GLOSSARY OF HEALTH INSURANCE TERMS

Benefit Year - A year of benefits coverage under an individual health insurance plan. The benefit year for plans bought inside or outside the Marketplace begins January 1 of each year and ends December 31 of the same year. Your coverage ends December 31 even if your coverage started after January 1. Any changes to benefits or rates to a health insurance plan are made at the beginning of the calendar year.

Brand Name (Drugs) - A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Cafeteria Plan - A written plan that meets the requirements of Code 125 and offers Covered Employees a choice between cash and particular nontaxable benefits, such as health insurance, thereby providing a funding mechanism by which employees may pay for the benefits they choose on a pre-tax basis.

Claim - A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

Claimant - Insured or beneficiary exercising the right to receive benefits.

Co-Insurance - A cost-sharing arrangement under which a covered person pays a specified percentage of the cost of a specified service, such as 20% of the cost of a doctor's office visits.

Coordination of Benefits - A clause included in health plans or established by law to determine the order of responsibility for benefits in situations where a Participant has coverage under more than one plan. Most plans use a variation of the NAIC model coordination of benefits rule (also known as the birthday rule).

Co-Payment - A cost-sharing arrangement under which a covered person pays a specified dollar amount for a specified service, such as $10 for a prescription or $20 for a doctor's office visit.

Creditable Coverage - Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children's Health Insurance Program (CHIP); or, a state health insurance high risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

GLOSSARY OF HEALTH INSURANCE TERMS

Deductible - An amount that a person must pay towards a covered health benefit before any benefit is payable from a plan.

Dental Insurance - policies providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.

Dependent - Employee's legal spouse; and/or any unmarried children of the insured, whether natural or adopted who are within the age limits as described in the group application; and not in active military service.

Diagnosis - The determination of the nature and circumstances of a disease condition.

Drug List - A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a formulary.

Durable Medical Equipment (DME) - Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Effective Date - The date that insurance coverage goes into effect.

Eligibility Date - The date on which a member of an insured group may apply for insurance.

Eligible Employees - Those employees who have met the eligibility requirements for insurance set forth in the policy.

Emergency Room Care - Emergency services you get in an emergency room.

Employee - Actively at work, full-time, employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is actively at work for the minimum hours per week as stated in the Application and is reported on the employer's records for Social Security and withholding tax purposes.

Exclusions - The section of a policy that outlines specific circumstances under which benefits will not be paid.

GLOSSARY OF HEALTH INSURANCE TERMS

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

Group Insurance - An arrangement for insuring a number of people (employees) under a single, master insurance policy.

Group Policyholder - The legal entity to which the master policy is issued.

Health Insurance - a generic term applying to all types of insurance indemnifying or reimbursing for losses caused by bodily injury or illness including related medical expenses.

Health Maintenance Organization (HMO) - a medical group plan that provides physician, hospital, and clinical services to participating members in exchange for a periodic flat fee.

Home Health Care - Health care services a person receives at home.

Hospice Services - Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Inpatient Care - Health care that you get when you're admitted as an inpatient to a health care facility, like a hospital or skilled nursing facility.

Insurance - A plan of risk management that, for a price, offers the insured an opportunity to share the costs of possible economic loss through an entity called an insurer.

Insured - The person (employee, dependent or group member) who is covered for insurance under the group policy and to whom, or on behalf of whom, the insurer agrees to pay benefits.

Medical Provider - Medical practitioner licensed to treat illness and acting within the scope of that license.

Network - The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Out-of-Pocket Costs - Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Policy - The contract between the policyholder and GIS including the application which provides insurance benefits.

GLOSSARY OF HEALTH INSURANCE TERMS

Policyholder - The person, firm, or institution named on the face of the policy. Policyholder also means any covered subsidiaries or affiliates set forth on the face of the policy.

Preauthorization - A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preventive Services - Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider - A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Reasonable and Customary Charges (Usual and Customary Charges) - A charge for dental care that is consistent with the average rate or charge for identical or similar services in a certain geographic area.

Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Specialist - A physician specialist 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.

Section 125 Plan - See Cafeteria Plan.

Urgent Care - Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Vision Coverage - A health benefit that at least partially covers vision care, like eye exams and glasses.

Waiting Period - The period of time an employee must satisfy before being eligible for insurance.

GLOSSARY OF HEALTH INSURANCE TERMS

Well-baby and Well-child Visits - Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.