Benefits Lingo Made Simple

It helps to speak the language!

We've removed as much jargon as possible, but these are terms you'll likely encounter as you enroll in and use your benefits.

Common Terms

Balance billing

When you use an out-of-network **medical** or **dental** provider, they might bill you the difference between what they charge and the amount your insurance pays.

Medical: this is in addition to - and does not count towards - your out-of-pocket maximum.

Coinsurance

After you've met your deductible, you're sometimes responsible for a percentage of the cost of the **medical** or **dental** care or **prescription** medication you received. This percentage is known as coinsurance.

Copay

A flat fee you pay each time you receive a copay-eligible **medical**, **dental**, or **vision** service or **prescription** medication.

Copays do not apply to all services, you'll see a flat dollar amount listed when a copay applies.

Deductible

The amount you're responsible for paying in care expenses before the **medical** or **dental** plan starts paying deductible-eligible expenses.

Generally, any service with a percentage coverage (other than preventive care) is subject to the deductible.

In-network

In-network care is always your lowest cost option. Networks are groups of **medical**, **dental** and **vision** providers, **pharmacies**, and **facilities** that agree to discount the cost of their care.

Out-of-pocket maximum

The most you'll pay for covered in-network **medical** care in a year. This includes your deductible, any coinsurance or copays, and prescription drugs.

The out-of-pocket maximum does not include your premium (the amount you pay for coverage), non-covered expenses, or out-of-network care that's been balance billed.

Primary Care Provider (PCP)

A PCP is your main **medical** doctor - usually a general practitioner (GP), family doctor, internist, OB/GYN, or pediatrician (for children).

*If you elect the **HMO medical plan**: you'll be required to designate a PCP who will coordinate all of your non-primary medical care. If you do not designate a PCP, one will be assigned to you.*

Referral / Pre-authorization

Some specialty **medical** providers and services require a referral from a primary doctor. These may include but are not limited to cardiology, psychiatry, rheumatology, orthopedic surgeons, surgery, and imaging (CT/MRI).

*Sometimes a referral is required by the provider and sometimes it's required by your insurance plan (this is usually known as a **pre-authorization**). It's always best to check before making an appointment for the first time.*

Other Terms

COBRA

A federal law that allows you to temporarily continue health insurance through your employer after you lose coverage. You'll be notified by mail if you lose coverage and are able to continue coverage; you'll be responsible for paying the full cost of the premium.

Covered Expenses

Expenses that your insurance determines are eligible for coverage.

Dependent

Someone covered on your insurance plan.

Exclusion

Specific services, care, medications, or equipment that are not covered under your insurance plan.

Explanation of Benefits

A statement from your insurance that describes what care you received, how much was billed, what insurance paid, and what you owe. **If this amount is less than what your in-network provider is asking you to pay**, contact your insurance company for assistance.

Flexible Spending Account (FSA)

An account that allows you to pay for qualifying care or expenses with tax-free money. Eligible expenses are determined by the type of FSA.

Grievance

A complaint you file with your health insurer or plan, is usually about coverage for services.

Health Savings Account (HSA)

A bank account, owned by you, that allows you to pay for eligible health care (medical, prescription, dental, and vision) expenses with pre-tax dollars. You'll need to be enrolled in a **qualifying High Deductible Health Plan** and meet IRS eligibility requirements to contribute, though your funds never expire – even if you change jobs or health plans.

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Other Terms Continued

High-Deductible Health Plan (HDHP) sometimes called Consumer Driven Health Care (CDHC)

A lower-cost, higher deductible plan designed to give you more control over your health expenses. Most allow you to contribute pre-tax funds to a Health Savings Account (HSA) if you meet IRS eligibility requirements.

Health Reimbursement Arrangement (HRA)

A specific type of health fund that's owned and funded by an employer. If you're enrolled in an HRA health plan, your employer will set a certain amount of money aside for you and your covered dependents to pay for eligible care.

Medically Necessary / Medical Necessity

Care designed to prevent, diagnose, or treat an illness, injury, condition, or disease that meets accepted standards of medicine.

Member

You and your covered dependents become members when you enroll in coverage.

Premium

The amount you pay for your insurance coverage.

Prescription Drugs: Formulary

A list of all covered medications describing how they're covered (tiers). Formularies can change once or twice a year; it's important to check every time before you get medication filled.

Specialist

A doctor or health care professional who focuses on a specific area of medicine.

Health Maintenance Organization (HMO) & DMO

A specific type of health insurance plan that requires you to use in-network providers and facilities, except in the case of an emergency. Many HMOs require that you select a primary care physician (family doctor, OB/GYN, pediatrician) who will manage and coordinate all your health care. **Dental coverage:** a DMO plan works much the same way.

Inpatient - Hospital Care

When you're admitted to the hospital or healthcare facility for care – usually an overnight stay.

Medicare

Health insurance administered by the federal government to provide care for those 65 or older, or with certain disabilities/illnesses.

Outpatient - Hospital Care

When you receive care but aren't formally admitted to a hospital or healthcare facility (same-day surgery, physical therapy, mental health, etc.)

Prescription Drugs: Generic

Lower-cost prescriptions that contain the exact same **active ingredient(s)** as their more expensive brand-name counterparts. The FDA approves generic medications to be just as effective and safe as their brand-name counterpart.

Prescription Drugs: Specialty

Complex medications – often self-injectable but not always – are often required to be filled by a **specialty pharmacy** due to unique storage and packing requirements. If your doctor prescribes one of these medications, you'll be referred to contact your insurance company's specialty pharmacy.

Subscriber

The primary person on the insurance policy (usually the employee).

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