Glossary

Balance billing

If your out-of-network expenses exceed the plan's maximum allowed amount, your out-of-network doctor may bill you for the difference between his or her charge and the plan's maximum allowed amount.

This is called balance billing. These excess amounts don't count toward the annual deductible or out-of-pocket maximum.

In-network or preferred providers have agreed to accept the plan's contracted rates for covered services. But you might get a bill from non-network or non-preferred providers—because they haven't agreed to accept the plan's maximum allowed amount for covered services.

EXAMPLE

If your out-of-network doctor charges $100 for a service and the maximum allowed amount is $60, your doctor may bill you for the remaining $40. You'll be responsible for paying the $40 in addition to any deductible, copayment or coinsurance you may owe.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You're protected from balance billing when you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center. For more information, see the **No Surprises Act Notice** at **mypgebenefits.com > Resources > Legal Information**.

Chronic condition

An ongoing physical or mental condition that requires long-term monitoring or management to control symptoms. Rheumatoid arthritis is an example of a chronic condition.

Coinsurance

Your share of the cost of covered health services after you pay the annual deductible. Coinsurance is usually 5% to 30% of the maximum allowed amount under the PG&E-sponsored medical plans.

EXAMPLE

- Jerry has a non-Medicare plan, and he has already paid his plan's calendar-year deductible.
- Jerry needs a lab test, which is covered at 90% after the deductible.
- Jerry's coinsurance for the lab test is 10%.
- Let's say the contracted or maximum allowed amount for his lab test is $80.
- Jerry's plan pays $72 (90% of $80), and Jerry pays the remaining $8 (10% of $80).

Copayment or copay

A fixed amount you pay for a covered service—usually when you receive the service.

EXAMPLE

Some plans charge a copay when you go to see the doctor. Most copays are $10 to $20 per visit under the PG&E-sponsored medical plans for retirees, surviving dependents and employees on Long-Term Disability.

Lab tests and X-rays are covered separately from office visits, so you may owe more than the office visit copay.

Covered services

Health services covered by the plan. Charges for covered services are eligible expenses—up to the contracted or maximum allowed amount.

Deductible

The amount you have to pay every year for covered services before the plan pays benefits for covered services. The Kaiser Permanente HMO plans don't have deductibles.

Durable medical equipment

Equipment or supplies ordered by a health care provider for everyday or extended use.

EXAMPLE
Walkers, wheelchairs and oxygen equipment are all examples of durable medical equipment.

Eligible expense

An expense covered by the plan. Eligible expenses are those that the plan considers medically necessary and that do not exceed the negotiated rate (for preferred providers), or the maximum allowed amount (for out-of-network providers). Expenses that don't meet this definition are not covered by the plan.

Explanation of Benefits (EOB)

After you visit the doctor, you'll get a statement in the mail—an Explanation of Benefits (EOB) from your claims administrator. The EOB will show how much the plan paid for your treatment or service, and how much you owe.

If you have Medicare, you may receive two EOBs—one from Medicare showing what Medicare covered—and one from your claims administrator showing what your health plan covered.

Always keep your EOBs. You may need them to file a claim for reimbursement from your Health Account (if you have leftover credits) or to question a charge.

Formulary

A list of Food and Drug Administration (FDA)-approved, brand-name and generic prescription drugs that are proven to be effective and that are covered by the plan.

Generic

Generic drugs have the same active ingredients as brand-name drugs, and they're subject to the same FDA standards. Generic drugs generally cost less because they're no longer under patent.

Health Account

The Health Account is available to active employees enrolled in the Anthem or Kaiser Permanente Health Account Plan (HAP). Employees on Long-Term Disability also may have the Health Account if they were enrolled in the HAP as an active employee and have leftover credits.

If you're a PG&E employee enrolled in a PG&E-sponsored medical plan—and if you have a Health Account—you can use your Health Account to help pay for deductibles, coinsurance, copayments and amounts you pay out of pocket for eligible medical, dental, vision and mental health expenses—including crowns, braces, eyeglasses and contact lenses, among other things. You can also use your Health Account to help pay for your dependents' eligible expenses—only if they're enrolled in your PG&E-sponsored medical plan.

For details, see your Open Enrollment guide at **mypgebenefits.com > Resources > Open Enrollment Guides**.

Are you retired? See page 4 for the **Retiree Health Account** and other terms for retirees.

In-network providers or network providers or preferred providers

Licensed health care providers (doctors, hospitals, medical groups) that charge lower rates negotiated by the claims administrator—and that meet quality standards required by the claims administrator. Network providers agree to accept as payment in full the plan's negotiated rates for services and treatment.

Maintenance medications

Medications that require regular, ongoing use to treat long-term or chronic conditions, such as asthma, diabetes, high blood pressure and high cholesterol.

Maximum allowed amount

The maximum allowed amount is the maximum amount of reimbursement the claims administrator will allow for covered medical services and supplies.

When your out-of-network provider charges more than the plan's maximum allowed amount, you have to pay the difference. These excess charges won't count toward the annual deductible or out-of-pocket maximum.

In-network or preferred providers have agreed to accept the plan's contracted rates for covered services, so you won't have charges that exceed the maximum allowed amounts. See **balance billing**.

EXAMPLE

Suppose your plan allows $100 for an office visit but your out-of-network doctor charges $150. You'll have to pay the extra $50—plus any amounts you owe for the office visit. The extra $50 won't count toward your deductible or out-of-pocket maximum.

Non-formulary

The most expensive prescription drugs. These drugs tend to be the latest, most heavily marketed brand-name drugs.

Out-of-network providers or non-network providers or non-preferred providers

Licensed health care providers (doctors, hospitals, medical groups) that have not signed a contract with a claims administrator to provide services at a negotiated rate. Non-network providers may charge more than the plan's maximum allowed amount.

As a patient, you're responsible for paying any amounts charged by out-of-network providers that exceed the maximum allowed amount. Charges that exceed the maximum allowed amount don't count toward the annual deductible or out-of-pocket maximum.

Out-of-pocket maximum

The most you'll have to pay for covered services in a calendar year. After you spend this amount on deductibles, coinsurance and copayments, the plan will pay 100% of the cost of eligible expenses for the rest of the year.

The out-of-pocket maximum doesn't include amounts you pay for premiums, services that aren't covered or out-of-network charges that exceed the maximum allowed amount.

Premium

The amount charged for health care coverage. You and PG&E share the cost of coverage.

Preventive care

Care that focuses on disease prevention and health maintenance, including early diagnosis of health problems.

Primary care

Basic or general health care provided when you first seek care from a doctor.

Primary care physician (PCP) or primary care provider (PCP)

The doctor, nurse practitioner or physician assistant who provides or coordinates your care, referring you to specialists when needed.

Provider

Licensed health care professional or facility, including doctors, nurse practitioners, physician's assistants, hospitals, clinics, medical groups, pharmacies, durable medical equipment providers, labs and other licensed health care providers.

Retiree Health Account

Are you eligible for PG&E-sponsored retiree medical coverage? You may have a Retiree Health Account if you:

- Retired in 2013 or later and had the Anthem or Kaiser Permanente Health Account Plan (HAP) when you retired—or
- Had no Health Account Plan (HAP) coverage, but you had Capped Sick Time that was converted into a Retiree Health Account when you retired*—or
- Have a Retiree Medical Subsidy for participating in the 2022 Voluntary Separation Program**

PG&E set up and funded your Health Account while you were an employee enrolled in the Anthem or Kaiser Permanente HAP. When you retired, PG&E stopped funding your Health Account—and transferred any unused credits in your Health Account to a Retiree Health Account, provided you were enrolled in the HAP when you retired.

You can use your Retiree Health Account to help pay for health care premiums (including PG&E-sponsored retiree medical premiums), Medicare Part B premiums and eligible medical, dental, vision and mental health expenses. You can also use your Retiree Health Account to help pay for your dependents' eligible health expenses—even if they're not enrolled in a PG&E-sponsored plan.

*If you were a Management, A&T or ESC employee who retired after January 1, 2017, with Capped Sick Time, 25% of your Capped Sick balance was converted as credits to your Retiree Health Account even if you weren't enrolled in the HAP when you retired. IBEW- and SEIU-represented employees do not have Capped Sick Time.

**As a participant in the Voluntary Separation Program, you received Retiree Health Account credits even if you waived HAP coverage while you were an active employee.

Retiree Medical Employer Contribution (RMEC)

Available if you retired before 2011 and did not elect the Retiree Medical Savings Account (RMSA) during the special, one-time election period in 2010.

The RMEC is a PG&E-paid, non-taxable contribution that helps cover the cost of PG&E-sponsored retiree medical premiums. You can't use the RMEC for any other coverage—including active employee coverage.

Retiree Medical Savings Account (RMSA)

Available if you retired in 2011 or later—or if you elected it during the special, one-time election period in 2010.

The RMSA is an account-based, PG&E-paid, nontaxable contribution that accumulated over your career. You can only use your RMSA to help pay for PG&E-sponsored retiree medical coverage. You can't use it for any other coverage—including active employee coverage.

Retiree Premium Offset Account (RPOA)

Available if you have the Retiree Medical Employer Contribution (RMEC) and you retired with at least 10 years of credited service.

The RPOA50 is a one-time allotment of $500 for each year of credited service beyond your first 10 years of credited service—up to $7,500. The RPOA25 is an extra allotment in addition to the RPOA 50 if you retired before January 1, 2007. You can only use your RPOA to help pay for PG&E-sponsored retiree medical coverage. You can't use it for any other coverage—including active employee coverage.

You can start or stop your RPOA only during Open Enrollment.