

KNOW YOUR BENEFITS.

From

Open Enrollment Glossary of Terms

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

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 give you more control over your health care expenses. Under CDHC plans, you can use health care services more effectively and have more control over your health care dollars. CDHC plans are designed to be more affordable because they offer reduced premium costs in exchange for higher deductibles. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are common examples of CDHC plans.

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

Covered Expenses – Health care expenses that are covered under your health plan.

Deductible – A specific dollar amount you pay out of pocket before benefits are available through a health plan. 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. Most funds must be used by the end of the year, as there is only a limited carryover amount.

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

Health Management Organization (HMO) – A type of health insurance plan that usually limits coverage to care from doctors who work for or contract within a specified network. Premiums are paid monthly, and a small copay is due for each office visit and hospital stay. HMOs require that you select a primary care physician who is responsible for managing and coordinating all of your health care.

Health Reimbursement Arrangement (HRA) – An employer-owned medical savings 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.

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 period. HSAs must be coupled with qualified high-deductible health plans (HDHP).

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

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

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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 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 federal government to provide health coverage to individuals aged 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 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 toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-pocket Maximum (OOPM) – The highest out-of-pocket amount paid for covered services during a benefit period.

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) – A doctor that is selected to coordinate treatment 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.



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