GLOSSARY OF KEY BENEFIT TERMS

Navigating the world of employee benefits can be challenging. This comprehensive glossary simplifies benefit terminology by providing clear definitions of key terms such as copay, coinsurance, balance billing, and more. This resource is designed to help you understand your benefits better and make informed decisions. Keep this glossary on hand for quick reference and clarity.

Balance Billing: Balance billing, sometimes called surprise billing, is a medical bill from a healthcare provider billing a patient for the difference between the total cost of services being charged and the amount the insurance pays.

Coinsurance: The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment: A flat fee you pay toward the cost of covered medical services.

Coverage Tier: There are four types of coverage tiers: employee, employee + spouse, employee + child(ren), and family**.** If you are not enrolled in the single coverage tier you are considered family and the family deductible will apply.

Deductible: A specific dollar amount you pay out-of-pocket before the insurance company will pay any expense. Under some plans, the deductible is waived for certain services.

Dependent: A person who qualifies for and is enrolled in a health plan to receive benefits because of their relationship to the insured employee.

Flexible Spending Account (FSA)

- **Healthcare FSA:** An account an individual establishes through his or her employer to pay for out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copays and deductibles, and qualified prescription drugs, dental, and vision expenses. The maximum contribution to an FSA is determined by the IRS and must be used within a given plan year.
- **Limited Purpose FSA:** Allows you to set aside money from your paycheck on a pretax basis to pay for out-of-pocket dental and vision costs. The limited purpose FSA is for individuals who are also enrolled in an HSA account.

Generic Medication: Has the same active ingredient as a brand name drug, however, it is more cost effective. The FDA rates these medications to be as safe and as effective as brand name medications.

Health Savings Account (HSA): An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time frame. HSAs must be coupled with the enrollment in a high-deductible health plan (HDHP).

High Deductible Health Plan (HDHP): A qualified health plan the combines reasonable monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

In-Network: Healthcare providers that have contracted with a particular health insurance plan to provide services at pre-negotiated rates.

Inpatient: A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary (or medical necessity): Services or supplies provided by a hospital, health care facility, or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease, or injury; (2) serve to provide diagnoses or direct care and/or treatment of the condition, illness, disease, or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily service as convenience; and (5) are considered the most appropriate care available.

Medicare: An insurance program administered by the federal government to provide health coverage to individuals age 65 and older, or who have certain disabilities or illnesses.

Member: You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries, and surviving spouses.

Out-of-Network: Health care providers that do not have a contractual agreement with a particular health insurance plan. As a result, out-of-network providers typically result in higher out-of-pocket cost for insured individuals.

Out-of-Pocket Expenses: Amount that you must pay toward the cost of health care services. This includes deductibles, copayments, and coinsurance.

Out-of-Pocket Maximum (OOPM): The highest out-of-pocket amount that you can be required to pay for covered services during a benefit period.

Preferred Brand vs. Non-Preferred Brand Medication: Often two brand name drugs that help treat the same problem, but one has been shown to be more cost - or medically effective than the other. That more effective drug becomes a preferred drug and the other becomes a non-preferred drug.

Preferred Provider Organization (PPO): A health plan that contracts to create a network offering both in- and out-of-network coverage. Members pay less when using in-network providers.

Premium: The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Preventive Care: Most preventive care is covered under the Affordable Care Act (ACA). Find what is covered at **www.healthcare.gov/coverage/preventive-care-benefits**.

Primary Care Physician (PCP): A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Prior Authorizations: Also known as preauthorization or precertification, this process requires physicians and other healthcare providers to obtain approval from a health plan before delivering a specific service to the patient.