Glossary

Carrier/vendor fair
An event where representatives from plan providers are available to answer questions about coverages provided by their plans.

Claim
Request for payment that the member or their health care provider submits to the health insurer, when services or supplies believed to be covered are provided.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
Federal law that allows you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee or another qualifying event.

Co-insurance
Percentage of allowed charges for covered services a member is required to pay after the deductible has been met and up to the out-of-pocket maximum. For example, health insurance may cover 70% of charges for particular service; the member is responsible for the remaining 30%. In this example the 30% is the co-insurance.

Consumer-Driven Health Plan (CDHP)
Health insurance plan which encourages members to become actively involved in making their own healthcare decisions (i.e., selecting healthcare providers with the lowest cost and highest quality, when receiving services and managing their own fitness and wellness). This type of plan features higher deductibles compared to that of what is known as traditional insurance plans. CDHPs can be paired with a health savings account (HSA) to allow a member to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Deductible
Dollar amount an employee must pay for medical and prescription services before their health insurance plan begins to pay. This amount varies based upon the plan and coverage level chosen by the employee. These costs can be covered pre-tax by the funds in a HSA if the health plan is a CDHP. Otherwise, they are paid by the employee's personal financial means.

Dependent(s)
Dependents of eligible employees may be covered under the state's benefit plans and are defined as:

1. Spouse: An individual to whom you are legally married. IC 31-11-8-5 provides: a marriage is void if the marriage is a common law marriage that was entered into after Jan. 1, 1958. Employees are not allowed to claim dependents based on common law marriages. An ex-spouse is not eligible for coverage even if court ordered.
2. Children: Natural-, step-, foster, or legally adopted children; children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian or awarded legal custody by a court, until the end of the month in which they turn 26.
3. Age limitation: Dependent children are eligible for coverage until the end of the month in which they turn 26.
4. Disabled dependent: If the dependent child is both incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon the employee for support and maintenance prior to age 19, the dependent child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the maximum agae is attained. Coverage for the dependent will continue until the employee discontinues his coverage or the disability no longer exists.

   A dependent child of the employee who attained age 26 while covered under another health care policy and met the disability criteria specified above, is an eligible dependent for enrollment so long as no break in coverage longer than 63 days has occurred immediately prior to enrollment. Proof of disability prior to age 19 and proof of prior coverage will be required. The plan requires annual documentation from a physician after the child's attainment of the limiting age.

Adult relatives: Even in situations where the employee possesses a court order or legal guardianship, adult relatives (e.g. father, mother, aunt, uncle, niece, nephew) do not qualify as dependents and are not eligible for benefits through the state of Indiana - except under the Dependent Care Spending Account.

Dependent Care (Flexible Spending Account)
FSA established to pay for certain expenses to care for the dependents of an employee while working (married spouse must be employed as well). While this most commonly means child care, for children under the age of 13, it can also be used for children of any age who are physically or mentally incapable of self-care. It can additionally be used for adult day care for senior citizen tax dependents who reside with the employee, such as parents or grandparents. The maximum annual contribution limit is $5,000.

Dual coverage
Enrollment of a member in more than one State-sponsored insurance plan with the same type of benefits. The state does not allow its employees to have dual coverage.

Employer contribution
Fees paid by an employer toward the cost of its employees' coverage.

Enrollee/subscriber/member
With the state of Indiana, the employee is the enrollee.

Enrollment
Process by which an employee chooses the insurance plans/

coverage that best meets their needs. State employees do this online through the PeopleSoft system.

Exclusion
Specific listed services or circumstances that are defined in the insurance contract for which benefits will not be provided.

Explanation of Benefits (EOB)
Statement provided to the member by the health insurance plan explaining the benefit calculations and payment of medical services. It details services rendered and benefits paid or denied for each claim submitted. An EOB lists the charges submitted, amount allowed, amount paid and any balance possibly owed as the patient's responsibility.

Family coverage
An employee and at least one eligible dependent enrolled in an insurance plan.

Family and Medical Leave Act (FMLA)
Federal law that guarantees up to 12 weeks of job-protected leave for employees if they need to take time off due to serious illness or disability, have/adopt a child or to care for another family member.

Family status change/qualifying event
Personal change in status which may allow an employee to modify their benefit elections.

Examples are, but not limited to, the following:

1. Change in legal marital status – marriage, divorce, legal separation, annulment or death of a spouse
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
3. Change in employment status of the employee's spouse or employee's dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage
4. Dependent satisfies or ceases to satisfy eligibility requirement – such as attainment of the limiting age. See DEPENDENT.

Qualifying events are defined by the IRS and must be reported to the Benefits Hotline within 30 calendar days of the event occurring.

Flexible Spending Account (FSA)
Account offered to employees which allow a fixed amount of pre-tax money to be set aside for qualified medical expenses. That amount must be determined in advance and employees pay it back over the course of the 26 pay periods of the calendar year. Any money not spent out of the account by the end of the calendar year is lost to the employee. The maximum annual contribution limit is $2,500.

Formulary
A list of medications that are approved to be prescribed under a prescription drug plan. The development of formularies is based on evaluations of efficacy, safety and cost-effectiveness.

Front-load (HSA)
Initial contribution the state makes into an employee's HSA. The state front loads approximately 50% of its annual contribution commitment into the employee's HSA at the beginning of each calendar year. The remainder of the contribution is divided among the remaining 26 pay periods. See HEALTH SAVINGS ACCOUNT or further information.

Health Insurance Portability and Accountability Act (HIPAA) of 1996
Designed to streamline all areas of the health care industry and to provide additional rights and protections to participants in health plans.

Health Savings Account (HSA)
Account created for employees covered under a CDHP to save for medical expenses with pre-tax contributions, made by the state and can be made by the employee. Contributions can also be made by third parties. If an employee chooses to contribute to the HSA, that money is deducted from their pay check on a pre-tax basis. The amount that the employee contributes can be changed at any time throughout the year by contacting the Benefits Hotline. The maximum contribution limit for a HSA paired with a single coverage CDHP is $3,350; for family coverage, the limit is $6,650. This includes contributions from the state, the employee and any third-part contributions. Employees 55 and older may make an additional $1,000 catch-up contribution until they enroll in Medicare. The money in the HSA can be used to pay for qualified medical expenses, which include most medical care such as dental, vision and prescription drugs. Any money not spent out of the account by the end of the calendar year rolls over and remains in the account until it is spent. If the money in an HSA is used for anything other than qualified medical expenses, it can become a taxable event. Eligible medical expenses are defined by the IRS and can be found in Publication 929.

Immunizations
Vaccines against certain diseases, which can be administered either orally or by injection (i.e., flu shots).

In-network
Healthcare providers who contract with the insurance plan to provide services at a discounted rate.

Limited Purpose Medical Spending Account (Flexible Spending Account)
If someone has an HSA and elects to have a Flexible Spending Account (FSA), the FSA becomes a Limited Purpose Medical Spending Account. Expenses under the Limited Purpose Medical Spending Account are limited to:

- Dental care services/treatments,
- Vision care services/treatments,
- Preventive care services - limited to diagnostic procedures and services or treatment taken to prevent the onset of a disease or condition that is immediately possible. This

does not include services/treatments to treat an existing condition. A diagnosis or letter of medical necessity may be required to consider claim reimbursement. See also Flexible Spending Account

Mail order pharmacy
Alternative to retail pharmacies, members can order and refill prescriptions via mail, Internet, fax or telephone in 90-day quantities. Prescriptions are mailed directly to the member's home. All state health insurance plans cover mail order pharmacy through Express Scripts or the pharmacy benefit provider.

Maintenance drug
Medication anticipated to be taken on an ongoing basis for at least several months to treat a chronic condition such as diabetes, high blood pressure, asthma, etc.

Medical Flexible Spending Account
See *Flexible Spending Account*

Member
Eligible individual enrolled in an insurance plan; member may be the employee or any dependent.

Network
Group of medical professionals contracted to provide services to members of a health insurance plan.

Non-Tobacco Use Incentive
Agreement to which an employee commits and signs (electronically) to not use tobacco for the benefit year and agrees to random tobacco testing. The incentive is only available to employees enrolled in medical coverage.

If an employee accepts the Non-Tobacco Use Incentive and later uses tobacco, that employee will be terminated. The only exception to the job loss penalty is if the employee revokes the agreement by logging in to PeopleSoft and completing the self-service process to revoke their agreement prior to the use of any tobacco product.

Open Enrollment
Specific time of year when employees can enroll in state-offered benefits.

For the State, this usually fall from the end of October through the middle of November. Email notifications are sent out to all employees to notify them of these dates.

Out-of-pocket costs
Expenses for medical care that are not reimbursed by insurance. This includes all deductibles and co-insurance paid under the insurance plan. Costs can be covered pre-tax by the funds in a HSA if the health plan is a CDHP or FSA. Otherwise they are paid by the member's personal financial means.

Out-of-pocket maximum
Limit set on each insurance plan that caps the maximum a member has to pay for medical services during a calendar year. This includes all deductibles and co-insurance paid under the insurance plan. These costs can be covered pre-tax by the funds in a HSA if the health plan is a CDHP or FSA. Otherwise they are paid by the member's personal financial means. Premiums do not count toward out-of-pocket maximums. Employees must still pay premiums, even if they meet their out-of-pocket maximum.

Participating provider
Individual physicians, hospitals and professional health care providers who have a contract to provide services to a network's members at a discounted rate and to be paid directly for covered services. See *Network.*

Prior-authorization
Approval required for specifically 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.

Premium
Amount each employee pays for an elected health plan.

Prescription medication
FDA-approved medicine regulated by legislation to require a medical prescription before it can be obtained.

Preventive care/services
Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Services are covered 100% by all insurance plans by law (i.e. annual physicals, well baby visits, flu shots, etc.).

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

Self-insurance
Practice of an employer 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. The state is self-insured.

Termination of Coverage Date
The actual date the coverage ceased.

Webinar
Short for web-based seminar; a presentation, lecture, workshop or seminar that is transmitted over the Internet.

Wellness program
Health management program which incorporates the components of disease prevention, medical self-care and health promotion.