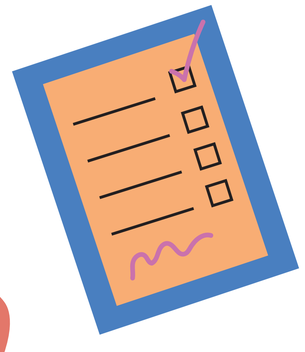
HEALTH INSURANCE TERMINOLOGY



Open enrollment can be a hectic time, so it's important you fully understand the terms used in your benefit descriptions.

Coinsurance
The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment
A flat fee that you pay toward the cost of covered medical services.

Deductible
A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Eligible Medical Expenses
Expenses that you are allowed to spend money on, as specified by the medical plan.

Group health insurance
Typically acquired through your employer and covers many people.

Health Savings Account (HSA)
An employee-owned medical savings account used to pay for eligible medical expenses. HSAs can only be used with qualified high deductible health plans.

Health Reimbursement Arrangement (HRA)
An employer-owned medical savings account in which the company deposits pre-tax dollars for each of its covered employees. You can then use this account to pay for qualified medical expenses.

High Deductible Health Plan (HDHP)
A type of health plan that has lower monthly premiums, but higher deductibles and out-of-pocket limits, than a traditional health plan.

Individual insurance
Purchased by an individual or a family and is not tied to a job.

Out-of-pocket maximum (OOPM)
The most you should have to pay for health care during a year, excluding the monthly premium. After you reach the annual OOPM, your plan begins to pay 100 percent of the allowed amount for covered health services.

In network
Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners. Basically, this is a term used to describe a doctor whom you can visit without it costing you more money.

Out of network
Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to higher deductibles and copays. Basi- cally, this is a term used to describe doctors who are not pre-approved by your plan. You can still visit them, but you may have to pay more.

Participant
There are a few different "participants" involved in health insurance. One is the "provider", or a clinic, hospital, doctor, lab, health care practitioner or pharmacy. The "insurer" or the "carrier" is the insurance company providing coverage. The "policyholder" is the individual or entity who purchased the coverage, and the "insured" is the person with the coverage.

Premium
The amount you pay for a health plan in exchange for coverage. This is sometimes shown as a per-paycheck, monthly or annual amount, so pay attention to how it's written in your benefits descriptions.