Glossary

Calendar Year Deductible – The amount the insured (member) must pay before insurance starts paying covered expenses during a one year period, excluding copays, coinsurance, and noncovered expenses. The process of meeting the deductible begins January 1 and begins again each January 1.

Certificate of Coverage – A written document provided to members that sets forth the terms of their health plan. It explains among other things coverage, member cost share obligations, appeal rights and important enrollment information.

Change from current – Percent difference in premium costs based on the current plan's premium.

Coinsurance (in/out) – Portion of covered health care costs that UnitedHealthcare will pay after deductible is met.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – COBRA applies to employers who generally employ 20 or more full-time equivalent employees. It allows employees and dependents who no longer qualify under an employer approved group health plan to continue insurance under the group benefit plan.

Deductible – The amount of covered expenses that the insured (member) must pay before the insurance starts paying covered expenses, excluding copays, coinsurance and noncovered expenses.

Flexible Spending Account (FSA) – The Flexible Spending Account portion of Section 125 allows employee contributions to a dedicated savings account be made on a pre-tax basis.

Health Insurance Portability and Accountability Act (HIPAA) – This law sets standards for the security and privacy of protected health information. In addition, the law makes it easier for individuals to change jobs without the risk of extended waiting periods due to pre-existing conditions.

HRA (Health Reimbursement Account) – An account to which an employer can make contributions that are not taxable to the employee, and which the employee can use to pay for certain covered medical expenses.

HSA (Health Savings Account) – A trust or custodial account that one, if eligible, can establish with a bank, insurance company, or other IRS-approved trustee, to pay for certain covered medical expenses with pre-tax or taxable contributions and/or the employer's nontaxable contributions.

Med/Rx Ded Combined – A plan design in which pharmacy and medical expenses accumulate to the same deductible.

Metallic Levels – A qualified health plan's level of coverage is determined based on the actuarial value of the plan, which is a value that indicates the percentage of health care costs that would be covered by the health plan. A plan must meet one of the four levels of coverage: Bronze (60%), Silver (70%), Gold (80%) and Platinum (90%).

Monthly medical premium – Amount paid to a carrier for providing coverage under a contract.

Office copays (PCP/Spec) – Fixed dollar amount one must pay directly to a physician at the time they receive certain covered health services. A primary care physician (PCP) is a doctor who is usually trained in pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. A specialist (Spec) is a physician who specializes in other areas of medicine. Some medical plans offer different copay amounts for primary care physicians versus specialists.

Out-of-network – Employees and their covered dependents receiving non-network services may have additional financial responsibility beyond any applicable plan deductible, coinsurance amount, and co-payment. This additional financial responsibility will not apply to any out-of-pocket maximum.

Out-of-pocket max – Maximum dollar amount that one pays under the terms of the health plan in a year for covered health services.

Patient Protection and Affordable Care Act (PPACA) – Also referred to as the "Affordable Care Act," begins the implementation of a staged set of rules with an initial effective date of March 23, 2010. The law is intended to increase access to health care for more Americans, and includes many changes that impact the commercial health insurance market, Medicare and Medicaid.

Plan deductible – Fixed dollar amount one must pay for covered services each year before the health plan begins to pay benefits.

Policy Year Deductible – The amount the insured (member) must pay before insurance starts paying covered expenses during a one year period, excluding copays, coinsurance and noncovered expenses. The process of meeting the deductible begins on the effective date of the employer policy and ends a year from that date.

Pre-Tax Premium (PTP) – The PTP Plan allows the employer to deduct employee portions of many employer-sponsored insurance premiums from your employees' paychecks before deductions are taken for FICA, federal, and in most cases, state and local taxes.

Rate – The amount of money per enrollment classification paid to a carrier for medical coverage. Rates are usually charged on a monthly basis.

Renewal Date – The date a contract becomes in force.

Single and Family Benefit Coverage – The benefit coverage for a given group product in which coverage is assigned based on subscriber enrollment type (i.e., employee, employee/spouse, employee/child or children, employee/family).

Subscriber – The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health plan.