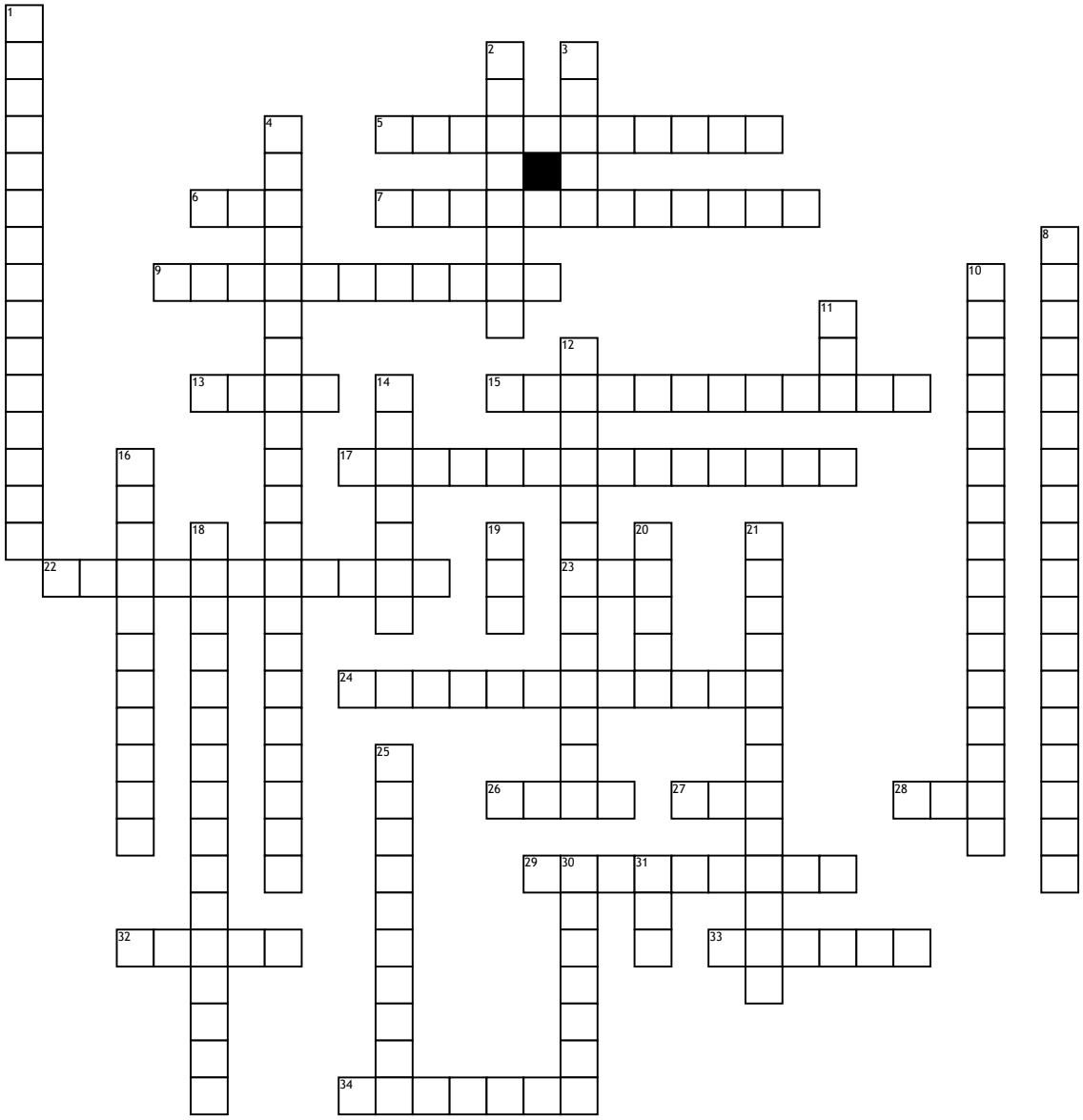
Name: _____ Date: _____

Benefits & Eligibility Key Terms



Across

5. Total amount that a member would pay in a calendar or plan year for services rendered to them.

6. HIPAA prohibits the sharing of PHI without written permission of the patient. PHI includes but is not limited to medical diagnosis, medical treatment, eligibility for a health plan, health plan premium payments, and health care claim status. When PII is linked with health condition, treatment or payment of healthcare, it becomes PHI in the hands of a covered entity like WPS.

7. A medical condition or pre-existing condition noted in the application process and added to the policy as a waiver by Underwriting. The waiver is signed by the member and is part of policy. Benefits will not be available for these conditions unless waiver is removed.

9. The process of an analyst reviewing claims for medical necessity, frequency, etc.

13. An online resource of corporate wide information including individual departmental information.

15. Describes a provider or health care facility which is not part of a health plan's network. Insured individuals usually pay more when using an out-of-network provider, if the plan uses a network.

17. Is an area in Facets that is used to provide a quick reference of the patients' benefits. Access to the patients benefit language is done through Benefit Summary.

22. A prescription legend drug sold by the pharmaceutical company or other legal entity other than the one holding the original United States patent for that prescription legend drug.

23. A type of contract between a large group (100 + lives) and WPS. The group maintains a money account in which WPS has access to in which the medical claims are paid from. An ASO group pays WPS to administer their benefits and to pay the medical claims for them. These are commonly referred to as self-funded groups.

24. Time period in which the benefits renew beginning January 1st.

26. A type of a contract in which WPS is paid a monthly premium for our services. A risk plan can be a small group, a large group or an individual plan.

27. Primary Care Physician

28. Type of managed care plan that requires members to use in-network providers for all their health care needs. There is no coverage for services received from providers who are outside of the HMO's network, except for emergency care.

29. A group of doctors, hospitals and other providers contracted to provide services to insured individuals for less than their usual fees. Provider networks can cover large geographic markets and/or a wide range of health care services. If a health plan uses a preferred provider network, insured individuals typically pay less for using a network provider.

32. A request by an individual (his or her provider) to an individual's insurance company for the insurance company to pay for services obtained from a health care professional.

33. A system which holds the eligibility data base and the claim system

34. A group of providers who have agreed to provide services at a contracted rate.

Down

1. Total amount that WPS will pay for claims over the lifetime of the policy.

2. Any person or entity providing health care services, including hospitals, physicians, home health agencies and nursing homes. This is an inclusive term to define any person or entity that delivers medical care.

3. A privacy rule which protects the privacy of individually identifiable health information.

4. The date a policy goes into effect.

8. Owned and maintained by other companies and WPS rents the use of these networks to offer more providers to our members .

10. A request for an inpatient service prior to the admission.

11. A type of plan where there are two or more benefit levels in which a claim can be paid under. A PPO has a network of preferred providers. If a patient goes to a provider not in their network, the claim will be paid at the lesser level of benefit, called out of network or Tier 2. Typically, a PPO does not have a referral option but can; however, referrals are not required.

12. Certain benefits required to be covered in commercial health insurance plans by the State.

14. The amount of money you and/or your employer pays in exchange for insurance coverage.

16. Percentage that the insurance company pays for services rendered to the member.

18. A request for a service to be reviewed for the medical necessity prior to the patient receiving the service. This review is recommended vs. required.

19. This was created by the federal government to prevent identity theft by improving information security. PII is information that can be used to uniquely identify, contact, or locate a single person or can be used with other sources to uniquely identify a single individual. PII includes but not limited to: Full name, tax identification number, driver's license number, credit card number, date of birth, address, age, race or gender, and salary or job description.

20. Specific dollar amount that a member must pay for every visit.

21. Certain services require a medical necessity review prior to the service being provided based on the patient's benefit language. Some benefit language also indicates that if the medical necessity review is not done prior to the service being provided, then a penalty or a benefit reduction will be applied to that service.

25. The amount that a member must pay before the insurance company will start paying for services.

30. Individual Medicare supplement polices are designed to supplement the benefits available under the original Medicare program. Medicare supplement policies pay a percent of Medicare approved charges that Medicare does not pay. Some Medicare supplement policies will pay for benefits for services after Medicare will no longer pay.

31. A type of plan where there is only one benefit level and referrals are required if the patient is seen by an out of network provider. If a referral is not obtained, the services will not be covered.