ADROIT HEALTH GROUP

GLOSSARY OF COMMONLY USED INSURANCE TERMS

The following terms are commonly used in health insurance policies and the marketing and sales of those policies. In order to avoid confusion and ensure that the consumer has a full understanding of what is being purchased, the following common terms and their associated definitions are provided for reference:

Accident Insurance - insurance for unforeseen bodily injury.

Accident Only - an insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident.

Accident Only or AD&D - policies providing coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents. Types of coverage include student accident, sports accident, travel accident, blanket accident, specific accident or accidental death and dismemberment (AD&D).

Accidental Bodily Injury - unexpected injury to a person.

Accidental Death & Dismemberment - an insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

Admission - hospital inpatient care for any medical condition.

Affordable Care Act aka "ACA" - The Patient Protection and Affordable Care Act (PPACA) - law enacted in 2010 which increases health insurance coverage for the uninsured to provide preventative care.

Agent - a licensed person or organization authorized to sell insurance by or on behalf of an insurance company.

Aggregate - the maximum dollar amount or total amount of coverage payable for a single loss, or multiple losses, during a policy period, or on a single project.

Beneficiary - an individual who may become eligible to receive payment due to will, life insurance policy, retirement plan, annuity, trust, or other contract.

Benefits (Medical & Hospital Expenses) - total expenditures for health care services paid to or on behalf of a member.

Bodily Injury - physical injury including sickness or disease to a person.

Cancellation - the termination of insurance coverage during the policy period. Flat cancellation is the cancellation of a policy as of its effective date, without any premium charge.

Claim - notice to an insurer that a loss may be covered under the terms of a policy.

Claimant - any person who asserts right of recovery under a contract of insurance either as a first or third-party.

Comprehensive Health Care - a health plan which provides broad coverage of a wide range of healthcare services such as physician visits, hospitalization, and emergency room visits.

Copay - a cost sharing mechanism in group insurance plans where the insured pays a specified dollar amount of incurred medical expenses, and the insurer pays the remainder.

Credible Coverage - coverage that is at least as good as what Medicare provides.

Date of Issue - date when an insurance company issues a policy.

Deductible—the amount of money a policy holder must pay each year to cover eligible medical expenses before the insurance policy starts paying.

Dental Insurance - policies providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.

Dependent—any individual, either spouse or child, that is covered by the primary insured customer's plan.

Discount Health Plans - products that provide discounts for medical services, often issuing a card to the consumer for that purpose. Discount health plans are **NOT** insurance. Note that providers are *not* obligated to accept the discount plan, and not all providers participate. Be aware of these limitations when deciding to purchase a

discount health plan. Discount health plans do not qualify as minimum essential coverage for purposes of carrying health insurance and the Affordable Care Act.

Drug formulary—a list of prescription medications covered by the Member's plan.

Disability Insurance - health insurance that provides income payments to the insured wage earner when income is interrupted or terminated because of illness, sickness, or accident.

Exclusion - certain causes and conditions, listed in the policy, which are not covered.

Expiration Date - the date on which the policy ends.

Explanation of Benefits - Each time the insurer pays for a service that has been used, they send the insured party an Explanation of Benefits (EOB). The EOB is the insurance company's written explanation for that claim, showing the name of the provider that covered the service and date(s) of service. The insurer is also required to send the insured party a clear explanation of how they computed the benefits. This may include the amount billed, the allowed amount, what the insurer paid, and/or the insured person's share of the cost (if any). If any claims are denied in whole or in part, the insured party will receive a written explanation of the reason(s) for the denial.

Face Amount – the dollar amount that the insurance policy would pay out upon the death of the Insured.

Fixed Indemnity - a type of medical insurance that pays a pre-determined amount on a per-period or per-incident basis, regardless of the total charges incurred.

Generic Drug - a drug which is similar to a name brand drug but not covered by the original patents for that drug, which therefore generally makes the generic alternative less expensive.

Health Insurance - a policy that will pay specific sums for medical expenses or treatments. Health policies can offer many options and vary in their approaches to coverage.

Health Maintenance Organization (HMO) - a medical group insurance plan that provides physician, hospital, and clinical services to participating members in exchange for a periodic flat fee.

Health Plan – a written promise of coverage given to an individual, family, or group of covered individuals, where a beneficiary is entitled to receive a defined set of health care benefits in exchange for a defined consideration, such as a premium.

Health Insurance Portability and Accountability Act (HIPAA) - HIPAA is a Federal law that does three things:

1. It makes it easier to take your health information with you when you change employers;
2. It sets very strict rules about the privacy of your medical records (which includes information about your health condition, health services, and payment for health services); and
3. It gives consumers the right to purchase individual health insurance after exhausting COBRA benefits.

Health Maintenance Organization (HMO) - a collection of hospitals, doctors, and other health services all organized under one network. By managing care and contracting with the providers, HMOs keep costs down while providing a full range of health services. Consumers usually pay only small co-pays when using services, no matter how many or what kind of services are used. In return, consumers must usually use the hospital(s), doctors, and other health providers in the HMO's network. In an HMO, the consumer must select a primary care physician, and if a specialist is needed, the primary care physician must first refer the consumer to that specialist before care can be received.

Independent Agent - a representative of multiple insurance companies who sells and services policies for records which they own and operate under the American Agency System.

Insurance - an economic device transferring risk from an individual to a company and reducing the uncertainty of risk via pooling.

Insured - the person(s) protected under a policy of insurance in the event of a loss or claim.

Insurer - the insurance company responsible for payment of benefits to an insured under a policy of insurance.

Lapse - termination of a policy due to failure to pay the required renewal premium.

Life Insurance - a policy that will pay a specified sum to beneficiaries upon the death of the insured.

Limit – the maximum amount an insurance policy will pay either overall or under a particular coverage.

Limited Medical Benefit - policies that provide coverage for specific services, such as vision, prescription drug, and/or any other single service plan or program. Limited medical benefit plans may also include short-term care policies providing coverage for less than one year for medical and other services provided in a setting other than an acute care unit of a hospital.

Major Medical Plan - a specific type of health insurance which covers a wide array of medical expenses and health services associated with the treatment and care of illness and injury, including preventative care.

Medicaid - policies issued in association with the Federal/State entitlement program created by Title XIX of the Social Security Act of 1965 that pays for medical assistance for certain individuals and families with low incomes and resources.

Medical & Hospital Expenses (Benefits or Claims) - total expenditures for health care services paid to or on behalf of members.

Medicare - a state assistance program, passed under Title XVIII of the Social Security Amendments of 1965, to provide hospital and medical expense insurance to those over 65 years of age.

Medicare + Choice - the Medicare Part C benefit under which Medicare beneficiaries may select from among several managed care options or a Medicare system for the provision of their Medicare-related benefits.

Medicare Advantage Plan - an HMO, PPO, or Private Fee-For Service Plan for the provision of Medicare-related benefits that offers prescription drug benefits as well as a suite of various, extra coverages for vision, hearing, dental, and/or other health and wellness programs. Medicare pays a fixed amount for insured's care every month to the companies offering Medicare Advantage plans.

Medicare Cost – a contract with Center for Medicare and Medicaid Services (CMS) for Medicare coverage whereby CMS agrees to provide reimbursement through pre-determined monthly amount per member based on a total estimated budget. Under this type of arrangement, the beneficiary may use providers outside the provider network. This does not include stand-alone Medicare Part D Plans.

Medicare Part D - Stand-Alone - stand-alone Part D coverage written through individual contracts, or group contracts and certificates, or employer groups where the reporting entity is responsible for reporting claims to the Centers for Medicare & Medicaid Services (CMS).

Medicare Supplement - insurance coverage sold on an individual or group basis to help fill the "gaps" in the protections granted by the federal Medicare program. This is strictly supplemental coverage and does. not duplicate any benefits provided by Medicare. It is structured to pay part or all of Medicare's deductibles and co-payments. It may also cover some services and expenses not covered by Medicare. It is also known as Medigap" insurance.

Member - a person who has enrolled as a subscriber or an eligible dependent of a subscriber and for whom the health organization has accepted the responsibility for the provision of health services as may be contracted.

Open Enrollment - the annual time period during which consumers can change their health plan under the employer's group plan. During this time, consumers can also purchase individual/family coverage.

Policy - the written contract of insurance.

Policy Limit - the maximum amount a policy will pay for a specified period, either overall or under a particular coverage.

Pre-existing Condition - a health problem which the insured had before the date new health insurance coverage began.

Preferred Provider - a provider who is a participant in a plan's network of providers.

Preferred provider organization (PPO) - a type of medical plan in which coverage is provided to participants through a network of selected health care providers, such as hospitals and physicians. Enrollees may seek care outside the network but will pay a greater percentage of the cost of coverage than if care had been received within the network.

Premium – The monthly or annual amount that a consumer must pay in order to have the insurance coverage.

Primary Care Physician ("PCP") - the doctor an insured chooses to provide basic health care. With the exception of an OBGYN, in an HMO, the PCP must refer the patient to a specialist if the patient needs to see a different provider for specialized care.

Provider - a health professional or organization that provides health care services, such as a doctor, physical therapist, hospital, lab, or clinic.

Producer - an individual who sells, services, or negotiates insurance policies either on behalf of a company or independently.

Provisions - contingencies outlined in an insurance policy.

Quote - an estimate of the cost of insurance based on information supplied to the insurance company by the applicant.

Reinstatement - the restoring of a lapsed policy to full force and effect. The reinstatement may be effective after the cancellation date, creating a lapse of coverage. Some insurers require evidence of insurability and payment of past due premiums plus interest.

Short-Term Medical Insurance - policies that provide major medical coverage for a short period of time, which typically range from 30 to 180 days. These policies may be renewable for multiple periods.

Supplemental Insurance - an insurance policy that supplements a consumer's primary health insurance coverage. Supplemental insurance includes a variety of policies that can be offered by employers or purchased on their own, including life Insurance, Short-Term Medical Insurance, Disability Insurance, Dental Insurance, and Vision Insurance, Accident insurance, and Critical illness insurance.

Vision Insurance – a limited benefit expense policy that provides benefits for eye care and eye care accessories. Generally, vision insurance provides a stated dollar amount per annual eye examination. Benefits also often include a stated dollar amount for glasses and contacts and may include surgical benefits for other injury or sickness associated with the eye.

Waiting Period - a period of time set forth in a policy which must pass before some or all coverages begin.

For additional information concerning common health insurance terms, please access the glossary of insurance terms compiled by the National Association of Insurance, which may be accessed at:

https://content.naic.org/consumer_glossary