KEY TERMS

Balance Bill – When a healthcare provider bills a patient for the difference between the patient's health insurance reimbursement and what the provider chooses to charge.

Benefit Card - Debit card given to those enrolled in the Flexible Spending Account and/or Limited FSA. This card is used to pay for eligible expenses.

Brand-Name Prescription – A prescription drug that is marked with a specific brand name by the company that manufactures it. These drugs are covered at higher copay than generic drugs.

Coinsurance – A form of medical cost-sharing in a health insurance plan that requires a member to pay a stated percentage of medical expenses after the deductible, if applicable, has been paid.

Consumer Driven Health Plan (CDHP) – A high deductible health plan that has lower premiums and higher deductibles than a traditional health plan. The concept behind a CDHP is that covered individuals will "shop" to find the lowest cost services since they are paying 100% of the service up to the designated out of pocket maximum.

Copayment – A form of medical cost-sharing in a health insurance plan that requires a member to pay a fixed dollar amount when a medical service is received. The insurance plan is responsible for paying the remaining cost of the service received.

Deductible – A fixed dollar amount during the benefit period that the member must pay before the insurance plan will begin making payments for covered medical and dental services. Plans may have both per individual and family deductibles. Deductibles may differ if services are received in-network versus out-of-network.

Elimination Period – Period of time that must pass before a benefit begins.

Explanation of Benefits (EOB) – The statement sent to a health plan member after services have been received, which lists the services received, amounts paid by the plan, and the amounts the member may be responsible for.

General Purpose Health Reimbursement Arrangement (HRA) - Employer-funded health benefit plan that reimburses employees for out-of-pocket medical expenses.

Generic Prescription – The chemical equivalent to a brand-name drug and typically have lower costs than the brand name counterpart.

Guaranteed Issue – When an insurance policy is offered to any eligible applicant without regard to the health status of the individual that applies and typically without health questionnaires or exams.

Health Savings Account (HSA) - A Health Savings Account is a savings account that is used to pay for qualified medical expenses. The account is available on a tax-free basis to individuals enrolled in high deductible health plans. HSA funds roll over and accumulate year-to-year if not spent. In addition, the HSA is owned by the individual and funds remain even upon separation of employment. The employer and the employee can contribute to the HSA up to the annual limit for an individual or a family as stated by IRS guidelines.

In-Network – Describes a provider or health care facility that is part of a health plan's contracted network. When applicable, insured individuals usually pay less when using an in-network provider.

Maintenance Medications – Medications taken on a regular basis.

Out-of-Network – Describes a provider or health care facility that is not part of a health plan's network. Insured individuals usually pay more of the bill if an out of network provider is used.

Out-of-Pocket Maximum – The maximum amount the member will have to pay during the benefit plan year for allowable covered expenses under a health plan. Deductible is included for EKU health plans.

Policyholder – The individual who is the primary subscriber on an insurance policy.

Preventive Care – Regularly scheduled checkups with your doctor to identify health risks and prevent illness. Many of these services are covered in full by our health plan.

Provider – Any person or entity providing health care services, including hospitals, physicians, home health agencies, and nursing homes. A provider is typically licensed by the state.

Qualifying Event- An occurrence such as marriage/divorce, death, termination of employment, childbirth/adoption, involuntary loss of coverage, etc. which triggers employee's ability to make changes to their benefit elections at the time the qualifying event occurs.

Regular full-time – Employee in a position that is at least 30 hours per week for non-exempt employees or .70 FTE (full time equivalent) for exempt employees and are eligible to participate in all University provided benefits.

Regular part-time – Employee in a position that is between 20 and 24 hours per week and are eligible to participate in the following benefit plans: supplemental tax deferred retirement plans, prorated vacation, sick time, and holiday pay.

Self-insured – This is a type of insurance in which the employer and employees pay for the claim's expenditures. EKU's health plan is administered by Anthem in order to utilize their nation-wide network; however, Anthem does not pay the claims, EKU does. This is why it is so important to be mindful of healthcare expenses since the cost is shared between EKU and its employees.

Sponsored Dependent - An adult that shares primary residence with the covered EKU employee for at least 12 months prior to the effective date of coverage, is not a relative and is not employed by the EKU employee.

Vested – In order to be vested with a Kentucky retirement system, a member must have at least five (5) years of completed service.