Insurance Benefits Glossary

**Beneficiary (Life) Insurance**

The beneficiary, when related to life insurance, is someone who receives the monetary benefits of a life insurance contract.

**Brand-name Drug**

Prescription drugs marketed with a specific brand name by the company that manufactures it. When patents run out, generic versions of many popular drugs are marketed at lower cost by other companies.

**Calendar Year**

A 12 month period of time that starts on January 1 and ends on December 31.

**Copayment**

Is the flat fee that an individual pays for specific health care services. For example, PPO5 requires a $45 copayment for each in-network office visit. The insurance plan pays the remainder of expense.

**Dependent**

Is a spouse, partner, child; adopted child; step-child; foster child, who depends on another person for health coverage and who may be eligible for coverage under a health plan because of his or her relationship to the person enrolled in a health plan.

**Deductible**

Cost-sharing arrangement between an insured person and health insurance company in which the insured person will be required to pay a fixed dollar amount of covered expenses each calendar year before the health insurance company will reimburse or begin paying benefits for covered health care expenses.

**Donate-A-Day**

Is a way to help employees who need additional leave beyond their own available leave days to care for a seriously ill member of their immediate family.

**Emergency**

Any injury or sickness that would jeopardize or impair the health of the covered person if not treated immediately. A condition is considered to be an emergency care situation when a sudden and serious condition such that a prudent layperson could reasonably expect the patient’s life would be jeopardized, suffer severe pain or serious impairment of bodily functions would result unless immediate medical care is rendered. Examples include but are not limited to: chest pain, hemorrhaging, loss of consciousness, fever equal to or greater than 103°, presence of foreign body in throat, eye, internal cavity or a severe allergic reaction.

**Employee Assistance Program (EAP)**

The benefits include information, consultation and referrals to community resources for a variety of concerns, including but not limited to:
- Marital or relationship difficulties
- Stress management

Current as of 08/05/2015
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Employees and their dependents have access to a member advocate 24 hours a day, 365 days a year. They may benefit from the personal confidential, screenings, training modules, use of the large reference library, goal and success planning and follow-up. Employees must be enrolled in the district’s disability plans to be eligible for EAP benefits.

**Explaination of Benefits (EOB)**
Is the insurance company’s written explanation regarding a claim, showing what they paid and what the insured must pay. The document is sometimes accompanied by a benefits check.

**Flexible Spending Account (FSA)**
Is a tax-advantage benefit offered to an employee by an employer which allows a fixed amount of pre-tax wages to be set aside for qualified medical expenses and dependent care expenses. One significant disadvantage to using an FSA is that funds not used by the end of the plan year are lost to the employee, known as the “use it or lose it” rule”.

**Formulary Drug**
A list of certain drugs and their proper dosages. Under most health plans, better benefits are provided for formulary drugs than are provided for non-formulary drugs and result in lower out-of-pocket costs for the insured.

**Generic Drug**
Once a company’s patent on a brand-name prescription drug has expired, other drug companies are allowed to sell the same drug under a generic label. Generic drugs are less expensive and most prescription and health plans reward clients for choosing generic drugs.

**Health Care Provider**
A doctor, hospital, laboratory, nurse, or anyone who is licensed to provide or delivers medical or health-related care by the state in which care is rendered.

**In-network**
Refers to providers or health care facilities that are part of a health plan’s network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider because of the negotiated rates contract between the in network provider and insurance carrier.

**Long Term Disability (LTD)**
Is an insurance plan that protects the income of an employee who is unable of performing the essential duties of his/her job and causes a loss of income due to illness, injury, or accident.

**Network**
Physicians, hospitals or other providers of medical services that have agreed to participate in a network, to offer their services at negotiated rates, and to meet other negotiated contractual provisions. Also called "participating provider."
**Out-of-Network**
This phrase refers to physicians, hospitals or other health care providers who are considered nonparticipants in an insurance plan (HMO, PPO). Depending on an individual’s health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual’s insurance company.

**Out-of-Pocket Maximum**
Total dollar amount an insured will be required to pay for covered medical services during a specified period, such as one year, before an insurance company or (self-insured employer) will pay 100 percent of an individual’s health care expenses.

**Pre-admission Certification**
Also called pre-certification review, or pre-admission review. Approval by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or in-patient facility, granted prior to the admittance. Pre-admission certification often must be obtained by the individual. However, some physicians/surgeons’ offices will contact the insurance carrier for pre-certification. The goal of pre-admission certification is to ensure that individuals are not exposed to undue hospitalization admission costs regarding the length of stay.

**Preventive Care**
An approach to health care which emphasizes preventive measures and health screenings such as routine physicals, well-baby care, immunizations, blood draws, pap smears, mammograms, colonoscopy and other early detection testing. The purpose of offering coverage for preventive care is to diagnose a problem early, when it is less costly to treat, rather than late in the stage of a disease when it is much more expensive, or too late to treat. Some wellness screenings or tests are subject to age or required period of time between screenings.

**Preferred Provider Organization (PPO)**
Is a managed care organization of health providers who contract with an insurer or third-party administrator (TPA) to provide health insurance coverage to policy holders represented by the insurer or TPA. Policy holders receive substantial discounts from health care providers who are partnered with the PPO. If policy holders use a physician outside the PPO plan, they typically pay more for the medical care in the form of the annual deductible and lower insurance co-payment (60/40) after the deductible is met.

**Prior authorization/Pre-treatment Review**
Review of need for, and type of, health care services or treatment before services are rendered or products are provided. While not required, prior authorization is recommended wherever the patient or physician is not certain how, or if, the expenses for care will be covered. The health plan provides notification to the member and physician whether or not the costs will be covered.

**Primary Care Provider (PCP)**
A health care professional (usually a physician) who is responsible for monitoring an individual’s overall health care needs. Typically, a PCP serves as a “quarterback” for an individual’s medical care, referring the individual to more specialized physicians for specialist care.
Provider
Any person (doctor or nurse) or institution (hospital, clinic, or laboratory) that provides medical care.

Sick Leave Bank
A benefit that provides financial wage to the member who has experienced a loss of salary due to a serious personal medical condition, as defined by the Family and Medical Leave Act (FMLA), which prevents the member from performing his/her job. The treatment/surgery must be medically necessary under the American Medical Association guidelines. Common ailments or claims that fall under another insurer, e.g. auto claims, workers’ compensation claims are not covered by the bank.

Specialist
A doctor who does not serve as a primary care physician, but who provides secondary care and specializing in a specific medical field.

Term Life Insurance
Is the simplest form of life insurance. It provides protection for a specific period of time and pays a benefit only if the insured person dies during the term of coverage. If you live beyond the specified term or term employment, the policy expires without value. It is sometimes called temporary life insurance.

Timely Submission of Claims
All claims are required to be submitted within twelve (12) months from the date of service. If claims are not submitted within these guidelines, payment will not be assured.

Urgent Care
Health care provided in situations of medical duress that have not reached the level of emergency. Claim costs for urgent care services are typically much less than for services delivered in emergency rooms.

Usual, Customary and Reasonable (UCR)
The average fee charged by a particular type of health care practitioner within a geographic area. The term is used by medical and dental plans as the amount of money allowable for a specific test or procedure. If the fees are higher than the allowable amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, a provider might reduce the charge to the amount that the insurance company has defined as reasonable and customary.

Workers’ Compensation
Provides specific benefits as defined by Colorado revised statutes to employees who are injured in the course and scope of their employment as defined by Colorado. All claims must be reported to Benefits and Risk Management Office in the district within 24 hours of the incident.

Human Resource Department Contacts