

GLOSSARY OF TERMS



Balance Billing – Out-of-network reimbursements are based on a maximum allowable fee schedule. If the provider’s charge exceeds the maximum allowable fee schedule amount, you pay the excess amount as out-of-pocket expenses.

Beneficiary – means the person or entity designated by the participant to receive any death benefits payable under the terms of any benefit plan.

CHEIBA Trust – The Colorado Higher Education Insurance Benefits Alliance Trust (CHEIBA Trust) is a benefit purchasing consortium and trust made up of Adams State University, Auraria Higher Education Center, Colorado School of Mines, Colorado State University - Pueblo, and Colorado State University - Global Campus, Fort Lewis College, Metropolitan State University of Denver, University of Northern Colorado and Western State Colorado University.

CHEIBA Trust Committee – The Trust Committee was formed pursuant to Article III of the Colorado Higher Education Insurance Benefits Alliance Trust (CHEIBA Trust) Agreement. Each participating college shall designate one of its Employees to serve as a Trustee and member of the Trust Committee.

Copayment – a cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as \$15 for an office visit. The covered person is usually responsible for the charge at the time the health care is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayments are flat or variable dollar amounts and coinsurance is a defined percentage of the charges rendered.

Coinsurance – the portion of covered health care costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – is a federal law that, among other things, requires employers to offer continued health insurance coverage to certain Employees and their beneficiaries whose health insurance coverage has terminated.

Creditable Coverage – under the simplified method, a prescription drug plan is deemed to be creditable if it:

- 1) Provides coverage for brand and generic prescriptions;
- 2) Provides reasonable access to retail providers and, optionally, for mail order coverage;
- 3) It is designed to pay on average at least 60% of participants’ prescription drug expenses; and
- 4) Satisfies at least one of the following:

For plans that are not integrated (a plan that provides Rx benefits that are separate from the medical plan, i.e., does not share a common deductible):

- a) The prescription drug coverage has no annual benefit maximum or a maximum benefit payable by the plan of at least \$25,000, or
- b) The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least \$2,000 per Medicare eligible individual in 2008.

For integrated plans (a plan where medical and Rx expenses are subject to the same deductible):

- a) For entities that have integrated health coverage, the integrated health plan has no more than a \$250 deductible per year, has no annual benefit maximum or has a maximum annual benefit payable by the plan of at least \$25,000 and has no less than a \$1,000,000 lifetime combined benefit maximum.

Deductible - the amount of eligible expenses a covered person must pay each year from his/her own pocket before the plan will make payment for eligible benefits.

Drug Formulary – a listing of prescription medications which are preferred for use by the health plan and which will be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan. A plan that has adopted an “open or voluntary” formulary allows coverage for both formulary and non-formulary medications. A plan that has adopted a “closed, select or mandatory” formulary limits coverage to those drugs in the formulary.

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Federal Family and Medical Leave Act (FMLA) – This Act requires an employer which employs 50 or more employees (within a 75-mile radius) to allow an employee who has been employed for at least 12 months by the employer and for at least 1,250 hours of service with such employer during the previous 12-month period, to take a total of 12 weeks of leave during any 12-month period, as defined by the employer for:

- 1) the birth of a child;
- 2) the placement of a child with the employee for adoption or foster care;
- 3) the care for a spouse, child or parent of the employee if the individual has a serious health condition; or
- 4) a serious health condition which prevents the employee from performing the function of his/her regular position.

Flexible Spending Accounts – tax-free accounts which allow Employees to set aside pre-tax dollars from their gross wages to later be reimbursed tax free for eligible expenses incurred during the Plan Year. Unclaimed dollars are forfeited to the employer. Accounts include a Health Care Spending Account for out-of-pocket health care expenses for the family and a Dependent Care Spending Account for dependent care expenses necessary to employment. There is also a pre-tax insurance payments process which allows Employees to use their pre-tax dollars to pay their share of all the CHEIBA Trust sponsored health-related insurance premiums.

Generic Drug – a chemically equivalent copy designed from a brand name drug whose patent has expired. A generic is typically less expensive and sold under a common or “generic” name for that drug (e.g., the brand name for one tranquilizer is Valium, but it is also under the generic name diazepam). *Also called generic equivalent.*

Health Maintenance Organization (HMO) - an entity that provides, offers or arranges for coverage of designated health services needed by Plan members for a fixed, prepaid premium. There are four basic models of HMOs: group model, individual practice association, network model and staff model. Under the federal HMO Act, an entity must have three characteristics to call itself an HMO: an organized system for providing health care or otherwise assuring health care delivery in a geographic area, an agreed upon set of basic and supplemental health maintenance and treatment services and a voluntary enrolled group of people.

Health Savings Account – An HSA is a tax-favored savings account that, when paired with a qualified High Deductible Health Plan (HDHP), allows you to pay for qualified medical expenses, or leave funds invested in the account for future medical expenses tax-free. An HSA account is a personal, portable account and remains in your control regardless of your employment. A Health Savings Account can be established through any qualifying financial institution. Please contact your financial advisor or banking institution for more information.

High Deductible Health Plan – A High Deductible Health Plan is a health insurance plan that has a high minimum deductible which does not cover the initial costs or all of the costs of medical expenses. The deductible must be met by the insurance holder before the insurance coverage kicks in.

HIPAA - HIPAA is the “Health Insurance Portability and Accountability Act of 1996”. HIPAA is federal legislation designed to improve the portability of health coverage, to make system administrative simplification changes and to protect privacy rights.

In-Network Services – health care delivered by a participating provider who has contracted with the health plan to deliver medical services to covered persons.

Medicare Part “D” – prescription drug benefit provisions (Medicare Part D) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Part D prescription drug program is available to Medicare beneficiaries.

Out-of-Network Services – health care delivered by a non-participating provider who has not contracted with the health plan.

Out-of-Pocket Costs / Expenses – the portion of payments for health services required to be paid by the enrollee, including copayments, coinsurance and deductibles.

Out-of-Pocket Limit – the total payments toward eligible expenses that a covered person funds for himself/herself and/or Dependents: i.e., deductibles, copayments, and coinsurance, as defined per the contract. Once this limit is reached, benefits will increase to 100% for health services received during the rest of that calendar year. Some out-of-pocket costs (e.g., mental health, penalties for non-pre-certification, etc.) are not eligible for out-of-pocket limits.

Plan Year – the CHEIBA Trust Plan year is a calendar year.

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Point-of-Service (POS) Plan – a health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. Point-of-Service can be provided in several ways:

- an HMO may allow members to obtain limited services from non-participating providers;
- an HMO may provide non-participating benefits through a supplemental major medical policy;
- a PPO may be used to provide both participating and non-participating levels of coverage and access; or
- various combinations of the previous options may be used.

Preferred Provider Organization (PPO) – is a network of physicians and hospitals who have agreed to a set fee schedule, thereby saving money for the covered person.

Primary Care Physician (PCP) – a physician the majority of whose practice is devoted to internal medicine, family/general practice and pediatrics. A primary care physician is accountable for the total health services of enrollees, arranges referrals and supervises other care, such as specialist services and hospitalization.

Trust or Trust Agreement – refers to the CHEIBA Trust, as defined above.