

Accreditation: Certification that an organization meets the reviewing organization's standards. Examples: accreditation of HMOs by the National Committee on Quality Assurance (NCQA) or accreditation of hospitals by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO).

Administrative Services Only (ASO): An arrangement in which a licensed insurer provides administrative services to an employer's health benefits plan (such as processing claims), but doesn't insure the risk of paying benefits to enrollees. In an ASO arrangement, the employer pays for the health benefits. Cypress-Fairbanks ISD's PPO plan is administered by CIGNA HealthCare on an ASO basis.

Ancillary care: Diagnostic and/or supportive services such as radiology, physical therapy, pharmacy or laboratory work.

Appeals: A process used by a patient or provider to request re-consideration of a previously denied service.

Benefit year: The coverage period, usually 12 months long, which is used for administration of a health benefits plan. (May 1 through April 30).

Benefits: The portion of the costs of covered services paid by a health plan. For example, if a plan pays the remainder of a doctor's bill after an office visit copayment has been made, the amount the plan pays is the "benefit."

Brand-name drugs: A drug manufactured by a pharmaceutical company, which has chosen to patent the drug's formula and register its brand name.

Case management: Coordination of services to help meet a patient's health care needs, usually when the patient has a condition which requires multiple services from multiple providers. This term is also used to refer to coordination of care during and after a hospital stay.

Coinsurance: A traditional method of paying for covered health services in which a portion of covered expenses are shared by the health benefits plan and the participant. It's a defined percentage of the covered charges for services rendered. For instance, a health plan may pay 80% of the cost of covered services, and a participant pays 20%.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A federal statute that requires most employers to offer to covered employees and covered dependents who would otherwise lose health coverage for reasons specified in the statute, the opportunity to purchase the same health benefits coverage that the employer provides to its remaining employees. This continuation of coverage can only last for a maximum specified period of time (usually 18 months for employees and dependents who would otherwise lose coverage due to loss of employment or work hour reduction, or 36 months for dependents who would lose coverage for certain reasons other than employment loss by the employee).

Copayment (copay): What the participant pays at the time of service. Copayments are predetermined fees for physician office visits, prescriptions or hospital services. Copays do not apply to deductibles.

Credentialing: A process that reviews a health care provider's credentials against the credentials required to participate in a managed care network. To participate in a CIGNA HealthCare network, physicians and facilities are thoroughly credentialed before being admitted and are recredentialed every two years. They must meet specific criteria for continued participation in a CIGNA HealthCare provider network.

Deductible: The money an individual or family must pay from their own funds toward covered medical expenses, usually based on a calendar year. For example, if a plan has a \$100 deductible, the deductible is met once the first \$100 of the covered medical expenses for that year have been paid. After that, the plan begins to pay toward the cost of covered health care services.

Dependent: Your lawful spouse; and any unmarried child of yours who is less than 25 years old; 25 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. A child includes a legally adopted child. It also includes a stepchild who lives with you. Anyone who is eligible as an Employee will not be considered as a Dependent. No one may be considered as a Dependent of more than one Employee.

District Contribution: A defined dollar amount determined and paid by the district on a monthly basis to offset the covered person's plan costs.

Emergency: An accident or sudden illness that a person with an average knowledge of medical science believes needs to be treated right away or it could result in loss of life, serious medical complications or permanent disability. Whenever there's a serious accident or sudden illness, and symptoms are severe and they occur unexpectedly, seek medical help immediately.

Examples of emergency situations include: uncontrolled bleeding, seizure or loss of consciousness, shortness of breath, chest pain or squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, severe burns, broken bones or severe pain.

Employee Contribution: The dollar amount the covered employee pays for coverage after the district's contributions have been subtracted. This amount is based upon the selected plan and the coverage level (employee only, employee and spouse, employee and child(ren), and employee and family).

Explanation of benefits (EOB): A statement provided by the health benefits administrator that explains the benefits provided, the allowable reimbursement amounts, any deductibles, coinsurance or other adjustments taken and the net amount paid. A participant typically receives an explanation of benefits with a claim reimbursement check or as confirmation that a claim has been paid directly to the provider.

Formulary drugs: A list of preferred, commonly prescribed prescription drugs. These drugs are chosen by a team of doctors and pharmacists because of their clinical superiority, safety, ease of use and cost. The formulary was developed to assist the physicians and patients in selecting medications with the most therapeutic value. The criteria for evaluating and selecting drugs include:

- Efficacy - A drug's ability to treat a condition or prevent a disease.
- Safety - The incidence of side effects and drug interactions.
- Cost - Cost is the last consideration, after the first two criteria are met

Generic drugs: A prescription drug that has the same active-ingredient formula as a brand-name drug. A generic drug is known only by its formula name and its formula is available to any pharmaceutical company. Generic drugs are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs and are typically less costly.

Guest Privileges: A CIGNA HealthCare benefits option that, under certain circumstances, can provide an in-network level of coverage to covered persons who are temporarily outside of their "home" network service area for 90 days or longer. For more information, call the number on the back of your Cypress-Fairbanks ISD's HMO plan ID card.

Health Maintenance Organization (HMO): An organization that arranges a wide spectrum of health care services which commonly include hospital care, physicians' services and many other kinds of health care services with an emphasis on preventive care.

ID card: Identification cards are provided to all participants for proper identification under their group health plan. ID card information helps providers verify patient eligibility for coverage.

In-Network: The term used to describe the use of providers who have contracted with a managed care company (PPO) network. Many benefit plans encourage enrollees to use participating (in-network) providers to reduce the enrollee's out-of-pocket expense

Maintenance medication: Medications that are prescribed for long-term treatment of chronic conditions, such as diabetes, high blood pressure or asthma.

Medical Necessity: Medical necessity is a term used to refer to a course of treatment seen as the most helpful for the specific health symptoms you are experiencing. The course of treatment is determined jointly by you, your health professional and the insurance carrier. This course of treatment strives to provide you with the best care in the most appropriate setting.

Network: A group of health care providers under contract with a managed care company within a specific geographic area, commonly referred to as a Preferred Provider Organization (PPO).

Network Provider: Doctors, hospitals and other providers who have contracted with the network.

Non-Network Provider: A medical provider who has not contracted with a managed care company (PPO).

Non-Formulary Drugs: Drugs that are typically higher priced and do not provide additional value (as documented in unbiased medical research). These drugs are not included on the formulary list and are the most expensive to use.

Out-of-Network: The term used to describe the use of health care providers who have not contracted with a managed care company (PPO) to provide services.

Out-of-Pocket: Copayments, deductibles or fees paid by participants for health services or prescriptions. Please refer to Cypress-Fairbanks ISD Summary Plan Description for a description of eligible fees going toward your out of pocket.

Plan year: The plan year for CFISD is May 1st through April 30th.

Pre-Admission Certification/Continued Stay Review (PAC/CSR): The process through which the reviewer evaluates the attending physician's request for admission to an acute care hospital and length of stay. Medical necessity is determined using established criteria. Admission or continued stay must be certified for full payment of a claim. Please review the Cypress-Fairbanks Summary Plan Description for a complete description of the requirements applicable to PAC/CSR.

Precertification: The process of obtaining certification from the health plan for routine hospital stays or outpatient procedures. The process involves reviewing criteria for benefit coverage determination.

Pre-existing Condition: Any physical or mental condition for which an individual sought or received care, medical advice, treatment or diagnosis during the six months prior to the individual's enrollment date. (Only applies to optional plans, not HMO and PPO)

Preferred Provider Organization (PPO) plan: A managed care company that is a network of health care providers, including doctors and hospitals. This plan allows the participant to choose any health care provider. However, if care is received from a "preferred" (participating in-network) provider, there are generally higher benefit coverage, lower deductibles, and lower out-of-pocket expense.

Prescription drug: A drug that has been approved by the Federal Food and Drug Administration, which can only be dispensed according to physician's prescription order.

Prescription drug formulary: A list of drugs that our plan prefers, physicians to prescribe based on cost-effectiveness and quality standards. The list is distributed to providers, pharmacies and/or plan participants and offers guidelines for cost-effective prescribing.

Preventive care: Medical and dental services aimed at early detection and intervention.

Primary Care Physician: In an HMO plan, the Primary Care Physician (PCP) is the first or primary source of medical care. The PCP you choose coordinates all of your medical care, from your annual checkups to referrals to specialists, lab and x-ray services, and hospital admissions.

Provider Directory: Provider directories are listings of providers who have contracted with a managed care network (PPO) to provide care to its participants. Participants may refer to the directory to select in-network providers.

Qualifying Event: An event that occurs that allows a participant to make a change in coverage status (i.e., add/delete a dependent) during a plan year.

Referral: When a provider determines that a patient has a condition that requires the attention of a specialist, the physician makes a referral or a medical recommendation for that patient to see a specialist. A referral is not required for those enrolled in the Cigna PPO plan. However, under the Cigna HMO plans, a referral by your provider is usually required before seeing another provider or specialist.

Status change: A lifestyle event that may cause a person to modify their health benefits coverage category. Examples include, but are not limited to, the birth of a child, divorce or marriage. See the Cypress-Fairbanks Summary Plan Description for a more detailed list of the events that qualify for a status change.

Urgent Care: When prompt medical attention is needed in a non-emergency situation, that's called "urgent" care. Examples of urgent care needs include ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent situations are not considered to be [emergencies](#).