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Benefits Terminology

Following are definitions of terms commonly used when discussing benefits.

Coinsurance:

The percentage the plan or you pay for a covered service or supply. For example, the plan may pay 80% while you pay 20%.

Copayment (Copay):

A copay is a flat-dollar amount you pay for specific covered services upon each visit to the provider. It is not impacted by the plan deductible, coinsurance or out-of-pocket maximum.

Deductible:

The amount you pay each year before the plan begins to pay coinsurance.

Evidence of Insurability (EOI):

The documentation of the good health condition of the insurance beneficiary and his/her dependent's health in order to be approved for coverage. It is only required in certain circumstances.

Explanation of Benefits (EOB):

After you receive medical services, your insurance will provide you with an EOB. It will outline details regarding how your insurance processed your medical claim, including what portion of the charges your insurance paid and what portion, if any, you are responsible for paying.

Flexible Spending Account (FSA):

An FSA is a tax-advantaged account that lets you put money aside on a pre-tax basis to pay for a wide range of health and/or dependent care expenses (as defined by the IRS) not covered by your plan that you incur during the plan year. Unlike the HSA, any unused funds remaining after the plan year ends will be forfeited.

Formulary:

A medical plan's formulary is a preferred brandname drug list of the most cost-effective outcome-based drugs. You pay less when using a drug on the plan's formulary list.

Health Savings Account (HSA):

An HSA is a tax-advantaged savings account for high-deductible health plan (HDHP) participants that lets you put money aside on a pre-tax basis to pay for a wide range of health care expenses (as defined by the IRS) not covered by your plan. Unused money remaining in the account at the end of the plan year rolls over to be used the next year. Please refer to IRS Publications 502 and 969 for complete details on eligible expenses.

High-Deductible Health Plan:

A plan that provides competitive health insurance along with a tax-advantaged health savings account (HSA) that lets you decide how to spend your health care dollars. Essentially, you pay a lower premium in exchange for a higher deductible, much like car insurance.

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HSA Contribution:

This refers to a contribution, or “deposit,” an employee may make to his/her HSA, or a deposit made by the company to the HSA of an employee participating in the HDHP.

In- And Out-of-Network Providers:

Benefit plans develop networks by contracting with doctors, hospitals, labs, etc., who have agreed to provide health care services to members at negotiated rates. You generally pay less out of pocket when you use in-network providers.

Out-of-Pocket Maximum:

The maximum amount you will pay out of pocket for covered medical expenses per calendar year, including your deductible. After your share of covered expenses reaches this annual limit, the plan pays 100% for eligible network services and supplies for the remainder of the calendar year.

Preferred Provider Organization (PPO) Plan:

A type of health plan that contracts with doctors, hospitals, labs and other health care providers to create a network of participating providers. You generally pay less when you use providers that belong to the PPO network. You may use providers that fall outside of the plan’s network at an additional cost. This type of plan typically has higher premiums and a lower deductible than a high-deductible health plan (HDHP).

Prescription Drug Out-of-Pocket Maximum:

The maximum amount you will pay out of pocket for covered prescription drug expenses per calendar year. After your share of covered prescription drug expenses reaches this annual limit, the plan pays 100% for eligible prescription drugs for the remainder of the calendar year. The prescription drug out-of-pocket maximum is separate from the medical out-of-pocket maximum.

Reasonable and Customary (R&C) Charges:

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount sometimes is used to determine the allowed amount.

Summary Plan Description (SPD):

An important document that tells plan participants what the plan provides and how it works.