Benefits Terminology

To help you better understand your medical benefits, here are definitions of some key words and phrases used to describe the plans.

Brand-name drugs — A prescription drug that is protected by a patent, supplied by a single company, and marketed under the manufacturer's brand name. Brand-name drugs may be significantly higher in cost than generic drugs, even though, by law, both must have the equivalent active ingredients.

Co-insurance — Cost sharing requirement under the health insurance policy where the insured pays a percentage of the costs of covered services.

Co-payment (or Co-pay) — The amount you're required to pay directly to the provider each time you use medical services (for example, you pay a small co-payment each time you visit a doctor's office), and it is the amount you pay to the pharmacy for your prescription.

Covered expense — Any expense for medical services or products that is eligible for benefits under your medical plan.

Deductible — The amount that you must pay each calendar year before the plan begins paying benefits. The deductible applies only if you go for out-of-network service.

Emergency care — Any illness or injury that, without immediate medical attention, could result in loss of life or limb, or cause serious harm to bodily functions (for example, an apparent heart attack, severe bleeding, loss of consciousness, or severe or multiple injuries).

Explanation of benefits (EOB) — The document you receive after you file a claim. The EOB shows how much of the expense the plan paid and how much you are expected to pay. If part or all of the expense is not covered, the EOB should explain why.

Generic Drug - A generic medication is an equivalent of a brand name drug (see definition). A generic drug provides the same effectiveness and safety as a brand name drug and usually costs less. A generic drug may have a different color or shape than its brand name counterpart, but it must have the same active ingredients, strength, and dosage form (pill, liquid or injection).

In-network services – Medical care or treatment you receive from doctors, clinics, health centers, hospitals, medical practices and other providers with whom your plan has an agreement to care for its members.

In-patient hospital care — A hospital stay (usually 24 hours or more) for which a room and board charge is made by the hospital.

Maintenance medication – Medications used over a long term to treat or control chronic conditions, i.e. medication taken daily for high blood pressure or diabetes.

Medically necessary — Services and supplies, including tests and examinations that are consistent with generally accepted practices for the diagnosis of an illness or injury, or the medical care of a diagnosed illness or injury.

Network — A group of health care providers and facilities that have agreed to provide employees with services at a reduced cost.

Open enrollment — Annual period during which you may choose to add dependent(s) to your medical coverage.

Out-of-network — Health care providers who have not contracted with the health plan/insurance company to provide services. A member may go out of network, but he/she will pay additional costs in the form of deductibles and coinsurance.

Out-of pocket maximum – A cap placed on out-of-pocket costs that a member would pay in a calendar year for out-of-network services.

Outpatient hospital care — A hospital stay (usually less than 24 hours) for which no room and board charge is made by the hospital.

Pre-certification — A requirement under the plan to have all non-emergency hospital admissions approved in advance.

Qualifying event — Events (such as marriage, divorce, childbirth or change in spouse's job status) that qualify you to change your medical coverage during the year without waiting until open enrollment.

Urgent care — Illness or injury that requires immediate but not emergency care (that is, the condition is neither life- nor limb-threatening). Examples include high fever, flu, earaches, sprains, nausea, and headaches