Glossary of Benefit Terms

International Plan

Admitted

- When the patient changes status from outpatient to inpatient. Note that "under observation" status does not qualify as "Admitted," even though an individual may stay in the hospital for one or more nights.

Benefit Maximum

- A dollar limit that an IDB plan will pay for covered services during a specified period of time.

Brand-name Drug

- A drug still under patent by a specific pharmaceutical company.

Case Management

- A free service the Claims Administrator provides, designed to ensure you receive the right medical care in the right setting when coping with a serious condition or illness.

Coinsurance

- The portion (usually expressed as a percentage) of the total covered benefit costs that you pay, (e.g., 10%) while the Plan pays the remainder.

Continued Stay Review

- Process for ensuring that a continued hospital stay is the most effective setting for medical treatment. It takes place after you are admitted and focuses on whether additional days in the hospital are appropriate.

Coordination of Benefits ("COB")

- When considering a claim for reimbursement of an eligible expense that is payable by an IDB Group plan and at least one other plan, the process of determining how much of the expense should be paid by the IDB Group. Coordination of benefits ensures the IDB Group will pay no more for such an expense than it would have had you been eligible for benefits under only the IDB Group plan.

Co-payment or Co-Pay

- The fixed amount in dollar terms you pay out of pocket up front for prescription drug costs or ER utilization.

DAW

- Short for "Dispense as Written," an abbreviation doctors sometimes use on prescription forms when they want the pharmacy to dispense medicine exactly as prescribed, with no generic or other drug substitutes.

Glossary of Covered Medical Services

International Plan

Deductible

- An annual amount you must pay for out-of-network services before the medical plan pays benefits for eligible expenses. There is no deductible when you use in-network providers.

Emergency Care

- Medical services you receive at an Emergency Room or Urgent Care Center for accidental injuries or life-threatening medical conditions.

Explanation of Benefits (EOB)

- A statement you receive from the plan administrator each time you receive Medical Plan services, showing how submitted charges affect your deductible (for out- of-network services), the portion of the submitted charges that were paid by the plan, and what portion (if any) is your responsibility.

Generic Drug

- A drug that contains the same ingredients and provides the same therapeutic benefits as an equivalent, higher-cost brand-name drug. Generic drugs become available when brand-name drug patents expire.

Home Health Care

- Care provided by one or more of: Private Duty Skilled Nursing, Intermittent Home Nursing, or Home Health Aides, depending on the medically necessary needs of the patient.

Hospice

- A health care facility or service providing medical care and support services to terminally ill individuals and their families.

Mail Order

- An option available in the U.S. for receiving prescription drugs through the mail. Mail Order prescriptions include up to a 90-day supply.

Maximum Reimbursable or Reasonable and Customary Charges (MRC or R&C).

- It refers to the prevailing out-of-network cost for a specific medical plan service within a given geographical area of the United States. For purposes of the IDB Group Plan in the U.S., administered by Cigna Healthcare, an MRC for any out of network service will be determined at 200% of the Medicare rate for that service in the geographical area where the service was provided.

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- Outside the U.S., where Cigna Global administers the IDB Group program, an R&C rate for any service in each country will be determined by the administrator based on prevailing costs within each country. Furthermore, when a member residing outside of the U.S. seeks professional services from an out-of-network provider in a particular geographical area in the U.S., an R&C rate will be applied, and it will be determined by Cigna Global as the 90th percentile of the cost of the service in the Zip Code where the service was performed established in nationally recognized databases utilized by third-party administrators and insurers as the acceptable rate of payment (i.e., limit). This means that, for a specific service, 90% of the providers in the geographic area charge the same or less than the R&C rate.

Medically Necessity

or "Medically Necessary" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

- a) in accordance with the generally accepted standards of medical practice (as approved by national relevant authorities and specialty associations, as well as in the assigned administrator's Clinical Policy Bulletins);
- b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- c) not primarily for the convenience of the patient, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. It is important to understand that even if you have a benefit for a particular service, if you do not have a medical need for that benefit, it will not be covered by the health plan

Medicare

- The hospital and medical insurance program sponsored by the U.S. Government.

Network

- A group of hospitals, doctors, and other health care professionals contracted by a Plan administrator that provide medical care at discounted rates.

Out-of-Pocket Maximum

- An annual individual or family limit on the amount you spend out of your own pocket for medical plan expenses that the plan doesn't cover in full. If you cover only yourself under the Medical Plan, there is an individual maximum that applies to you only. If you are covering yourself and your family members, there is a maximum that applies to all of you. If your eligible expenses exceed these maximums, the plan will pay 100% of the cost for any additional eligible Medical Plan expenses for the rest of the calendar year, except for service specific maximums.

Glossary of Covered Medical Services

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Over-the-Counter ("OTC") Drug

- A medicine that is available for purchase without requiring a prescription from a doctor. Over-the-counter drugs are not covered under the IDB Medical Plan.

Preferred Provider Network

- In the U.S., a broad network of doctors, hospitals and other health care providers contracted by a Plan administrator, that delivers services for set fees, usually at a discount. While you may use any licensed medical provider you like, your benefits are highest (and your out-of-pocket costs lower) when you use in-network providers.

Pre-Admission Certification

- The review and approval process the plan administrator conducts before you enter the hospital for treatment. Your doctor, you, or anyone close to you can start the process by notifying the plan administrator.

Pre-Admission Testing

- Tests your doctor may want to do before you enter the hospital.

Pre-Existing Condition

- Any diagnosed illness, injury, or other condition that you received treatment for before being covered by the IDB Group medical plan (applies to Sponsored Parents only).

Prior Creditable Coverage

- A period of time when you were covered for a pre-existing condition under another health plan that reduces the pre-existing waiting period under the IDB Group medical plan.

Routine Preventive Care

- Regular medical plan benefits that you receive on a non-emergency basis for the maintenance of your good health.

Service-Specific Maximums

- Specific dollar maximums that apply for certain medical plan benefits.

Subrogation

- A legal process that entitles IDB Group to recover payment(s) it made for medical plan or long- term disability plan expenses that a third party was obligated to pay.

International Plan

To learn more about your Medical Benefits for the International Plan visit the Handbook following this link.