

Benefits Glossary

A

Accidental Death and Dismemberment

AD&D insurance pays a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident.

Accumulation Period

The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible

A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Maximum

A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount

The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center

A healthcare facility that specializes in same-day surgical procedures.

Annual Limit

The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

B

Balance Billing

Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges \$100 but the plan's allowed amount is only \$70, an out-of-network provider can bill you for the \$30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary

The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug

A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

C

Claim

A request for payment that you or your provider submits to your insurance plan after you receive services.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Coinsurance

The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)

A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

D

Deductible

The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services

Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive

Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services

Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Dependent Care Flexible Spending Account

An employer-sponsored, tax-advantaged account you can use to pay for qualified work-related expenses for the care of children younger than 13 or dependents who are incapable of self-care.

E

Eligible Expense

Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible

A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Maximum

A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Excluded Service

A service for which your insurance will not pay any portion of the cost. These services may also be referred to as “ineligible,” “not covered,” or “not allowed.”

F

Formulary

A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

G

Generic Drug

A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, atorvastatin is the generic name for medicines with the same formula as the brand-name drug Lipitor.

Grandfathered

A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

H

Health Reimbursement Arrangement

An HRA is a fully employer-funded account you can use to pay for eligible healthcare expenses.

Health Savings Account

An HSA is a tax-advantaged personal savings account you can use to pay for eligible healthcare expenses. You can only contribute to an HSA if you are enrolled in an HDHP.

Healthcare Flexible Spending Account

A healthcare FSA is an employer-sponsored, tax-advantaged account you can use to pay for eligible healthcare expenses.

High Deductible Health Plan

An HDHP is a medical insurance plan with a higher deductible than a traditional health insurance plan. Premiums are typically lower, and you can offset deductible expenses with an HSA.

I

In Network

Also known as participating or preferred providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

L

Life Insurance

Life insurance pays your beneficiary a lump sum if you die.

Limited-Purpose FSA

A limited-purpose FSA is a healthcare FSA that can only be used for qualified dental and vision expenses.

Long-Term Disability Insurance

LTD insurance replaces a portion of your income if you are unable to work for an extended period of time due to a qualified illness, injury, or disorder. LTD generally starts after a 90-day waiting period.

M**Mail Order**

A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

O**Open Enrollment**

An annual period of time during which you can make changes to your benefits without any particular reason.

Out-of-Network

Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan's allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs

Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum

The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care

Care from a hospital or clinic that doesn't require you to stay overnight.

P**Participating Pharmacy**

Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year

A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug

A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a "formulary," is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care

Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider

Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

S**Short-Term Disability Insurance**

STD insurance replaces a portion of your income if you are temporarily unable to work due to a medical procedure or condition.

T**Telehealth/Telemedicine**

A virtual visit with a provider using video chat on a computer, tablet or smartphone.

U**Usual, Customary, and Reasonable**

The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care

Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

V**Vaccinations**

Also known as “immunizations,” vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit

An optional benefit offered by your employer for which you pay the entire premium, often through payroll deduction.