UNDERSTANDING EMPLOYEE BENEFIT JARGON

GLOSSARY OF TERMS

The following are terms commonly used when discussing employee benefits and insurance. Sometimes a definition is not enough, so we strongly encourage you to include examples directly after the definition of each term, where it will help to further illustrate the meaning of the word. We strongly suggest that any examples you include be tailored to your specific benefit plan(s): you'll only confuse matters if you use a co-pay in your example which is different than the co-pay in your plan(s).

COMMONLY USED TERMS

Aggregate Deductible: Once a person covered under a family plan reaches the individual deductible, all covered expenses for that individual will be paid at the co-insurance amount, even when the family deductible may not have been satisfied. For example, pretend you have a plan which features an in-network family deductible of $5,000; if one member of the family satisfies the individual $2,500 deductible, the Carrier will pay 70% of remaining in-network expenses. Once another person or a combination of persons meet the remaining $2,500, the family deductible would be considered satisfied.

Aggregate Out-of-Pocket Maximum: Once a person covered under a family plan reaches the individual out-of-pocket maximum, all covered expenses for that individual will be paid at 100%, even when the family out-of-pocket maximum may not have been satisfied. For example, pretend you have a plan which features a family out-of-pocket maximum of $12,700; if one member of the family satisfies the individual out-of-pocket max of $6,350, the Carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the family out-of-pocket would be considered satisfied.

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

Balance Billing: When an out-of-network 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. An in-network provider cannot balance bill you for the covered services.

Beneficiary: A person who is designated as the recipient of proceeds from an insurance policy.

Biometric Screening: Typically a series of Body Mass Index (BMI) measurements and blood tests (e.g. pressure, cholesterol, and glucose) used to gain an overall picture of an individual's health.

Co-insurance: Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. For example, if your plan has a 30% co-insurance rate, the Carrier will pay 70% of the allowed amount while you pay the balance.

Consumer Driven Healthcare (CDHC): A trend in health insurance to lower premiums and raise deductibles in an effort to stem rising healthcare costs by incentivizing individuals to become more informed and price-conscious consumers of healthcare. (Also see Consumer Driven Health Plan.)

Consumer Driven Health Plan (CDHP): A type of health insurance growing in popularity amongst individuals with traditionally low medical expenses. These plans allows individuals to pay less in monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles. (Also see High Deductible Health Plan.)

Co-payment: A fixed amount that you pay at the time of service. Co-pays are most common for emergency room, urgent care and prescription drugs. In some cases you may be responsible for paying a co-pay as well as percentage of the remaining charges.

Diagnostic Test: Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than

screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

Deductible: The amount you must pay for eligible expenses before your plan begins to pay for benefits. A deductible may be per service/test, per visit, per supply or per coverage year. For example, many plans require an individual to pay $1,000 in cumulative deductibles before they begin paying out.

Dependent: Typically a relative of an employee who may be eligible for benefits' coverage if they meet certain criteria. Many benefit plans offer coverage to spouses, domestic/civil union partners, and children up to age 26 who are totally or substantially reliant on their parents for support, thereby defined as "dependent children".

Dependent Care Account: A flexible spending account (FSA) designed to provide tax-exempt funds to employees for eligible childcare and dependent care expenses. (See FSA.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible Expense: Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "negotiated rate". If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Employee Contribution: The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Explanation of Benefits (EOB): Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you owe. The EOB also shows the total cost of care, how much your plan paid and the amount an in-¬network doctor or other healthcare professional is allowed to charge a plan member (called the "allowed amount").

Flexible Spending Account (FSA): Funded through pre-tax payroll deductions, an FSA is a cost-savings tool that allows you to pay for qualified healthcare-related expenses with pre-tax dollars. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as “use it or lose it”.

Generic Drugs: Medications that are comparable to brand name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand name counterparts.

High Deductible Health Plan (HDHP): A type of health insurance growing in popularity amongst individuals with traditionally low medical expenses. These plans allow individuals to pay less in monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles. (Also see Consumer Driven Health Plan.)

Health Reimbursement Account (HRA): An employer-funded savings plan that will reimburse you for out-of-pocket medical expenses. Unlike an FSA, however, you don't "use it or lose it" – unused balances will roll over and accumulate over time, though the account cannot be “cashed-out”.

Health Savings Account (HSA): Similar to an FSA, and funded through pre-tax payroll deductions by the employee (and sometimes employer contributions), HSA’s are only available to people enrolled in a high-deductible health plan. Unlike an FSA, however, you don't "use it or lose it" – unused balances will roll over and accumulate over time and can be “cashed-out”.

In-network Co-insurance: The percent you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network co-insurance costs you less than out-of-network co-insurance payments.

In-Network Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. In-Network Providers have contracted with the insurance carrier to accept reduced fees for services provided to plan members. Using in-network providers will cost you less

money. When contacting an In-Network Provider, remember to ask “are you a contracted provider with my plan?” Never ask if a provider “takes” your insurance, as they will all take it. The key phrase is contracted.

Limited Benefit Plan: A plan which assists with the costs of everyday healthcare – things like doctors’ office visits, prescriptions and short hospital stays. It is not a traditional health plan such as a major medical plan, which would be more comprehensive and generally covers larger medical expenses resulting from major illness or accidents. Typically plans like this do not meet the minimum essential coverage criteria as defined by the ACA.

Mail Order: Many carriers offer this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can usually obtain a 90-day supply at one time vs. 30 days at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your co-pay is almost always cheaper through mail order.

Major Medical Plan: Insurance that covers most serious medical expenses up to a maximum limit, usually after a deductible and coinsurance have been met.

Medical Savings Account (MSA): A flexible spending account (FSA) designed to provide tax-exempt funds to employees for eligible medical and dental expenses, including copayments and deductibles. (See FSA.)

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

Member Health Statement: Every time you use your health insurance, your health plan sends you a record called a “member health statement” or an “explanation of benefits” (EOB) that explains how much you owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-¬network doctor or other healthcare professional is allowed to charge a plan member (called the “allowed amount”).

Negotiated Rate: Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “payment allowance” or “eligible expense”. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Network: The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at pre-negotiated discount. Your out-of-pocket expenses will be lower and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-Preferred Brand Name Drugs: Generally these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand name drug or a generic.

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, sometimes referred to as a non-preferred provider.

Open Enrollment: A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-Network Provider: A provider who doesn’t have a contract with your health insurer or plan to provide services to you at a pre-negotiated discount. You’ll pay more to see an out-of-network provider, sometimes referred to as an out-of-network provider.

Out-of-Network Co-insurance: The percent you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network co-insurance costs you more than in-network co-insurance. An out-of-network provider can balance bill you for charges over the allowed amount. (See Balance Billing.)

Out-of-Pocket Limit: The most you will pay during a policy period (a year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-Counter Drug: A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment Allowance: Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “negotiated rate” or “eligible expense”. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Preauthorization: A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called prior authorization, prior approval or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn’t a promise your medical plan will cover the cost.

Precertification: A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn’t a promise your medical plan will cover the cost.

Preferred Brand Name Drug: These are medications for which generic equivalents are not available. They have been in the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Premium: The amount that must be paid upfront, typically via semi-monthly or bi-weekly payroll deductions, for insurance coverage.

Prescription Drugs: Medications you can only obtain with a prescription from your Doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicadin and Abuteral can only be obtains with a prescription. The opposite of an over-the-counter drug.

Prescription Drug Coverage: Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the co-payment you will pay for the drug. These tiers typically, but not always, are: Generic, Preferred Brand, Non-Preferred Brand and Speciality. Your cost will depend on the level of drug specified by your Doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand name drugs generally do not have a generic equivalent, while those listed as non-preferred brand name drugs generally do have a generic or preferred brand name equivalent. Your co-pay for preferred brand name drugs is less than the co-pay for non-preferred brand name drugs because you don't have the generic option available to you.

Pre-tax Deduction: Payments deducted from your gross pay before Medicare, Federal, and State taxes are calculated, thus reducing your taxable wages and tax liability.

Prior Approval: A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Prior Authorization: A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior approval or precertification, many plans require preauthorization for certain services before you can receive

them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax Deduction: Payments deducted from your net pay after Medicare, Federal, and State taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventative Care: Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventative.

Primary Care Physician (PCP): A physician who directly provides or coordinates a wide range of medical services for a patient. Primary Care Physicians include Medical Doctors, Doctors of Osteopathic Medicine, Internists, Family Practitioners, General Practitioners, OB/ GYNs and Pediatricians. The opposite of a specialist.

Provider: A physician, healthcare professional or healthcare facility, certified or accredited as required by state law.

Qualifying Life Event (QLE): A change in your life that allows you to make changes to your benefits' coverage outside of the annual open enrollment period. These changes include a change in marital status (marriage, divorce, death of spouse), a change in the number of eligible children (birth, adoption, death, aging-out), and a change in a family member's benefits eligibility under another plan (losing a job, Medicare or Medicaid eligibility, etc.)

Special Enrollment Period: A time outside of an open enrollment period during which you and your eligible dependents have the right to sign-up for, and/or modify employee benefits. A special enrollment period is almost always triggered by a qualifying life event (QLE) and typically lasts 30 days.

Specialist: A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a Primary Care Physician (PCP). For example, a Dermatologist is considered a specialist.

Specialty Drugs: Prescription medications that require special handling,

administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

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

Wellness: Wellness refers to a healthy state of being. Many employers have wellness programs that encourage and sometimes incentivize employees to become more physically and mentally fit