Franklin Essex Hamilton School Districts' Health Insurance Consortium

JOINT GOVERNING BOARD OVERVIEW

2023/24

Definitions

- **Affordable Care Act (ACA**) – A comprehensive health care reform law and its amendments. The law addresses health insurance coverage, health care costs, and preventive care. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010.
- **Benefit** - General term referring to a service (hospital admission, office visit, laboratory test, surgical procedure, etc.) or supply (prescription drugs, durable medical equipment, etc.) covered by a health insurance plan in the normal course of a patient's health care.
- **EGWP** – Employer Group Waiver Plan (EGWP) combines a tradition Medicare Part D drug plan with supplemental coverage allowing Medicare eligible retirees to maintain similar benefits (deductibles and copayments) to those provided to the non-retirees.
- **Health Insurance Company** : a corporation authorized under state law to engage in business involving the payment of money or another thing of value in the event of loss resulting from illness, injury or other guaranteed benefit .
- **Medical Plan Definitions –** Attached Center for Medicare and Medicaid (CMS) glossary includes many commonly used medical benefit plan terms.
- **Medicare**– Medicare is the federal health insurance program for people who are 65 or older, eligible younger people with disabilities and people with End-Stage Renal Disease. The three parts of Medicare include Part A (hospital insurance, Part B (medical insurance) and Part D (prescription drug coverage.)
- **Municipal Cooperative Agreement (MCA)** – The appropriate cooperative agreement authorized by New Yor State article 5-G of the general municipal law outlining the membership eligibility and administrative responsibilities of participating municipalities.
- **Premium Equivalent** – The cost per covered enrollee, or the amount the organization would expect to pay in premiums if the plan were insured by someone else. The premium equivalent is equal to the per-capita amount of claims, administration, and stop-loss premiums for a self-funded plan.
- **Self-Funded Health Plan** – A fully insured plan, usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrators.
- **Third Party Administrator (TPA)** - A firm or a person that provides administrative services such as record keeping, adjudication as well as the processing of claims on behalf of an employer that self-insures. A TPA is not an insurance company.

Municipal Cooperation

- Article 5-G of the General Municipal Law authorizes municipal corporations to enter into municipal cooperative agreements for the performance of those functions or activities in which they could engage individually.
- School districts or BOCES located within the service area of the Franklin, Essex, Hamilton BOCES, who can provide satisfactory proof of financial responsibility, are eligible for participation in the Plan.
- The participating school districts/BOCES agree to share the costs of, and assume the liabilities for, medical, surgical, hospital and prescription benefits provided to covered employees (including retirees) and their dependents.
- A Board of Directors is composed of the Superintendents of the 8 component school districts and the District Superintendent of FEH BOCES. The Board of Directors review and confirm the votes of the Joint Governing Board.
- The Board of Directors shall adopt rules and policies establishing the responsibility for the management, control and administration of the Plan.

Member Districts

Franklin Essex Hamilton BOCES

Brushton-Moira Central School District

Chateaugay Central School District

Lake Placid Central School District

Malone Central School District

St. Regis Falls Central School District

Salmon River Central School District

Saranac Lake Central School District

Tupper Lake Central School District

Memorandum of Understanding

The agreement that was reached in 1995 between the BOCES and component School Districts and Employee Associations was titled the Memorandum of Understanding. The components of the agreement included:

- Establishment of a joint governance board to make decisions about all aspects of the health insurance plan within carefully defined parameters.
- An immediate increase in the drug co-pay and major medical deductibles.
- Modification of dual coverage within the Consortium to provide the same level of benefit to eligible employees while sharing costs equally between the affected school districts.
- A moratorium on health insurance bargaining expiring July 1, 2002.
- Establishment of an IRS Section 125 Plan (Flex Spending).
- Provision for a “triggering event” which would necessitate the Joint Governing Board to act.

Joint Governing Board

- **The Joint Governing Board (JGB)**: composed of 9 District representatives and 9 Employee representatives from the component school districts/BOCES with the responsibility for the management, control and administration of the Plan.
- **Employee Representatives**: have one vote representing the majority (or unanimous) position of all the unions in a district by whatever agreed upon procedure is made within that district. Districts may have Teachers' Unions, Non-instructional Employee Unions and Administrative Unions. One employee representative may represent multiple unions. Each employee representative is selected based on an agreement among the employee unions in the district.
- **Employer Representatives**: have one vote representing each of the eight school districts and one BOCES. Representatives are appointed by component districts for multiple years and are often the Superintendent or School Business Manager.
- **Co-Chairs**: Two members of the Joint Governing Board, one employer and one employee, are selected by their respective constituent groups within the Joint Governing Board. Between meetings, the Co-chairs work with the plan consultants and vendors to stay updated on issues related to the Consortium. The Co-chairs may also be empowered by a motion at the table to take action on a topic in the absence of a Joint Governing Board meeting.
- **Meeting Quorum**: The in-person attendance of at least 14 members is required to convene a meeting and conduct consortium business. Regardless of the actual number of members present at least 14 must vote in the affirmative to approve any motion.

JGB Arbitration Decisions

- **Weisman Decision**: January 2000, stemming from a change in the way BCBS paid claims to doctors using a new scale (Resourced Based Relative Value Scale) the district claimed the covered procedure was the benefit, not how much was paid out of pocket. The employee side claimed out of pocket expenses were the benefit. Weisman held that levels of reimbursement for doctors or procedures was not specified and could change. BCBS had made this change without notification or information to the Joint Board. Impact: the Joint Governing Board begins efforts to keep a much closer watch on the practices of the plan administrator (BCBS) eventually resulting in performance guarantees and penalties.

- **Campagna Decision**: March 2000, under the provisions of Item #5 of the Memorandum of Understanding, after Medical CPI has been applied to the prior years' rates, and there still remains a deficit, is the Board of Governance required to act further. If so, are any actions excluded from consideration by the Board?

  - Impact: the decision indicates that Districts are not limited to Medical CPI for premium increases and that the Governing Board has full authority to take whatever actions are necessary to insure the continued existence of the Consortium.

- **Markowitz Decision**: January 2002, on October 26, 2000, the Joint Governing Board passed a resolution (15-3) which made certain changes, including but not limited to, reductions in the amounts of drug co-payments. The changes went into effect on January 1, 2001. These changes were made under the original moratorium. This grievance asked to have the changes made to the health insurance program. Markowitz maintained that the Joint Governing Board may make such changes.

JGB Member Responsibility

- The JGB shall meet, at least annually, at a site selected by the Co-Chairs within the geographic area served by the Franklin Essex Hamilton BOCES. Additional meetings through-out the year may be scheduled at the discretion of the Co-Chairs. JGB Members are required to attend all scheduled meetings.
- The JGB may enter into an agreement with a contract administrator or other service provider determined by the JGB to be qualified, to receive, investigate recommend, audit, approve, or make payment of claims.
- The JGB shall establish premium equivalent rates based on a community rating methodology using the experience of the entire pool of risks covered under each benefit plan, without regard to age, sex, health status or occupation.
- The JGB is authorized to make benefit plan design changes not limited to changing deductibles, copayments, benefit limits and approving medical and prescription drug utilization programs.
- The JGB shall be authorized to assess the Participants for additional contributions if actual losses due to benefits paid out, administrative expenses and reserve and surplus requirements exceed amounts held in the Plan's joint funds or refund amounts in excess of established reserves and surplus.

JGB Meeting Procedures

Organization of Meetings: Robert's Rules of Order: Joint Governing Board (JGB) meetings are run alternately by one of the two Co-Chair using Robert's Rules of Order.

Motions: When a motion is made on a topic, a second is required. While not required, a motion and second should come from two different districts when possible. Once seconded, the floor is open for discussion. Once discussion is finished, the Co-chair will call for a vote. There are potentially 18 votes at the JGB; 14 are required pass a motion.

Caucuses: At any time, a caucus may be called by either Employer or Employee Representatives. Once a caucus is called, a private space will be identified where the representative group may discuss issues at hand. Upon the return from a caucus, traditionally, the group requesting the caucus gives a brief report to the JGB on the substance or outcome of the caucus.

Voting: A district's named Employer and Employee representative each have one vote, if the district's Employer or Employee representative is unable to attend a JGB meeting someone may be sent as a guest to take notes and report back to the representative but may not vote on issues at the JGB meeting. In the event of a prolonged absence, such as a long-term illness, the JGB member may ask to be replaced with a new voting member.

Agenda/Minutes: Prior to each meeting the JGB members will be forwarded an agenda of the coming meeting and minutes from the previous meeting. At the start of each meeting, the agenda will be reviewed for additions, and the minutes from the previous meeting will be voted upon to be accepted. Once accepted, the minutes will be posted at a designated website.

JGB Meeting Agenda & Minutes

FRANKLIN-ESSEX-HAMILTON SCHOOL CONSORTIUM
HEALTH INSURANCE CONSORTIUM
JOINT GOVERNING BOARD MEETING
AGENDA

Thursday, April 27, 2023
Location – North Franklin Education Center
9:00AM – 3:00PM

1. Call to Order
2. Review of Agenda
3. Approval of Minutes from 02/07/23
4. Excellus – 30 Minutes
   a) Report
   b) Calm App Update
   c) Alice Hyde Update
5. Wellness Update – Committee Update
6. Keenan/ESI – 30 Minutes
   a) Report
   b) Silver Cloud, Evernorth, InMynd
   c) KPCM / Advanced Utilization
7. KBM
   a) Report
   b) PRF
8. Report on Investments – Jamie O'Dell
9. Communications Update – Jake Tolosky/Jess Collier
10. Member Issues – Chantal Cohen
11. Next Meeting Date
    a) TBD

DATE:	Tuesday, February 7, 2023, 9:00AM
LOCATION:	Adirondack Educational Center – Saranac Lake, NY
KIND OF MEETING:	Regular
MEMBERS PRESENT:	Alison Riley-Clark - FEH BOCES Emp Rep Dale Breault – Co-Chair, FEH Dist Rep Todd LaPage - Brushton-Moira Dist Rep Amber Spinner - Brushton-Moira Emp Rep Loretta Fowler – Chateaugay Dist Rep Carrie Blair-Wilcox – Chateaugay Emp Rep Dana Wood - Lake Placid Dist Rep Jenny Winch - Lake Placid Emp Rep Daniel Tusa – Co-Chair, Malone Emp Rep Natascha Jock - Salmon River Dist Rep Kristie Eddy - Salmon River Emp Rep Daniel Bower - Tupper Lake Dist Rep Lisa Hebert- Tupper Lake Emp Rep Julia Day – Saranac Lake Emp Rep Cindy Moody – Saranac Lake Dist Rep Joseph Ianaconi – SRF Emp Rep Dustin Relations - Malone Dist Rep
MEMBERS ABSENT:	Nicole Eschler - SRF Dist Rep
OTHERS PRESENT:	Raquel Fowler – FEH BOCES Chantal Cohen - FEH BOCES Jacob Tolosky – FEH BOCES Stacy Vincent – FEH BOCES Jess Collier – FEH BOCES (Arrived at Patrick Cowburn – KBM Patrick Calnon - Plan Coordinator Joey Aschoff -Keenan Colin Lovett – Express Scripts Gauri Patel – Express Scripts Mark Jones – Capital Region BOCES Thomas Dodd – Shadowing Doug Gruzca – Excellus BCBS Jennifer Delia – Excellus BCBS Deanna Smith – FEH BOCES Shadowing
CALL TO ORDER:	Co-Chair Breault called the meeting to order at 9:08AM.
REVIEW OF AGENDA:	Co-Chair Breault reviewed the agenda items. Co-Chair Tusa wanted to add two separate motions to the end of the agenda allowing the Co-Chairs to obtain Stop Loss and set the dollar amount for Wellness Funding.
APPROVAL OF MINUTES FROM 11/30/22:	Co-Chair Breault asked for a motion to accept the minutes of the 11/30/22 meeting. Amber Spinner moved, seconded by Dan Bower to accept the minutes. Yes - 17 No - 0 , motion carried

Medical Plan Options

Indemnity (Traditional) Plan Options:

- As a member of an Indemnity plan, you may see the doctors or specialists you like, with no referrals required. Though you may choose to get the majority of your basic care from a single doctor, your insurance company will not require you to choose a primary care physician. You are required to pay an annual deductible before the insurance company begins to pay for specific benefits such as office visits. Once your deductible has been met, the plan typically pays your claims at a set percentage of the "allowed amount" for the service. The patient may be responsible for a percentage of the cost (coinsurance) to an annual maximum out-of-pocket limit. The allowed amount is the amount that participating health care providers (in-network) will accept as payment-in-full for any given service.

Participating Provider Organization (PPO) Plan Options:

- As a member of a PPO plan, the patient is encouraged to use the insurance company's network of preferred doctors without having to choose a primary care physician. The patient may be responsible for per visit fee (copayment) or a percentage of the cost (coinsurance) to an annual maximum out-of-pocket limit. No matter which health care provider you choose, in-network healthcare services will be covered at a higher benefit level than out-of-network services. It's important to check if you provider accepts your health plan so you receive the highest level of benefit coverage.

Medical Plan Options

High Deductible Health Plan (HDHP)

- As a member of a HDHP you are exposed to the true cost of health care through deductibles in excess of the IRS minimum of $1,500 for individuals and $3,000 for families. HDHP have lower premiums by shifting cost to the patient. Higher deductibles clearly disclose the actual health care costs to patients fostering patient/doctor exchange prior to proceeding with expensive health care services

- **Funding the Deductible**
  - **Health Savings Account (HSA):** An employee owned, portable account that is funded with pre-tax dollars, or with post-tax dollars ("above-the-line" deduction may be taken). Earnings on account are tax free and may be accessed when deposited utilizing checks, debit card or cash withdrawal for qualified expenses.
  - **Health Reimbursement Account (HRA):** An employer owned account funded on an as needed or per claim basis. Employer chooses maximum funding level and may not discriminate based on employee class. Funds may be accessed by participant immediately (with qualified expense). Unused funds may be rolled over from year to year as designated by the employer and may be used for retiree expenses.
  - **Flexible Spending Account (FSA)** Employee/Employer elects the amount to deduct or contribute at the beginning of plan year. Funded with pre-tax dollars through an IRS Section 125 plan. Use-it-or-lose-it provision applies allowing for a limited "Carryover" amount or additional "Grace Period" up to additional 2 ½ months to submit qualified claims. May be limited when paired with HSA.

Medical Plan Premium Equivalents

2023/24 Premiums
Option 3

			2022/23	2023/24	
	Monthly Census	Prior Census	Monthly Premium	Monthly Premium	Annual Premium
Trad. Non-Medicare					
Individual	72	87	$880.00	$906.00	$10,872
Family	229	266	$2,312.00	$2,380.00	$28,560
Super Family	66	69	$1,156.00	$1,190.00	$14,280
One Over/ One Under*	46	46	$1,424.00	$1,476.00	$17,712
1 Over/1 Under Super	11	17	$712.00	$738.00	$8,856
PPO Non-Medicare					
Individual	493	468	$774.00	$797.00	$9,564
Family	850	836	$2,036.00	$2,096.00	$25,152
Super Family	210	205	$1,018.00	$1,048.00	$12,576
One Over/ One Under*	42	38	$1,318.00	$1,366.00	$16,392
1 Over/1 Under Super	5	5	$659.00	$683.00	$8,196
Medicare					
Individual	808	796	$544.00	$570.00	$6,840
Family	297	283	$1,088.00	$1,140.00	$13,680
HSA 4					
Individual	7	3	$388.00	$399.00	$4,788
Family	13	10	$996.00	$1,025.00	$12,300
Totals	**3149**	**3129**	$46,396,211	$47,795,893	

Medical Plan Budget/Reserves

- **Revenue**
  - District/Employee Premium: 87% -90% of total revenue
  - Interest: .5% - 1.5% of total revenue
  - Prescription Drug Rebates/Subsidies: 7% - 9% of total revenue
  - Miscellaneous: 1% - 2% of total revenue

- **Expenditures**
  - Medical Claims: 71% – 74% of total expenditures
  - Prescription Drug Claims: 22% - 24% of total expenditures
  - Claim Administration: (including stop-loss premium) 4% - 6% of total expenditures

- **Reserves**
  - Incurred But Not Reported (IBNR) Claims : 18% of projected expenditures
  - Surplus (Excellus Advance Deposit) : 5% of projected Premium Equivalents
  - Claim Stabilization Reserve : JGB approved 15% of projected expenditures
  - Equity : No limit

Stop-Loss Insurance

Stop-loss insurance (also known as excess insurance) is a commercial insurance product that provides protection against individual patient large dollar catastrophic claims (specific) or total group unpredictable losses (aggregate.) It is purchased by large group health care plans that self-fund their employee benefit plans, but do not want to assume 100% of the liability for large losses arising from the underlying risk.

- **Specific Stop-Loss**
  - limits a plan's risk on individual catastrophic claims by establishing a maximum liability for covered employees/retirees. The plan is only responsible for the payment of individual's claims up to the specific stop-loss attachment point or deductible. FEHSDHIC's present deductible is $500,000. In addition to the deductible, a stop-loss carrier may apply a laser with a higher deductible for individuals with a known condition that is likely to exceed the group specific deductible.
- **Aggregate Stop-Loss**
  - limits a plan's over-all risk during a specified policy period. The aggregate attachment point, or deductible is composed of projected claim cost plus an additional "corridor." The corridor places a cushion between the predicted claims and the point at which the carrier begins reimbursement. This corridor represents the risk the employer assumes, by self-funding, to a maximum of 125% of projected costs.

Administration

Excellus BlueCross BlueShield

- Insurance Company/Third-Party Administrator (TPA) responsible for the medical claim processing, customer service and provider network maintenance.
  - Kelly Lasher: Regional Sales Director
  - Doug Grucza: Strategic Account Manager
  - Jennifer Delia: Information Consultant

Express Scripts

- Prescription Benefit Manager (PBM) responsible for the prescription drug claim processing, customer service, pharmacy negotiations and rebates
  - Alison Brewer: Account Executive/Key Accounts
  - Gauri Patel: Clinical Account Executive
  - Wendy Lamaestra: Operations Director

FEHSDHIC Support

- **Plan Advisors:**
  - Offer perspective based on lengthy service as members of the JGB
    - Patrick Calnon: Plan Coordinator
    - Thomas Dodd: Plan Advisor
- **KBM Management:** Plan Consultant
  - Provides Plan assistance/advice including, but not limited to budgeting, benefit analysis, plan design, cost control measures and economic-medical developments.
    - Patrick Cowburn: Executive Vice President
- **Ferrara Fiorenza PC:** Legal Representation
  - Provides legal counsel to the municipal cooperatives.
    - Heather Cole: Partner
- **Capital Region BOCES/Keenan Pharmacy Services:** Prescription Plan Broker
  - Established statewide cooperative for the purchase of prescription benefit management (PBM) services. Provides oversight and offers cost containment options and services for the prescription drug plan
    - Brian Fassett : Pharmacy Coalition Representative: Capital Region BOCES
    - Joey Aschoff : Senior Account Manager: Keenan Pharmacy Services

Questions

FEH BOCES Office

Raquel Fowler: Health Plan Coordinator, rfowler@fehb.org
Chantal Cohen: Human Resource Specialist, ccohen@fehb.org

23 Huskie Lane
Malone, NY 12953
(518) 483-6420
www.fehb.org

Joint Governing Board Officers

Employee Chair: Daniel Tusa, Malone CSD, dtusa@maloneschools.org
Employer Chair: Dale Breault, FEH BOCES, dbreault@fehb.org
Treasurer: Jamie O'Dell
Secretary: Raquel Fowler

Glossary of Health Coverage and Medical Terms

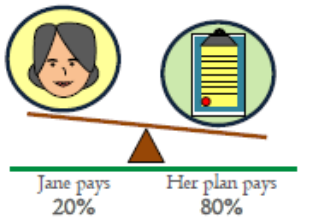
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

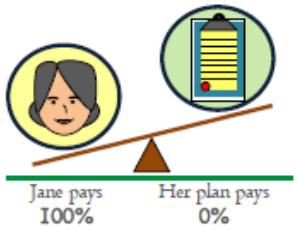


(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Glossary

Franklin Essex Hamilton School Districts' Health Insurance Consortium

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

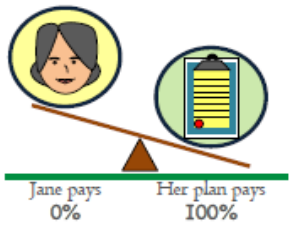
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Glossary

Franklin Essex Hamilton School Districts' Health Insurance Consortium

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Glossary

Franklin Essex Hamilton School Districts' Health Insurance Consortium