BK GROUP BENEFITS, LLC

Health Insurance Coverage

Glossary of Terms

This Glossary is intended to serve as a tool which will assist you in understanding some of the terms most frequently associated with health insurance coverage.
It is not intended to be all encompassing.

- A -

Annual Enrollment: The annual period during which you may choose to change your medical coverage level or switch plans for the next plan year.

Annual Out-of-Pocket Maximum: The maximum amount of coinsurance you pay for covered PPO medical expenses in any single calendar year. Once you have paid the out-of-pocket maximum, the PPO pays 100% of expenses (except for any required if applicable).

Approved Amount: The maximum dollar amount the plan will pay a health care provider (i.e. doctor, hospital) for a given service or procedure as negotiated.

Approved Charges: Charges for a medical service, including fee schedules and per diems, determined by the Plan (e.g., PPO) to be reasonable, which are used as the standard for payment of benefits. For out-of-network charges, plan benefits apply as a percentage of those established fees.

- B -

Benefit Maximum: The maximum expense for a particular benefit that will be payable for the entire period you are covered by the Plan. When a covered person reaches this level of Plan expense, no other payments will be made for that benefit. Once reached, the limitation will apply for as long as the person is covered by the Plan. Benefits paid toward a benefit maximum also accrue toward the Plan maximum.

Brand-Name Drugs: Prescription drugs that carry a trademark or brand name. Brand-name drugs may be significantly higher in cost than generic drugs, even through, by law, both must have the equivalent active ingredients.

- C -

Calendar Year Maximum: The maximum expense for a particular benefit that will be payable over a calendar year. When the expense level is reached, payments for that benefit terminate until the next calendar year begins. Benefits paid for calendar year maximums accrue toward the benefit and Plan maximums.

Coinsurance: Arrangement by which the Plan and you share, in a specified ratio, payment for eligible services covered by the policy after the deductible is met.

Copay (also known as copayment): The dollar amount required from you when medical services are used or prescription drugs are purchased. This is similar to coinsurance except with coinsurance the amount is usually a percentage of charges.

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Coverage: Another word for insurance. Insurance companies use the term coverage to mean either the dollar amounts of insurance purchased (e.g., medical coverage, $200,000 of liability coverage).

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

- D -

Dependent Care Flexible Spending Account (DCFSA): A Dependent Care Flexible Spending Account (DCFSA) allows you to be reimbursed on a pre-tax basis for child care or adult dependent care expenses for qualified dependents that are necessary to allow you or your spouse to work, look for work, or attend school full-time. An adult (e.g., parent, grandparent, and adult disabled child) may qualify as a dependent if you provide more than half of that person's maintenance for the year.

Deductible: The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.

Dependent: An individual who receives health insurance through a spouse, parent, or other family member.

Disability: Physical or mental condition that prevents a person from performing one or more or all occupational duties short-term (temporarily) or long-term.

Drug Maintenance List: A list that identifies medications for disease states that are long-term chronic, 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).

- E -

Elimination Period: Days at the beginning of a period of disability when no benefits are paid. (See also waiting period)

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, serve bleeding, loss of consciousness, or sever or multiple injuries).

Employee Assistance Program (EAP): A generic term for the variety of counseling services made available to employees (and frequently their families) through employer-sponsored programs.

Employee Contribution: The portion of the insurance premium paid by the employee for their health benefit coverage.

Explanation of Benefits (EOB): The document you receive highlighting your claim information. The EOB shows how much of the expenses 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.

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- F -

Flexible Spending Account (FSA): An account under a cafeteria plan through which you are reimbursed for medical and other expenses not covered by insurance. FSAs may not be used to accumulate funds in one year in order to pay benefits in future years. Separate FSA accounts must be maintained for medical expenses and eligible dependent care expenses.

Formulary Drugs: Formulary drugs are specified alternative prescription drugs for specific brand name drugs. Formulary drugs have been reviewed for safety, quality, effectiveness, and cost. The formulary drug list is periodically reviewed and modified by a panel of physicians and pharmacists.

Fully Insured Plan: Under this plan the employer purchases coverage from an insurance company. The insurance company assumes the risk to pay all health claims. Beyond the listed deductibles and co-pays, and subject to lifetime maximums, the insurance company assumes the risk if premiums do not cover the allowable claims.

- G -

Generic Drugs: "Generic drugs" is a term used for prescription drugs identified by their chemical name. When the patent has expired on a brand name drug, the FDA permits manufacturers other than the original developer to create an equivalent of the brand name drug and make it available to the public. Generally, more than one manufacturer will create the generic version, although in many cases the same pharmaceutical firm that produces the brand name drug also makes the generic version. This prompts competitive pricing of the generic version and usually results in a less expensive drug.

- H -

Health Care Flexible Spending Account (HCFSA): A Health Care FSA (HCFSA) helps you pay for eligible health care expenses that are not paid by the Plan. An HCFSA is not insurance, but it can help you get more for your money by using pre-tax dollars to stretch the money you would normally spend out-of-pocket on health care services.

Health Reimbursement Arrangement "Fund": A fund established by Metro to help you pay covered health care expenses during the year. Amounts paid by the fund for eligible expenses are put toward your annual deductible. Dollars left in the fund at the end of the calendar year are rolled over to be used in the next year.

Indemnity: A benefit paid by an insurance policy for an insured loss.

- I -

In-Network: A group of doctors, hospitals, pharmacies and other health care providers who participate in a network and agree to charge discounted rates to members who use the network.

Inpatient Hospital Care: A hospital stay (usually 24 hours or more) for which a room and board charge is made by the hospital.

Insurance: A formal social device for reducing risk by transferring the risks of several individual entities to an insurer. The insurer agrees, for a consideration, to pay for the loss in the amount specified in the contract.

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- L -

Life-changing Events: Events (such as marriage, divorce, childbirth or change in job status) that qualify you to change your level of medical coverage during the year without waiting until annual enrollment.

- N -

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

- O -

Out-of-pocket (OOP): Out-of-pocket medical expenses include cost-sharing amounts, such as copayments, deductibles or coinsurance, as well as medical expenses not covered by insurance.

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

- P -

Plan Type: The plan type provided to employees and pensioners include BCBS PPO, CIGNA Choice Fund and BlueAdvantagePlus (for Medicare-eligible pensioners).

Pre-existing Condition: Any physical and/or mental condition(s) of an insured that exist prior to the effective date of coverage.

Preferred Provider Organization (PPO): A mode of health care delivery through which a sponsoring group negotiates price discounts with providers in exchange for more patients. The sponsor may be an insurer, employer, or third-party administrator.

Preventive Care: Preventive Care services may include routine physical examinations, eligible screenings and tests. Eligible services are paid at 100% of the allowed amount. No deductions will be taken from your Health Reimbursement Arrangement for this allowance.

- R -

Rollover: Any unused balance in the Health Reimbursement Arrangement (HRA) will roll over to be used in future years. The amount of the rollover will be added to your HRA in the next plan year, reducing your annual deducible and out-of-pocket costs.

- S -

Self Insured: With a self-insured plan, the employer is financially responsible for all the obligations of the plan. Two types of reinsurance are typically purchased to reduce the financial risk to the employer.

- U -

Urgent Care: An 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. Urgent care facilities are available and may be a more affordable solution than visiting the emergency room.