EMPLOYEE BENEFITS EDUCATION

HEALTH INSURANCE TERMINOLOGY

The health care system in the United States can be confusing. In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, the government, health plans and health care providers. This way, you can make better decisions and ultimately receive better care.

BENEFITS - The amount of money payable by an insurance company to a claimant under the insurance policy.

CLAIM - A request by an individual (or his or her provider) for the insurance company to pay for services obtained.

COINSURANCE - The money that an individual is required to pay for services after the deductible has been met. It is often a specified percentage of the charges. For example, the team member pays 20% of the charges while the health plan pays 80%.

COPAYMENT - An arrangement where an individual pays a specified amount for various health care services, and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. Copayments are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.

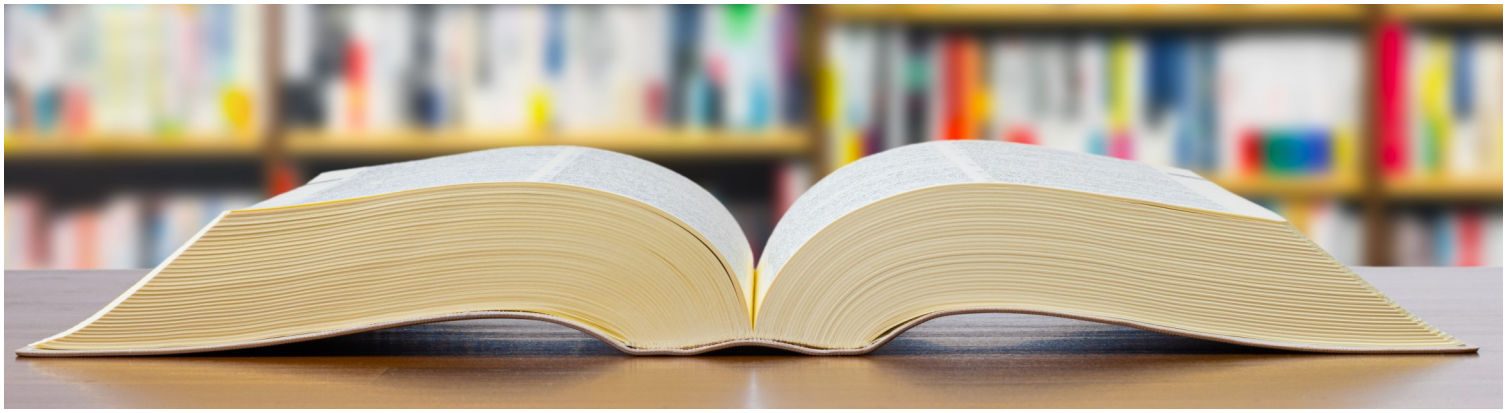
DEDUCTIBLE - A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.

IN-NETWORK - Typically refers to physicians, hospitals or other health care providers who contract with an insurance plan (usually an HMO or PPO) to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

OUT-OF-NETWORK - Typically refers to physicians, hospitals or other health care providers who do not contract with an insurance plan to provide services to its members. Depending on the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

OUT-OF-POCKET MAXIMUM (OOPM) - The total amount paid each year by the team member for the deductible, coinsurance, copayments and other health care expenses excluding the premium. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.

PREFERRED PROVIDER ORGANIZATION (PPO) - A type of managed care plan in which health care providers and insurers agree to offer substantially discounted fees for covered health care services and to lower copays and deductibles for in-network services. The plan's payment ratio



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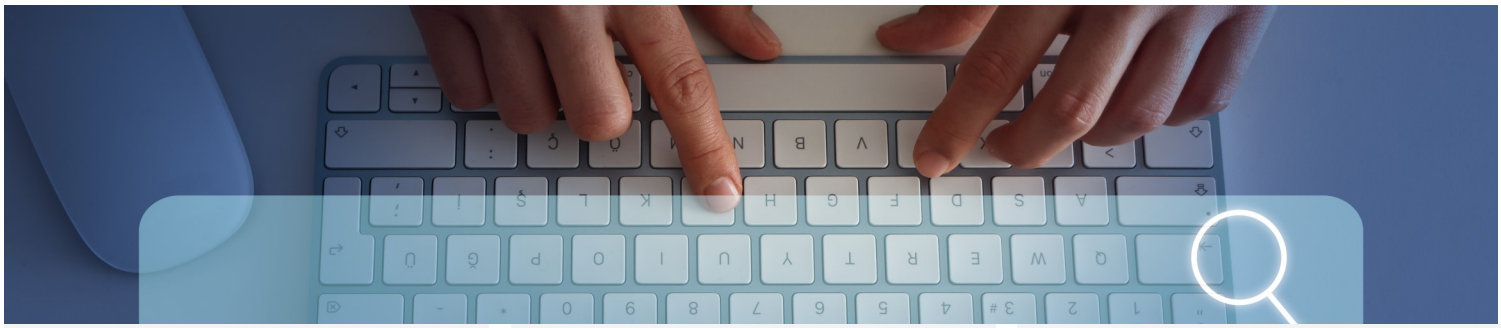

(what your insurance company pays compared to what you pay) may be high - for example, it could be 90/10, with the insurance company paying 90% of medical costs and you paying 10% after the copay and deductible.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

PREMIUM - The amount of money charged by an insurance company for coverage.

PRESCRIPTION INSURANCE - Insurance that helps pay for prescription drugs and medications. Prescription insurance is often offered as part of a larger health insurance plan, though this is not always the case. Stand-alone individual prescription insurance may be available for people who are not offered prescription drug coverage or who have no health insurance. Eligibility for specific medications and the cost of insurance varies among health plans. Also known as drug coverage.

PREVENTIVE CARE - Any medical checkup, test, immunization, or counseling service used to prevent chronic illnesses from occurring.

PRIMARY CARE PHYSICIAN (PCP) - A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a gatekeeper for an individual's medical care, referring them to specialists and admitting them to hospitals when needed.

QUALIFIED MEDICAL EXPENSE - The costs attached to the diagnosis, cure, mitigation, treatment or prevention of diseases, or for the purpose of affecting any structure or function of the body.

REASONABLE AND CUSTOMARY CHARGES - The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for that particular service. The remaining charges are the responsibility of the patient.

SUMMARY OF BENEFITS AND COVERAGES (SBC) - An outline of a health insurance plan that allows somebody to evaluate costs and coverage and compare against other health plans.

VISION INSURANCE - Insurance that covers specific eye care benefits defined in the policy. Vision insurance policies typically cover routine eye exams and other procedures and provide specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. Some vision insurance policies also offer discounts on refractive surgery.

WELLNESS PROGRAM - A program intended to improve and promote health and fitness, usually offered through the workplace, although insurance plans can offer them directly to their team members. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs and preventive health screenings.

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