

KEY TERMS AND DEFINITIONS

Important benefit terms used during the open enrollment period and throughout the year.

The following pages provide general definitions of insurance terms for medical, prescription, life, disability, pension, and other benefits. Not all of these definitions will apply to your employee benefit plan. In all cases, the definitions which appear in your policies or certificates will apply.

457 PLAN: A tax-exempt Deferred Compensation program for retirement made available to employees of state and federal governments and agencies.

ACTIVELY AT WORK: Within some insurance plans, coverage is not effective until an employee is at work on the day coverage is scheduled to begin. Actively at Work for dependents means not being hospitalized or able to perform certain activities of daily living. Each insurance policy has its own definition of Actively at Work.

ALLOWABLE AMOUNT/CHARGE: The maximum dollar amount that a Carrier will pay for a given service or procedure as negotiated or per Usual and Customary fee schedules.

ANNUAL MAXIMUM: The amount of benefit you can receive each year for selected services in medical, dental, and vision plans.

BALANCE BILLING: The practice of billing a patient for the difference between the Usual and Customary amount paid by the Carrier and what the provider charged for the service. This does not include your Deductible, Copayment, or Coinsurance.

BRAND NAME DRUG: A prescription drug that has no Generic equivalent or a prescription drug that is the innovator or original formulation for which a Generic equivalent exists.

CARRIER: The insurance company (i.e., Blue Cross Blue Shield), PBM, or TPA

CERTIFICATE OF CREDITABLE COVERAGE: A document that proves an individual previously had health care coverage. It can be applied to reduce or eliminate any Pre-Existing Condition exclusion period that might otherwise apply when someone changes jobs.

CLAIM: An itemized bill for services or request for benefit when a loss occurs (such as income due to disability) submitted to a Carrier for payment.

COB (COORDINATION OF BENEFITS): The process of determining which Carrier pays first or second and how much when a patient has two or more insurance plans.

COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT): Federal health benefit provisions legislation passed in 1986 which applies to employer groups of 20 or more employees. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Service Act to provide temporary continuation of group health coverage that otherwise might be terminated.

COINSURANCE: The percentage of costs you pay for a covered service (i.e., 10%, 20%, 50%); the Carrier pays the remaining percentage (i.e., 90%, 80%, 50%).

COINSURANCE ANNUAL MAXIMUM: The amount of percent copayments you pay for covered services is defined and stated in the policy. Once this amount is reached, the plan pays most services at 100% for the remainder of the plan year.

COLLECTIVE BARGAINING AGREEMENT (CBA): A negotiated agreement between the employer and its employees.

CONVERSION: A policy or plan provision that allows employees to convert their group coverage to individually-owned coverage, without any medical questions or health statement requirements, when their group insurance ends. Benefits may be different and the cost usually higher than the group plan.

COPAY(MENT): The fixed dollar amount you pay for a covered service such as an office visit to the doctor, Generic or Brand Name drug prescription, emergency room, etc.

COVERED SERVICES: Services, drugs, or supplies identified as payable in an insurance policy or plan.

DAW (DISPENSE AS WRITTEN): Physician's instructions on a prescription which specify a Brand Name pharmaceutical or medical device.

DEDUCTIBLE: The amount you pay first before your Carrier pays for some services. A Family Deductible is one that is satisfied by the combined expenses of all covered family members.

DISCOUNT PROGRAM: A program providing discounts for services such as vision care offered to employees, sometimes at a nominal cost. It is not an insurance plan or policy.

DISEASE MANAGEMENT: Programs designed by a Carrier to help members manage chronic conditions through a partnership between members, physicians, and the health plan. Disease Management focuses on member education and self-management strategies in an effort to reduce costs and improve quality.

DMO (DENTAL MAINTENANCE ORGANIZATION): A network of dental clinics or dentists which provide dental services in exchange for Copayments published by dental service codes.

ELIMINATION PERIOD: In a disability policy, the number of consecutive days during which an employee cannot work because of disability, due to accident or illness as defined by the policy, before monthly or weekly benefits are payable.

ENDODONTICS: In dentistry, services dealing with disease and injuries to the nerve of the tooth, including root canal therapy.

KEY TERMS AND DEFINITIONS continued

EOB (EXPLANATION OF BENEFITS): A document you receive from the Carrier explaining how your Claim was processed and what amounts, if any, are your responsibility to pay.

EVIDENCE OF INSURABILITY: Any medical or other information, including a health statement that a Carrier may require and which is found satisfactory in order to provide coverage under the policy or for any increases in insurance. Also referred to as Proof of Good Health.

FMLA (FAMILY AND MEDICAL LEAVE ACT): Federal law of 1993 which requires employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for certain family and medical reasons.

FORMULARY: A regularly updated list of FDA-approved prescription drugs and supplies developed by a Carrier or PBM. Medications are selected based on clinical effectiveness, safety, and opportunity for cost savings and grouped into copayment tiers. Some plans have voluntary or mandatory and open or closed formularies.

FSA (FLEXIBLE SPENDING ACCOUNT): An employer group or employee funded account that allows employees to set aside pre-tax dollars to pay for unreimbursed medical/dental/vision/prescription drug expenses or day/night care for dependent children or spouses to allow the employee to work. Unused money is forfeited at the end of the year.

GENERIC DRUG: A prescription drug that is medically equivalent to a Brand Name Drug as determined by the FDA. It is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient. It meets the same standards as a Brand Name Drug for purity, safety, strength, and effectiveness.

GUARANTEE ISSUE: The amount of coverage which an insurance company will provide to an employee without answers to medical questions or providing other Evidence of Insurability.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT): A 1986 federal law affecting all participants in the country's health care system. It was developed to improve the portability of coverage for people who lose coverage or change employment, to promote administrative simplification through the use of electronic transactions, and to ensure the security and privacy of member information.

HMO (HEALTH MAINTENANCE ORGANIZATION): A state-licensed Carrier which focuses on wellness /preventive care and provides managed health care through a network of contracted Primary Care Physicians.

HRA (HEALTH RISK ASSESSMENT): A survey or inventory, usually taken on-line from a Carrier's website, that provides a member with a printed report regarding their overall health condition and which identifies specific risks, such as for heart disease or diabetes. The report may include an action form for the member to share with his or her doctor.

HRA (HEALTH REIMBURSEMENT ARRANGEMENT): An employer group funded account that allows employees to pay for un-reimbursed medical expenses.

HSA (HEALTH SAVINGS ACCOUNT): An employer group or employee funded employee-owned account that allows employees to set aside pre-tax dollars to pay for un-reimbursed medical expenses. Employees must be enrolled in a high deductible health plan that meets federal government requirements. Account balances rollover from year to year.

INDEMNITY PLAN: Traditional fee-for-service insurance. Under this plan, Members have a free choice of service providers.

IN-NETWORK: The level of benefits you receive for covered services from a PPO provider.

LIFETIME MAXIMUM: The total amount of benefit you can receive while you are enrolled in a medical or dental plan.

LONG-TERM CARE: Continuing maintenance and health services – inpatient, outpatient or at home – to the chronically ill, disabled, or developmentally disabled.

MAIL ORDER: A method of obtaining a 90 day supply of Maintenance Drugs by mail through a duly licensed pharmacy operated by or associated with the Carrier.

MAINTENANCE DRUGS: Prescription drugs that must be taken regularly for more than a 30 day period (i.e., insulin, high blood pressure or cholesterol medications).

MANDATORY GENERIC: A plan or policy provision which requires pharmacies to dispense Generic Drugs when available.

MASTER / MAJOR MEDICAL COVERAGE: The hospital, surgical and medical plans that supplement basic benefits by extending hospital days and providing additional benefits. Usually a reimbursement program.

MEDICARE: The federal health insurance program for the aged, disabled and individuals with end stage renal disease established by Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE COMPLEMENTARY/SUPPLEMENTAL: Coverage that pays many of the costs not covered by Medicare.

MEMBER: A Subscriber or a dependent of the subscriber covered by a specified insurance plan.

OPEN ACCESS: A plan that allows members to see participating providers, usually Specialists, without a referral from their PCP.

OTC (OVER-THE-COUNTER): Drugs or medicines which can be sold without a prescription.

OUT-OF-AREA BENEFITS: Coverage available to individuals living in or traveling outside the Service Area.

OUT-OF-NETWORK: The level of benefits you receive for covered services from a non-PPO provider.

OUT-OF-POCKET LIMIT: The amount of Coinsurance that a member needs to pay before the Carrier or plan begins paying at 100%.

PBM (PHARMACY BENEFIT MANAGER): An entity which performs pharmacy benefit management including procurement of prescription drugs at a negotiated rate for dispensation; Mail Order service; claims processing; retail network management; clinical Formulary development

KEY TERMS AND DEFINITIONS *continued*

and management services; certain patient compliance, therapeutic intervention and Generic substitution programs; and Disease Management programs.

PCP (PRIMARY CARE PHYSICIAN): In an HMO, the physician you select to provide you with all of your medical care including arrangement for hospitalizations and referrals to Specialists. PCPs typically include internists, general practitioners, family practitioners, and pediatricians.

PERIODONTICS: In dentistry, services that treat diseases and conditions affecting the bone and gums supporting the teeth.

PORTABILITY: A plan provision which allows participants, usually in group life insurance plans, to continue their insurance, at their own expense at the employer's group rate, if coverage under the employer's plan ends due to certain Qualifying Events.

PPO (PREFERRED PROVIDER ORGANIZATION): A network of service providers who has signed an agreement with a Carrier to accept their credentialing and re-credentialing process, managed care protocols, customer satisfaction evaluation, office and medical records reviews, as well as the Carrier's fee schedule (to accept the Carrier's payment in full).

PREAUTHORIZATION or PREDETERMINATION: A process that allows service providers to determine, before treating a patient, if the Carrier will cover the cost of a proposed service.

PRE-EXISTING CONDITION: A condition for which medical advice, diagnosis, care or treatment was recommended or given during a period stated in the insurance policy. Coverage for that condition may be provided or delayed as stated in the policy.

PREVENTIVE CARE: Covered services provided for health, dental and vision maintenance such as routine/periodic exams and tests.

QMCSO (QUALIFIED MEDICAL CHILD SUPPORT ORDER): A court order that requires an employee to provide available medical coverage for a child.

QUALIFYING EVENT: A change in an employee's life status that allows the employee to make appropriate changes to their benefit plan elections. Qualifying Events include marriage, birth, adoption, divorce, death of spouse, change in employee or spouse employment status, and change in dependent status. An employee who experiences a Qualifying Event has 30 days from the date of the event to request changes.

REFERRAL: The written or appropriately authorized recommendation by a PCP or dentist for a member to receive specialized care from a practitioner or facility. Most PCPs refer their patients to Specialists who are affiliated with his/her physician or dentist group and works out of the same hospital.

REIMBURSEMENT: The amount returned to you or a service provider after a Claim has been submitted to a Carrier.

SECTION 125 PLAN: A plan which complies with the provisions of Section 125 in the Internal Revenue Service Code. This section allows eligible employees to pay for certain fringe benefits that are sponsored by their employer, with pretax dollars. Also called Cafeteria and Premium Only Plans.

SERVICE AREA: The geographical area in which a Carrier, especially HMO's, operate.

SPECIALIST PHYSICIAN: A doctor who, by education/training and certification/license, specializes in a discipline, i.e. dermatologist, cardiologist, radiologist, anesthesiologist.

STEP THERAPY: A program administered by Pharmacy Benefit Managers for people who take prescription drugs regularly to treat an ongoing medical condition, such as arthritis, asthma or high blood pressure. In Step Therapy, the covered drugs you take are organized in a series of "steps," with your doctor approving and writing your prescriptions. The program usually starts with generic drugs in the "first step" while more expensive brand-name drugs are usually covered in the "second step." Specific high cost drugs are covered by the plan only after clinically appropriate, proven, and more cost effective step one drugs are tried.

SUBROGATION: The right for a Carrier or plan to recover payment when another person, insurance company or organization may be legally obligated to pay for services that the Carrier or plan has already paid; for example, in the case of a court judgment.

SUBSCRIBER: The individual whose name appears on the insurance policy or the person who is employed by the group that holds the contract for insurance. The subscriber is also a member.

TPA (THIRD PARTY ADMINISTRATOR): An entity that performs all or part of the administrative services for health plans or Carriers, including the processing of Claims.

USUAL (or REASONABLE) AND CUSTOMARY (UCR): A percentile which indicates the service providers in a geographic area who would accept a Carrier's payment for services. For example, a Carrier which pays at the 90th percentile means that 90% of the non PPO service providers would accept the Carrier's payment in full.

VOLUNTARY: A benefit which is an employee's choice in which to enroll and make some or all of the premium payments.

WAITING PERIOD: The period of time specified by an employer before an employee becomes eligible to receive benefits.

WAIVER OF PREMIUM: A policy provision in life and disability insurance policies which allows continuation of coverage, without premium payments, if the employee is and remains totally disabled as defined by the policy.