

Adjustment – contractual adjustment – writeoff The difference in the billed charges and allowed charge on a participating claim.

Allowable Charge

The maximum amount that a Health Benefit Plan will pay for a given Covered Service or supply. Also called Maximum Benefit Allowance, Maximum Allowance.

Authorization / Pre-Authorization

A procedure governed by the Contract used to review and assess the medical necessity and appropriateness of elective hospital admissions and non-Emergency Care before the services are provided. Also called Pre-Certification and Prior Authorization.

Aggregate/Family Deductible (Individual Plans, not applicable for Individual KeyCare HSA):

Once two or more covered persons meet two times their individual deductible, no other deductible has to be met for the benefit period. In other words, if you have more than two family members and you choose the \$300 deductible, you and your family members are only responsible for a \$600 deductible for the benefit period. No one person can contribute more than their individual deductible to the family deductible.

Benefit

Covered Services to which the Member is entitled under the terms of the policy. Benefit payments may be paid to the Member (or Subscriber), or on his behalf, to the medical provider. Benefit design includes the types of benefits offered, limits e.g., number of visits, percentage paid or dollar maximums applied, subscriber responsibility (cost sharing components), or Subscriber incentives to use network providers.

Benefit Period

The period of time for which we pay Benefits for Covered Services rendered while the Contract was in effect.

Capitated

Health care system in which a medical provider (PCP) is given a set fee per patient regardless of the treatment required.

Case Management

A coordinated set of activities designed to assist a Member in managing with specific health care needs.

Certification

See Pre-certification.

Claim

A request for payment of Benefits.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) generally provides that virtually all employers who sponsor group health plans must permit Members who lose coverage under the plan as the result of specific events to elect to continue their coverage under the group plan for a certain period of time on a self-paid basis.

Coinsurance

A cost sharing feature in which the Member pays a fixed percentage of the cost of medical care after the deductible has been satisfied.

Coinsurance maximum

See Out of Pocket Maximum.

Contract

An agreement between an individual Subscriber or an employer group and a Health Benefit Plan that describes the duties of each party, including the benefits and limitations of the coverage. One Subscriber could have two contracts (policies) - one for health and one for dental. Can also be called a Benefit Certificate or Policy. The Contract may include more than one document, such as a master group policy, a Benefit certificate, amendments, policies and procedures, or applications.

Contract Holder

See Subscriber.

Coordination of Benefits (COB)

The provision which applies when a Member is covered by multiple Health Benefit Plans at the same time. The provision is designed so that the payments by all plans do not exceed 100% of the Covered Services. The provision also designates the order in which the multiple health plans are to pay benefits. Under a COB provision, one plan is determined to be primary and its benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" among all of the Health Benefit Plans.

Co-payment (or co-pay)

A cost sharing feature where the Member pays a fixed dollar amount for the cost of medical care after the deductible has been satisfied. An example of a common co-pay is \$10 per physician office visit.

Medicare Supplement Plans: Means a flat, fixed dollar amount for a medical service

- or medical supply.

Individual Plans: A flat, fixed fee you may pay for prescriptions, or for doctor's visits

- in the PPO plans.

Covered Services

Hospital, medical, and other health care services and supplies provided to a Member for which Benefits are paid under a Contract.

Deductible

A cost sharing feature in which the Member pays a fixed dollar amount prior to being eligible for payment for some or all Covered Services.

Dependent

Person (for example a spouse or child) other than the Subscriber who is covered in the Subscriber's Contract. Also called a "Member."

Effective Date

The date on which the Health Benefit Plan goes into effect.

Emergency Care

Those health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity that without immediate medical attention could be reasonably expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in: a) placing the Member's physical and or mental health in serious jeopardy; b) serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Exclusions

Specific conditions or circumstances that are not covered under the Health Benefit Plan. It is very important to consult the Health Benefit Plan to understand what services are not Covered Services.

Experimental/Investigational Procedures

Any treatment, procedure, drug, supply or service that does not meet standard treatment criteria as described in the Health Benefit Plan.

Expiration Date

The date on which coverage under the Health Benefit Plan expires.

Explanation of Benefits (EOB)

A form that may be sent to the Member after a Claim has been processed by the Health Benefit Plan. The form explains the action taken on that Claim. This explanation usually includes the amount paid, the benefits available, reasons for denying payment, or the Claims appeal process.

Group

An employer, association or trust that applies for and accepts Health Benefit Plans on behalf of its Members.

Health Benefit Plan

A policy, contract, certificate or agreement issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Health Maintenance Organization (HMO)

A type of Health Benefit Plan under which the Members are required to receive care through a specific group of participating doctors and hospitals in order to receive Benefits.

Health Savings Account (HSA)

A tax-favored savings account that allows eligible individuals to pay for current and future qualified medical expenses tax-free, as long as they meet HSA enrollment criteria and are covered by a High Deductible Health Plan that meets federal guidelines.

I.D. Card/Identification Card

A card issued to a Subscriber and possibly his/her dependents, which allows the Member to identify himself/herself to a Provider in order to obtain health services. The I.D. Card may contain information about the Member's Benefits.

Indemnity

A traditional health insurance plan that generally does not require use of a specific provider network to receive Benefits.

In-Network

Refers to the use of providers who participate in the Health Benefit Plan's Provider Network. Many Health Benefit Plans require Members to use participating (in-network) Providers to receive Benefits or the highest level of Benefits.

Lifetime Maximum

The maximum amount of Benefits the Health Benefit Plan will pay for any Member.

Managed Care

Any form of Health Benefit Plan that uses Network Providers to deliver care to Members. Typically, Benefits are determined by use of Network Providers.

Medically Necessary

Procedures, treatment, supplies, equipment or services determined to be:

- appropriate for the symptoms, diagnosis or treatment of a medical condition, and
- provided for the diagnosis or direct care and treatment of the medical condition; and
- within generally accepted standards of good medical practice; and
- not primarily for the convenience of the Member or the Member's Provider; and
- the most appropriate procedure, treatment, supply, equipment or level of service which
- can be safely provided.

Medicare Assignment (Medicare Supplement Plans):

Doctors who accept Medicare assignment agree to accept Medicare's approved amount as the total charge for a service or supply. Always ask your doctors and medical suppliers whether they accept assignment of Medicare claims.

Member

Any person who is enrolled in and covered by a Health Benefit Plan.

Network

The doctors, clinics, hospitals and other medical providers with whom the Health Benefit Plan contracts to provide health care to its Members. Members may be limited to Network Providers for full Benefits.

Network Provider

A Provider in the Network.

Non-Covered Service

Services not covered such as exercise equipment, stop-smoking programs, over-the-counter drugs, experimental treatment, whirlpool baths, private duty nursing in a hospital, transportation to and from the doctor, among others. This may be policy driven.

Non-Network Provider

A medical provider who has not contracted with a Health Benefit Plan to participate in the Network. Also known as a non-participating provider or out-of-network provider.

Out-of-Network

The use of Non-Network Providers. HMO Members are generally not allowed to go Out-of-Network except to receive Emergency Care. Members enrolled in preferred provider organizations (PPO) and point-of-service (POS) Health Benefit Plans can go Out-of-Network, but may pay some additional costs.

Out-of-Pocket Maximum

The maximum amount that a Member will have to pay for Covered Services under the Health Benefit Plan. The maximum is typically the sum of all Deductible and Co-payment or Coinsurance amounts paid by the Member.

Participating Provider

A physician, hospital, pharmacy, laboratory, or other appropriately licensed facility or provider of health care services or supplies, that has entered into an agreement with a Health Benefit Plan to provide services or supplies to a Member enrolled in a Health Benefit Plan.

PFFS – Private Fee for Service – Medicare replacement plan

Point of Service (POS)

A type of health benefit plan that allows Members to go outside the Network for non-Emergency Care, but may result in a lower level of Benefits being paid by the Health Benefit Plan.

Preventive Care

Care rendered by a physician to promote health and prevent future health problems for a Member who does not exhibit any symptoms (for example routine physical examination, immunizations).

Pre-Existing Condition

A health condition or medical problem that was diagnosed or treated before enrollment in a Health Benefit Plan. Consult your Contract to determine whether Pre-Existing Conditions may be excluded from your coverage and the waiting period time frame.

Preferred Provider Organization (PPO)

A type of Health Benefit Plan designed to give Members incentives to use health care providers designated as Network Providers, but that also provide reduced Benefits for Covered Services received from Non-Network Providers. PPO plans can also be distinguished from HMO plans by the ability of PPO members to see any specialty physician without referral from a PCP.

Prescription Drug

A narcotic or medicine approved by the Federal Drug Administration for Outpatient use, dispensed under a physician's written order.

Primary Care Physician (PCP)

A physician in the Network selected by the Member to be the first physician contacted for any non-Emergency Care medical problem. The physician acts as the patient's regular physician and coordinates any other care the patient needs, such as a visit to a specialist or hospitalization.

Provider

A health care facility, program, agency, physician or health professional that delivers health care services or supplies.

Per Diem - Per day – per diem is a set rate paid for services rendered per day

Qualified Medical Expenses (HDHPs and HSAs)

Funds withdrawn from your HSA are only tax-exempt when spent on qualified medical expenses. Qualified medical expenses for HSAs are identified by the Federal government and defined by the IRS Code Section 213(d). The list of qualified medical expenses is updated periodically, so it's important to check the listing before planning medical care. You can find a complete and current listing on the IRS web site (www.irs.gov/publications/p502/index.html).

Qualified medical expenses aren't restricted to services covered by your High Deductible Health Plan. They also include certain services that may not be covered by your health plan, or may have cost limitations applied to them (a capped benefit.) For example, you may need a dental care service that is not covered by your HDHP, or is only covered up to a certain amount. If the IRS considers the service a qualified medical expense, you can still take advantage of withdrawing funds for that expense tax-free. This is another way HSAs give you added savings over traditional health insurance.

Reasonable Charge

See Allowable Charge.

Referral

A recommendation by a physician that a Member receive health care services from a specialty physician or facility. Consult your Contract since some Referrals may require Pre Authorization.

Second Opinion

The optional or mandatory requirement to visit an independent physician or surgeon regarding diagnosis, course of treatment or having specific types of elective surgery performed.

Service Area

The geographic area in which a Health Benefit Plan is authorized to deliver Covered Services through a Network.

Subscriber

Eligible employees, retired employees or members of the Group whose coverage is in effect and whose name appears on I.D. Cards. It also means the individual in whose name a Contract is issued. The Subscriber can enroll dependents under family coverage.

Utilization Management

The process used to determine the Medical Necessity, appropriateness, efficacy or efficiency of health care services. Techniques include inpatient admission review, continued inpatient stay review, discharge planning, post-care review and case management.

Waiting Period

The period of time required by a Member's Group or the Health Benefit Plan, before the Member's coverage under the Health Benefit Plan begins.

Well Baby/Well Child Care

Routine care, testing, checkups and immunizations for a generally healthy child typically from birth through the age of six.

Wellness Program

A health management program which incorporates the components of disease prevention, medical self-care, and health promotion. It utilizes proven health behavior techniques that focus on preventive illness and disability which respond positively to lifestyle related interventions.

Yearly Out-of-Pocket Maximum (Individual Plans)

This annual limit helps protect you from high-dollar medical costs. Once you reach it, we cover 100% of most of your costs for the rest of the year. You remain responsible for certain coinsurance amounts and other items that never count toward the out-of-pocket limit. (Please see Explanation of Eligibility, Renewability, and Limitations & Exclusions for a list of exclusions.) Also, our PPO plans have a separate out-of-pocket limit when you use providers out of the network. Also called stop loss.