

DEFINITIONS OF LINES OF BUSINESS

Comprehensive (Hospital & Medical):

Business that provides for medical coverage including hospital, surgical, & major medical. Includes State Children's Health Insurance Program (SCHIP) Medicaid Program (Title XXI) risk contracts. Also includes medical only programs that provide medical only benefits without hospital coverage. Does not include self-insured business as well as federal employees health benefit programs (FEHBP), Medicare & Medicaid programs, and dental only business.

Medicare Supplement:

Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statements. Does not include Medicare (Title XVIII) or Medicaid (Title XIX) risk contracts.

Dental-Only:

Policies providing for dental only coverage issued as stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits. Does not include self-insured business as well as federal employees health benefits plans (FEHBP) or Medicare & Medicaid programs.

Vision-Only:

Policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits. Does not include self-insured business, federal employees health benefit plans (FEHBP) or Medicare & Medicaid programs.

Federal Employees Health Plans (FEHBP):

Business allocable to the Federal Employees Health Benefit Plan premium that are exempted from state taxes or other fees by Section 8909 (f) (1) of Title 5 of the United States Code. Does not include Medicare & Medicaid programs.

Medicare Cost:

Contracts with the Centers for Medicare & Medicaid Services (CMS) to provide services that are paid a pre-determined monthly amount per member based on a total estimated budget. The beneficiary can use providers outside the provider network. Does not include policies providing stand alone Medicare Part D Prescription Drug Coverage which are reported within the Other Health line of business.

Medicare Risk:

Contracts with the Centers for Medicare & Medicaid Services (CMS) whereby managed care is paid a per capita premium per member. Assume full financial risk for all care provided to Medicare Risk members. With the exception of emergency and out-of-area urgent care, members must receive all of their care through the managed care plan; however, an out-of-network option can be provided. Does not include policies providing stand alone Medicare Part D Prescription Drug Coverage which are reported within the Other Health line of business.

Medicare Other:

Health Care Prepayment Plans (HCPP) – similar to Medicare Cost. Contracts with the Centers for Medicare & Medicaid Services (CMS) but only covers part of the Medicare Benefit package. HCPP's do not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice and some home health care).

Medicare +Choice –Contracts with the Centers for Medicare & Medicaid Services (CMS) and a variety of different managed care and fee-for-service entities (i.e. HMO, PPO, PSO) with benefits to members similar to Medicare Risk as defined under the Balanced Budget Act of 1997.

Does not include policies providing stand alone Medicare Part D Prescription Drug Coverage which are reported within the Other Health line of business.

Medicaid Cost:

Those members enrolled under a prepaid contract between the reporting entity and the appropriate state agency administering medical assistance under a state plan approved under Title XIX of the Social Security Act where that agency agrees to pay part or all of the member's financial obligation to the reporting entity. The beneficiary can use providers outside the provider network.

Medicaid Risk:

A prepaid contract between a managed care entity and the appropriate state agency administering medical assistance under a state plan approved under Title XIX of the Social Security Act where that agency agrees to pay part or all of the member's financial obligation to the Health Organization.

Self-Funded:

Business where the health-care organization agrees to provide services to a third party self-insured group. Includes Administrative Services Contracts where the organization advances its own funds in payment of claims and issues its own membership card and use of their provider network to the members of the groups and Administrative Services Only Contracts where the organization utilizes the group's funds in payment of claims.

Product Lines:

HMO (Health Maintenance Organization):

An entity that provides, arranges or offers coverage of designated health services needed by plan members for a fixed prepaid premium.

There are four basic HMO models:

- a. Group Model
- b. Individual Practice Association
- c. Network Model
- d. Staff Model

An entity must have three characteristics to be an HMO:

1. An organized system for providing health care or otherwise assuring health care delivery in a geographic area.
2. An agreed upon set of basic and supplemental health maintenance and treatment services.
3. A voluntary enrolled group of people

PPO (Preferred Provider Organization):

A program in which contracts are established with providers of medical care, referred to as preferred providers. Usually the benefit contract offers better benefits (fewer copayments) for services received from a preferred provider, thus encouraging members to use these providers. Members are allowed benefits for non-participating provider services on an indemnity basis with significant copayments. Providers may be paid on a discounted fee-for service basis. A PPO arrangement can be insured or uninsured

POS (Point of Service):

A type of health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers.

There are several ways POS can be provided:

- a. An HMO may allow members to obtain limited services from non-participating providers.
- b. An HMO may provide non-participating benefits through a supplemental major medical policy.
- c. A PPO may be used to provide both participating and non-participating levels of coverage and access.

Hospital/Surgical:

An entity that provides coverage for inpatient care and surgical procedures associated with this inpatient care

Dental (Only):

Entity providing Dental coverage in addition to health care coverage. Can also be a rider offered by the insuring company but covered by the dental insurer.

Vision (Only):

Entity providing Vision coverage in addition to health coverage provided by health care company.

Other (Specify):

Coverage provided by entities that do not fall within any of the other categories, including stop loss, disability and long-term care. Indemnity plans where the insured person is reimbursed for covered expenses would fall within this area.

Miscellaneous Definitions:

Encounter:

A contact between a member and a provider of health care services who exercise independent judgment in the area and provision of health services to the member. A claim would be one encounter.

Hospital Encounter:

An encounter administered in a hospital environment. Includes emergency room services.

Non-hospital Encounter:

An encounter administered outside a hospital environment, such as in the health care provider office.

Physician:

A licensed doctor of medicine or osteopathy licensed to practice medicine under the laws of the state or jurisdiction where the services are provided

Non-physician:

Anyone other than a physician who is licensed, where required, to render covered services. Non-physician providers can include:

- a. Chiropractor
- b. Clinical Psychologist
- c. Dentist
- d. Optometrist
- e. Physical Therapist
- f. Physician Assistant
- g. Nurse Practitioner
- h. Social Worker

Inpatient:

A member who is treated as a registered bed patient in a hospital and for whom a room and board charge is made.

Outpatient:

A member not officially admitted as an inpatient, but who receives hospital care without occupying a hospital bed or receiving a room and board charge.

Admission:

Hospital inpatient care for any medical condition.

Hospital Day:

A day for which contractual coverage is provided to a member while receiving inpatient care. A stay up to and including midnight of the date of admission shall be considered one day, and an additional day will be counted at each midnight census after the first day that the member is still a patient.

Individual:

The health organization contracts directly with the subscriber.

Group:

The health organization contracts with an entity to provide health care services to a group of subscribers.

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 for.