Important Terms

We know that benefits can be confusing, especially with all of the terms that are used to describe them. To help you better understand your options, we put together a listing of commonly used benefit terms used throughout this Guide.

Coinsurance – percentage of covered expenses you pay after the plan's applicable deductible.

Consumerism features – choices you make to save money, such as using network providers instead of out-of-network providers, or requesting a generic drug instead of a brand name drug alternative.

Contributions – the amount that is deducted from your paycheck to pay for your share of benefits.

Copayment – the fixed dollar amount you pay to the provider for some services, such as office visits and prescription drugs.

Deductible – the amount you pay each calendar year before the plan reimburses you for covered expenses.

Exchange – another name for the Health Insurance Marketplace that has been available since October 1, 2013 to help individuals and small employers compare and purchase health insurance.

Health Assessment – online questionnaire that you complete to help you identify potential health risks.

Health Care Reimbursement Account (HCRA) – a company-funded account that can be used to pay for a portion of your deductible or coinsurance. (Only available with the Health Care Reimbursement Account Plan).

Health Insurance Marketplace – a way for individuals and small employers to compare and purchase health insurance.

In-network – service received from a participating medical, dental or vision care network provider. Also, can be used to define the level of benefits paid when you use a network provider.

Out-of-network – service received from a provider that does NOT participate in the applicable Aetna, MetLife and/or EyeMed networks. The medical plan pays out-of-network benefits based on Medicare reimbursement levels (up to 110% of Medicare for professional services and 140% for facility charges). In addition to your coinsurance, you are responsible for amounts that exceed these levels.

Out-of-pocket maximum – maximum expense limit you are responsible for paying such as your deductible, coinsurance, and copays in a given plan year - this does not include your contributions. After this limit is reached, the plan reimburses 100% for most remaining covered medical expenses (excluding prescription drugs and the amount above the Medicare reimbursement level).

Primary care physician (PCP) – the network doctor, generally a family practice, internist or pediatrician, you choose to provide care for you and to help you coordinate your overall health care, and make referrals to specialists, when appropriate.

Reasonable and Customary (R&C) Charges (for dental plan) – the negotiated fee your network dentist and the insurance provider have agreed on to perform certain services. If you visit an out-of-network provider, you will be required to pay any charges that exceed the R&C charge.