

Healthcare Terms and Definitions

Premiums – The semi-monthly or monthly amount paid for your health insurance. Premiums are primarily influenced by utilization of services by the members benefit plan design and the cost of healthcare. For active employees under a collective bargaining agreement, the employer contribution to your premium is negotiated by your employee organization/union.

Eligible charge – The lower of the participating provider's actual charge or the amount the plan establishes as the maximum allowable fee (the maximum amount that the plan will pay for the covered services or supplies). This is the amount on which your coinsurance is based.

Copayment – A fixed amount (for example, \$15) you pay for a covered service, usually when you receive the service. The amount can vary by plan and the type of covered service.

Coinsurance – Your share of the costs of a covered service, calculated as a percent (e.g. for most services under the HMSA 90/10 PPO medical plan, coinsurance is 10%) of the eligible charge. For example, if the plan's eligible charge for a primary care office visit is \$100, your coinsurance payment of 10% would be \$10. The plan pays the remainder of the eligible charge or \$90 in this example.

Deductible – The amount you must pay for covered services before your plan begins to pay. For example, if you select the self EUTF HMSA 75/25 PPO medical plan your deductible is \$300. For services that the deductible applies to (e.g. inpatient hospital services), you must pay the first \$300 in eligible charges. Once the \$300 deductible is met, the plan benefits begin (e.g. for eligible charges, you will pay your copayment or coinsurance and the plan will pay the remainder). The deductible does not apply to all services.

Out-of-Pocket Costs – Costs paid by the member related to deductibles, copayments and coinsurance for services. Out-of-pocket costs exclude premiums.

Maximum Out-of-Pocket Limits (MOOP) – The most you pay during a calendar year before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not include premiums, additional amounts for nonparticipating providers and other out-of-network charges, or spending for non-essential health benefits. The MOOP protects the members from catastrophic losses.

In-Network or Participating Provider – A physician, hospital, pharmacy, laboratory, or other healthcare provider your insurance carrier has contracted with to provide services at a negotiated fee or eligible charge rate. In most cases, participating providers are preferable to non-participating providers because of the lower out-of-pocket costs to the member.

Out-of-Network or Nonparticipating Provider – A physician, hospital, pharmacy, laboratory or other healthcare provider who has not contracted with your insurance carrier to provide services. When you receive services from a nonparticipating provider, you owe the plan's standard copayment or co-insurance plus the difference between the nonparticipating provider's charge for the services and your insurance carriers' eligible charge.

For example, if the nonparticipating provider's charge for a primary care office visit is \$120, the plan's eligible charge is \$100 and coinsurance is 10%, the plan will pay \$90 (\$100 * 90%) and you would pay \$30 (\$10 coinsurance plus \$20 for the excess of the actual charge over the eligible charge). If the primary care provider was a participating provider, your total cost would be \$10.

Patient Protection and Affordable Care Act (ACA) – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Medicare – A Federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Coordination of Benefits – A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim. For example, if a EUTF employee is covering his spouse, and his spouse is also covered by his or her own insurance plan, the spouse's insurance plan will be considered the primary plan and the EUTF will be considered the secondary plan for any services he or she receives.

MEDICAL PLANS

Preferred Provider Organization (PPO) – A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network (participating providers). You can use doctors, hospitals, and providers outside of the network for an additional cost. Most of HMSA's EUTF and HSTA VB medical plans are PPO plans.

Health Maintenance Organization (HMO) – A type of health insurance plan that usually limits coverage to care from medical providers who work for or contract with the HMO. A HMO generally won't cover out-of-network care except in emergency situations. HMOs often provide integrated care and focus on prevention and wellness. Kaiser Permanente and one EUTF active employee medical plans are HMO plans.

Primary Care Provider (PCP) – A provider (usually an internist, family/general practitioner or pediatrician) who provides a range of services such as prevention, wellness, and treatment for common illnesses. PCPs often maintain long-term relationships with you, and advise and treat you on a range of health related issues. PCPs may also coordinate your care with specialists.

Specialist – A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

PRESCRIPTION DRUG PLAN

Generics – A prescription drug that has the same active-ingredient formula as a brand-name drug. The color or shape may be different, but the active ingredients must be the same. Generic

drugs usually cost significantly less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Brand Name – A prescription drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand prescription drugs are either preferred or other brand/non-preferred. You will pay more if you use other brand/non-preferred drugs than preferred or generic prescription drugs.

Formulary – A list of prescription drugs covered by a prescription drug plan. A formulary is also called a drug list. The formulary is normally updated quarterly for the active employee and the non Medicare retiree plans and annually for the Medicare retiree plans.