persons are generally allowed benefits for non-participating providers' services, usually on an indemnity basis with significant copayments. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee for services basis.

Premium/Contribution: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Premium Tax Credits: Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium/contribution costs.

Prescription Drug Coverage: Health benefit plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Preventive Care: Routine health care including screenings, check-ups, and patient counseling to prevent or discover illness, disease, or other health problems.

Primary Care Physician: A physician (M.D. – Medical Director 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.

Primary Care Provider: A physician (M.D. – Medical Director or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

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

Provider Network: The plan encourages you to access network providers by charging a lower out-of-pocket network deductible and benefit percentage.

Quality Assurance (Improvement): A formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies in the quality or direct patient, administrative and support services.

Quality Improvement Program: The program established by a health plan at least annually to gather and analyze the performance data specific to care received by Members and/or provided by participating providers.

QHP: Qualified Health Plan

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

Referral: A written order from your primary care provider for you to see a specialist or get certain health care services. In many Health Maintenance Organization (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you do not get a referral first, the plan or health insurance may not pay for the services.

Referral Access: A type of health plan in which covered persons are required to select a PCP from the plan's participating listing. The patient is required to see the selected PCP for care and referrals to other health care providers within the plan. These types of health plans are typically found in the staff, group or network model POS. Also called closed access, closed pane, coordinator or gatekeeper model.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Reserves: Funds for incurred but not reported health services or other financial liabilities. Also refers to deposits and/or other financial requirements that must be met by an entity as defined by various state or federal regulatory agencies.

Resource Based Relative Value Scale (RBRVS): A fee schedule introduced by HCFA to reimburse physicians' Medicare fees based on the amount of time and resources expended in treating patients, with adjustments for overhead costs and geographical differences.

Retention: That portion of the cost of a medical benefit program which is kept by the health plan to cover internal costs or to return a profit.

Retrospective Review: A determination of medical appropriateness and/or appropriate billing practices for services already rendered.

Screening: A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs or prevailing medical history of a disease or condition.

Service Area: The geographic area serviced by the health plan as approved by State regulatory agencies and/or as detailed in the certification of authority (state approval to do business document).

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 are 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 are of health care.

Specialty Drug/Biotech Prescription: A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. If the plan's formulary uses "tiers", and specialty drugs are included as a separate tier, you will likely pay more in cost-sharing for drugs in the specialty drug tier.

SSA: Social Security Administration

SHOP: Small Business Health Options Program

Standard Benefit Package: A set of specific health care benefits that would be offered by delivery systems. Benefit packages could include all or some of the following: preventive care services, hospital and physician services, prescription drug coverage, limited mental health and chemical dependency services and/or long-term care.

Third Party Administrator: A company that accepts responsibility for administering some or all of an employer's benefits programs.
Trending: A calculation used to predict future utilization of a group based on past utilization by applying a trend factor.
UCR (Usual, Customary, and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.
Unbundling: Separately packaging units that might otherwise be packaged together. For claims processing, this includes providers billing separately for health care services that should be combined according to industry standards or commonly accepting coding practices. Also refers to the practice of providing separate prices and administrative support for services such as prescription drug benefit administration, mental health/substance abuse services or utilization review services.
Uniformed Services Employment and Reemployment Rights Act: USERRA ensures that employees who leave their jobs to serve in the military will not lose benefits, including 401(k) plan contributions, when they return to work.
Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
USP: United States Pharmacopeia
Usual and Reasonable (U&R): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The U&R amount sometimes is used to determine the allowed amount.
Utilization Review Accreditations Commission (URAC): 1996 URAC began accrediting organizations. The accreditation process by which an impartial organization (URAC) will review a company's operations to ensure that the company is conducting business in a manner consistent with national standards. URAC's accreditation process consists of a review of policies and procedures (the desktop review and an onsite visit to the applicant organization to determine that it is, in fact, operating according to its stated polices. URAC reviews organizations such as health plans, case management and/or credentialing procedures. This accreditation is an external seal of approval.
Voluntary Employees' Beneficiary Association: A trust tax-exempt under Code Section 501c (9) that is created to fund life insurance, sick leave, accident or certain other benefits for a nondiscriminatory class of employees, their dependents or designated beneficiaries.