# KNOW YOUR BENEFITS.

From Niagara Falls City School District

## Frequently Asked Benefit Questions

Open enrollment is the time of year reserved for you to make changes to your benefit elections, and unfamiliar terms can make this process confusing. Use these definitions of common open enrollment terms to help you navigate your benefits options.

What is Coinsurance? The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

What is a Copayment? A flat fee that you pay toward the cost of covered medical services.

What are Covered Expenses? Health care expenses that are covered under your health plan.

What is a Deductible? A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Who is a Dependent? Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

What is a Flexible Spending Account (FSA)? An account that allows you to save tax-free dollars for qualified medical expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year. All of the funds must be used by the end of the year. There is no carryover.

At open enrollment time, you have many decisions to make. Don't let confusing terms trip you up. Refer to this handy list of commonly used terms.

What is a Dependent Care Account (DCA)? An account that allows you to save tax-free dollars for qualified dependent care expenses only. You determine how much you want to contribute to the DCA at the beginning of the plan year. All of the funds must be used by the end of the year. There is no carryover.

What is a Health Reimbursement Arrangement (HRA)? An employer-owned medical savings account in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account as reimbursement for qualified health care expenses.

What is In-network? Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

What is considered Inpatient? A person who is treated as a registered patient in a hospital or other health care facility.

What is Medically Necessary (or medical necessity)? Services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

What is Medicare? An insurance program administered by the federal government to provide health coverage to individuals aged 65 and older, or who have certain disabilities or illnesses.

Who is the Member? You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

What is Out-of-network? Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

What are Out-of-pocket Expense? Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

What is the Out-of-pocket Maximum (OOPM)? The highest out-of-pocket amount paid for covered services during a benefit period.

What is a Preferred Provider Organization (PPO)? A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

What is a Health Management Organization (HMO)? A type of health insurance plan that usually limits coverage to care from doctors who work for or contract within a specified network. Premiums are paid monthly, and a small copay is due for each office visit and hospital stay. HMOs require that you select a primary care physician who is responsible for managing and coordinating all of your health care.

What is a Premium? The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

What is a Primary Care Physician (PCP)? A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

What is an Usual, Customary and Reasonable (UCR) Allowance? The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances.

What is an Explanation of Benefits (EOB)?
An EOB is a description your insurance carrier sends to you explaining the health care benefits that you received and the services for which your health care provider has requested payment.