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Open Enrollment Glossary of Terms

Health insurance terms made easy

Open enrollment is the time of year reserved for you to make changes to your benefit elections. Unfamiliar terms can make this process confusing. To help you navigate your benefits options, check out these definitions of common open enrollment terms.

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.

Consumer-Driven (also known as consumer-directed or consumer choice) Health Care (CDHC) – Health insurance programs and plans that are intended to make you more informed about your health. Under these plans, you can use health care services more effectively, have more control over your health care dollars and the plans are designed to be more affordable. These medical plans also offer reduced premium costs in exchange for higher deductibles. Generally, they include preventive coverage, such as a mammogram or annual physical, at little or no cost. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are common examples of CDHC plans.

Copayment– The flat fee that you pay towards the cost of covered medical services.

Covered Expenses – Health care expenses that are covered under your

“ At open enrollment time, you have decisions to make. Don't let confusing terms trip you up with this handy list of commonly used terms. ”

health plan.

Deductible – Before benefits are available through a health plan, you must pay a specific dollar amount out of pocket. Under some plans, the deductible is waived for certain services.

Dependent – Individuals who meet eligibility requirements under a health

plan and are enrolled in the plan as a qualified dependent.

Flexible Spending Account (FSA) – An account that allows you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year. If there are funds left in the account at the end of the plan year, the money is forfeited back to your employer.

Health Management Organization (HMO) – An approved and licensed organization that [C_Officialname] has established a relationship with to provide our employees with benefits and services. Requires you to see only doctors or hospitals that are on a specified list of providers.

Health Reimbursement Arrangement (HRA) – An account in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account as reimbursement for qualified health care expenses. If there are funds left over in the account at the end of the plan year, it can be carried over into the next year. The account belongs to the employer.

Health Savings Account (HSA) – This is a medical savings account set up

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and used to pay for eligible medical expenses. Contributions can be made by both you and [C_Officialname]. The money is taken directly from your paycheck before taxes and is then placed in the account. Balances carry from one year to the next, and the account belongs to you. Withdrawals for non-medical expenses are subject to income taxes, and an additional penalty if age 65 or under. HSAs must be coupled with qualified high-deductible health plans (HDHP).

High-Deductible Health Plan (HDHP) – A qualified health plan that gives you more control over your health care spending by offering lower monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA or HRA.

In-Network – Care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Inpatient – A person who is treated as a registered patient in a hospital or other health care facility. This person accrues room and board charges.

Medically Necessary (or medical necessity) – Services or supplies provided by a hospital, other 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 diagnosis 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 serving as convenience; and (5) are considered the most appropriate care available.

Medicare – An insurance program administered by the U.S. government to provide health coverage to those typically age 65 and older.

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 – Care you receive without a physician referral or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-Pocket Expense – Amount that you must pay towards the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-Pocket Maximum (OPM) – The top amount paid for covered services during a benefit period. Both the deductible and the coinsurance apply towards meeting the OPM, but copayments may not apply. Under some plans, the deductible and OPM may have the same dollar limit.

Preferred Provider Organization (PPO) – A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

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

Primary Care Physician (PCP) – The doctor that you select to coordinate your care under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance – The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances, etc.