AVON LOCAL SCHOOLS

INSURANCE 101 GLOSSARY OF TERMS

Benefit Period

A 12-month period during which benefits are available for covered services.

Open Enrollment

The time, once a year, when your employer or group health plan lets you make changes in your coverage. Typically, this is the time to add or delete dependents from your coverage, select different types of coverage if offered, change your network if others are offered, or enroll in the group health plan if you elected not to join in the past. The choices you make at open enrollment are locked in for the next year. Only certain specific events -- such as marriage, birth or adoption, and the termination of a spouse's employment -- qualify you to add dependents to your coverage throughout the year. In most cases, these requests must be made within 31 days after the wedding, birth or job change in order to ensure coverage.

Dependent

Another family member covered under a person's health insurance plan. May be a spouse, and/or married or unmarried children who meet eligibility requirements of the plan.

Claim

A request for payment of benefits under the terms of your health plan. When you use doctors, hospitals and caregivers in your network, they file your claims for you.

Covered Service

A Medically Necessary service or supply shown in the Contract for which benefits may be available.

Medically Necessary (or Medical Necessity)

Services which have been determined, by the plan, to be of proven value for use in the general population. To be Medically Necessary a service must:

- Have final approval from the appropriate government regulatory bodies.

  - Have scientific evidence permitting conclusions concerning the effect of the service on health outcomes.

- Improve the net health outcome.
- Be as beneficial as any established alternative.
- Demonstrate the improvement outside the investigational setting.
- Not be an experimental or investigational service.

Deductible or deductible amount

A deductible is a fixed-dollar amount that a plan member must pay for eligible services before your health plan begins applying insurance benefits. Deductibles apply every calendar year

Family Deductible

The maximum dollar amount of Covered Services stated in the Schedule of Benefits that must be incurred and paid by a member and his or her eligible dependents before benefits can be paid for all or part of the remaining Covered Services.

Coinsurance

The portion of an eligible medical bill a member must pay out of pocket before your health plan begins paying insurance benefits. Coinsurance amounts are usually a percentage of the total eligible medical bill, such as 10 percent. Coinsurance applies after the member meets a required deductible or copay amount.

Family Out-of-Pocket Maximum

The dollar amount stated in the Schedule of Benefits for which a member and his or her covered, eligible dependents are responsible to pay for Covered Services during a Benefit Period.

Out-of-Pocket Maximum

The highest dollar amount you will need to pay on your own each year for covered medical services from network providers, including coinsurance and deductibles. Once you reach the out-of-pocket maximum for the year, your health plan reimburses your network caregivers for any remaining covered services that year. Using out-of-network providers affects your out-of-pocket maximums and increases the amount you pay. Non-covered services, copay amounts and amounts over the maximum allowable charge do not apply to an out-of-pocket maximum.

Copay/Copayment:

A co-pay is a fixed-dollar amount that a plan member pays to a participating network doctor, caregiver, or other medical provider or pharmacy each time health care services are received. A copay is paid before your health plan pays the covered benefit amount.

Generic Drug

A prescription drug that is made and sold by a drug firm under its general formula name. Generic drugs are not protected by a patent or registered tradename. But they are required by the FDA to have the same quality, safety and effectiveness standards as brand-name drugs. Generic versions of many higher-priced brand drugs are usually available to treat the same medical condition. In almost all cases, you save money and pay the lowest copay amount when you or your doctor request generic drugs

Formulary

The prescription drug formulary is an extensive list of drug choices that are commonly prescribed by doctors based on the drugs' proven effectiveness, safety and cost. The drug formulary is an important reference guide for you and your doctor, and can help save you money. The formulary is divided into tiers that indicate different copay costs for generic drugs, preferred brand drugs, or non-preferred drugs.

Non-Preferred Brand Drug

A brand-name drug that is not included on your Preferred Drug List. Many different brand drugs may be available to treat a medical condition. When you or your doctor choose an elective non-preferred brand drug, you will pay the highest copay amount.

Emergency or Emergency Medical Condition

An emergency is the sudden occurrence of a medical condition so severe that, without immediate **medical attention, the condition could reasonably be expected to cause serious impairment to bodily** functions, serious dysfunction of a bodily organ, or otherwise place the member's health in serious danger. For behavioral health benefits, an emergency is a sudden or rapidly escalating behavioral condition that, without immediate psychiatric or substance abuse attention, could reasonably be expected to cause serious emotional or physical dysfunction, or otherwise place the member's or others' health and well-being in serious danger.

Diagnostic Service

A procedure ordered by a physician or other provider to determine a specific condition or disease. Some common diagnostic procedures include:

- X-rays and other radiology services;
- Laboratory and pathology services; and
- Cardiographic, encephalographic, and radioisotope tests.

Durable Medical Equipment (DME)

A certain type of health care equipment that may be a part of your treatment. These items can only be used for a specific medical purpose, are made to withstand repeated use, are appropriate to use at home, and are of little or no use to someone without injury or illness. Examples include hospital beds, wheelchairs.

Skilled Nursing Facility

A facility which provides convalescent and rehabilitative care on an Inpatient basis. Skilled nursing care must be provided by or under the supervision of a Physician.

Specialist

A doctor who is trained to diagnose and treat specific diseases, diagnose and treat conditions within certain areas of the body, or care for people at a certain age.

Disease Management

Programs and services that provide extra information and assistance to people with chronic illnesses. Disease management can help people better manage their chronic illness and symptoms, and stay on track with the prescribed treatment plan. Disease management services are provided free of charge to plan members.

Case Management

An added level of benefit service for critical injuries or complex illness. Case management helps coordinate your care -- before, during and after treatment or surgery -- to make sure special needs are met, and appropriate services and care sites are used.

Inpatient

Inpatient medical care is when treatment is provided to a member who is admitted as a bed patient in a hospital or other medical facility, and room and board charges are incurred. For behavioral health benefits, inpatient care can refer to treatment received at a hospital, a behavioral health facility or a behavioral health program.

Outpatient

Outpatient medical care is when treatment is provided to a member in a facility or setting where room and board charges are not incurred. Outpatient medical services may be provided in a doctor's office, the outpatient department of a hospital, or in some other medical setting. For behavioral health benefits, outpatient care refers to routine visits to a behavioral health professional

Outpatient Surgery

Surgery performed in an outpatient department of a hospital, Physician's office or Facility Other Provider.

Network (or Provider Network)

The doctors, hospitals and other health care providers that participate in contract agreements with United Healthcare. You will always receive the highest level of benefits when using providers that participate in your specific network. Choosing services from providers that do not participate in your particular provider network will increase the amount that you pay for those services.

In Network

Doctors, caregivers and medical facilities are considered "in network" if they participate in an agreement with Medical Mutual of Ohio to provide services according to specific terms and rates. Your benefit level when using the providers in your health plan's network is referred to as "in-network" on your benefit summary chart.

Balance Billing

A doctor, hospital or other caregiver may sometimes bill more for a service than the maximum allowable charge for that service. If you use the doctors and hospitals in your plan network, they are not allowed to bill you for the balance of that amount, and you are not responsible for the extra charge. If you use doctors and hospitals that do not participate in your health plan network, you may be responsible for the balance billed amount.

Out of Network

Doctors, caregivers and medical facilities are considered "out of network" if they do not participate in an agreement with United Healthcare to provide services according to specific terms and rates. Your benefit level available when using the providers in your health plan's network is referred to as "out-of-network" on your benefit summary chart.