Employee Benefits Glossary of Terms

DEFINITIONS YOU CAN USE

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EMPLOYEE BENEFITS FREQUENTLY USED TERMINOLOGY

Below are sample definitions you can use to customize and publish your own glossary of terms specific to your employee benefits package. Our clients find it particularly helpful to embed these definitions in their benefits brochures, their online enrollment system, and any place else insurance and benefits jargon is used which may confuse someone.

Sometimes a definition is not enough, so we strongly encourage you to include examples directly after the definition of each term, where it will help to further illustrate the meaning of the word. We suggest that any examples you include be tailored to your specific benefit plan(s) as you'll only confuse matters if you use a co-pay in your example which is different than the co-pay in your plan(s).

As always, you should consult with your legal counsel and benefits advisor to ensure the accuracy and applicability of these terms to your benefits program.

Aggregate Deductible

Once a person covered under a family plan reaches the individual deductible, all covered expenses for that individual will be paid at the co-insurance amount, even when the family deductible may not have been satisfied. For example, pretend you have a plan which features an in-network family deductible of $5,000; if one member of the family satisfies the individual $2,500 deductible, the Carrier will pay 70% of remaining in-network expenses. Once another person or a combination of persons meet the remaining $2,500, the family deductible would be considered satisfied.

Aggregate Out-of-Pocket Maximum

Once a person covered under a family plan reaches the individual out-of-pocket maximum, all covered expenses for that individual will be paid at 100%, even when the family out-of-pocket maximum may not have been satisfied. For example, pretend you have a plan which features a family out-of-pocket maximum of $12,700; if one member of the family satisfies the individual out-of-pocket max of $6,350, the Carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the family out-of-pocket would be considered satisfied.

Allowed Amount

This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their explanations of benefits (EOBs). For example, a provider may charge $120 per hour of psychotherapy, but the insurance company pays them $95 — the allowed amount for that service.

Balance Billing

This type of billing is typically done with out-of-network providers. It means that the enrollee is charged the difference between the provider-billed amount and the insurance-allowed amount. For example, if a primary care physician bills an insurance company $150, but the allowed amount is only $90 (60 percent), the physician would charge the patient $60 (40 percent) under a balance billing situation.

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Biometric Screening

Typically a series of Body Mass Index (BMI) measurements and blood tests (e.g. pressure, cholesterol, and glucose) used to gain an overall picture of an individual's health.

Co-insurance

This is the percentage of medical expenses the enrollee is required to pay, usually after the deductible has been met. For example, if an enrollee's deductible has been satisfied, and the policy stipulates 25 percent coinsurance, the enrollee will be responsible for 25 percent of whatever bills are incurred for the rest of the plan year (until the enrollee reaches the out-of-pocket maximum).

Consumer Driven Healthcare (CDHC)

A trend in health insurance to lower premiums and raise deductibles in an effort to stem rising healthcare costs by incentivizing individuals to become more informed and price-conscious consumers of healthcare.
(Also see Consumer Driven Health Plan.)

Consumer Driven Health Plan (CDHP)

A type of health insurance growing in popularity amongst individuals with traditionally low medical expenses. These plans allows individuals to pay less in monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles.
(Also see High Deductible Health Plan.)

Co-Payment

Oftentimes referred to as a "copay," this is the amount enrollees are responsible for when seeing a doctor, picking up a prescription, or visiting an urgent care or emergency room.

Deductible

The term deductible refers to the amount an enrollee must pay prior to the insurance company covering eligible expenses. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is $6,000; your plan will not pay anything for certain medical services until you have paid $6,000. The deductible may not apply to all services i.e. services that are covered by a co-pay.

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA) who is eligible to be included on your health insurance policy. Some employers allow for domestic partners to be included, as well.

Dependent Care Account

A flexible spending account (FSA) designed to provide tax-exempt funds to employees for eligible childcare and dependent care expenses. (See FSA.)

Diagnostic Test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible Expense

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "negotiated rate". If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Embedded Deductible

Once a person covered under a family plan reaches the individual deductible, all covered expenses for that individual will be paid at the co-insurance amount even when the family deductible may not have been satisfied. For example, PPO with HRA (Option I) features an in-network family deductible of $5,000; if one member of the family satisfies the individual $2,500 deductible, Horizon will pay 70% of remaining in-network expenses. Once another person or a combination of persons meet the remaining $2,500, the family deductible would be considered to be satisfied.

Embedded Out-of-Pocket Maximum

Once a person covered under a family plan reaches the individual out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, PPO with HRA (Option I) features a family out-of-pocket maximum of $12,700; if one member of the family satisfies the individual out-of-pocket max of $6,350, Horizon will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the family out-of-pocket would be considered satisfied.

Employee Contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Explanation of Benefits (EOB)

Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you owe. The EOB also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other healthcare professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather, a tool enrollees can use to make sure they're not paying more than their insurer expects them to for services rendered.

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".

Generic Drugs

Medications that are comparable to brand name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand name counterparts.

High Deductible Health Plan (HDHP)

A type of health insurance growing in popularity amongst individuals with traditionally low medical expenses. These plans allow individuals to pay less in monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles. (Also see Consumer Driven Health Plan.)

Health Reimbursement Account (HRA)

An employer-funded savings plan that will reimburse you for out-of-pocket medical expenses. Unlike an FSA, however, you don't "use it or lose it" – unused balances will roll over and accumulate over time, though the account cannot be "cashed-out".

Health Savings Account (HSA)

Similar to an FSA, and funded through pre-tax payroll deductions by the employee (and sometimes employer contributions), HSA's are only available to people enrolled in a high-deductible health plan. Unlike an FSA, however, you don't "use it or lose it" – unused balances will roll over and accumulate over time and can be "cashed-out".

In-network Co-insurance

The percent you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network co-insurance costs you less than out-of-network co-insurance payments.

In-Network Provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower and you will not be responsible for filing claims if you visit a participating In-Network provider.

Limited Benefit Plan

A plan which assists with the costs of everyday healthcare – things like doctors' office visits, prescriptions and short hospital stays. It is not a traditional health plan such as a major medical plan, which would be more comprehensive and generally covers larger medical expenses resulting from major illness or accidents. Typically plans like this do not meet the minimum essential coverage criteria as defined by the ACA.

Mail Order

Many carriers offer this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can usually obtain a 90-day supply at one time vs. 30 days at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your co-pay is almost always cheaper through mail order.

Major Medical Plan

Insurance that covers most serious medical expenses up to a maximum limit, usually after a deductible and coinsurance have been met.

Medical Savings Account (MSA)

A flexible spending account (FSA) designed to provide tax-exempt funds to employees for eligible medical and dental expenses, including co-payments and deductibles. (See FSA.)

Medically Necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member Health Statement

Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-¬network doctor or other healthcare professional is allowed to charge a plan member (called the "allowed amount").

Negotiated Rate

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense". If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Network

The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at pre-negotiated discount. Your out-of-pocket expenses will be lower and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-Preferred Brand Name Drugs

Generally these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand name drug or a generic.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-Network Co-insurance

The percent you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network co-insurance costs you more than in-network co-insurance. An out-of-network provider can balance bill you for charges over the allowed amount.
(See Balance Billing.)

Out-of-Network Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-Pocket Maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-Counter Drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment Allowance

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense". If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.
(See Balance Billing.)

Precertification

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred Brand Name Drug

These are medications for which generic equivalents are not available. 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

A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Prescription Drugs

Medications you can only obtain with a prescription from your Doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicadin and Abuteral can only be obtained with a prescription. The opposite of an over-the-counter drug.

Prescription Drug Coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the co-payment you will pay for the drug. These tiers typically, but not always, are: Generic, Preferred Brand, Non-Preferred Brand and Speciality. Your cost will depend on the level of drug specified by your Doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand name drugs generally do not have a generic equivalent, while those listed as non-preferred brand name drugs generally do have a generic or preferred brand name equivalent. Your co-pay for preferred brand name drugs is less than the co-pay for non-preferred brand name drugs because you don't have the generic option available to you.

Premium

The amount that must be paid for your health insurance or plan, after premium contributions paid by the employers. Employee premiums are paid via pay period deductions.

Pre-tax Deduction

Payments deducted from your gross pay before Medicare, Federal, and State taxes are calculated, thus reducing your taxable wages and tax liability.

Prior Approval

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Prior Authorization

Prior authorization is a pre-approval requirement imposed by insurance companies before agreeing to cover a procedure, prescription, or medical device. The rules for when this prior authorization is required and the circumstances under which it will be approved varies among carriers, but your doctor can write letters to advocate for you.

Post-tax Deduction

Payments deducted from your net pay after Medicare, Federal, and State taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventative Care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventative.

Primary Care Physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary Care Physicians include Medical Doctors, Doctors of Osteopathic Medicine, Internists, Family Practitioners, General Practitioners, OB/ GYNs and Pediatricians. The opposite of a specialist.

Provider

A physician, healthcare professional or healthcare facility, certified or accredited as required by state law.

Qualifying Life Event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual open enrollment period. This usually means the birth or adoption of a child, marriage, divorce, death of a spouse, or change in the spouse's employment or insurance status. These changes must typically be made within 30 or 31 days of the QLE.

Special Enrollment Period

Special enrollment periods allow you to make changes to your insurance plan or sign-up for a new policy outside of open enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a Primary Care Physician (PCP). For example, a Dermatologist is considered a specialist.

Specialty Drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

Urgent Care

An illness or injury serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wellness

Wellness refers to a healthy state of being. Many employers have wellness programs that encourage and sometimes incentivize employees to become more physically and mentally fit.