

A Pravven guide

Key Benefits Terms

The words in your benefits documents, in plain English.

How to use this guide

Benefits documents use the same few dozen words over and over. Knowing them is most of the work of reading a plan. This guide defines 49 of them in plain English, grouped the way you meet them during enrollment.

Look for **Watch for** notes. They flag the terms where people most often get surprised by what a plan costs or covers.

What you pay

Types of plans

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What you pay

The numbers that decide what a plan costs you.

Premium

The amount you pay for coverage, usually taken from each paycheck. You pay it whether or not you use care.

Watch for The premium is only part of your cost. A low premium can come with a high deductible.

Employee contribution

Your share of the premium, after your employer pays its share. This is the amount you see on your pay stub.

Employer contribution

The part of the premium your employer pays for you. It is real compensation even though it never reaches your paycheck.

Deductible

The amount you usually pay for covered care before the plan starts paying more of the cost. Some services, such as preventive care or copay visits, may be covered before you meet it.

Watch for Check which services skip the deductible. It changes how a plan feels day to day.

Family deductible

The deductible for coverage that includes dependents. Plans handle it in one of two ways: embedded or aggregate.

Watch for Ask which one your plan uses. With a family, it can matter as much as the dollar amount.

Embedded deductible

A family deductible with an individual deductible built in. Once one person meets their individual amount, the plan starts paying more for that person, even if the family total isn't met yet.

Aggregate deductible

A family deductible with no individual amount inside it. The whole family amount must be met before the plan pays more for anyone.

Copay

A fixed amount you pay for a covered service, like a doctor visit or a prescription.

Coinsurance

Your share of the cost after the deductible, shown as a percentage. If coinsurance is 20%, you pay 20% of the allowed amount and the plan pays 80%.

Out-of-pocket maximum

The most you generally pay in a plan year for covered in-network care. Deductibles, copays and coinsurance count toward it. Premiums, non-covered services and most out-of-network costs do not.

Watch for This is the number to look at when you ask, "What's the worst year I could have?"

Allowed amount

The most a plan will pay for a covered service. For in-network care it is the rate the plan negotiated with the provider. Your coinsurance is a percentage of this number, not of the provider's full charge.

Balance billing

When an out-of-network provider bills you for the difference between their charge and the plan's allowed amount. Federal law now protects you from many surprise bills, such as most emergency care, but not every situation.

Explanation of benefits (EOB)

A statement from your plan after you get care, showing what was charged, what the plan paid and what you may owe. It is not a bill. Compare it with any bill you receive.

Types of plans

The plan type sets the rules for which doctors you can see and how.

HMO (Health Maintenance Organization)

A plan that usually covers care only from its network, except in emergencies. You typically choose a primary care provider and need a referral to see a specialist.

PPO (Preferred Provider Organization)

A plan that lets you see in-network and out-of-network providers, usually without referrals. Out-of-network care costs more.

EPO (Exclusive Provider Organization)

A plan that covers care only from its network, except in emergencies, but usually without requiring referrals.

POS (Point of Service)

A mix of HMO and PPO rules. You usually need a primary care provider and referrals, but some out-of-network care is covered at a higher cost.

High-deductible health plan (HDHP)

A plan with a higher deductible and, usually, a lower premium. An HDHP that meets IRS rules lets you contribute to a Health Savings Account.

Primary care provider (PCP)

The doctor, nurse practitioner or physician assistant you see for routine care. Some plans require you to choose one.

Referral

A written approval from your primary care provider to see a specialist. Some plans, often HMOs and POS plans, won't cover specialist visits without one.

Preventive care

Routine care to keep you healthy, such as checkups, screenings and many vaccines. Most plans cover listed preventive services in-network at no cost to you.

Watch for A visit that starts as preventive can include a diagnostic service that is billed separately.

Networks and approvals

Where you get care often matters more than the plan's headline numbers.

Network

The doctors, hospitals, pharmacies and other providers that have contracts with your plan.

In-network

Providers that have contracted rates with your plan. They usually cost you less.

Out-of-network

Providers that do not have contracted rates with your plan. They may cost more or may not be covered at all.

Watch for Check your doctors, hospital and pharmacy against the plan's directory before you enroll, not after.

Prior authorization

Approval your plan may require before it covers certain services, medications or procedures. Without it, the plan can deny the claim.

Prescriptions

Drug coverage has its own rules, and they change more often than the rest of the plan.

Formulary

The list of prescription drugs a plan covers. Drugs not on it may not be covered, or may cost much more.

Drug tiers

Groups the formulary sorts drugs into, often generic, preferred brand, non-preferred brand and specialty. Higher tiers usually cost you more.

Watch for Look up each medication you take. Its tier sets what you'll pay.

Specialty drug

A high-cost medication, often for complex or chronic conditions, that may need special handling or a specific pharmacy.

Step therapy

A rule that you try a lower-cost drug first and move to the prescribed drug only if the first one doesn't work.

Pharmacy benefit manager (PBM)

The company that runs a plan's prescription coverage: the formulary, pharmacy network and drug pricing.

Accounts

Ways to pay for care with pre-tax money. Contribution limits are set each year by the IRS.

HSA (Health Savings Account)

A savings account you can use with a qualifying high-deductible health plan. Contributions are pre-tax, the money is yours to keep, and it rolls over from year to year, including if you change jobs.

Watch for You can only contribute while you're covered by a qualifying HDHP.

FSA (Flexible Spending Account)

An employer account for eligible health expenses, funded with pre-tax pay. Money you don't use by the deadline may be lost, unless your plan allows a carryover or a grace period.

Dependent care FSA

A separate pre-tax account for eligible child or adult day-care costs so you can work. It does not cover medical expenses.

HRA (Health Reimbursement Arrangement)

An account funded only by your employer that reimburses eligible expenses. Your employer sets the rules, and the money usually stays with the employer if you leave.

Enrolling and keeping coverage

The dates and rules that decide when you can change your choices.

Open enrollment

The yearly window when you can choose or change your benefits. Outside it, most changes need a qualifying life event.

Plan year

The 12-month period your benefits run for. Deductibles and out-of-pocket maximums usually reset when it starts. It isn't always January to December.

Qualifying life event

A change such as marriage, a birth or adoption, or losing other coverage that lets you change benefits outside open enrollment. You usually have 30 days to act, sometimes 60.

Watch for The deadline is short and easy to miss. Tell HR as soon as the event happens.

Waiting period

The time between starting a job and when coverage begins. Federal rules cap it at 90 days for most employer health plans.

Dependent

A family member you can cover on your plan, such as a spouse or child. Plans that cover children must allow them to stay on until age 26.

COBRA

A federal law that lets you keep your employer's group health coverage for a limited time after you lose it, for example when you leave a job. You usually pay the full premium plus a small administrative fee.

Summary of Benefits and Coverage (SBC)

A standard summary every health plan must provide, in the same format, so plans can be compared side by side. It is a summary; the plan documents govern.

Summary Plan Description (SPD)

The detailed document explaining how an employer plan works: who is eligible, what is covered, and how to file claims and appeals.

Beyond medical

The other benefits in your enrollment, and what each one pays.

Short-term disability

Insurance that replaces part of your income for a limited time if illness, injury or childbirth keeps you from working.

Long-term disability

Insurance that replaces part of your income for a longer period if you can't work, usually starting after short-term disability ends.

Elimination period

The waiting time between when a disability starts and when benefits begin.

Basic life insurance

Life insurance your employer provides, often at no cost to you. Employer-paid coverage above \$50,000 is taxable to you as imputed income.

Supplemental life insurance

Extra life insurance you can buy through work, usually paid through payroll. It may require health questions above certain amounts.

Voluntary benefits

Optional coverage you pay for, such as accident, critical illness or hospital indemnity insurance. These usually pay you a set cash amount when a covered event happens. They don't replace health insurance.

Employee assistance program (EAP)

A confidential employer-provided service offering short-term counseling and referrals for personal, family or work issues, usually at no cost.

Questions to ask before you enroll

1. Are my doctors, hospital and pharmacy in-network?
2. Are my prescriptions on the formulary, and at which tier?
3. Is the family deductible embedded or aggregate?
4. What will I pay per paycheck, and how often is it taken?
5. Does the employer put money into an HSA or HRA?
6. Which services are covered before the deductible?

Take these to HR, your broker or the carrier. If your documents don't answer them, that is worth knowing too.

About these definitions. They are general definitions for education. Plans differ, and your plan documents, Summary of Benefits and Coverage and HR team are the authority for how your coverage works. Pravven does not provide legal, tax, medical or insurance advice.

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