Important Terms and Definitions

Terms	Definition
Admission	The time you are an inpatient in a hospital, skilled nursing home or other facility. The admission runs from the day you are admitted until discharge.
Allowable Charge	The price your health carrier (i.e., Highmark Delaware or Aetna) determines is reasonable for care or supplies. The amount the plan pays for covered services is based on the allowable charge. If an out-of-network provider bills more than the allowable charge, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
Brand-Name Drug	A drug that is protected by a patent. When the patent protection for a brand-name drug expires the generic versions of the drug can be offered if FDA approved.
Capitation	A payment arrangement for healthcare providers whereby the provider receives a set amount for each enrolled member assigned to them. Under the HMO Plan design, members are required to choose a PCP who will issue referrals to specialists. In New Castle County, the choice in PCPs will also automatically assign specific Podiatrists, Radiologists, and Physical Therapists. Some of these providers in the HMO plan may be assigned members and paid based on a capitation arrangement.
Carriers	Examples of carriers for the State GHIP include Highmark Delaware, Aetna and CVS Caremark.
CDH Gold Plan	The Aetna Consumer-Directed Health (CDH) Gold Plan offers in and out-of-network coverage and the ability to see any doctor you want without a referral. Preventive services are covered in-network at 100% of the allowable charge (age and gender parameters may apply) and are not subject to a deductible or coinsurance. Each year the State provides the member with a fund called a Health Reimbursement Account (HRA) that you can use to pay eligible out-of-pocket healthcare costs before you satisfy the deductible. Unused amounts roll over to the next year as long as you remain in the CDH Gold Plan. However, if you change employers or leave the health plan, you can't take the fund with you.
Center of Excellence (COE)	High-quality facility proven to provide care that results in better outcomes, fewer complications and readmissions for specific procedures (i.e., Orthopedic, Spine, Bariatric and Transplants). Sometimes referred to as Blue Distinction Centers, Institutes of Quality or Institutes of Excellence.
Choosing the Right Care	Includes understanding your care options, where to go for services, how much services cost and making informed decisions to ensure you and your family receive the high quality, safe and affordable care you deserve.
Claim	A detailed invoice that your healthcare provider sends to your insurance carrier that shows what services you received.
Coinsurance	The part of the medical bill that you pay after you have satisfied any deductible required by the health plan. Coinsurance is a percentage of the charge or allowable charge for a service. For example, if the health plan covers 80% of the allowable charge for a specific service, you are required to pay the remaining 20% as coinsurance. If your bill for covered medical services is $100 and your coinsurance is 20%, you would pay $20. The health plan would pay the remaining $80.
Comprehensive PPO Plan	The Highmark Delaware Comprehensive Preferred Provider Organization (PPO) Plan allows you to use in-network services and you would pay a small copay/coinsurance with no deductible. If you use out-of-network providers, you must meet a deductible unless otherwise noted. Preventive services are covered in-network at 100% of the allowable charge (age and gender parameters may apply) and are not subject to a deductible or coinsurance.

Copay	The fixed dollar amount that you may pay each time you receive services covered under your benefit plan. The amount can vary based on the type of service you receive, such as seeing your doctor, visiting a specialist or filling a prescription medication.
Deductible	The dollar amount you must pay before your plan begins to pay for most covered services. For instance, if you have a $1,500 deductible, that's the amount you must pay up front, out-of-pocket, before your plan starts to pay. If you are in an employee and spouse, employee and children, or employee and family plan, at least two individuals need to meet the individual deductible for the plan before the plan will begin to pay for most covered services. Keep in mind that the deductible must be satisfied each plan year and for the State plans, the deductible does not apply to prescription coverage.
Dependent Child	State employees, pensioners and employees of participating groups may cover their dependent children to age 26 in their State healthcare plan, dental plan and/or vision plan with no restriction on marital, employment, student, resident or tax status. Pursuant to the Group Health Insurance Plan (GHIP) Eligibility and Enrollment Rules, an employee or pensioner's children are defined as sons, daughters, stepchildren and adopted children.
Dependent Child Coordination of Benefits Form	In accordance with the Group Health Insurance Plan (GHIP) Eligibility and Enrollment Rules, Dependent Coordination of Benefits forms must be completed for each enrolled dependent regardless of age, upon: • Enrollment in other health coverage, • Any time other health coverage changes, or • Upon request by the Statewide Benefits Office, Highmark Delaware or Aetna.
Diagnostic Care	Procedures used to evaluate or to treat your condition or disease.
Emergency Care	Treatment provided in Emergency Departments (ED). Emergency Departments are prepared for every kind of medical emergency, including heart attacks, stroke, motor vehicle crashes and other life-threatening situations. Emergency Departments are available 24 hours a day, 365 days a year, and have special equipment and highly qualified heath care providers to respond to every kind of adult or childhood medical emergency.
Explanation of Benefits (EOB)	A statement prepared by a health plan that details the charges for the service(s) received, the covered and non-covered service(s), the plan's allowable charge(s) for the covered service(s), the amount the health plan pays for the service(s) and the amount(s) the member is responsible for paying.
First State Basic Plan	The First State Basic Plan is administered by Highmark Delaware. The First State Basic Plan pays the highest benefit when using in-network services. If you choose to see a provider or doctor that is out-of-network, you will have to pay more money out of your pocket. Preventive services are covered in-network at 100% of the allowable charge (age and gender parameters may apply) and are not subject to a deductible or coinsurance. The plan includes a deductible that must be met before services other than preventive and urgent care are covered.
Fully Insured	Certain benefits, like dental and vision, offered by the State of Delaware are fully insured. This means that the State and/or enrolled employee or retiree pays a pre-negotiated premium to the carrier. The carrier then uses the premium to pay claims for services incurred by enrolled members and to cover administrative costs. If the claims and administrative costs exceed the pre-negotiated premium, the carrier assumes the financial responsibility for continuing to cover costs for services incurred by members. Any plan year premium left after payment of claims and administrative costs is kept by the carrier as profit.
Generic Drugs	A pharmaceutical drug that is equivalent to a brand-name drug in dosage, strength, route of administration, quality, performance and intended use, but does not carry the brand name. The generic drug may differ from the original in non-essential characteristics such as color, taste and packaging. According to the U.S. Food and Drug Administration (FDA), generic drugs can be trusted to have the same quality as brand

	name drugs. Typically, generic medications are less expensive because the patent has expired on the name brand version, so a generic version can be made without the added expense of research and development.
GHIP	State of Delaware Group Health Insurance Plan (GHIP)
Health Reimbursement Account (HRA)	A notional account funded by your employer, used to pay for out-of-pocket medical costs like copayments and deductibles. The State Aetna CDH Gold Plan includes a HRA Fund. Unused amounts roll over to the next year as long as you remain in the CDH Gold Plan; however, you can never receive cash for any amounts in the account nor can you transfer the account balance if you change employers or leave the CDH Gold Plan.
Healthy Lifestyles	Combination of behaviors that reduce health risk factors, including regular exercise, proper nutrition, avoidance of tobacco, moderation of alcohol use, preventive care, and active management of chronic conditions.
High-Quality Healthcare	Healthcare that meets nationally recognized standards of care established by various governmental and non-governmental healthcare organizations (e.g., Agency for Healthcare Research and Quality (AHRQ), National Committee of Quality Assurance (NCQA), The Leapfrog Group).
HMO Plan	The Health Maintenance Organization (HMO) Plan is an in-network only plan administered by Aetna and offers local and national network access. The plan does not have a deductible. Primary Care Physician (PCP) selection is required since your PCP will assist in managing your care with your other healthcare providers. Referrals are required for certain services and are obtained through your PCP. Preventive services are covered at 100% of the allowable charge (age and gender parameters may apply) and are not subject to a copayment or coinsurance.
In-Network	Doctors, hospitals, labs and other providers that a health insurer has contracted with to provide healthcare services to its members. You usually pay less when you utilize providers that are “in-network.”
Inpatient	A person in a hospital, skilled nursing home or other facility for an overnight stay.
Livongo	A FREE diabetes monitoring program that provides access to coaches that are Certified Diabetes Educators to help with diabetes management. The program is available to employees, pensioners and their covered spouses and dependent children living with type 1 or type 2 diabetes who are enrolled in a State of Delaware Aetna or Highmark Delaware health plan and includes a meter, test strips and access to Diabetes Response Specialists who are available 24/7.
Medical Aid Unit (MAU)	Urgent Care Facilities that treat injuries or illnesses that are not life-threatening, but require care within a few hours or the same day. With a MAU, you don’t need an appointment, and you may avoid the longer waits you might find at a busy Emergency Department (ED).
Medically Necessary	Care, required to identify or treat a condition, which: • is consistent with the symptoms or treatment of the condition • meets the standards of accepted practice • is not solely for anyone's convenience, and • is the most appropriate supply or level of care which can be safely provided. For inpatient care, it means the care cannot be safely provided as an outpatient.
myBenefitsMentor®	An online consumer decision tool available to State of Delaware employees and non-Medicare Pensioners (may not be available in certain situations). The tool is designed to help members make the best selection from the four health plans offered by the State.
Network	Doctors, hospitals, labs and other providers that a health insurer has contracted with to provide healthcare services to its members. You usually pay less when you utilize providers that are “in-network.” You may pay extra if you see a provider who is “out-of-network.”

Network Provider	A doctor, hospital, lab or other provider that an insurance company has contracted with as a participant in a network to provide healthcare services to its members.
Never Events	Serious errors in the delivery of healthcare services that should never happen to a patient, such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, or discharging an infant to the wrong person.
Non-Hospital Affiliated Freestanding Facility	An entity that provides healthcare services and that is neither associated with, nor a department of, a hospital. Generally speaking, costs for services (i.e., lab and imaging/radiology) are lower at these facilities compared to hospital affiliated ones. Note: Physically separate facilities either on or off the campus of a hospital and that are associated with a hospital, are not considered non-hospital affiliated freestanding facilities.
Open Enrollment	The only time of the year you can enroll or make changes to your benefit elections, unless you experience a qualifying event.
Out-of-Network	Doctors, hospitals, labs and other providers that a health insurer has not contracted with to provide healthcare services to its members. You usually pay more when you utilize providers that are "out-of-network." You may also be responsible for amounts billed by an out-of-network provider that are above the allowable charge covered by the health plan.
Out-of-Pocket Limit (Max)	The most you could pay during a coverage period (usually one plan year) for your share of the cost of covered services. This limit helps you plan for healthcare expenses.
Outpatient	A person receiving care while not an inpatient.
Patient Safety	The prevention of errors, injuries, accidents, and other preventable harm (i.e., infections) to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care.
Plan Administrator	The contracted vendor(s) who manage the healthcare plan(s) for the GHIP. This includes providing a network of doctors, hospitals, labs and other providers, processing claims and providing member support services and tools.
Premiums	The amounts paid to the Group Health Insurance Plan (GHIP) for coverage. In most instances, the employee or pensioner pays a portion of the premium and the employer or former employer (the State or participating group employer) pays a portion. The amount paid by the employee or pensioner is deducted from their paycheck or pension check.
Preventive Care	Medical care that is rendered not for a specific complaint but focused on prevention and early detection of disease. Preventive care is one of the most important ways to keep you and your family healthy. Examples include: annual physical exam; OB/GYN exam; cancer screening, including mammograms and colonoscopies; flu, pneumonia and other shots (age parameters may apply); and preventive medications such as aspirin to prevent cardiovascular events. Preventive or routine care is not the same as diagnostic care. Most preventive care is covered at 100% (meaning no charge) to covered members through their State health and prescription plan. Check your plan for details and prior authorizations. Preventive care must be submitted to the plan administrator for payment as preventive in order for the plan to pay 100% of the cost.
Primary Care Provider (PCP)	PCPs can be family practitioners, pediatricians, internists, geriatricians and nurse practitioners and physician assistants. A PCP is your regular, go-to healthcare provider that takes care of you in non-emergency situations and provides general primary care services, exclusive of any areas of specialty (e.g. cardiology, oncology, nephrology). PCPs treat common illnesses and injuries and help you find the right kind of doctor if you have a complicated health issue. If your plan requires you to select a PCP, be sure to use the plan administrator's search tools to find the best PCP.
Provider	A doctor, hospital, lab or other provider that offers healthcare services.

Qualifying Event	Other than during Open Enrollment, you may not make changes at any other time of the year to your benefit elections unless you experience a Qualifying Event. Qualifying Events which are life events that allow you to make changes during the plan year other than during Open Enrollment include, but may not be limited to, birth or adoption of a child; marriage/civil union; divorce; employment of spouse; involuntary loss of spouse's coverage; spouse's employment termination; child now eligible for coverage; death of a spouse or dependent; or spouse becomes a State employee.
Referral	Authorization or permission from your Primary Care Provider (PCP) to receive care from a specialist or provider other than your PCP. You may also need a Referral for services like lab work or imaging. Members enrolled in the Aetna HMO must obtain referrals for most services not provided by their PCP in order for the services to be covered under the plan.
Self-Insured	The State Group Health Insurance Plan (GHIP) is self-insured. This means that the State pays claims for services received by members and contracts with carriers for administrative services only. The State assumes financial risk for providing health and prescription benefits to members. In other words, the State budgets a certain amount for the expected claims and administrative services of the GHIP members each fiscal year. If the expenses are greater than the budgeted amount, the GHIP will have a deficit and the State must provide additional funding to the GHIP if there are not enough funds in reserve to pay for actual expenses. The GHIP is a large, self-insured plan and using historical data, is able to estimate with a high degree of accuracy, the cost of claims and budget appropriately. While not an exact science, as a large employer, the State has a greater ability to implement program efficiencies and keep premiums lower by offering health and prescription benefits to members under a self-insured model.
Special Medicfill Plan	Medicare supplement coverage (also known as Medigap) is available to State pensioners, spouses and dependents who are enrolled in Medicare Parts A and B coverage. Special Medicfill covers services which are not covered under Medicare Parts A and B. State pensioners, spouses and dependents enrolled in Medicare Parts A and B for primary medical coverage and also eligible for or enrolled in the Highmark Delaware Special Medicfill plan DO NOT make changes in Special Medicfill coverage until a separate Open Enrollment period available each fall for the following January. The Special Medicfill Plan is not available to active State employees or active employee spouses.
Specialist	A provider who focuses on a particular area of medicine or a group of patients to prevent, diagnose, manage or treat certain types of symptoms and conditions.
Spousal Coordination of Benefits Form	If you cover your spouse in one of the State's Group Health Insurance non-Medicare health plans, you MUST complete a Spousal Coordination of Benefits Form upon initial enrollment, each year during your Open Enrollment period, and anytime your spouse's employment or insurance status changes.
Spousal Coordination of Benefits Policy	This policy became effective on January 1, 1993 for a spouse who is eligible for healthcare coverage through his or her own employer. Effective July 1, 2011, the Spousal Coordination of Benefits Policy became applicable to retiree healthcare coverage available to a spouse through his or her employer from whom he or she is collecting a pension benefit.
Spouse	A person to whom you are married or partnered in a civil union, pursuant to the laws of the jurisdiction.
State Employee Benefits Committee (SEBC)	A Committee comprised of members of various State agencies, union representatives and elected officials responsible for the management of employee benefits. The Statewide Benefits Office (SBO) functions as the administrative arm of the SEBC by executing the decisions made by the Committee and overseeing the day-to-day operations of the benefit programs.

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Subscriber	The employee or pensioner who is the contract holder.
Summary of Benefits and Coverage (SBC)	An easy-to-understand summary that uses simple language to explain a health plan's benefits and coverage.
SurgeryPlus	A service that is available to all Group Health Insurance Plan (GHIP) members who are enrolled in an Aetna or Highmark non-Medicare health plan. SurgeryPlus is a voluntary benefit separate from the member's health plan and provides GHIP members with access to a network of surgeons who have met rigorous standards for quality, safety and outcomes in their area of specialty. Use of this benefit is limited to planned surgical procedures that are not an emergency. There are no member out-of-pocket costs, travel expenses are included, and members receive a financial incentive for using the benefit. The State is able to offer this benefit to GHIP members because SurgeryPlus is able to negotiate with high quality surgeons and facilities that have agreed to accept a lower "bundled" rate for all services associated with the procedure rather than billing the State separately for each service. For example, rather than paying separately for the surgeon, facility, anesthesiologist and radiologist, SurgeryPlus negotiates one "bundled" rate. As part of the SurgeryPlus service, members have access to a Care Advocate who will assist the member regarding treatment options available through the SurgeryPlus network and guide the member through the entire surgical experience.
Telemedicine	A form of telehealth that allows the delivery of health care from the comfort of where you are by using telephones, computers, smartphones or tablets.
Urgent Care Center	A non-emergency facility to treat common medical problems (i.e., cold and flu symptoms, coughs, sore throat, ear or sinus pain, headaches, pinkeye, skin rashes and minor burns, cuts and scrapes) when a physician's office is closed or unable to provide an appointment (also referred to as Medical Aid Units (MAUs) by Highmark Delaware). Many Urgent Care Centers are open seven days a week, with evening, weekend and holiday hours. Try an eligible Urgent Care Center when you have an immediate need that's not life-threatening. It is less expensive than the emergency room.
Walk-In Clinic	Walk-in clinics are able to treat minor illnesses like strep throat, ear or eye infections. No appointment is needed to be treated.
Wise Health Care Consumer	A person who: takes action to improve or maintain their health and well-being; understands their benefit plans; uses their benefits and healthcare services appropriately; feels confident asking questions of their healthcare provider; and plays an active role in understanding the services they receive, by comparing options and choosing services or treatment that are equally effective but less costly to them and the State.