# PRISMHealth Committee
# Standard Operating Procedures

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# Introduction

In every conversation we have, every initiative we explore, and every action we take, we must hold them up against PRISM's Mission, Vision and Core Values. Together, the Mission, Vision and Core Values are our strategic framework and clarify why PRISM exists and what we aim to be. As you review this document, please keep these in mind:

## Mission:

PRISM is a member-directed risk sharing pool of public agencies committed to providing risk coverage programs and risk management services, which drive member stability, efficiency, and best practices.

## Vision:

PRISM will continue to be internationally recognized as a leading risk sharing pool for its member-directed operating philosophy and commitment to member fiscal sustainability. PRISM will continue to influence and shape the future of the risk management profession.

## Core Values:

PRISM is dedicated to preserving a member-directed culture, defining standards for quality and performance throughout the industry, and ensuring programs and services are:

- **C**ompetitive in scope and price over the long term
- **A**daptable and customized to meet member needs, based on high-quality standards
- **R**esolute in delivering timely solutions that address present and emerging risks
- **E**quitable in allocating costs and services between various members in a fair and consistent manner
- **S**table in supporting cost-effective, fiscally prudent operations *and* long-term solvency, and in building long-term relationships with members and program/service partners

# Composition

The Committee is comprised of 9 members that participate in the PRISMHealth Program, of which seven (7) are voting members and two (2) are alternates who are eligible to vote at any meeting where a voting member is absent. One of the voting seats is designated for a Public Entity representative.

Reference: Committee Composition

# Roles

## Committee:

Pursuant to the PRISMHealth Memorandum of Understanding (MOU), the PRISMHealth Committee is responsible for all matters pertaining to the PRISMHealth Program, including but not limited to approval of renewals, reinsurance placements when applicable, premium allocations, new member applications, Third Party Administrators (TPA) and vendor selections. The Committee will report their activities to the Executive Committee and Board of Directors.

From time to time, the Committee may consider contracting with outside parties for services. PRISM's Executive Committee has adopted a Service Provider Contracting Policy which outlines the process for competitive bidding as well as protocols and authorities for entering into such contracts. The PRISMHealth Committee is responsible for determining whether a competitive selection process should be used for procurement of any new member service offerings or a new service provider for an existing member service in excess of $50,000. Any renewal contract must go to the Committee for approval of the vendor and the amount to be expended.

| Carrier/Vendor | Scope of Services (Primary Function) |
|---|---|
| **Accolade** | Healthcare Navigator |
| **Alliant** | Program Broker Consultant & Underwriting |
| **Anthem** | Provider Network, Claims Administration |
| **Benefit Coordinators Corporation (BCC)** | TPA - Benefits Administration |
| **Blue Shield of California** | Provider Network, Claims Administration |
| **BRMS** | TPA - Benefits Administration |
| **Businessolver** | TPA - Benefits Administration |
| **Carrum Health** | Surgical Benefit Program |
| **Deerwalk Data Analytics** | Program Data Analytics |
| **Express Scripts** | Pharmacy Benefit Manager |
| **Hinge Health** | MSK Program |
| **Kaiser Permanente** | Provider Network, Claims Administration |
| **Livongo (Teledoc)** | Diabetes Management |
| **Pinnacle Claims Management** | Mexico Provider Network, Claims Admin. |
| **Self Insured Schools of California (SISC)** | Pool Access and Administration |
| **Surest** | Dynamic Copay |
| **Turner Consulting** | Actuarial Services |
| **UMR** | TPA |
| **Workterra** | TPA - Benefits Administration |

Reference: Service Provider Contracting Policy

## Chair

- Call/authorize meeting to be scheduled
  - Staff will contact Chair to arrange date, time, location (in-person or Web/Video Meeting)
  - Once authorized, staff will notify the Committee members via email
- Call the meeting to order
- Orchestrate agenda items
- Recognize members to facilitate orderly debate
- Preside over voting
- Enforce rules of the group
- Expedite the business of the group
- Declare meeting adjournment
- Attend the PRISM's Annual Strategic Planning Retreat
- Conduct meetings according to Robert's Rules of Order and the Brown Act

## Vice Chair

- Assume the responsibilities of the Chair in their absence

## Staff

- Assist Chair in facilitating meeting, prepare agenda, take minutes, summarize meetings for those not in attendance
- Advisory to the Committee
- Will make recommendations to assist Committee
- Execute Committee's directions
- Sidney DiDomenico is the staff liaison for the PRISMHealth Committee

## Broker

- Advisory to the Committee
- Will make recommendations to assist Committee

Reference: PRISMHealth Scope of Services from Alliant Contract 1/1/2018

## Consultants

PRISM utilizes consultants for various services, including but not limited to actuarial, legal advice, third party claims administration, and underwriting. Their role is:

- Advisory to the Committee
- May make recommendations to assist Committee

# Committee Responsibilities

## Memorandum of Understanding

The PRISMHealth Committee oversees the provisions of the PRISMHealth Program MOU and will approve changes from time to time.

Reference: PRISMHealth MOU

## Program Administration

The PRISMHealth Committee is responsible for approval and oversight of the carriers and vendors associated with PRISMHealth Program administration. Annually, the PRISMHealth Committee reviews and approves the administrative expenses of the PRISMHealth Program. The following is a table of current administrative costs (or fixed costs) associated with the Program for the 2024 plan year, approved by the Committee on May 24, 2023.

| **Carrier/Vendor** | **2024 Fixed Costs** | |
|---|---|---|
| Alliant | Non-Kaiser Plans<br>Jumbo (2,000+)<br>$3.00 PEPM<br>Large (1,000-1,999)<br>$5.00 PEPM<br>Mid-Market (250-999)<br>$8.00 PEPM<br>Small Group:<br>$11.00 PEPM | Kaiser Plans<br>Jumbo (2,000+)<br>$3.00 PEPM<br>Large (1,000-1,999)<br>$4.00 PEPM<br>Mid-Market (250-999)<br>$7.00 PEPM<br>Small Group<br>$10.00 PEPM |
| Alliant Pharmacy Consultation | $0.85 PMPM | |
| Alliant Underwriting Services | $3.00 PEPM | |
| Accolade | $18.45 PEPM | |
| Anthem | $51.64 to $55.01 PEPM | |
| Benefit Coordinators Corp. (BCC) | $7.00 PEPM | |
| Blue Shield of California | $47.89 PEPM | |
| BRMS | $7.50 PEPM | |
| Businessolver | $7.05 PEPM | |
| Carrum Health | $0.75 PEPM | |
| Deerwalk Analytics | $0.35 PEPM | |
| Pinnacle Claims Management | $3.72 to $5.00 PEPM | |
| PRISM Administrative Fee | $2.00 PEPM | |
| SISC Pool Access & Administration | $2.75 PEPM | |
| Surest | $57.50 PEPM | |
| UMR | $25.49 PEPM | |
| Workterra | $6.75 PEPM | |
| **Carrier/Vendor** | **2024 Fee for Service** | |
| Hinge Health | Chronic Program – $995 PPPY<br>Acute Program – $250 PPPY<br>Surgery Program – a $995 PPPY | |
| Livongo (Teledoc) | $71.00 PPPM | |

### PRISM Administrative Fee

PRISM has administrative oversight of the PRISMHealth Program and charges an administrative fee that accumulates and is transferred into to the PRISM General Administration budget. This fee covers the cost of PRISM program operations, governance, staff, legal, actuarial and the annual PRISM Healthcare Symposium.

### Alliant Consulting Fee

Alliant is the exclusive broker consultant for the PRISMHealth Program and charges a per employee, per month fee based upon the employee count of the member. The Committee has reviewed the Alliant fee over the years and has updated it as the Program has expanded and additional resources have been needed. The master Alliant Consulting contract is reviewed and approved by the Executive Committee every three years.

The Committee is also responsible for overseeing the administrative expenses of the Program and determining how those costs will be allocated amongst the members. Budget Policies are annually reviewed by the Committee in advance of the budget being developed for adoption by the Board. The Committee may make changes from time to time.

## Program Services

The Committee has discretion to approve program services on an optional or mandatory implementation basis. When determining additional services, the Committee will approve how the service costs are to be allocated amongst the members or if the cost is to be charged as an expense of the Program. Most often, the services are designed to provide cost-saving opportunities. Some of the service options may be programs that are offered by the existing carriers and vendors or contracted with an outside source.

Reference: PRISMHealth Program Budget Policies 2/15/2023

## Coverage Matters

The carriers and vendors are responsible for coverage matters for the members within the Program. The carriers base their coverage on each member's specific Evidence of Coverage or Plan Summary. If a covered plan participant has a dispute with the way a claim was processed, they must file an appeal with the carrier or vendor. The vendor must respond to the appeal in a timely manner with either an approval or denial. The Committee has approved the PRISMHealth Administrative Guidelines that provide guidance in addressing program retroactivity, mid-year qualifying events, dependent definitions, and benefit substitutions. The PRISMHealth Administrative Guidelines do not apply to the HMO or Kaiser members, as their policy statements are part of the carrier contracts.

Reference: PRISMHealth Committee Minute Order 4/21/2010
Reference: PRISMHealth Administrative Guidelines 2/16/2022

## Coverage Documents

The PRISMHealth Committee does not oversee the coverage documents provided to the members in the Program. The program's major carriers (Anthem, Blue Shield of California, Kaiser and Express Scripts) provide the coverage documents, and the program consultant, Alliant, works directly with each carrier and member to ensure the coverage documents are correct.

Based upon the MOU, each member is responsible for their plan designs and the Committee does not approve member specific plan changes. If a member wants to change any provisions to their coverage documents, they request Alliant to review and price the requested change. The member decides if they want to make the coverage change and then works with Alliant to adjust their rates accordingly, and ensure the carriers make the appropriate changes to the coverage documents.

## Approval of New Members

The PRISMHealth Program is comprised of two member segments, large group and small group. These categories have been established to reflect the number of employee lives represented in each segment. These member sizes, as defined in the table below, are meant to be a guideline for program segment placement.

| Segment | Member Size |
|---|---|
| **Small Group** | Minimum: 2 Full-Time Eligible Employees<br>Maximum: 200 Full-Time Eligible Employees |
| **Large Group** | Minimum: Subject to Review<br>Maximum: None |

In 2014, the PRISMHealth Committee created a policy addressing the approval of prospective members into the large group segment. This policy, referenced below, outlines the member evaluation process that is to be followed prior to being presented to the Committee for consideration. In addition, member evaluation is conducted by Alliant Underwriting Services (AUS) based on the PRISMHealth underwriting guidelines, which outline specific criteria for participation. Based on the underwriting results, AUS makes a recommendation for approval of the new member into the large group segment. This recommendation is reviewed by the Committee as a new member application with the Committee having final authority for approval or declination.

The Committee has delegated authority to staff and AUS to approve all new members in the small group program segment, based upon the underwriting guidelines. Disclosure of the delegated authority is reviewed with the Committee at the first Committee meeting of the year.

Reference: PRISMHealth Committee Approval of Prospective Members 11/12/2014
Reference: PRISMHealth Underwriting Guidelines 8/2/2023

## Premium Allocation Methodologies

The Committee oversees the provisions of the PRISMHealth premium allocation methodologies and may approve changes from time to time.

The Committee has authority to:

- Approve premium deviations from the standard allocation methodologies
- Declare dividends
- Approve reinsurance or insurance premiums
- Approve fixed costs

The Committee has adopted the Claims Performance Risk Adjustment (CPRA) formula, which was designed to provide a loss allocation strategy that was concurrent with PRISM's philosophy of equitable long-term stability. The goal of any pool, is to make sure that over time each member is paying their equitable share of premium. This formula takes into account the size of the member as compared to the pool as a whole; claims experience over multiple years, and large claims based upon the member's size. The intent of the formula is to ensure the member's rate is appropriate to their actual claims experience, but more predictable than if they were on their own. This formula is reviewed by the Committee annually to see if any adjustments are necessary for the upcoming year.

Reference: PRISMHealth Committee Minute Order 5/25/2011

## Premium Development and Renewals

The premium for all new members is developed by Alliant Underwriting Services (AUS) and Turner Consulting, program actuary. They review all of the data submitted by the prospective member, and develop rates that account for the demographics of the group, plan designs, claims experience and incorporate all of the necessary administrative costs into the rates, based upon the needs of each member.

For program renewal, AUS and Turner Consulting review the claims data for the previous 24-30 months, as well as the any changes to medical/pharmacy trends and legislative requirements. Due to the program size, margin is no longer needed, but if the size changed substantially, it may need to be added back in. Once the renewal is calculated for the Program as a whole, the CPRA formula is applied to see if any members warrant upward or downward adjustments to their renewal. The PRISMHealth Pool Renewal and Member Specific Renewals are approved annually, adjustments or changes cannot be made without the majority approval of the PRISMHealth Committee.

Reference: PRISMHealth Committee Minute Order 4/21/2010

### Reinsurance Placements

The PRISMHealth Committee is responsible for review and approval of the program's reinsurance placements.

ReliaStar Years 7/1/03-6/30/05 - ReliaStar provided coverage for both stop loss and aggregate stop loss insurance.

ReliaStar Years 7/1/05-6/30/06 - ReliaStar provided coverage for stop loss insurance. The Committee elected to stop purchasing aggregate insurance effective July 1, 2006.

Self Insured Schools of California (SISC) Years 7/1/2006-12/31/2018
From 2006 through 2018 plan years, the PRISMHealth Program members purchased stop loss pooling insurance from SISC in varying amounts throughout the years. Any specific claim amount above the purchased stop loss limit was covered by SISC and not calculated in the overall program claims experience for renewal purposes. For the 2019 plan year, the Committee approved the elimination of the SISC stop loss pooling arrangement, this was done after actuarial analysis showed that the pool had grown large enough to absorb and retain that risk within their own premium volume.

Future review of potential reinsurance placement will be conducted at the direction of the Committee.

## Meetings

### PRISMHealth Program Member Participation

The PRISMHealth Committee welcomes and encourages all members of the PRISMHealth Program to attend Committee meetings. Because of this, all PRISMHealth members have been added to the meeting distribution list.

### Code of Conduct/Ethics Policy

The Board has adopted a Code of Conduct which is applicable to all members, staff, Committees and the Board.

Reference: Code of Conduct

### Scheduling

The PRISMHealth Committee will meet based upon the approved calendar of meetings for the current year and at the call of the Chair. Below are generally when the Committee will meet to address certain matters:

- **February**
  - Member Statistics
  - Program Performance Report
  - New Member Applications

- **April/May**
  - Fixed Costs Review and Approval
  - PRISMHealth Program Renewal
  - New Member Applications
- **June/July/August**
  - New Member Applications
  - General Business
- **October/December**
  - Contractual/Legislative Updates
  - New Member Applications
  - General Business
  - Strategic Planning

Reference: 2024 PRISMHealth Committee Meeting Schedule

## Quorum

Pursuant to the Bylaws, a quorum consisting of a majority of the Committee must be present in order to conduct a meeting.

Reference: PRISM Bylaws

## Voting

Voting Requirements
Pursuant to the Bylaws, the voting requirement is a majority of the Committee (at least 4 members) for all actions of the PRISMHealth Committee.

Conflicts - Pertinent PRISM Code of Conduct Provisions:

1. We are committed to the concepts of democratic, effective and efficient governance by responsible, knowledgeable members of the Board of Directors and Committees with an understanding that official decisions made and actions taken by PRISM are always made in the best interests of PRISM's membership, as opposed to the interests of PRISM's staff, service providers, or other outside interests.

2. We are committed to the principle that conflicts of interest, (defined as situations in which a person has a financial or other interest or the appearance of a conflicting interest that would call into question the person's ability to act in an impartial manner with respect to a matter affecting PRISM) should be avoided and where present shall be fully disclosed. This includes situations when a member of the Board, a Committee, staff, or vendor has personal interests (including those of his/her family) that are contrary to his/her loyalty to PRISM.

Vote on behalf of the PRISM or the Entity I Represent?
Attorney General Opinion No. 00-708 dated 12/8/00 concluded that a member of the governing board (in this case the PRISMHealth Committee) of a joint powers agency may cast a valid vote on a matter before the agency that is inconsistent with the position by the legislative body which appointed the member.

Reference: Attorney General Opinion No. 00-708

Voting When Conflict Arises:
According to FPPC

- Disqualification
  - For financial interest (exception when action required)
- Abstention
  - Conflicting loyalties
  - Perception you can't be fair
  - Ethical dilemmas (exception for necessity to take action)

According to Roberts Rules of Order

- Duty to vote if you have an opinion
- Right to abstain
- Personal interest – must abstain except
  - vote for self in an election
  - vote if other's interests are included in the motion

## Closed Session

Closed sessions may be held in accordance with the provisions of state law and the Brown Act. Information discussed in closed session is confidential. In addition to the PRISMHealth Committee and Legal Counsel, only individuals necessary for the discussion will be present. The Executive Committee has appointed PRISM's General Counsel to serve as legal counsel to PRISM's Board of Directors and all PRISM Committees for purposes of obtaining legal advice during closed sessions in accordance with the Brown Act (2/2/12 Executive Committee Meeting, Item 5.B.).

Reference: Executive Committee Minute Order 2/2/2012

# Glossary of Terms

## HEALTH BENEFITS TERMINOLOGY

**Actual Charge:** Amount a physician or other practitioner charges for a particular medical service or procedure. The actual charge may differ from the allowed charges under insurance programs.

**Adjudication:** Determination of the amount of payment for a claim.

**Admission:** Formal acceptance as an inpatient by an institution, hospital or health care facility**.**

**Administrative Services Only (ASO):** An arrangement under which an insurance carrier or an independent organization will handle the administration of claims, benefits and other administration functions for a self-insured group but does not assume any financial risk for the payment of benefits.

**Adverse Events/Never Events:** Accidents that happen in hospitals that are considered preventable.

**Allowed Benefits:** Benefits available for health care services received when a covered person is not confined to a hospital bed as an inpatient. Examples include outpatient care, emergency room care, home health care and pre-admission testing.

**Ambulatory Services:** A wide range of health care services, including preventive care, acute care, surgery and outpatient care, in a medical care facility. Services do not require an overnight hospital stay.

**Ambulatory Surgery:** Surgery which does not require an inpatient hospital admission for convalescence or recuperation. May also be referred to as one-day, same-day or outpatient surgery.

**Ancillary Services:** Hospital services other than bed, board and nursing care. Examples include drugs, dressings, operating room services, special diets, radiology, laboratory examinations, anesthesia and medications. Ancillary may include inpatient ancillary services, but also commonly includes services provided by ancillary providers in the home or outpatient setting (i.e., free-standing ambulatory surgical facility, radiology, laboratory and/or home health care).

**Appeal:** A process used by a patient or provider to request the health plan to reconsider a claim decision.

**Assignment:** The provider has agreed to accept Medicare's allowed amount as payment-in-full for the service rendered. The provider may not balance bill for these services. This amount may be reduced by specific coinsurance and deductible amounts to be paid by the member.

**Attending Physician:** Physician primarily responsible for the care of a patient in a health care setting (e.g. during hospitalization).

**Authorization:** Approval necessary for designated procedures or hospital admissions. When care is received in-network, the primary care physician or specialist is usually responsible for obtaining pre-authorization. For out-of-network services, the member is responsible for obtaining pre-authorization.

**Balance bill:** Refers to the leftover sum that a provider bills to the patient after insurance has only partially paid the charge that was initially billed.

**Benefit:** Any service or supply covered by the member's health insurance plan or contract.

**Benefit Period:** A period of time for which covered services (or benefits) are eligible for payment.

**Benefits Administrator:** Individual responsible for handling employee health benefits for the employer.

**Carrier:** Commercial insurance company or a Medicare claims agent.

**Carve-Out Benefits:** Coverage stipulating that Medicare-eligible members of a group receive benefits at least equal to benefits received by non-Medicare group members. Members are reimbursed up to the group's contract limitations, less what Medicare paid or would have paid if the member were Medicare-eligible and Medicare were the primary coverage.

**Calendar Year Deductible:** The dollar amount for covered services that must be paid during the calendar year (January 1 – December 31) by members before any benefits are paid by the plan.

**Case Management:** Assignment of health insurance plan staff to help a member manage chronic or severe medical conditions.

**Centers of Expertise (COE) Network:** The network of health care providers that have entered into contracts with the carrier and/or one or more of its affiliates. These providers have agreed to participate in a transplant program or other designated specialty program that is/are to be based upon the member’s benefit agreements.

**Claim:** A request for payment for benefits received or services rendered. Either the member or the provider submits claims to the carrier.

**COBRA - Consolidated Omnibus Budget Reconciliation Act of 1986:** Federal legislation that includes a requirement for groups with 20 or more employees to offer extended health insurance coverage at the member's expense to members and eligible dependents who leave the group or are otherwise no longer eligible for the group's coverage.

**Coinsurance:** An arrangement under which the member pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable charge, with the member responsible for the remaining 20%, which is then referred to as the coinsurance amount.

**Coinsurance Maximum:** The total amount of coinsurance that an individual pays each year before the carrier pays 100% of allowable charges for covered services. Coinsurance amounts differ with each contract.

**Continuity Coverage:** Procedure by which individuals transferring from one insurance plan to another are allowed uninterrupted coverage from the date of original enrollment.

**Coordination of Benefits:** The anti-duplication provision to limit benefits for multiple group health insurance in a particular case to 100% of the covered charges and to designate the order in which the multiple carriers are to pay benefits. Under a COB provision, one Plane is determined to be primary and its benefits are applied to the claim. The unpaid balance is usually paid by the secondary Plan to the limit of its liability.

**Co-Payment:** The fixed dollar amount a patient pays for a medical service.

**Contract:** A legal agreement between an individual subscriber or an employer group and a health plan that describes the benefits and limitations of the coverage.

**Coordination of Benefits (COB):** Contractual provision which reduces the benefits under one contract to the extent that those benefits are available under a second contract. The purpose is to prevent double payment for one service. See Duplicate Coverage.

**Cosmetic:** A term that describes the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma or previous therapeutic intervention.

**Cost Sharing:** Health insurance policy provisions that require insured individuals to pay some portion of covered medical expenses. Examples are deductibles, coinsurance and copayments.

**Covered Person:** Person, including eligible dependents, entitled to benefits under the contract and also known as the "insured."

**Covered Services:** Applies to services or supplies specified in the contract for which benefits are available under the member's plan**.**

**Custodial Care:** Care which is provided primarily to meet the personal needs of the patient. Custodial Care does not require the continuous attention of skilled medical or paramedical personnel. Such care includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administering medicine or any other care that does not require continuing services of medically trained personnel.

**Deductible:** An amount the covered person must pay before payments for covered services begin. The deductible is usually a fixed amount. For example, an insurance plan might require the insured to pay the first $250 of covered expense during a calendar year.

**Dependent:** Person, (spouse or child), other than the subscriber who is covered under the subscriber's benefit certificate.

**Dependent Coverage:** Health insurance coverage extended to the spouse or partner and unmarried children of the primary insured member. Certain age restrictions on the coverage of children may apply.

**Disease Management:** Programs for members with chronic health conditions. Services range from quarterly mailings to case management with 24-hour access by phone to a support nurse.

**Durable Medical Equipment (DME):** Goods, implements, prosthetics, etc., that are prescribed for patient care, usually in an outpatient setting. Examples of such equipment include hospital beds, wheelchairs and walkers.

**Effective Date:** The date on which health care coverage begins.

**Elective Surgery:** Surgery for a condition that is not considered an emergency.

**Eligibility:** Insured person's qualification for coverage as an eligible member under the contract at the time health care is rendered.

**Eligibility Period:** Period of time before a group member becomes eligible for benefits. This is defined by each group.

**Emergency Care:** Care for patients with severe or life-threatening conditions that require immediate intervention.

**Emergency Service**: Procedure that must be performed in a situation that is serious or life-threatening for the patient.

**Enrollee:** An individual who is enrolled and eligible for coverage under a health plan contract. Also known as the "insured."

**Enrollment**: Process by which a person completes an enrollment form or application in order to become a member of health insurance coverage under a contract

**Evidence of Coverage:** A summary detailing the terms, conditions and limitations of your group coverage.

**Exclusion:** Specific circumstances or services listed in the contract for which benefits will not be provided.

**Experimental Procedures:** Any service or supply that is in the developmental stage or is in the process of human or animal testing.

**Explanation of Benefits (EOB):** A form sent to the covered person after a claim for payment has been processed by the carrier that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, or the claims appeal process.

**Fee-for-Service Payment System:** A system in which the insurer will either reimburse the group member or pay the provider directly for each covered medical expense after the expense has been incurred.

**Flexible Spending Account:** Accounts that let workers set aside pre-tax money from their paycheck toward premiums or costs not covered by their health plan, such as co-payments. All the money must be used within the plan year or it is lost.

**Formulary:** A formulary is a preferred list of drugs.

**Group:** The employer company, organization or association that contracts with your insurance company to provide health benefits to eligible employees and their dependents.

**Group Contribution/ Employee Contribution:** Portion of premiums that an employer or other group entity pays toward the cost of its members' and/or dependents' coverage.

**Group Number:** Group-specific identification number.

**Health Assessment:** More companies are asking workers to fill out such assessments, which give health improvement tips. Companies can give workers financial incentives to do so.

**Health Benefit Plan:** The health insurance product offered by a health insurance company. It is defined by the benefit contract and represents a set of covered services and a provider network.

**Health Insurance Portability and Accountability Act (HIPAA):** A federal health benefits law passed in 1996, effective July 1, 1997, which among other things, restricts pre-existing condition exclusion periods to ensure portability of health-care coverage between plans, group and individual; requires guaranteed issue and renewal of insurance coverage; prohibits plans from charging individuals higher premiums, co-payments, and/or deductibles based on health status.

**Health Savings Account:** The accounts are paired with a high deductible. Employees can fund these accounts, tax-free, to help offset the deductible. Employers can also fund such plans. Money not used within the plan year is rolled over to the next year.

**Hospice:** Program or facility that provides medical care and support services for terminally ill patients and their families. The hospice provides services either directly or on a consulting basis with the patient's physician or a community agency.

**Hospital:** An institution whose primary function is to provide inpatient, diagnostic and therapeutic services. The services are for a variety of medical conditions, both surgical and non-surgical. In addition, most hospitals provide some outpatient services, particularly emergency care.

**ID Card/Identification Card:** A card issued by a carrier to a covered person, which allows the individual to identify himself or his covered dependents to a provider for health care services. The card is subsequently used by the provider to determine benefit levels and to prepare billing statement.

**IBNR:** An acronym for “incurred but not reported”. This is an accounting estimate used by health plans to accrue for care that was provided “incurred” in one accounting period, but not paid or “reported” until another accounting period.

**In-Network:** Refers to the use of providers who participate in the carrier’s provider network. Many benefit plans encourage covered persons to use participating (in network) providers to reduce the individual’s out of pocket expense.

**Incidental Procedures:** Procedures carried out at the same time as a primary procedure that are clinically integral to the performance of the primary procedure. A participating provider has contractually agreed to write-off the charges.

**Indemnity Plan:** Also called a "fee-for-service" plan. Members typically pay a set percentage of the allowed benefit. Typically, members can see any provider they choose. The insurance reimburses the member, or pays the provider directly. These plans may involve more paperwork and out-of-pocket expenses for the member.

**Inpatient:** Person admitted to the hospital to receive hospital services, including room, board and general nursing care.

**Insured:** Person, including dependents, covered by a contract. Also known as "covered person" or "member."

**Lifetime Maximum:** Maximum amount the plan will pay toward a member’s coverage in a lifetime.

**Limitation:** Specific circumstances or services listed in the contract for which benefits will be limited.

**Mail Order Program:** Used as an alternative to retail pharmacies, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member’s home.

**Maintenance Program:** A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma.

**Mandated Benefits:** Specific component of health care coverage required by state or federal government.

**Maximum Annual Copayment:** The limit on the amount of money a member spends in copayments in a calendar year for covered in-network expenses.

**Medical Underwriting:** The process of reviewing each applicant's personal health history and current health status to determine enrollment eligibility.

**Medically Necessary:** The term "medically necessary" describes the use of a service or supply which is: commonly and customarily recognized as appropriate in the diagnosis and treatment of a member's/ subscriber's illness or injury; appropriate with regard to standards of good medical practice; not solely for the convenience of the member/subscriber, his or her physician, hospital or other health care provider; and the most appropriate supply or level of service which can be safely provided to the member/subscriber.

**Medicare:** A national, federally-administered health insurance program covering the cost of hospitalization, medical care, and some related health services for most people over age 65 and certain other eligible individuals.

**Medicare Approved Charge:** Amount on which Medicare bases its payment for medical services. It is the lower of either Medicare's fee schedule or the doctor's or suppliers actual charge for a service or supply.

**Medicare Eligible Employees:** All eligible employees over 65 that are not TEFRA eligible, as well as any retirees over 65. Medicare would be the primary coverage for these individuals.

**Medicare Supplement Contract:** Health insurance plan available to Medicare eligible to cover the costs of physicians' services and other medical and health services not covered by Medicare.

**Member:** An eligible individual who is enrolled in an insurance plan. A member may be a subscriber or a dependent.

**Network:** A group of multi-specialty medical groups and individual practice doctors that are contracted to provide services to members of a health plan.

**Network Provider:** A medical provider who has contracted with a health plan as a participating provider.

**Negotiated Rate:** The amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

**Non- Participating Provider:** A medical/ dental provider who has not contracted with a particular health plan within its participating provider network. The member is responsible for the total charge for services rendered. See Participating Provider.

**Not Medically Necessary:** Describes the use of a service or supply which does not meet the criteria for determining medical necessity. See Medically Necessary.

**Out-Of-Network:** The use of health care providers who have not contracted with the carrier to provide services.

**Out-of-Pocket Limit or Out-of-Pocket Maximum:** The maximum dollar amount a member will pay out-of-pocket in coinsurance, copays and/or deductibles in a calendar year for covered indemnity expenses. Once the out-of-pocket limit is met, the plan pays 100% of the allowed amount for covered services for the rest of the benefit period.

**Out Patient**: Patient who receives hospital care without being admitted as an inpatient.

**Out Patient Surgery:** Surgical procedures performed that do not require an overnight stay in the hospital or ambulatory surgery facility. Such surgery can be performed in the hospital, surgery center or physician's office.

**Participating Provider:** A physician, hospital, pharmacy, laboratory or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a health benefit plan.

**Plan Allowance (Allowed Amount of Allowable Charge):** The maximum dollar amount a contract allows for services covered, regardless of the provider's actual charge. A provider who participates in the network cannot charge the member more than this amount for any covered service.

**Pre-Authorization:** A procedure use to review and assess the medical necessity and appropriateness of elective hospital admissions and non-emergency outpatient services before the services are provided.

**Pre-Existing Condition:** An illness or condition that you or another member had prior to applying for health insurance. In some cases, these conditions may be subject to a waiting period for benefits or excluded from coverage.
**Premiums:** Periodic amounts paid by or on behalf of members for ongoing health care coverage. It does not include any deductibles or copayments the plan may require.

**Preventative Care:** Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms.

**Prior Authorization List:** This is a list of brand name and generic prescription drugs and used by providers and pharmacists when writing and filling prescriptions. Prior Authorization is used to insure the appropriate use of medications that have specific indications, safety concerns, or have a high potential for overuse.

**Provider:** Person, organization or institution licensed to provide health care services.

**Reasonable and Customary:** The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community) and the reasonable cost of services for a given patient after medical review of the case. Also known as Usual and Customary (U&C) or Customary and Reasonable (C&R).

**Reconstructive:** A term that describes procedures performed on structures of the body to improve or restore bodily function or to correct deformity resulting from disease, trauma or previous therapeutic intervention.

**Referral:** A written recommendation by a physician that a member may receive care from a specialty physician or facility.

**Schedule of Allowances:** List of dollar amounts payable for medical and surgical procedures performed by a provider.

**Second Opinion:** The option or recommendation to visit another physician or surgeon regarding diagnosis, course of treatment or having specific types of elective surgery performed.

**Second Surgical Opinion (SSO):** Included among the features of Medical Management programs, SSO provides coverage for a second opinion from a qualified surgical specialist to group members seeking elective surgery. Mandatory SSO requires that group members seek the second opinion.

**Self- Insurance:** Practice of an individual, group of individuals, employer or organization that assumes complete responsibility for losses, which might be insured against, such as health care expenses. In effect, "self-insured" groups have no real insurance against potential losses and instead maintain a fund out of which is paid the contingent liability subject to self-insurance.

**Specialist:** A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

**Subscriber:** The individual in whose name a contact is issued or the employee covered under an employer's group health contract.

**TEFRA (Tax Equity and Fiscal Responsibility Act of 1982):** Requires employers with 20 or more employees to offer active employees and their spouses aged 65-69 the same level of health care benefits offered to younger employees. These employees will have their regular group coverage as primary and Medicare as secondary.

**Termination Date:** The date indicated in an insurance contract as the date coverage expires.

**Urgent Care:** A condition that requires prompt medical attention, but is not a threat to life or limb.

**Utilization Management:** Managing the use of medical services to ensure that a patient receives necessary, appropriate high-quality care in a cost-effective manner.

**Utilization Review:** The evaluation of the medical necessity, efficiency and/or appropriateness of health care services and treatment plans.

**Wellness Program:** A health management program which incorporates the components of disease prevention, medical self-care and health promotion.