

Benefit Terms Glossary

Aggregate deductible: For family coverage, family as the whole deductible or out-of-pocket amounts must be met before copayments or coinsurance are applied for each family member.

Arrears: Unpaid or overdue debts or obligations toward benefits

Beneficiary: The person(s) named by you to receive any benefits provided by a life insurance and/or accidental death & dismemberment (AD&D) plan if you die. Benefits will be paid to the primary beneficiaries unless they have died before or at the same time or are unavailable. In this case, benefits will be paid to the contingent beneficiaries.

Brand-name drug: Drugs are developed and produced exclusively by a single pharmaceutical company. The formula for these drugs is protected by patent for several years before a generic can be developed.

Claim: A formal request submitted by you or your healthcare provider to your health insurer or plan, seeking payment or reimbursement for medical services, treatments, or expenses that are covered under your policy.

Co-insurance: A percentage of a health care cost (for example 20 percent) that the covered employee pays after meeting the deductible.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A federal law that may allow you to keep healthcare coverage after your employment ends temporarily, you lose coverage as a dependent of the covered employee or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Copay / copayment: The fixed dollar amount you pay directly to the medical service provider or pharmacy at the time of service. Copays do not accumulate toward your deductible but are applied to your in-network out-of-pocket maximum.

Deductible: A fixed dollar amount that the covered employee must pay out of pocket each calendar year before the plan will begin reimbursing for non-preventative health expenses. Plans usually require separate limits per person and per family.

Dependent: A person who is eligible for coverage under a policyholder's health insurance coverage

Embedded deductible: This means each covered family member only needs to satisfy their individual out-of-pocket maximum, not the entire family's out-of-pocket amounts. This can apply to the deductible and/or out-of-pocket maximum.

Evidence of insurability (EOI): An application process in which information on one's health or a dependent's health is provided to be considered for certain types of insurance coverage.

Explanation of benefits (EOB): A statement provided by a health insurer to the plan participant that explains how their claim was paid. The EOB typically includes the date of service, type of service rendered, eligible expense, amount paid by the plan, and the balance to be paid by the plan

participant. If applicable, it will also provide any reason(s) the plan did not cover the service or supply.

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.”

Formulary: A list of prescription drugs covered by the health plan that is often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic drug: A prescription drug chemically equivalent to a brand-name drug dispensed under its generic chemical name. Generic drugs are cheaper versions of expensive brand-name drugs with the same active ingredients, strength, and dosage form.

Guaranteed issue: A feature of certain insured benefits that permits you to enroll regardless of health status, age, gender, or other factors that might predict the use of the benefit.

Health reimbursement account (HRA): Unlike HSAs, only an employer may fund an HRA, and the funds revert to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs and may be paired with either high-deductible or traditional health plans.

Health savings account (HSA): A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. You can reduce your overall healthcare costs by using untaxed dollars in a HSA to pay for deductibles, copayments, coinsurance, and some other expenses. An HSA can be used only if you have a high deductible health plan (HDHP).

High-deductible health plan (HDHP): An HDHP features higher annual deductibles than traditional health plans, such as a preferred provider organization (PPO). Except for preventive care, covered employees must meet the yearly deductible before the plan pays benefits. However, HDHPs may have significantly lower premiums than a PPO, HMO, or another traditional plan.

Imputed income: This is the reasonable value of the additional benefit coverage for domestic partners and, under IRS regulations, is treated as taxable income to the employee. Imputed income is separate from and in addition to, your bi-weekly plan cost. For instance, if you include a domestic partner in your coverage (**which is not defined as a dependent by the IRS**), you will be responsible for paying imputed income tax based on the value of that coverage.

In-network: Doctors, clinics, hospitals, and other providers with whom the health plan agrees to care for its members. Health plans cover a greater, more significant share of the cost for in-network providers than for out-of-network providers.

Maximum out-of-pocket limit: The federal government sets the maximum each individual or family can be required to pay in cost-sharing during the plan year for covered, in-network services. This limit applies to most types of health plans and insurance. It may be higher than the out-of-pocket limits stated for your plan.

Medicaid: A medical benefits plan available for low-income persons, paid by federal and state government but administered by the state.

Medicare: A federal health insurance program for people 65 or older, certain younger people with disabilities, and people with end-stage renal disease.

Non-formulary drug: Any brand-name prescription drug not included in a particular health plan's list of approved formulary drugs.

Open enrollment period: The yearly period when you can enroll in health insurance plans for yourself and your dependent(s). Outside the Open Enrollment period, you are eligible if you have certain life events, such as getting married, having a baby, or losing other health coverage.

Out-of-network: A health plan will cover treatment for doctors, clinics, hospitals, and other out-of-network providers, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-of-pocket limit: The most an employee could pay during a coverage period (usually one year) for their share of the costs of covered services, including co-payments and co-insurance.

Over-the-counter drugs: Drugs that do not require a prescription. They can be bought at a pharmacy or drugstore and be dispensed to patients while at the hospital or doctor's office.

Plan year: The 12 months of coverage offered by a plan, like a subscription for your benefits that renews annually. The plan year for care and most other benefits is based on the calendar year (January 1 through December 31).

Pre-existing condition: A medical condition for which the patient has received treatment during a specific period of time prior to enrolling in a new insurance plan.

Preferred brand name drug: These are medications for which generic equivalents are unavailable. 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 organization (PPO): An organization of participating providers that have agreed to provide their services at negotiated discount fees in exchange for prompt payment and increased patient volume.

Premium: The amount that must be paid via payroll deductions for insurance coverage.

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

Pre-tax deductions: With pre-tax benefits, the benefit-cost is deducted from an employee's paycheck before income and employment taxes are applied. This lowers the total income amount that is taxed, which reduces the income taxes the employee is responsible for paying.

Preventive services: Routine healthcare, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary care physician: A physician, including a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.), who provides or coordinates a range of healthcare services for patients.

Qualifying life event (QLE): When changes happen in your work or personal life, your benefits may need to change too. If you're eligible to make changes, you must make the change within 31 days of

the date of your qualifying life event (e.g., gain a dependent child through birth, adoption, or legal custody, spouse/partner loses coverage due to loss of job and now needs coverage through you). If you miss the 31-day deadline, you will have to wait until the next open enrollment period.

Retro deductions: Created when there is a benefit plan change, or enrollment and the deduction begin date associated with the plan was in a pay period that has already been confirmed.

Specialist: A doctor not categorized as a general practitioner, family practitioner, pediatrician, internist, or OB/GYN. Examples of a specialist would include a dermatologist or cardiologist.

Specialty drug: A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional or is difficult to dispense. Specialty drugs are the most expensive drugs on a formulary.

Summary of benefits: This outlines what your plan covers, including deductible, copay, and coinsurance amounts. However, it is less detailed than a summary plan description (SPD) or evidence of coverage (EOC).

Vesting: A permanent right of ownership. This means that each employee will vest or own a certain percentage of their account in the plan each year. An employee who is 100% vested in his or her account balance owns 100% of it.