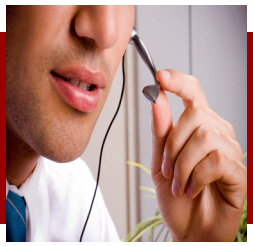
Glossary of Frequently Used Terms



Open enrollment is the time of year reserved for you to make changes to your benefit elections. Unfamiliar terms can make this process confusing. To help you navigate your benefits options, check out these definitions of common open enrollment terms.

Coinsurance – The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment– The flat fee that you pay towards the cost of covered medical services. Copayments do not apply toward coinsurance, deductibles, or out of pocket maximum expenses.

Covered Expenses – Health care expenses that are covered under your health plan.

Deductible – Before benefits are available through a health plan, you must pay a specific dollar amount out of pocket. Under some plans, the deductible is waived for certain services.

Dependent –Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Health Management Organization (HMO) – An approved and licensed organization. Requires you to see only doctors or hospitals that are on a specified list of providers.

In-Network – Care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Inpatient – A person who is treated as a registered patient in a hospital or other health care facility. This person accrues room and board charges.

Life Status Changes - Benefit elections will remain in effect throughout the plan year, unless you have a qualifying life status change as defined by the IRS. Examples include marriage, divorce, birth, adoption, death, loss of group coverage

Medically Necessary (or medical necessity) – Services or supplies provided by a hospital, other health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Member – You and those covered become members when you enroll in a health plan. This includes eligible students and their dependents.

Out-of-Network – Care you receive without a physician referral or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments. You may spend more money by using non-participating providers.

Out-of-Pocket Expense – Amount that you must pay towards the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-Pocket Maximum (OPM) – The maximum amount paid for covered services during a benefit period. Both the deductible and the coinsurance apply towards meeting the OPM, but copayments may not apply.

Premium – The amount you pay for a health plan in exchange for coverage.

Primary Care Physician (PCP) – The doctor that you select to coordinate your care under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance – The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances, etc.