Glossary of Health Care Terms

Use this glossary as a reference for common CalPERS health benefit terms and definitions. This glossary is intended to be educational and may be different from specific terms and definitions used by your health plan. Please refer to the Summary of Benefits and Coverage for your specific health plan to see how these terms apply to your plan.

Terms & Definitions

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Actuary

A health insurance actuary is someone who helps develop long-term care and health insurance policies by predicting expected costs of providing care under the terms of an insurance contract. Their predictions are based on numerous factors, including family history, geographic location, and occupation.

Activities of Daily Living

Activities performed as part of a person's daily routine of self-care, such as bathing, dressing, toileting, transferring to and from bed, and eating.

Admission

A registered patient, usually admitted for at least 24 hours, to a hospital, skilled nursing facility, or other health care facility.

Allowed Amount

The maximum payment a health plan will pay for a covered health care service. Also called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request for medical service, medical treatment, prescription, or benefit that has been denied (either in whole or in part) by the plan, where the plan will render a decision on the request.

- **Pre-Service Appeal:** A request to review a denial of coverage for a medical service, medical treatment, prescription, or benefit before it's received, often related to pre-authorization or pre-certification requirements. This is often related to pre-authorization requirements but can also include a plan exclusion that the member would like covered under their benefits.

- **Expedited Appeal:** A member may request an expedited decision when the routine decision-making process might pose an imminent or serious threat to your health, including but not limited to severe pain, potential loss of life, limb, or major bodily function. If, during the appeal process, the member, the party acting on their behalf, or the documentation received references severe pain, then the appeal must be reviewed to determine if it meets expedited criteria.
- **Post-Service Appeal:** A request to reconsider a denial of coverage or request for payment after the member has already received the medical service, treatment, prescription, or benefit item being appealed.

Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This happens most often when you see an out-of-network provider.

Beneficiary

A person who is eligible for or receiving benefits under a health plan, insurance policy, or government program (like Medicare or Medicaid). This person can be either the plan subscriber or a dependent.

Benefits (Covered Services)

Medically necessary services, medications and supplies covered by your health plan. Each plan outlines its full list of benefits in an annually updated Evidence of Coverage (EOC) document.

CalPERS Basic Plan

A CalPERS Basic health benefits plan provides coverage to members who are:

- Under age 65
- Over 65 but still working
- 65 or older but not eligible for Medicare Part A at no cost

CalPERS offers HMO, EPO, and PPO plans. Visit Plans & Rates to learn more about these options.

CalPERS Medicare Plan

A CalPERS Medicare health benefits plan provides coverage to members who are:

- Over age 65, retired, and enrolled in Medicare Parts A and B with the Social Security Administration (SSA)
- Under 65, retired, and enrolled in Medicare Parts A and B with the SSA due to an SSA-qualified disability
- Active or retired with End-Stage Renal Disease (ESRD)

CalPERS offers Medicare Advantage HMO, Medicare Advantage PPO, and Medicare Supplement plans. Visit Medicare & Your CalPERS Health Coverage to learn more about these options.

Care Coordination

Care coordination refers to specialized services designed to help members navigate the health care system, manage chronic or complex conditions, and ensure high-quality, efficient care.

Case Management

The process of identifying patients with specific health care needs, particularly chronic and/or complex conditions, and working with them and their provider(s) to coordinate medically necessary care across settings.

Centers for Medicare & Medicaid Services (CMS)

A federal agency created in 1977 under the Department of Health and Human Services, the CMS is responsible for administering the Medicare and Medicaid programs and ensuring that beneficiaries have access to high-quality medical care in appropriate settings.

Claim

A notice submitted to a health insurer requesting payment for services received under the terms of your health plan contract.

Combination Plan

A combination plan means at least one family member is enrolled in a Medicare health plan and at least one family member is enrolled in a Basic health plan through the same health carrier. CalPERS requires all family members to have the same health carrier.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A 1986 law, COBRA provides for continuation of group health coverage that otherwise might be terminated. COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children with the right to temporary continuation of health coverage at group rates. This coverage is only available when coverage is lost due to certain events.

Coinsurance

Coinsurance is the percentage of the cost of a covered health care service that you pay. After your deductible is met, your insurance pays the rest. For example, if your coinsurance is 20% of the allowed amount, you pay 20% of the bill and your plan pays 80%.

Copayment (Copay)

A fixed dollar amount you pay for a doctor’s visit or for receiving a covered service or prescription; usually paid when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

A general term describing your share of costs (copays, deductibles, and coinsurance) for covered services shared with your health plan that you must pay.

Deductible

The amount you pay for covered services each year before your health plan starts paying. PERS Gold and PERS Platinum Basic plans have an in-network and out-of-network deductible. These deductibles are separate and do not count towards each other. If you seek out-of-network services, the amount you pay does not count towards your in-network deductible. The amount you pay for in-network services does not count towards your out-of-network deductible.

Dependent

An individual – typically a spouse, domestic partner, or child – enrolled or eligible to enroll under a member's health plan.

Diagnostic Test

These tests help your provider diagnose your condition or health problem. For example, an x-ray to see if you have a broken bone.

Durable Medical Equipment

Equipment and supplies that serve a medical purpose and are ordered by a health care provider for everyday or extended use, such as oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom, or condition severe enough to risk serious danger to your health without immediate medical attention.

Emergency Medical Transportation

Ambulance services for an emergency medical condition, which may include transportation by air, land, or sea.

Emergency Room Care / Emergency Services

Services to check for and treat an emergency medical condition, usually provided in a hospital's emergency room.

Employer Contribution

The amount your current or former employer contributes towards your total health premium.

Employer Group Health Plan

Health coverage you receive through either your own or your spouse's active employment.

Employer Group Waiver Plan

Employer Group Waiver Plans are Medicare Advantage or Medicare Part D prescription drug plans governed by the Centers for Medicare & Medicaid Services. These plans can only be offered by employers or labor groups.

Excluded Services (Exclusions)

Health care services that your plan doesn't pay for or cover.

Exclusive Provider Organization (EPO)

EPO plans offer the same covered services as an HMO plan, but you must seek services from the plan's network of preferred providers. You are also able to access physicians and specialists who participate in the network without a referral. You pay copayments for some services, but you have no deductible, no claim forms, and a geographically restricted service area.

Explanation of Benefits (EOB)

An EOB shows you the total charges for health care services you have received. An EOB is not a bill. It helps show how much your health plan will pay, and what you're responsible for paying.

Evidence of Coverage (EOC)

The EOC is a document that describes in detail the health care benefits covered by the health plan. It provides documentation about what that plan covers and how it works, including how much you pay.

Formulary

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

Grievance

An expression of dissatisfaction or complaint with service by a health plan not involving a request to reconsider a denial of a medical service, medical treatment, or benefit.

Habilitation Services

Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, or other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Benefit Officer (HBO)

A designated, trained agency representative authorized to serve as the primary contact for employee health benefits. An HBO can sign enrollment forms, process health transactions, and provide health eligibility and enrollment information.

Health Coverage

Legal entitlement to payment or reimbursement for your health care costs. Coverage is generally available under a contract with a health insurance company, group health plan, or government program.

Health Insurance Plan

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium.

Health Insurance Portability & Accountability Act (HIPAA)

This federal law protects health insurance coverage for workers and their families when they change or lose their jobs. It also includes provisions for national standards to protect the privacy of personal health information.

Health Maintenance Organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO plan. It generally won't cover out-of-network care except in an emergency or unless approved by the health carrier.

Health Savings Account (HSA)

An account you can set up and put money into, tax-free, to pay for qualified medical expenses.

Home Health Care

Health care services and supplies you receive in your home under your doctor's orders.

Hospice Services

Services to provide comfort and support to patients and their families for those in the last stages of a terminal illness.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

In-Network Provider (Preferred Provider, Participating Provider)

A provider who has a contract with your health insurer or plan to provide services to members at negotiated rates.

Inpatient

An individual admitted to a hospital as a registered bed patient for at least 24 hours.

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. Specific definitions are outlined in your plan's Evidence of Coverage.

Medicaid

Medicaid is a joint federal and state program that helps cover medical costs for some people with limited income and resources. The federal government has general rules that all state Medicaid programs must follow, but each state runs its own program. This means eligibility requirements and benefits can vary from state to state.

Medicare

Medicare is a federal health insurance program for people aged 65 or older and certain younger people with disabilities.

Medicare Advantage Plan

A Medicare-approved health plan from a private insurance company that offers an alternative to Original Medicare. These “bundled” plans include Part A, Part B, and Part D. Plans may offer extra benefits that Original Medicare doesn’t.

Medicare Supplement Plan

Works with Original Medicare to cover costs Medicare doesn’t pay (such as deductibles and coinsurance) and includes Part D.

Network (Provider Network)

A group of providers, including doctors and hospitals, that has a contract with a health plan to provide covered services.

Open Enrollment Period

A specific period of time when you can enroll in or change health plans, add or remove dependents, or cancel coverage without a qualifying life event. CalPERS’ Open Enrollment occurs annually, typically in the fall.

Original Medicare

Includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). Original Medicare covers things like inpatient hospital care, doctors’ services and tests, and preventive services.

Out-of-Network Provider (Non-Preferred Provider, Non-Participating Provider)

A provider who does not have a contract with your plan to provide services. You’ll usually pay more to see an out-of-network provider when enrolled in a preferred provider organization (PPO) Plan. If enrolled in an HMO plan, out-of-network providers are not covered without prior approval from the carrier of the HMO plan.

Out-of-Pocket Costs/Expenses

The portion of payments for covered health services required to be paid by the enrollee, including copayments, coinsurance, and deductibles.

Out-of-Pocket Maximum (Limit)

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount.

Outpatient

A patient who receives care and leaves the facility the same day; no overnight stay is required.

Pharmacy Benefit Manager (PBM)

A company that manages the prescription drug benefits portion of a health insurance plan.

Physician

Any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed and qualified under the law.

Preferred Provider Organization (PPO)

A PPO is similar to a traditional fee-for-service plan, but you must use doctors in the PPO provider network or pay higher coinsurance (percentage of charges). You must usually meet an annual deductible before some benefits apply. You're responsible for a certain coinsurance amount and the plan pays the balance up to the allowable amount.

Premium

The monthly amount charged by a health plan to provide health benefits coverage. Employee costs for premiums may be reduced by employer contributions.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs, which are grouped together based on their type or cost. The amount you'll pay in cost sharing is dependent on the group or "tier" your drug is in.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Services)

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

Primary Care Provider (PCP)

A physician, nurse practitioner, clinical nurse specialist, or physician assistant who provides, coordinates, and helps you access a range of health care services.

Prior Authorization (PA)

An approval process required before receiving certain types of medication, treatment, or service.

Provider

A health care professional or facility, such as a physician, hospital, skilled nursing facility, medical equipment supplier, laboratory, pharmacy, or therapist.

Public Employees' Medical and Hospital Care Act (PEMHCA)

A California state law that applies to the CalPERS health program, members, employers, and health plans. PEMHCA sets standards for eligibility, coverage, and administration of health benefits to ensure comprehensive health care access.

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.

Referral

A written order from your primary care provider for you to see a specialist or get certain health care services.

Service Area

The geographic area in which your health plan provides coverage. You must reside or work in the health plan's service area to enroll in and remain enrolled in a plan. For some plans, the Medicare service area may not be identical to the Basic service area with the same carrier.

Skilled Nursing Facility (SNF)

A facility that accepts patients in need of rehabilitation and medical care, typically providing 24-hour nursing care.

Social Security Administration (SSA)

An agency under the Executive Branch of the U.S. government, the SSA is responsible for delivery of Social Security services including Medicare. The SSA is responsible for determining Medicare eligibility and premiums, and for Medicare enrollment. You should contact the SSA about Medicare enrollment and eligibility issues, name or address changes, questions about premiums, or to report a death.

Specialist

A physician specialist who 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.

Specialty Drug

A type of prescription drug that typically requires special handling, administration, or ongoing monitoring and assessment by a health care professional. Specialty drugs are generally the most expensive medications in a formulary.

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.