INSURANCE TERMS
GLOSSARY

This list contains commonly used insurance terms and is not intended to exhaustive. This list is intended to be an easy-to-use reference. The Summary Plan Description (SPD) and other materials specific to your Plan supersede this general information. Refer to the Plan Document for specific-benefit related terms.

accident

An unexpected traumatic incident or unusual strain which is:

- Identified by time and place of occurrence
- Identifiable by part of the body affected, and
- Caused by a specific event on a single day

active service

An employee is in service with the Participant Group on a day which is one of the Participant Group's regularly scheduled work days and that the employee is performing all of the regular duties of his/her employment with the Participant Group on a regular basis, either at one of the Participant Group's business establishments or at some location to which the Participant Group's business requires him/her to travel.

adverse benefit determination

A denial, decrease or ending of a benefit. This includes a failure to provide or make payment (in whole or in part) for a benefit including claims based on medical necessity or experimental and investigational exclusions.

Affordable Care Act

A comprehensive law passed in 2010, aimed at reforming America's health care system to improve access and affordability for more Americans.

air ambulance

Any form of aircraft equipped with medical supplies, equipment and qualified medical professionals that will provide mobile medical care to a patient during transport to a medical facility specialized in responding to the medical needs of the patient in transport. Air ambulances are largely used in emergency medical situations or situations where timing is of the essence in helping a patient receive treatment.

allowable fee

The maximum amount a health care plan will reimburse a doctor or hospital for a given service.

annual limit

An insurance plan may limit the dollar amount it will pay during one year for a certain treatment or service, or for all benefits provided in a year.

balanced billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A participating provider will not balance bill you for covered services.

benefit period

A time period as shown in the Schedule of Benefits. For the Participant, it is the same as for the contract except if the Participant's effective date is after the effective date for the contract; the Benefit

Period begins on the Participant's effective date and end on the same date the contract Benefit Period ends. Such Benefit Period will terminate on the earliest of the following dates:

- The last day of the time period so established, or
- The date the Plan terminates

care management

A process that assesses and evaluates options and services required to meet the Participant's health care needs. Care Management may involve a team of health care professionals, including Covered Providers, The Plan and other resources to work with the Participant to promote quality, cost-effective care.**certificate of creditable coverage**

A certificate issued by a group health plan that describes a person's prior period(s) of creditable health care coverage as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

claim

. Any request for a Plan benefit made by you or your authorized representative. A Participant making a claim for benefits is a claimant.

claim form

A form you or your doctor fill out and submit to your health care benefits plan for payment.

COBRA

This stands for Consolidated Omnibus Budget Reconciliation Act of 1985. This federal act requires group health care plans to allow employees and covered dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, termination of employment, a child becoming an over-aged dependent, Medicare eligibility, death or divorce of a covered employee.

coinsurance

A percentage of a covered service that you are responsible for paying or the percentage paid by your plan.

contracting hospital

A hospital that has contracted with a particular health care plan to provide hospital services to members of that plan.

copayment

A specific dollar amount you are required to pay for covered services at the time you receive care.

coordination of benefits

A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.

covered medical expense

Expenses incurred for Medically Necessary services, supplies, and medications that are based on the Allowable Fee and are:

1. Covered under the Plan and not more than a benefit maximum

2. In accordance with BCBSMT Medical Policy, and
3. Provided to the Participant by and/or ordered by a covered provider for the diagnosis or treatment of an active illness or Injury or in providing maternity care or covered preventive services

In order to be considered a Covered Medical Expense, the Participant must be responsible for charges for such services, supplies, and medications.

covered person

Any Participant or Dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

deductible

The dollar amount each Participant must pay for Covered Medical Expenses incurred during the Benefit Period before the Plan will make payment for any Covered Medical Expense to which the Deductible applies.

Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. Thus, Coinsurance, Copayment, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Participant's responsibility.

If two or more Participants covered under the same Employee health plan satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Participant of the Employee's health plan.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, only one Deductible will be applied to that Hospital stay (facility charges only). If the Participant satisfied the Participant's Deductible prior to that Hospital stay, no Deductible will be applied to that stay.dependent

- the beneficiary Participant's Spouse;
- the beneficiary Participant's unmarried or married child up to age 26, including an eligible foster child;
- children for whom the beneficiary Participant becomes legally responsible by reason of placement for adoption, as defined in Montana law; or
- an unmarried child of the beneficiary Participant who is 26 years of age or older and disabled.

For purposes of this contract the unmarried child will be considered disabled if the child:

- was covered under this Contract before age 26;
- cannot support himself/herself because of intellectual disability or physical disability; and
- is legally dependent on the beneficiary Participant for support.

Proof of those qualifications must be supplied to the Plan within 31 days following the child's 26th birthday. Although there is no limiting age for disabled children, the Plan reserves the right to require periodic certification from the beneficiary Participant of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child's 26th birthday.

domestic partners

Two individuals, either opposite- or same-sex, who meet all of the following criteria:

- Are 18 years of age or older and each has the capacity to enter into a contract
- Has had joint ownership or joint tenancy of a residence together for at least the most recent 12 consecutive months, and such residence has served as the primary place of residence for each of them during the same period
- Neither party meets the MUST eligibility requirements of a Spouse or Dependent child
- Neither party is in a parental relationship with the other
- Neither party is related by blood or marriage to the other, and
- Have a financially-interdependent relationship with each other as evidenced by at least three (3) of the following:
  - Joint ownership or lease of a motor vehicle
  - Joint liability, such as a loan or credit card (at least one)
  - Mutually granted powers of attorney or mutually-granted health care powers of attorney, or
  - Designation of each other as primary beneficiaries in wills, life insurance policies or retirement annuities

drug list

A list that identifies those Prescription Drug Products that are covered by the Plan for dispensing to Participants when appropriate. This list is reviewed quarterly and subject to modification.

calendar year

The 12-month period beginning January 1 and ending December 31 of the same year.

effective date of coverage

The date your coverage begins. **Please note:** The effective date can also represent the date a change in your coverage takes effect. If you have questions, call the number on the back of your ID card.

emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent person acting reasonably to believe a health condition exists that requires immediate medical attention, and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy

emergency medical condition

Services provided for the initial outpatient treatment of an acute medical condition, usually in a hospital setting. Most health care plans have specific guidelines to define emergency medical care.

employee contribution

The employee portion of the costs for a benefit plan.

employer responsibility

Starting in 2015, if an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through a Health Insurance Marketplace, the employer must pay a fee to help cover the cost of tax credits.

essential health benefits

Some benefits will be included in every insurance plan. Beginning in 2014, most insurance plans you can choose from — whether you buy on the Health Insurance Marketplace or go directly to the insurance company of your choice — will include many benefits that are meant to make sure basic health concerns are covered.

exclusions

Specific medical conditions or circumstances that are not covered under a health care plan.

explanation of benefits (EOB)

An EOB is created after a claim payment has been processed by your health care plan. It explains the actions taken on a claim such as the amount that will be paid, the benefit available, reasons for denying payment and the claims appeal process. EOBs are available both as a paper copy and online.

family coverage

Health care coverage for a primary policyholder/employee (called a "subscriber") and his or her spouse and any eligible dependents.

Federal Poverty Level (FPL)

A level of income issued annually by the Department of Health and Human Services – used to determine eligibility for certain programs and benefits. FPL will be used to determine the amount of tax credit you qualify for to offset the cost of purchasing health insurance.

fiduciary

A person or entity who exercises discretionary authority or control over the management of the plan or its assets or has discretionary authority or responsibility in Plan administration. The fiduciary for the MUST plan is MSSF.

generic drug

A prescription drug that is the generic equivalent of a brand name drug listed on your health plan's formulary and costs less than the brand name drug.

generic substitute

A prescription drug which is the generic equivalent of a drug listed on your health plan's formulary.

group (or participant group)

A group of people covered under the same health care plan and identified by their relation to the same employer or organization.

guaranteed issue

A requirement under the Affordable Care Act that health plans must permit you to enroll in some form of insurance coverage regardless of health status, age, gender or other factors.

Health Insurance Marketplace

The Health Insurance Marketplace, or Health Insurance Exchange, is a federal government website where you can shop, compare and buy plans offered by participating health insurance companies in your area. You can access the Marketplace via healthcare.gov or by phone.

Health Maintenance Organization (HMO)

An organization that provides health care coverage to its members through a network of doctors, hospitals and other health care providers.

health reimbursement account (HRA)

Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account.

health savings account (HSA)

A type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses if you have a high deductible health plan (HDHP).

Combining a HDHP with a HSA allows you to pay for certain medical expenses, like your deductible and copayments, with untaxed dollars. High-deductible plans usually have lower monthly premiums than plans with lower deductibles.

Unlike a flexible spending account (FSA), HSA funds roll over year to year if you don't spend them. You can take the funds with you if you change jobs or leave the work force. The HSA may also earn interest.

high deductible health plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. Usually the monthly premium is lower, but you have to pay more health care costs yourself (your deductible) before the insurance company starts to pay its share. A high deductible plan can be combined with a health savings account (HSA) or a health reimbursement arrangement. This allows you to pay for certain medical expenses with untaxed dollars. The IRS defines a high deductible health plan as any plan with a deductible of at least $1,300 for an individual or $2,600 for a family.

HIPAA

A federal law that outlines the rules and requirements employer-sponsored group insurance plans, insurance companies and managed care organizations must follow to provide health care insurance coverage for individuals and groups.

individual health insurance plan

Health care coverage for an individual with no covered dependents. Also knows as individual coverage.

in-network

Services provided by a physician or other health care provider with a contractual agreement with the insurance company and paid at a higher benefit level.

inpatient services

Services provided when a member is registered as a bed patient and is treated as such in a health care facility such as a hospital.

insurance carrier

The company that issues and assumes the risk of an insurance policy. MUST is an insurance carrier for its health benefit offerings. MUST contracts with other carriers for the life and long-term disability coverages.

insured person

The person who a contract holder (an employer or insurer) has agreed to provide coverage for, often referred to as a member/subscriber.

lifetime limit

A cap on the total lifetime benefits you may get from your insurance company for certain conditions. A health plan may have a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime), or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. Under the health care law, lifetime limits are no longer allowed on essential health benefits, such as emergency services and hospital stays.

Medicaid

A joint federal and state funded program that provides health care coverage for low-income children and families, and for certain aged and disabled individuals.

medical group

A licensed health care facility, program, agency, doctor or health professional that contracts with a health plan to deliver health care services to plan members.

medically necessary

A medical service or supply that meets all the following criteria:

- It is required for the treatment or diagnosis of a covered medical condition
- It is the most appropriate supply or level of service that is essential for the diagnosis or treatment of the patient's covered medical condition
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards
- It is not furnished primarily for the convenience of the patient or provider of services, and
- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.

The fact that a service or supply is furnished, prescribed or recommended by a physician or other provider does not, of itself, make it Medically Necessary. A service or supply may be Medically Necessary in part only.

Medicare

The federal program established to provide health care coverage for eligible senior citizens and certain eligible disabled persons under age 65.

Minimum Essential Coverage (MEC)

The type of health coverage an individual needs to maintain throughout the year in order to meet the individual responsibility requirement under the Affordable Care Act. Health plans that are considered MEC include individual and family plans bought through the Health Insurance Marketplace; qualified

health plans bought directly through an insurance company; job-based coverage; Medicare; Medicaid; and certain other coverage. If you have minimum essential coverage throughout the year, you don't have to pay the tax penalty for being uninsured.

MSSF

Montana School Services Foundation

multi-employer plan

In general, a group health plan that's sponsored jointly by 2 or more employers.

MUST

Montana Unified School Trust

network

The group of doctors, hospitals and other health care professionals that a managed care plan has contracted with to deliver medical services to its members.

non-contracting hospital

A hospital that has not contracted with a particular health care plan to provide hospital services to members in that plan.

off-exchange health plan

A health insurance plan that meets the minimum essential coverage requirements under the Affordable Care Act. These plans are not offered on the Health Insurance Marketplace and are not eligible for the premium tax credit. If you qualify for a premium tax credit and want to use it, you must enroll in an on-exchange plan.

on-exchange health plan

A health insurance plan that meets the minimum essential coverage requirements under the Affordable Care Act and is purchased on a state or federal health exchange. If you qualify for a premium tax credit, you must enroll in an on-exchange plan in order to use it.

open enrollment period

The defined period of time when you are allowed to enroll yourself and/or your dependents for benefit coverage, usually once a year.

out-of-network

Services provided by doctors and hospitals who have not contracted with your health plan.

out-of-pocket maximum

Also called OOPM, this is the most you have to pay out of your own pocket for expenses under your insurance plan during the year. Deductibles, coinsurance, copays and other expenses for in-network essential health benefits (EHBs) apply to the OOPM.

outpatient services

Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

participant

Any eligible employee or other eligible individual enrolled in the Plan. Also referred to as the member, insured or insured person.

Participating Provider Option (PPO)

A health care plan that supplies services at a higher level of benefits when members use contracted health care providers. PPOs also provide coverage for services rendered by health care providers who are not part of the PPO network, however the plan member generally shares a greater portion of the cost for such services.

Plan Administrator

The Plan Administrator for MUST is MSSF and/or its designee. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of eligible Participants and beneficiaries, without discrimination. The Plan Administrator has the power and exclusive authority necessary, at its discretion, to:

- Construe and interpret the Plan Document and to decide all questions of eligibility and participation
- Make all findings of fact for Plan administration, including payment of reimbursements
- Prescribe procedures to be followed and forms to be used by Participants and benefit
- Request and receive from all employees the information necessary for proper Plan administration
- Appoint and employ the individuals or entities to assist in Plan administration as necessary or advisable, including benefit consultants and legal counsel

Plan Document

The document that describes requirements for eligibility and enrollment, covered services, limitations and exclusions, and other terms and conditions that apply to participation in this Plan.

Plan Year

The 12 month period:

- Beginning July 1 and ending the last day of June of the next year for Participant Groups renewing on July 1 of each year, or
- Beginning September 1 and ending the last day of August of the next year for Participant Groups renewing on September 1 of each year

preauthorization

The process by which members or their primary care physicians (PCP) notify the health plan in advance of treatment plans, such as a hospital admission or a complex diagnostic test. Also called pre-notification.

pre-existing condition

A condition, disability or illness that you have been treated for before applying for new health coverage.

pre-notification

The process by which a plan member or their doctor notifies the plan, before the member undergoes a course of care, such as a hospital admission or a complex diagnostic test. Also called pre-authorization.

premium

The ongoing amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly. The premium may not be the only amount you pay for insurance coverage. Typically, you will also have a co-payment or deductible amount in addition to your premium.

premium tax credit

Based on your family size and income, you may qualify for a tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium costs. Sometimes called advanced premium tax credit (APTC), or tax credit. Use our premium tax credit estimator to see if you qualify.

prescription drugs

Prescription drugs must be ordered by a doctor and obtained at a pharmacy. They are reviewed and approved through a formal process set by the U.S. Food and Drug Administration (FDA).

prescription drug list

A list of commonly prescribed drugs (also known as a drug formulary). Not all drugs listed in a plan's prescription drug list are automatically covered under that plan.

preventive services

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

primary care physician (PCP)

The physician you choose to be your primary source for medical care. Your PCP coordinates all your medical care, including hospital admissions and referrals to specialists. Not all health plans require a PCP.

provider

A licensed health care facility, program, agency, doctor or health professional that delivers health care services.

qualified health plan

An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (deductibles, copayments, and out-of-pocket amounts) and meets other requirements.

referral

As applicable to HMO or point of service (POS) coverage, a written authorization from a member's primary care physician (PCP) to receive care from a different contracted doctor, specialist or facility. If you don't get a referral first, the services may not be covered.

specialist

A health care professional whose practice is limited to a certain branch of medicine, including specific procedures, age categories of patients, specific body systems or certain types of diseases.

special enrollment period

A time outside of the open enrollment period during which you can sign up for a health insurance plan. You generally qualify for a special enrollment period of 60 days following certain life events that changes your family status (for example, marriage or birth of a child) or loss of other health coverage.

Summary of Benefits and Coverage (SBC)

An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. Plan SBCs are available at mustbenefits.org.

tax credits

Based on your family size and income, you may qualify for a tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium costs. Sometimes called advanced premium tax credit (APTC) or premium tax credit. Use the BCBSMT premium tax credit estimator to see if you qualify.

wellness program

MUST's wellness program, Healthy Futures, is intended to improve and promote health. The program includes a blood screening and completion of the Total Health Management assessment form to help identify eligible participants' health risks.