

Health Benefits Glossary

Allowed Amount: The maximum fee a health plan will pay for a covered service or treatment. The allowed amount is determined by each health plan.

Cafeteria Plans: Plans under Section 125 of the Internal Revenue Code that allow employees to choose from a menu of one or more qualified benefits and to pay for those qualified benefits on a pre-tax basis.

CMS: Centers for Medicare and Medicaid Services. The agency of the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

COB: - Coordination of Benefits. If an employee, retiree, or eligible dependents are covered under more than one insurance plan, the insurance plan of the person with the earlier birthday in the calendar year is primary and the other plan is secondary. The employee or retiree's primary coverage will pay its benefits first, without regard to other coverage.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985. This law amended by ERISA, the Public Health Service Act (PHSA), and the tax code to require employers to offer the option of purchasing continuation coverage to qualified beneficiaries who would otherwise lose group health insurance coverage as the result of a qualifying event. The federal statute which applies to the State of Maryland health plans is the PHSA.

Coinsurance: The portion of medical services, usually a percentage that the employee must pay in addition to the deductible.

Copayment: The amount of money an employee, retiree, or covered dependent pays at the time service is rendered. The amount of the copayment varies by benefit.

Deductible: The amount an employee or retiree is required to pay before direct payment or reimbursement is available from the plan.

DHMO: Dental Health Maintenance Organization. A plan similar to a medical HMO, but provides dental services. Participants can use only designated dental providers approved by and registered with the DHMO.

Domestic Partner (See Same Sex Domestic Partner)

Emergency services or medical emergency: Healthcare services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the patient's health in jeopardy;
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part.

EPO: Exclusive Provider Organization. An EPO is a type of managed care plan. The EPO utilizes a network made up of providers from which members must choose. EPO members are restricted to in-network doctors only. Some carriers use a primary care physician while others do not require referrals.

ESRD: End Stage Renal Disease. A medical condition of the kidneys and renal system.

FMLA: Family Medical Leave Act. A type of Leave of Absence, as governed by Federal and State statutes, in which an employee may obtain leave due to an individual or family member medical condition.

FSA: Flexible Spending Account. A benefit option that reimburses employees for certain expenses from pre-tax deductions taken from the employee's paycheck. These arrangements are regulated by federal tax law and may be used for health care and medical expenses or dependent care expenses.

HIPAA: Health Insurance Portability and Accountability Act of 1996. A Federal Law which requires employers to provide certificates of coverage to minimize pre-existing condition exclusions by next employer.

HPV: Human Papillomavirus. A virus which has been currently identified as a possible causal agent for cervical cancer.

In-Network Service: Service provided by a participating provider, Primary Care Physician, or provider approved by the plan.

LAW: Leave of Absence Without Pay. An employer approved period of leave during which the employee is not paid, but does not terminate State service. Any approved leave of absence of two pay periods or less is considered a Short Term LAW. Any approved leave of absence more than two pay periods is considered a Long Term LAW.

Medicare: A federal health insurance program administered by the Social Security Administration for disabled individuals and those age 65 or older. Eligible Medicare participants must enroll in both Parts A & B, because the State plan is often the secondary payer, and will not cover expenses and claims covered by Medicare. The optional Part D program covers prescription drugs.

Network: A group of providers that have contracted with an insurance plan to provide services and treatment to individuals.

Open Enrollment Period: An annual period during which employees and retirees are given the option of enrolling in or changing one or more health care plans.

ORP: Special Retirement Programs available to certain faculty and staff of institution of higher education.

Out-of-Network Service: Service received from providers outside of the plan's network. Such services are subject to up-front deductibles and coinsurance.

Plan Year: The plan year for benefits begins July 1 and ends June 30 of the following year.

Premium: The amount of money an employee or retiree pays for insurance coverage. A premium does not include additional copayments or deductibles incurred for treatment.

Provider: Any approved health care professional who provides treatment or services.

QMCSO: Qualified Medical Child Support Orders. A court order that requires a parent to provide health care coverage for dependent children.

Qualifying Event: An event such as marriage, divorce, or the birth of a child, that allows a change in health care coverage outside of the Open Enrollment period.

Retroactive Coverage: The process of paying back premiums to back date coverage to the date of the qualifying event.

Same Sex Domestic Partner: An individual in a relationship with an employee or retiree who is the same sex as the employee or retiree, if both individuals: are at least 18 years old; are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule; are not marriage, in a civil union, or in a domestic partnership with another individual; have been in a committed relationship or mutual interdependence for at least 12 consecutive months in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and share a common primary residence.

State Subsidy: The portion of your insurance premium(s) that the State pays as a benefit to employees and retirees.