

## GLOSSARY OF TERMS

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**CAL-COBRA** – A California state law that allows employees and/or dependents, who were covered under a group health plan to continue their health coverage (at their own expense) when they lose group health coverage under certain circumstances; for example, when they leave their jobs, either voluntarily or involuntarily. CAL-COBRA applies to employers with 2 to 19 employees more than 50% of the prior calendar year.

**CARRIER** – An insurance risk taker such as MetLife, or a Health Maintenance Organization (HMO) such as Kaiser and Health Net. The carriers insure and administer the programs offered under the plan.

**COBRA** – The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, a federal law that allows employees and/or dependents, who were covered under a group health plan to continue their health coverage (at their own expense) when they lose group health coverage under certain circumstances; for example, when they leave their jobs, either voluntarily or involuntarily. COBRA applies to employers with 20 or more employees more than 50% of the prior calendar year.

**CO-INSURANCE** – Generally, the amount shared by the insured and the insurer. For example, PPO (80%), Non-PPO (60%), the carrier pays 80% and insured (individual) pays 20% for in-network PPO-covered services; and the carrier pays 60% and the insured pays 40% for out-of-network PPO-covered services *plus* the excess of covered expenses over Customary and Reasonable or Limited Fee Schedule. Refer to the applicable Evidence of Coverage for further explanation.

**CO-PAYMENTS** – Generally, the amount the insured must pay for medical services, such as doctor visits, prescription drugs and hospitalization. Usually stated in dollars: e.g., a \$20 office visit co-pay or a \$20 prescription co-pay. Refer to the applicable Evidence of Coverage for further explanation.

**COVERAGE** – A choice of coverage that can be selected to fit the needs of a family. There are usually four coverage elections available under a particular program: employee, employee/spouse (or domestic partner, if applicable), employee/child(ren), employee/family. Refer to the applicable Evidence of Coverage for further explanation.

**DEDUCTIBLE** – Generally, the amount a participant must pay for services before benefits are payable under a particular program or specific benefits. Refer to the applicable Evidence of Coverage for further explanation.

**ERISA** – The Employee Retirement Income Security Act of 1974, as amended.

**EVIDENCE OF COVERAGE** – The booklet prepared by the carrier of a particular program that describes the benefits, limitations, restrictions and other terms and conditions of coverage under the program.

**EXCHANGE/ASSOCIATION MEMBER** – A member in good standing of the Exchange / Association.

**LAYOFF** – Group coverage may not continue when an employee is laid off and no longer “Actively at Work.” See “Layoff” under Enrollment Requirements or call your plan administrator for details.

**LEAVE OF ABSENCE** – Sponsored carriers policies will be administered for: FMLA, non-workers comp related disability, military leave and workers comp leave. Other scenarios may be considered for coverage.

**MEMBERSHIP ACTIVATION DATE** – The date the Exchange/Association allows full membership rights. This is the date used to begin the applicable waiting period before becoming eligible to join the Health program.

**OPEN ENROLLMENT** – An annual “sign-up” period during which eligible employees, along with dependents, can enroll in a group health program offered by their employer. In addition, employees already participating are allowed to change carriers or enroll dependents not previously covered. Open Enrollment is held February 1 through February 28 with an effective date of April 1.

**OUT-OF-NETWORK (OON)** – Medical providers who are NOT contracted with a particular carrier. Usage results in greater out-of-pocket costs to the insured, additional limitations, and restrictions. Avoid if possible.

**OUT-OF-POCKET MAXIMUM (OOP)** – Limit on expenses borne by insured. Limitations and restrictions, especially with out-of-network providers, makes this limit very difficult to determine. Check Carrier’s “Evidence of Coverage” booklet.

**PART D, MEDICARE** – New prescription drug component for Medicare eligibles effective January 1, 2006.

**QUALIFYING EVENT** – Changes provided by law that allow employees to add or terminate coverage. See section under “Employer’s Statement” for examples.

**REHIRE** – Employees who are not on payroll for a period longer than 90 days will require re-enrollment by meeting stated waiting period. Details available from Plan Administrator.

**WAITING PERIOD** – The length of continuous employment required by a participating employer (as set forth in that Employer’s Participation Agreement) in order for an employee who otherwise meets the eligibility requirements to obtain coverage.