Glossary

Balance Billing: When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance: Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay: The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible: The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB): A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs): A special taxfree account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or a rollover into the next plan year.

- **Healthcare FSA:** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA:** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency: Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA): A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in an HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, so if you change jobs your account goes with you.

High Deductible Health Plan (HDHP): A plan option that provides choice, flexibility and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, there are no copays and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

Network: group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network:** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network:** Providers that are not contracted with your insurance company. If you choose an out-of- network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating:** Providers that do not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment: The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage.

Out-of-Pocket Maximum: The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications: Medications available without a prescription.

Prescription Medications: Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Preferred Drugs:** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs:** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs:** Prescription medications used to treat complex, chronic and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization:** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy:** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable & Customary Allowance (R&C): Also known as the UCR (Usual, Customary, and Reasonable) amount. 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 is sometimes used to determine the allowed amount.

Summary of Benefits and Coverage (SBC): Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD): The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.