KEY INFORMATION- TERMS TO KNOW AND UNDERSTAND

All terms below are with brief descriptions and general information. Keep in mind that any carrier or company may modify plans to fit their needs.

Medical

HMO-Health Maintenance Organization, This is an *In-Network* Medical plan that has the participant coordinate their care through a *PCP*. Many services are often provided for a *Co-Payment.*

PPO-Preferred Provider Organization, This is a Medical plan that provides an *In-Network* list of providers where the participant can get higher coverage. However, PPO's allow the participant to go *Out-of Network*, but at an increased cost. PPO's often have A few *Co-payments* for Key services, and then allows all other services to fall under the *deductable* and *co-insurance* schedule.

CDHP-Consumer Driven Health Plan, This a broad category of medical plans that often has a higher deductable then standard *PPO* plans and they are paired with an account option, giving the participant more control over their medical costs. CDHP can include plans paired with *FSA's*, *HRA's* and *HDHP* paired with *HSA's*

HDHP-High Deductable Health Plans, This is a Medical plan that provides an *In-Network* list of providers where the participant can get higher coverage. However, HDHP's allow the participant to go Out-of Network, but at an increased cost. HDHP must have a deductable of at least 1300 for an individual and 2600 for family coverage. HDHP participants will often need to reach the deductable before most service are paid for, and then they have co-insurance up to their Out of Pocket Max. HDHP can be paired with HSA.'s.

EPO-Exclusive Provider Organization- This is an *In-Network* Medical plan that has the participant coordinate their own care. They will generally have co-payments for some services while using a deductable and co-insurance schedule for others. Some what of a hybrid between an HMO and a PPO.

PCP-Primary Care Physician, This is a general doctor that can often help treat and coordinate your care in any medical plan. PCP's are often required in HMO plans, both medical and dental.

In-Network-This is the list of doctors that most participants with a medical plan should use, this list is unique to the carriers that negotiate the costs with different providers. In-Network providers are required with some medical plans, while other plans will give lower cost to those using them.

***Out-Of Network*-** This is any doctor or medical provider not on the participants list of in-*network doctors*. Many plans do allow for some coverage out-of network, but they could have significantly increased costs by using these providers. The deductibles and co-insurance costs are often higher, and their may be no negotiated rates reductions.

***Annual deductible*-**Your annual deductible is the amount you must pay for many covered medical services each year before the plan begins to pay its portion. Most services that are offered with a co-payment are not subject to the deductable, nor do co-payments apply towards the deductable.

***Aggregate Deductible*-** Used when the participant is insuring family members. This is when a family deductable must be met, before any services are covered by the insurance plan. The medical cost of all insured family members apply to one larger deductable. Once the deductable is met the plans co-insurance will begin.

Embedded Deductible – Used when the participant is insuring family members. Each insured family member only has to meet their own deductable before the plans *co-insurance* starts coverage. Embedded Deductibles often track the total

***Coinsurance*-**Once your annual *deductible* is met, the plan shares in the cost of your covered medical services through co-insurance.

***Out-of-pocket maximum*-**The out-of-pocket maximum is the most you will pay for covered medical services in a calendar year.

Co-Pay- Certain service can be covered for a fixed payment, once the participant pays their Co-payment the rest of the bill is covered by the insurance. Co-pay's are very common with HMO's and very rare with HDHP's.

Preventive Coverage- All ACA plans pay for "preventive" services at 100%. Immunizations, annual physicals, wellness exams are often covered. Be careful with how you word that coverage to employees though, if the doctor diagnosis or corrects anything during the "preventive" appointment, the normal deductibles, co-pays, or Co-insurance will apply.

Medical and Core Accounts

HC FSA-Health Care Flexible Spending Accounts- This is an account available to help participants cover the cost of qualified health care expenses (medical, dental and vision). They can elect to have up to $2,550 to be put in the FSA by their Employer. They will then pay back the elected amount through pre-tax payroll deductions. FSA's have a use it or lose it feature, if you don't have eligible expenses in the plan year, you may forfeit your remaining balance. Two variations to that are available, the FSA may allow for a $500 roll over to the following year, or they may allow for a 2.5 month extension to accrue expenses.

Limited FSA- This FSA is some times available when *HSA's* are offered. They follow most of *Health Care FSA* rules, except the funds can NOT be used for medical, only qualified dental and vision expenses.

HSA-Heath Savings Accounts- This is a bank account available to participants of HDHP's. They can elect up to $3,350 to go in for an Individual or $6,650 to go in for family level coverage; the contributions are pre-tax through pay roll. Those over 55 can "Catch up" $1,000 extra a year. Many employers will provide some funding for the HSA. The Employee is the owner of the account, it will roll over each year and it still belongs to the employee if they leave the company. If they use the funds in the account for qualified Health care expenses they come out tax free, funds used for non-eligible expenses will have extra tax penalties.

HRA-Health Reimbursement Accounts- This account is paired with a *CDHP*, the employer funds the account with a pre-determined annual amount. Those funds can then be used to reimburse the employee for medical expenses the company considers eligible. Often times the reimbursement is automatic. Unused funds can some times accumulate to a predetermined maximum.

Dep FSA-Dependant Care Flexible Spending Accounts- This is an account available to help participants cover the cost of qualified Dependant care. Babysitters and daycare for children, or elder care for adult dependants. They can elect to contribute up to $5,000 into the account to get reimbursed for those qualified expenses. The money is available for reimbursement only after it has been deposited through payroll deductions, it is not pre funded.

General Information

HIPAA- Health Insurance Portability and Accounting Act, HIPAA covers many things related to health insurance, your primary concern here, will be to protect the privacy of any heath information you may have access to.

Dependant- Eligible family member of the plan participant. A spouse, child, Step-child, child whom the participant has legal guardianship over. In many cases Domestic partners and their Children can be Eligible as well.

Dependant Verification- Many companies require Dependant to be verified when first put on a plan. Requirement vary by company, but birth certificates, marriage License, 1040's or court papers are commonly excepted.

Domestic Partner- The exact definition of a domestic partner varies a lot from company to company. They are generally partners in a mutually caring relationship for some length of time, most commonly a year. If a participant adds a domestic partner, they should be aware that premiums and benefits received for the DP will be post-tax, not pre-tax.

Beneficiary- The person, trust or organization the participant sets to receive any insurance proceeds in the event of death.

Wellness Program- Many companies have a program that allows participants to spend less on their insurance if they meet the Wellness Programs guide lines. The penalties/rewards for the program vary for each company, as well as the guide lines. Be sure to give employees accurate description of any programs that apply to them.

Dental

Dental PPO- Similar to medical this dental coverage will have a preferred providers list of In-Network dentists, but will allow for lower out of network coverage. Be sure to let Employees know the *deductibles, co-insurances*, and limits of the policy.

Dental HMO- This dental plan requires all care to go through one *PCP*, with referrals needed for any services that office cannot complete. Participants will be given a list of covered services; they will be responsible for the *co-payment* on that list for any covered services received.

Life and Disability

STD-Short Term Disability- This benefit is designed to replace some of the employee's income if they become to sick or hurt to work, but for a limited time period. Once the participant has doctor's approval, the DI plan will start paying after the elimination period has been met, and continue paying until the doctor approval runs out, or the max benefit period has been met. Work related injuries may not be covered for STD; they would fall under workers comp. Be sure to know the *pre-ex, elimination period, EoI,* payout amount and b*enefit period*s for any STD you are offering.

LTD-Long Term Disability- This benefit is designed to replace some of the employee's income if they become to sick or hurt to work, starting after s set time months, and lasting for years. LTD will protect part of an employee's income if they have a serious illness or injury. LTD will normally stop paying if; they get a different job, income source, if they get better, or if the benefit period runs out. *Pre-ex,* payout amount, *elimination period* and b*enefit periods* may apply.

Supplemental Life- Term insurance the Employee elects during enrollment, as the Employee ages the cost will increase. Amounts available may include *guaranteed issue* and coverage that requires *EoI*.

Whole Life- Permanent Insurance many employers offer this benefit as part of the benefit package. Whole life purchased at work is *portable.* Amounts available may have *Guaranteed Issue*, Simplified Issue, or require some *EoI*. Pointing out this will be available no matter when it is needed can add value to the employee.

Basic Life- Term insurance provided by the Employer, generally a flat amount, or a multiplier of the Employees salary.

Voluntary Benefits

CI-Critical Illness- This benefit is designed to provide a lump sum of money to the participant to use however they see fit. They are common with higher *deductable/out of pocket* plans to off set or pay for the cost of the medical treatment. When a participant is diagnosed with a covered illness, they receive the benefit amount directly. *EoI, Guaranteed Issue, Pre-Ex, Portable* or w*ellness benefits* may apply.

Accident Insurance- This is designed to give the Participant a lump sum of money when they receive medical service for an injury caused by an accident. The Money is paid directly to them and they may use it for what ever they like, off setting insurance *deductibles* is popular. Pay outs are according to a schedule of benefits and vary a lot based on the plans and the injuries. *Guaranteed Issue, Pre-Ex, Portable* or w*ellness benefits* may apply.

Hospital Indemnity- This is designed to give the participant a lump sum of money when they receive medical service in a hospital. Pay outs are according to a schedule of benefits and vary a lot based on the plan; the payout can be used to off set the un-covered medical expenses. It is common for plans to cover the initial hospitalization, surgeries and each day in the hospital. *EoI, Guaranteed Issue, Pre-Ex, Portable* or w*ellness benefits* may apply.

Pre-paid Legal- This plan is designed to give the participant limited access to a lawyer network to perform many simple duties. The Schedule of benefits varies from carrier to carrier, but often includes document review, document preparation services and consultations.

Identity Theft- This helps participants, review, monitor and correct identity issues that may arise if some one tries to steal and/or use their identity. The programs vary from plan to plan, but often monitor for unauthorized charges or accounts, and helps correct any issues.

EAP-Employee Assistance Program- This programs allow employees to call and speak with counselors regarding a wide range of issues, personal, emotional, legal, financial. EAP's are funded by most employers and when they are the employers want the employees to be made aware of the EAP's availability.

Important Terms

EoI-Evidence of Insurability- This is designed to make sure the participant is healthy enough to insure. It may be needed with Supp Life or any of the VB's. For VB's the questions are often built into the system and asked at the time of enrollment, Normally for Supp Life it is a form they will need to fill out and turn in.

Elimination Period- The amount of time that must past before the disability begins paying. Elimination periods can be from 0days on up and is an important piece of information for any plan you are working with.

Pre Ex-Pre Existing Conditions- How long it will take before the new policy will cover an existing issue. Many VB's and DI policies have limitations on them, and will not cover you for a certain time frame if a condition is pre existing. For Example a 6/12 Pre Ex, means that for the first 12 months you have the policy, it will not cover you for anything you had treatment for the 6 months preceding owning the policy. Evan Guaranteed issue policies often have a Pre-Ex.

Benefit Period- The maximum length of time a DI policy will pay out. With *STD* this is often in weeks, for *LTD* it is often in years, or to a certain age. If a participant becomes disabled they do not automatically get the benefit period, they will get what the doctors and the carrier approves, up to the benefit period.

Wellness Benefit- A cash payout from a VB for completing qualified health screening. When a participant turns in the wellness form they can receive a set amount, usually between $25 and $100.

Portable- The ability to continue a benefit after the participants is no longer employed at this employer. This is an important feature of most VB plans because they can continue to have the desired coverage after they have moved on.

Convertible- The ability to continue coverage, but under a new plan design. This is often available on Supp life, the participant can convert supp life into a Whole life when they leave, and it is generally at the current age so the insurance becomes much more expensive. This is useful if an employee leaves an employer in poor health.

GI-Guaranteed Issue- Allows a participant to enroll in a benefit without having any *EoI*. This can be a great selling point for any VB's that offer GI, but it is important to note that *DI* and *CI* normally have a Pre-Ex so they can have the policy and can claim for new issues, they may not be able to claim for an existing issue.

SI-Simplified Issue- Allows for a participant to get coverage if they can answer only a few health questions positively. It is the shortest form of *EoI.*

QLE-Qualifying Life Events- They allow Employees to change their pre-tax benefits in the middle of the plan year. Generally employees have 1 chance to change their benefits each year, during open enrollment. However if they have an IRS life event they can make changes relevant to that event with in 30 days. The common QLE are changes in marital status, lose of coverage, newly eligible for coverage, births or deaths.