Glossary of Terms

Annual Out-of-Pocket Maximum
The total amount paid each year by your insurance company for each family member enrolled in the dental plan.

Coinsurance
The sharing of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the cost of service after a deductible is met, and you will be responsible for the remaining 20% of the cost.

Copay
A fixed amount (for example $20) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you have to pay for covered health care services before your health plan begins to pay.

Preferred Provider Organization (PPO)
This type of plan lets you visit the doctor of your choice. Although you may see a provider who doesn't participate in the plan's network, in most cases your benefits are greater (and your out-of-pocket expenses smaller) when you see a network provider. You are not required to select a Primary Care Physician under this option.

Once you reach the Individual, Individual + Children or Individual + Spouse or Family in-network or out-of-network out-of-pocket maximum in any calendar year, the plan will pay 100% of additional covered in-network or out-of-network expenses you or your covered family members incur during the rest of that year, as applicable, and subject to plan rules. The out-of-pocket maximum, however, does not include penalties (such as late cancellation fees for doctors' appointments).

Flexible Spending Accounts (FSAs)
FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The **Health Care FSA** can be used to pay for services not covered by your medical, dental or vision plan such as copayments, coinsurance deductibles, prescription expenses, lab exams and tests, contact lenses, and eyeglasses. The **Dependent Care FSA** is used to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.

High Deductible Health Plan (HDHP)
A qualified HDHP is defined by the IRS as a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually and are subject to change.

The HDHP is similar to the PPO in the you have the option to choose any in-network provider when you need care. However, in exchange for a lower per paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses in using those for prescription drugs. Once your deductible has been met, you will continue to pay a prescription copay until your out-of-pocket maximum is met, then the plan pays 100%.

Health Savings Account (HSA)
A personal health care account for those enrolled in an HDHP. You may use your HSA to pay for qualified medical expenses such as doctor's office visits, hospital care, prescription drugs, dental care, and vision care. You can use the money in your HSA to pay for qualified medical expenses now, or in the future. Your HSA can be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP.