Glossary of Important Healthcare/Insurance Terms and Definitions

Terms	Definition
Administrative Fee	Monthly fee paid to insurance carrier/third party administrator for processing claims on behalf of the State.
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. This is called balance billing (Refer to Balance Billing).
Balance Billing	When a provider bills you for the difference between the provider's charge and the health carrier's allowed amount. For example, if the provider's charge is $1,500 and the allowed amount is $1,000, the provider may bill you for the remaining $500. An in-network provider may not balance bill you for covered services.
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. The provider receives a set amount of money 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	Insurance companies who manage the healthcare plans for the GHIP. This includes providing a network of doctors, hospitals, labs, and other providers, processing claims, and providing member support services and tools. Examples of carriers for the State GHIP include Highmark Delaware, Aetna, and CVS Caremark. Also known as plan administrators or contracted vendors.
CDH Gold Plan	A State of Delaware health insurance 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 notional fund called a Health Reimbursement Account (HRA) that you can use to pay eligible out-of-pocket healthcare costs before you satisfy the deductible. The HRA fund is managed by Aetna. 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. This is how the plan compares to the other four plans offered by the State of Delaware: Premiums (amount taken from your paycheck or pension check): $$ Out-of-Pocket Costs (amount you pay for services): $$$
Center of Excellence (COE)	High-quality facility proven to provide care that results in better outcomes and fewer complications and readmissions for specific procedures (i.e., orthopedic, spine, 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 paid the deductible required by the health plan. Coinsurance is a percentage of the charge or allowable charge for a service. For example, you have an office visit with a doctor that is $100 and your coinsurance for your plan is 20%. • If you have paid your deductible, you will pay 20% of $100, or $20. The GHIP will pay the rest of the bill. • If you have more than $100 to meet your deductible, you will pay the full bill, $100. However, if you have less than $100 to meet your deductible, then you would pay the amount owed and then 20% of your remaining bill.
Comprehensive PPO Plan	A State of Delaware health insurance plan. The Highmark Delaware Comprehensive Preferred Provider Organization (PPO) Plan allows you to use in-network services and you would pay a 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. This is how the plan compares to the other four plans offered by the State of Delaware: Premiums (amount taken from your paycheck or pension check): $$$$ Out-of-Pocket Costs (amount you pay for services): $$
Copayment (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 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. However, when an individual in a family plan meets the individual deductible before the family deductible is met, the plan will begin paying claims for that individual. 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/retirees 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. The Group Health Insurance Plan (GHIP) Eligibility and Enrollment Rules define an employee or pensioner's children as natural born children, adoptive children, or stepchildren. State employees, pensioners, and employees/retirees of participating groups may also cover other children who are not their or their spouse's natural, adoptive, or stepchildren in their health, dental, and/or vision plans to age 19 (or 24 if a full-time student) if the child is: unmarried, living with them in a regular parent-child relationship, dependent upon them for at least 50% support, and qualifies as their

	dependent under Internal Revenue Code §105b. An example of this situation is a GHIP member who takes in a grandchild. Disabled dependents who are incapable of self-support and are over the dependent limit age in the above categories may be eligible for coverage. Eligibility criteria and other details can be found in the applicable benefit plan booklet. The child or children must have been covered under employee's contract immediately preceding the appliable dependent limiting age.
Dependent Child Coordination of Benefits Form	A form for dependents covered by multiple health insurance plans that determines whether the GHIP (medical/prescription) coverage is primary or secondary. For example, a dependent may be covered by a State of Delaware employee under the GHIP and covered under the dependent's employer for health coverage. 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. Diagnostic care is not the same as preventive care. For example, a routine colonoscopy based on age is preventive, while a colonoscopy to diagnose GI symptoms is diagnostic.
Emergency Care	Treatment provided in Emergency Departments (ED) or Emergency Rooms (ER). 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 healthcare providers to respond to every kind of adult or childhood medical emergency.
Explanation of Benefits (EOB)	A statement prepared by an insurance carrier that details the charges for the service(s) received (the claim), which service(s) were covered and which were not, the plan's allowable charge(s) for the covered service(s), the amount the health plan pays for the covered service(s) and the amount(s) the member is responsible for paying.
First State Basic Plan	A State of Delaware health insurance 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. This is how the plan compares to the other four plans offered by the State of Delaware: Premiums (amount taken from your paycheck or pension check): $ Out-of-Pocket Costs (amount you pay for services): $$$$
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 premium to the carrier. The carrier then uses the premium to pay claims for services received by enrolled members and to cover administrative costs. If the claims and administrative costs exceed the premium, the carrier pays the difference. Any plan

	year premium left after payment of claims and administrative costs is kept by the carrier as profit.
Generic Drugs	A prescription 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 Aetna 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 Aetna CDH Gold Plan. The HRA is managed by Aetna.
Healthy Lifestyles	A 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 Health Care	Health care 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), and The Leapfrog Group).
HMO Plan	A State of Delaware health insurance 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. This is how the plan compares to the other four plans offered by the State of Delaware: Premiums (amount taken from your paycheck or pension check): $$$ Out-of-Pocket Costs (amount you pay for services): $
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 use providers that are “in-network.”
Inpatient	A person in a hospital, skilled nursing home, or other facility for an overnight stay.
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) or Emergency Room (ER).
Medically Necessary	Care that is required to identify or treat a condition and: • 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.
Member	The subscriber and any dependents enrolled in benefit coverage are known as covered members.
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 an insurance carrier has contracted with to provide healthcare services to its members. You usually pay less when you use 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. Also known as an in-network provider.
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	A facility that provides healthcare services and that is neither associated with, nor a department of, a hospital. Generally speaking, costs for services (i.e., lab, imaging/radiology, and outpatient surgery) 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 selections, unless you experience a qualifying event.
Out-of-Network	Doctors, hospitals, labs, and other providers that an insurance carrier has not contracted with to provide healthcare services to its members. You usually pay more when you use 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 (see Balance Billing).
Out-of-Pocket Costs	The expenses for healthcare services that are not reimbursed by insurance. Some examples of out-of-pocket costs include deductibles, coinsurance, and copayments for covered services. Finding the right plan for you requires managing your premium and out-of-pocket costs. Plans with a lower premium typically have higher out-of-pocket costs. Plans with a higher premium typically have lower out-of-pocket costs.
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. Once you reach the out-of-pocket limit, the insurance carrier pays 100% of the allowable charge for all covered services for the remainder of the coverage period. 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 while receiving health care and reduction of risk of unnecessary harm associated with health care.
Post-Tax Deduction	Also known as After-Tax Deduction. Premium subtracted from net income; therefore, do not reduce taxable income.

Premiums	The amount you pay for your insurance each month to be enrolled in the plan. Premiums are deducted from your paycheck or pension check. For some plans, like your health plan, the State or participating group employer pays the majority of the premium and you pay the rest. Finding the right plan for you requires managing your premium and out-of-pocket costs. Plans with a lower premium typically have higher out-of-pocket costs. Plans with a higher premium typically have lower out-of-pocket costs.
Pre-Tax Deduction	Premium subtracted from gross income, thereby reducing taxable income.
Preventive Care	Medical care that is not for symptoms 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 and gender parameters may apply); and preventive medications such as aspirin to prevent cardiovascular events. Preventive or routine care is not the same as diagnostic care. For example, a routine colonoscopy based on age is preventive, while a colonoscopy to diagnose GI symptoms is diagnostic. 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.
Primary Care Provider (PCP)	A PCP is your regular, go-to healthcare provider that takes care of you in non-emergency situations. PCPs can be family practitioners, pediatricians, internists, geriatricians, nurse practitioners, and physician assistants. PCPs treat common illnesses and injuries and help you find the right kind of specialist if you have a complicated health issue. The Aetna HMO Plan requires members to select a PCP. Insurance carriers have online directories where you can find an in-network PCP.
Prior Authorization	A process your health carrier uses to determine if a prescribed medical service or supply will be covered. This process helps to make sure you are receiving the most appropriate medical services or supplies for your condition. It also assists your doctors by ensuring you are receiving the service at the right time and place. If a prior authorization is required, your doctor will need to contact your health carrier to start the process. Prior authorizations are not required for emergency care situations.
Provider	A doctor, hospital, lab, or other entity that offers healthcare services.
Qualifying Event	Life events that allow you to make enrollment/changes during the plan year outside of Open Enrollment.
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.
Sanctioned	A sanction means medical claims will be processed at 20 percent of the allowable charges and you will be responsible for the remaining balance. In addition, while a sanction is in place, you must pay for all prescriptions in full at the pharmacy and then you must submit the claim to the pharmacy benefit manager for a reduced reimbursement of the allowable charge. A sanction may be applied due to the following: • Failure to complete a Spousal Coordination of Benefits Form as required. • Failure to provide additional spousal employer information as required. • Failure of a spouse to enroll in their own coverage when required. • Failure of a pensioner or LTD beneficiary to enroll in Medicare Part A and B when eligible.

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.
Special Medicfill Plan	Medicare supplement coverage (also known as Medigap) is available to State pensioners, participating group retirees, 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, participating group retirees, spouses, and dependents enrolled in Medicare Parts A and B for primary medical coverage and eligible for or enrolled in the Highmark Delaware Special Medicfill plan participate in Open Enrollment each fall. Their healthcare plan year is January through December. The Special Medicfill Plan is not available to active State employees or participating group employees or their 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.
Specialty Medication	Specialty medications are used to treat complex and chronic conditions like rheumatoid arthritis, multiple sclerosis, psoriasis, rare genetic disorders and cancer. Specialty medication are often injected or infused, and many require prior authorization (PA) before they can be covered.
Spousal Coordination of Benefits Form	A mandatory electronic form that determines your spouse's eligibility for coverage in a non-Medicare healthand prescription plans under the State GHIP. 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 applies to all spouses covered under the State of Delaware Group Health Insurance Plan and the intention of this policy is to ensure fiscal responsibility for the State of Delaware Group Health Fund where other employers are offering health care benefits to their employees and retirees. The SCOB Policy does not apply to the State's dental or vision plans.
Spouse	A person to whom you are legally married or partnered in a civil union.
State Employee Benefits Committee (SEBC)	A committee comprised of members of various State agencies, union representatives, elected officials, and a state retiree responsible for the management of employee and retiree benefits. The Statewide Benefits Office (SBO) functions as the administrative arm of the SEBC by carrying out the decisions made by the Committee and overseeing the day-to-day operations of the benefit programs.
Statewide Benefits Office (SBO)	The Statewide Benefits Office (SBO) functions as the administrative arm of the SEBC by carrying out the decisions made by the Committee and overseeing the day-to-day operations of the benefit programs.
Subscriber	The employee, participating group retiree, or pensioner who is responsible for paying the insurance premium for a benefit for themselves and any covered dependents.
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 and travel expenses are included, and members receive a financial incentive* for using the benefit. 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. Spouses and dependents who are enrolled in a State of Delaware Aetna or Highmark Delaware non-Medicare health plan as their secondary or tertiary plan are not eligible for SurgeryPlus except for those seeking bariatric surgery. **Effective July 1, 2023, State of Delaware non-Medicare health plan members needing bariatric (weight loss) surgery are required to use SurgeryPlus. Financial incentives do not apply.*
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, sprains, strains, minor burns, cuts, and scrapes) when a physician's office is closed or unable to provide an appointment. Highmark Delaware also refers to Urgent Care Centers as Medical Aid Units (MAUs). 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 Departments (ED) or Emergency Room (ER).
Walk-In Clinic	Walk-in clinics are similar to urgent care centers; however, walk-in clinics usually have fewer capabilities and equipment to treat illnesses or injuries. Walk-in clinics are able to treat minor illnesses like strep throat and 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 high quality, safe, and affordable.