BENEFITS GUIDE

September 1, 2026 – August 31, 2027

Click to explore your benefit options

ABILENE ISD

OPEN ENROLLMENT DETAILS

Remember, Open Enrollment is an opportunity to make changes to your benefits without a qualifying life event. During this time, you can:

- Add, cancel or change your coverage
- Add or remove eligible family members
- Elect your 2026-2027 HSA contributions
- Enroll in the health care and/or dependent care FSAs (The IRS requires you to re-enroll in the FSAs each year)
- **You must take action**; your current benefit elections will not roll over. Complete your enrollment online before August 14th.

MARK YOUR CALENDARS

Open Enrollment Begins:

July 13, 2026

Deadline to Enroll:

August 14, 2026

Benefits in Effect:

September 1, 2026

Important Changes

Each year the Abilene Independent School District reviews our benefits program to ensure our partners provide comprehensive and affordable coverage. This year, we're pleased to announce new offerings for our employees to help you better manage your health and well-being in the new year.

2026 Medical Updates At-a-Glance

- AISD will continue to provide medical coverage in partnership with BlueCross BlueShield of Texas
- HDHP deductibles were updated to comply with annual increases as imposed by the IRS. And AISD added a new HDHP plan offering.
- Two HMO plan options remain with benefit plan design changes introduced.
- With plan offerings renewing, there is an increase in how much full-time benefit eligible employees pay out of each paycheck for health insurance (medical premiums).

Click here to watch a video about Open Enrollment.

BENEFIT ELIGIBILITY

Who Is Eligible?

The following individuals are eligible to participate in the Abilene Independent School District's medical program:

- Active, full-time employees working 10 or more hours per week
- Your legally married spouse or registered domestic partner
- Your dependent children (biological, stepchildren, adopted, or for whom you have legal custody) up to age 26
- Your unmarried children aged 26 or older who are mentally or physically disabled and who rely on you for support and care

Dependent Information for Enrollment

To enroll your eligible dependents in benefits, you must provide their full legal names, Social Security numbers and dates of birth, so keep this information handy when making your benefit elections online.

DEPENDENT VERIFICATION DISCLAIMER

Dependent Verification Required

If you plan to cover any dependents, you will need to provide documentation confirming their eligibility. You may be asked to submit proof of dependent status by providing a marriage certificate, birth certificate, tax return, etc. You are responsible for ensuring that any dependents who become ineligible are removed from the Abilene Independent School District benefits. Dependents covered under the employee's benefits who are determined to be ineligible, or for whom sufficient proof of eligibility cannot be provided, will be removed immediately. Premiums will not be refunded, and you will be responsible for any claims that may have been paid on their behalf. You may also be subject to corrective action up to and including termination.

Dependent Information for Enrollment

When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA) requires the Abilene Independent School District to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

REGISTERED DOMESTIC PARTNER DISCLAIMER

Is My Domestic Partner Eligible?

Your domestic partner is eligible for coverage under the Company's plans if:

- You have an active **registered** domestic partnership with a governmental body, or

Dependent children of your domestic partner are also eligible for coverage if they are:

- Unmarried
- Primarily dependent on you or your partner for support
- Living with you (unless waived for student status)
- Meet age, student and incapacity requirements for the plan

Changes in Domestic Partnerships

When enrolling your registered domestic partner in coverage, you agree that you will notify the Abilene Independent School District of any changes in your partnership status that would make your partner and/or their children ineligible for coverage. You must submit notice within 30 days of the change. Termination of coverage for registered domestic partners (and, in some cases, for children of domestic partners) is not a qualifying event for the purpose of continuing coverage under COBRA.

Required Documentation

Employees wishing to enroll a registered domestic partner for the first time will need to submit proof of an active registered domestic partnership with a governmental body prior to completing their enrollment.

Please contact Joy Wiggins, Benefits Coordinator, at 325-677-1444 Ext. 1131 or joy.wiggins@abileineisd.org with any question.

BENEFIT ENROLLMENT

Enrollment Periods

Annual Open Enrollment

Each calendar year, the Abilene Independent School District conducts an Open Enrollment. This is the time for you to re-evaluate your needs and elect benefit options for the new plan year.

New Hire and Newly Eligible Employee Enrollment

Newly hired or newly eligible employees must complete their online enrollment within 31 days of their date of hire.

Between Enrollment Periods

Generally, once you enroll, you cannot make changes to your enrollment selections until the next annual Open Enrollment period. You may make changes to your benefit elections outside of the annual Open Enrollment ONLY if you experience a Qualifying Life Event (QLE), as defined by the IRS. You must notify Human Resources of your QLE within 31 days of the event and benefit changes must be consistent with your QLE. Qualifying life events (QLEs) that may allow you to make benefit changes include:

- Change in legal marital status
  - Marriage
  - Divorce, legal separation, annulment
  - Death of your spouse
- Change in your eligibility
  - Taking or returning from a leave of absence
  - Change in work schedule or status that causes a gain or loss of eligibility
  - Change in family member's eligibility

Click here to watch a video about QLEs.

- Change in the number of eligible children
  - Birth, adoption or death of a child
  - Child gains or loses eligibility for coverage under the plan
- They gain a benefit option or lose coverage
  - New coverage choices made during their employer's annual enrollment
  - You or your family member's COBRA coverage from another employer expires
  - You or your family member becomes eligible for or loses Medicare, Medicaid or CHIP
  - You or your family member loses coverage under a government's or educational institution's plan

BENEFIT ENROLLMENT

When Coverage Begins

New Hires: You must complete the enrollment process within 31 days of your date of hire. If you enroll on time, eligible employees will have the option to choose medical coverage effective date as date of hire or first of the month following date of hire.

If you fail to enroll on time, you will not have benefits coverage (except for employer-paid benefits) until you enroll during our next annual Open Enrollment period.

Open Enrollment: Changes made during Open Enrollment are effective September 1.

When Coverage Ends

Coverage for you and your family will end on the last day of the month in which your employment ends or last day of the month in which you or a dependent loses eligibility status.

When Coverage Ends for Your Children

Your children are eligible for coverage until the end of the month in which they turn 26.

COBRA

If your health care coverage ends, you and your family may have coverage continuation rights under the federal law known as COBRA. If your coverage terminates, you will be notified of your COBRA rights.

BENEFIT ENROLLMENT

Enroll Online

Enrolling in benefits is easy. FFEnroll is available 24 hours a day, 7 days a week, so you can visit the site anytime and anywhere you have computer access.

Step 1:

Visit the Abilene Independent School District Employee Benefits Center to get started.

Step 2:

Click on **How to Enroll** and scroll down to select the red **Enroll Now** link.

Step 3:

Enter your Employee ID/SSN and PIN[1] to login. Download the How to Enroll guide for navigation assistance.

After You Enroll

Save Your Summary

Save or print a copy of your Enrollment Confirmation Statement Summary after making your coverage selections. Review it thoroughly to ensure that your benefit elections have been recorded correctly.

If there are errors, contact the Enrollment Solutions HelpDesk or Human Resources so the necessary corrections can be made. Errors that are not reported within your initial 30-day enrollment period or before the end of annual open enrollment cannot be corrected. Your next opportunity to make changes to elections will be during the next annual Open Enrollment or within 30 days of experiencing a Qualifying Life Event.

Benefits Documents and Resources

Benefits resources and information documents can be accessed in the Employee Benefits Center anytime you want additional information on our benefit programs.

QUESTIONS?

For questions about any of your benefits, contact the Enrollment Solutions HelpDesk Mon-Fri, 7am-5pm CST at **855-523-8422** or by email at **ffenroll@ffga.com.**

If you have additional questions, you may also contact Joy Wiggins, Benefits Coordinator, at **325-677-1444** or **joy.wiggins@abileneisd.org**

MEDICAL COVERAGE

HDHP-HSA

The HDHP-HSA (High-Deductible Health Plan compatible with Health Savings Account), provided through BCBSTX, is an insurance plan that typically offers lower premiums and higher deductibles. The highlight of this plan is that it allows you to open a Health Savings Account (HSA), which is a tax-advantaged personal savings account that lets you save pre-tax dollars to pay for any qualified health-related expenses (state taxation rules may apply). This includes most medical care and services, prescriptions, dental, vision and expenses related to meeting the plan's deductible. For a complete list of qualified health-related expenses, visit Publication 502.

For more information on HSA, visit the Employee Benefits Center referenced on page 8 of this guide.

Individuals with HDHPs normally pay a lower amount each month but pay more on their yearly medical expenses before their insurance policy begins paying. You can visit any doctor, hospital or other health care provider you want, with greater cost savings in-network.

How You Pay for Services

- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible. The deductible is waived for in-network routine preventive care services and medications on the preventive drug list.
- The HDHP includes copays for prescription drugs only. You must meet the annual deductible before prescription copays apply.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance), and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, this plan pays the full cost of all qualified health care services for the rest of the year.

To find an in-network provider, see page 18 in this benefit guide.

MEDICAL COVERAGE

HMO

The Health Maintenance Organization (HMO) plan, provided through BCBSTX, has a network of providers and hospitals that discount their services. With this plan, you select a primary care provider (PCP) from the participating network of providers, who will coordinate your health care needs, refer you to specialists (if needed) and approve further medical treatment. Services received outside of the HMO's network are not covered, except in the case of emergency medical care. For HMOs, premiums and out-of-pocket costs are typically low if you stay within the HMO plan's network.

How You Pay for Services

- You pay a predetermined flat dollar amount—or copay—for services received from your PCP.
- You must obtain a referral for treatment from outside specialists and certain types of tests and procedures. **Note:** Women generally do not need a referral to see an obstetrician/gynecologist or OB-GYN for routine care.
- If you go outside of the HMO's network, you are responsible for 100% of the cost of the services you receive.

To find a primary care provider, see page 18 in this benefit guide.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Plan Booklets. **Note:** The deductible and out-of-pocket maximum are per plan year.

Key In Network Benefits	HDHP-HSA Option 1	HDHP-HSA Option 2	HMO[1] Option 1	HMO[1] Option 2
Deductible (Individual/Family)	$6,000 / $10,000	$3,300 / $6,600	$6,000 / $12,000	$2,000 / $4,000
Out-of-Pocket Max (Individual/Family)	$8,300 / $16,600	$6,900 / $13,800	$7,000 / $14,000	$6,000 / $12,000
Coinsurance	20%*	20%*	20%*	20%*
Office Visits (physician/specialist)	20%*	20%*	$45 / $55 copay	$45 / $55 copay
Virtual Visits (MD Live)	20%*	20%*	$35 copay	$35 copay
Routine Preventive Care	No charge 100% Covered	No charge 100% Covered	No charge 100% Covered	No charge 100% Covered
Diagnostics (standard outpatient lab/X-ray)	20%*	20%*	No charge 100% Covered	No charge 100% Covered
Complex Imaging	20%*	20%*	20%*	20%*
Ambulance	20%*	20%*	20%*	20%*
Emergency Room[2]	$750 Copay & 20%*	$750 Copay & 20%*	$750 Copay & 20%*	$750 Copay & 20%*
Urgent Care Facility	20%*	20%*	$100 copay	$100 copay
Inpatient Hospital Stay	20%*	20%*	20%*	20%*
Outpatient Surgery	20%*	20%*	20%*	20%*
Out of Network Benefits	$6,000 / $12,000 Deductible Unlimited Out of Pocket Max 50%* Coinsurance	$6,000 / $12,000 Deductible Unlimited Out of Pocket Max 50%* Coinsurance	Not Available	Not Available

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying. If you use an out of network provider, you will be responsible for any charges above the maximum allowed amount. *Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. HMO Plans have only in-network services and discounts available. You will be responsible for 100% of the cost if you visit an out-of-network provider.
2. Emergency room copays may be waived if admitted. Out of Network emergency services are covered same as In Network.

Click here to watch a video about comparing medical plan types.

PRESCRIPTION COVERAGE

Retail Pharmacy

When you fill a prescription at a participating retail pharmacy, you may purchase up to a 30-day supply. At the participating pharmacy, you will need to present your ID card and an applicable payment. Most major pharmacies are in our plan's pharmacy network. To find a participating pharmacy near you, visit mybam.bcbstx.com or call 800-521-2227.

Specialty Program

With a rare or complex medical condition (e.g., cancer, hepatitis, hemophilia, rheumatoid arthritis or HIV), the appropriate use of specialty medications can be critical to maintaining or improving a patient's health and quality of life. We use the **Accredo Specialty Pharmacy** program to make these medications accessible and cost effective for plan members. It provides focused, specialized support to individuals with complex medical conditions that often require multiple specialty medication therapies.

Save Money on Medications

Ask for Generic Drugs

You can save money by asking for generic drugs. The FDA requires that generic drugs have the same high quality, strength, purity and stability as brand-name drugs. The next time you need a prescription, ask your doctor to prescribe a generic drug if it is available and appropriate.

Use Mail Order

If you require regular medication for a long-term or chronic condition, such as arthritis or diabetes, you can save money by using your plan's mail-order service.

Key In Network Benefits	HDHP-HSA[3] Option 1	HDHP-HSA[3] Option 2	HMO Option 1	HMO Option 2
Retail Pharmacy - 30 days				
Generic	$20*	$20*	$20	$20
Preferred Brand	$50*	$50*	$50	$50
Non-Preferred Brand	$80*	$80*	$80	$80
Specialty Drugs	$150*	$150*	$150	$150
Mail Order Pharmacy - 90 days				
Generic	$50*	$50*	$50	$50
Preferred Brand	$125*	$125*	$125	$125
Non-Preferred Brand	$200*	$200*	$200	$200

Copay amounts shown in the above chart represent what the member is responsible for paying. Extended Supply Network retail pharmacies may dispense 31-90 days supply of maintenance drugs.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

3. On HDHP-HSA plans, the deductible must be met before copays apply to prescription drugs. HDHP-HSA plans provide access to maintenance preventive drugs at little or no cost share for the member. HDHP-HSA out of network pharmacy drugs will be subject to an additional 50% coinsurance.

Click here to watch a video about prescription drug coverage.

PREVENTIVE CARE

What is Preventive Care?

Regular preventive care can help you stay well, catch problems early on and may be potentially lifesaving. The ACA requires that certain preventive care services are provided for no cost, copayment or coinsurance. All medical plans cover preventive care services like screenings, immunizations and exams. When you visit in-network providers, you don't have to worry about any out-of-pocket costs for preventive care services. If you use an out-of-network provider, a deductible and out-of-network expenses may apply.

Preventive vs. Diagnostic Care

Preventive care is generally precautionary. For example, if your doctor recommends having a colonoscopy because of your age or family history, this would be considered preventive care. But if your doctor recommends a colonoscopy to investigate symptoms you're having, this would be considered diagnostic care, and your plan cost share will apply.

Click here to watch a video about preventive care.

VIRTUAL VISITS

MD Live by BCBSTX

Our telehealth program is a convenient and cost-effective way to get quick medical advice by phone, online or on your mobile device about many non-emergency conditions. It's just one more way our organization invests in you and your family.

Why Use Telehealth?

It's Affordable

A trip to the ER, urgent care center or doctor's office can easily set you back hundreds of dollars in out-of-pocket costs. A call to our telehealth program will cost you a flat $30 or $10 copay/fee, regardless of your condition, depending on the plan you choose.

It's Convenient

Long wait times at the ER, urgent care center or doctor's office are an unfortunate reality for many. Whether you are at home or work or on the road, a medical professional is available 24/7/365 so you can get the care you need when and where it's convenient for you. Even better: There is no time limit to the consult, giving you plenty of time to ask questions and resolve your issue.

It's Easy to Use

A telehealth medical professional is never more than a phone call, click or tap away! Call 888-680-8646 24 hours/7 days a week, or visit mybam.bcbstx.com

Click here to watch a video about how telehealth works.

Get Care in Minutes

It takes just a few minutes to set up your medical history online. Once you submit a request, it often takes less than 10 minutes for a doctor to call you back.

Common Reasons to Call

- Allergies
- Anxiety issues
- Back problems
- Bronchitis
- Cold and flu symptoms
- Ear infections
- Diarrhea or constipation
- Headaches and migraines
- Rash and skin problems
- Sore throat and stuffy nose
- Sprains and strains
- Urinary tract infections
- Behavioral health
- Non-emergency symptoms

WELLNESS

Well on Target

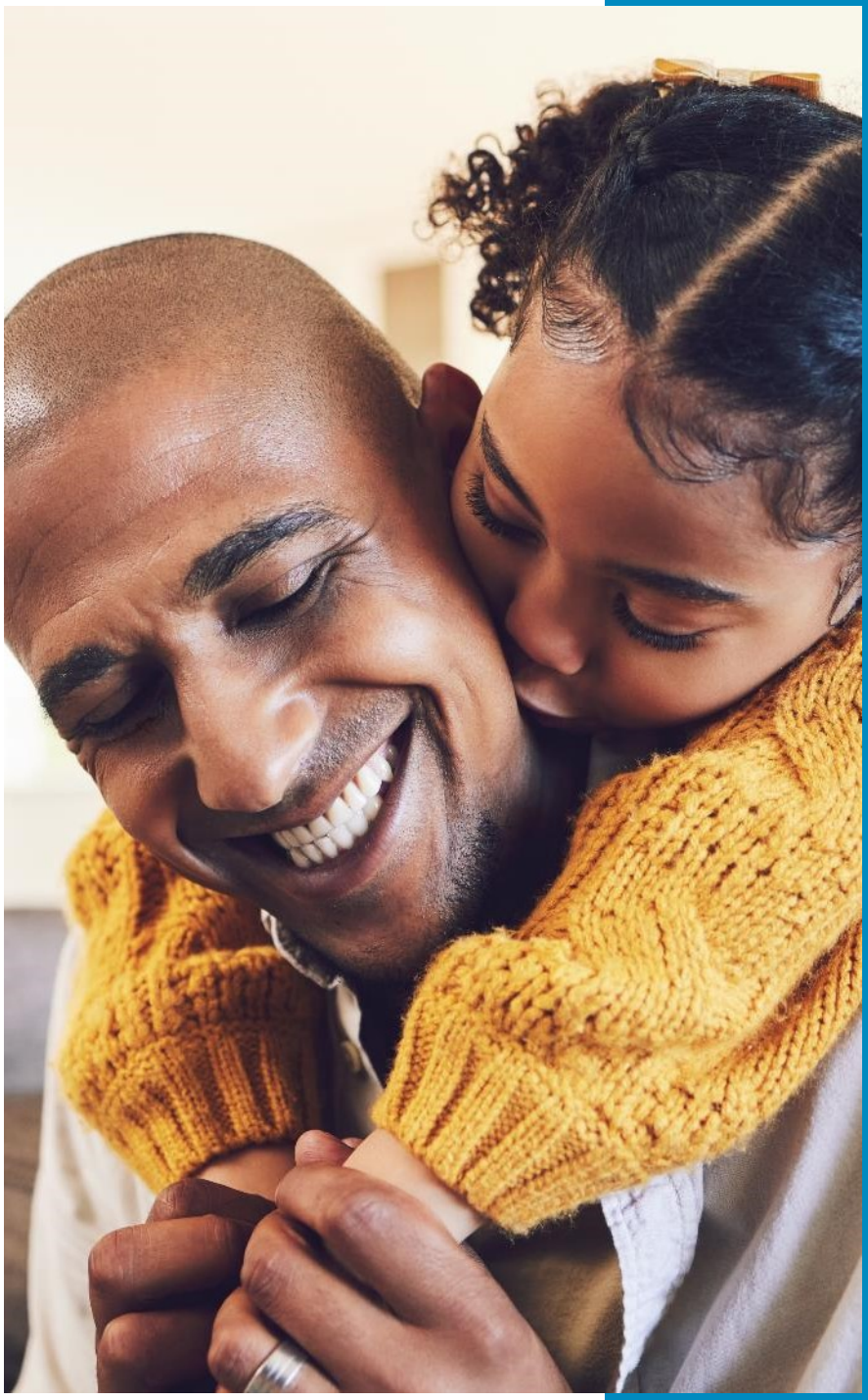
Taking one small, first step can set you on a path to better health throughout your life. Whether you need support for a specific health issue or you're looking to boost your overall wellbeing, you'll have help along the way. Here are a few things you can do with the tools included in your BCBSTX plan:

- Improve your mental health
- Get support to manage your chronic illness
- Join a weight-loss program and work with a lifestyle coach
- Access resources to help with fertility, pregnancy and parenting
- Talk with a nurse any time, day or night
- Complete on demand courses and programs to reach wellness goals
- Earn rewards for completing healthy activities
- Redeem rewards for items or cash
- Access a nationwide network of fitness centers[1]
- Mobile app with fitness and nutrition tracking
- Vast library of online educational resources

Log in at mybam.bcbstx.com to get started.

1. Fees apply. Individuals must be at least 18 years old to purchase a membership.

Click here to watch a video about wellness.



PARTNERS FOR HEALTH

Wherever you are in your health journey, your BlueCross BlueShield of Texas plans can support you at no extra cost. Check out all the programs included by logging into your Blue Access for Members portal at mybam.bcbstx.com.

24/7 Nurseline

Nurses can answer your questions and help you decide whether to visit the emergency room, an urgent care center, or make an appointment with a physician. Access an audio library with over 1,000 health topics and get live help with questions about:

- Asthma
- Dizziness, severe headaches, or fever
- Cuts or burns
- Back pain
- Sore throat
- Diabetes
- A baby's nonstop crying
- And more

MD Live Virtual Visits

Virtual visits with MD Live help you remotely connect with a board-certified doctor via online video, mobile app, or phone, anytime, anywhere. Address a variety of non-emergency care issues, ranging from the cold and flu to pink eye. It's a great tool for behavioral health concerns as well. MD Live doctors can send prescriptions to nearby pharmacies for many common medical conditions.

Access and register for MD Live using Blue Access for Members to access appropriate prices associated with your plans. Visit mybam.bcbstx.com to get started.

Teladoc for Diabetes & Hypertension

At no additional cost, members with diabetes or hypertension claims will receive an outreach call from a professional at Teladoc, a digital health platform determined to empower you to take control of your condition. If you choose to participate, you will receive digitally connected glucose monitors, scales, and/or blood pressure cuffs that will monitor and transmit your data in real time to your own personal Teladoc coach, who will help you manage your condition.

Get started today. Visit mybam.bcbstx.com, download the Teladoc Health app, call 800-835-2362, visit the website, or text Go Well-BCBSTX to 85240 to learn more and join.

Wondr for Weight-loss Management

A behavioral counseling program for weight management and metabolic syndrome reversal. There are no points, plans, or counting calories. Wondr teaches you the science of how to eat your favorite foods so you can lose weight, sleep better, stress less and so much more. Learn simple, behavioral skills that are clinically proven to improve health.

- Simple, repeatable skills through weekly master classes
- Reinforce and practice through weekly personalized curriculum
- Build momentum toward your healthiest self in the maintenance phase

PARTNERS FOR HEALTH

Omada Diabetes/Hypertension Prevention

Benefit from digital educational opportunities for reducing the risk of type 2 diabetes and heart disease with Omada. This supplemental remote care can be done in the comfort of your home. Omada, a behavioral medicine program, inspires and enables people who are at risk for chronic conditions like type 2 diabetes and heart disease to change the habits that put them most at risk.

- Professional health coach to provide ongoing digital support and guidance
- Weekly lessons to empower healthier habits around food, activity, sleep and stress
- Cellular-connected scale that automatically uploads readings to a member's account
- Small online group for real-time motivation from a community of peers
- Simple employer reporting for enrollment, engagement, and outcomes

Ovia Health Woman/Family Health

Get support from Ovia Health's complete app suite to provide support from pre-pregnancy to delivery all the way through parenting and menopause. On top of being great tracking apps for every step of the parenting journey, Ovia Health helps manage both the children's and the mother's health, including support for postpartum depression.

Download the Ovia Health apps from the Apple App Store or Google Play. Make sure to choose "I have Ovia Health as a benefit," then select BCBSTX as your health plan.

LearntoLive for Mental Health

More than half of people will struggle with a mental health concern at some point in their lives. But you can learn new skills to break old patterns that may be holding you back. Digital mental health programs from LearntoLive can help you get your mental health on track so you can feel better and enjoy life more.

- Learn to adjust unhelpful thoughts and control your moods
- An expert coach can guide you
- Your personal details are private

Hinge Health Musculoskeletal Aid

Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your needs, technology for instant feedback in the app, personal coach and physical therapist. Join for your back, knee, hip, neck, or shoulder. On average, participants cut their pain as much as 68%.

- Conquer pain or limited movement
- Recover from a past injury
- Reduce stiffness in achy joints

FIND A PROVIDER

Find a Medical Provider

1. Visit my.providerfinderonline.com (to search as a guest)
2. Fill in the fields as indicated online. Fields marked with an "*" are required. To find the plan network, select Employer Plans.
3. Select your plan/insurance:
    - For the HDHP-HSA and EPO Plan, select: PPO, **Blue Choice PPO** network
    - For the HMO Plan, select: HMO, **Blue Essentials** network
4. Enter a provider name to view important provider information, including a listing of the plans the specific provider accepts. You must call and check with the provider before scheduling your appointment or receiving services to confirm the physician is still participating in the Blue Choice or Blue Essentials network, depending on your Plan.

You can also log in to your personalized member portal at mybam.bcbstx.com. Conducting a provider search using your Blue Access for Member (BAM) portal provides the most accurate results.

Click here to watch a video about choosing a provider.

PLAN CONTRIBUTIONS

Medical

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Plan/Coverage Tier	Monthly Premium and Employee Contributions	
	Monthly Premium	Employee Contribution
HDHP-HSA Option 1		
Employee Only	$664.11	$154.11
Employee + Spouse	$1,340.63	$830.63
Employee + Child(ren)	$1,163.29	$653.29
Employee + Family	$1,944.94	$1,434.94
HDHP-HSA Option 2		
Employee Only	$1,004.45	$494.45
Employee + Spouse	$2,027.66	$1,517.66
Employee + Child(ren)	$1,759.43	$1,249.43
Employee + Family	$2,941.66	$2,431.66
HMO Option 1		
Employee Only	$819.19	$309.19
Employee + Spouse	$1,948.69	$1,438.69
Employee + Child(ren)	$1,434.93	$924.93
Employee + Family	$2,399.08	$1,889.08
HMO Option 2		
Employee Only	$1,193.23	$683.23
Employee + Spouse	$2,408.77	$1,898.77
Employee + Child(ren)	$2,090.13	$1,580.13
Employee + Family	$3,494.55	$2,984.55

CONTACTS

Contact	Questions About	Phone/Website/Email
BlueCross BlueShield of Texas Helpline Group No. TX368950	Medical benefits, procedures, complex imaging (i.e. MRI/CT Scans), cost estimates for procedures, claims, Explanation of Benefits, select or change primary care physician, find in-network providers, Blue Access for Members portal,	855-762-6084 mybam.bcbstx.com
Accredo Specialty Pharmacy	Specialty medication for complex and chronic conditions like multiple sclerosis, hepatitis C and rheumatoid arthritis	833-721-1619 855-762-6084 www.accredo.com
MD Live	Non-emergency symptoms, prescriptions, behavioral health	888-680-8646 www.mdlive.com/bcbstx
Well onTarget	BCBSTX's wellness program and resources	877-806-9380 www.wellontarget.com
Ovia Health	Women's health, fertility, parenting, LGBTQ, surrogacy, adoption, pregnancy, menopause, support for dads and partners, autism, family health	888-421-7781 mybam.bcbstx.com
Teladoc	Diabetes and hypertension management	800-835-2362 800-945-4355 teladochealth.com/register
24/7 Nurseline	Healthcare options and decisions, baby or teen health, diabetes and blood pressure, and more	800-581-0393

BENEFIT TERMINOLOGY

Allowed amount

This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their Explanation of Benefit statements (EOBs). For example, a provider may charge $120 per hour of psychotherapy, but the insurance company pays them $95—the allowed amount for that service.

Balance billing

When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is $100 and you've met your deductible. If your plan pays 80%, then you are responsible for the remaining 20%, which is $20.

Copayment

Oftentimes referred to as a "copay," this is the amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is $3,300, your plan will not pay anything for certain medical services until you have paid $3,300. The deductible may not apply to all services, such as services that are covered by a copay.

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA), who is eligible to be included on your health insurance policy.

Dependent care FSA

A flexible spending account (FSA) is designed to provide tax-exempt funds that can be used to offset qualifying expenses for children and elderly dependents. Eligible dependent care expenses include daycare, before- and after-school care, summer day camps and eldercare for dependents claimed on your income taxes. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as "use it or lose it."

Diagnostic test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

BENEFIT TERMINOLOGY

Durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible expense

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. See balance billing.

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, HDHP-HSA Option 1 features an in-network family deductible of $6,000. If one member of the family satisfies the individual $6,000 deductible, the medical carrier will pay 80% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining $4,000 the embedded family deductible is considered satisfied.

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, HDHP-HSA Option 1 features a family out-of-pocket maximum of $16,600. If one member of the family satisfies the individual out-of-pocket maximum of $8,300, the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

Employee contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn't pay for or cover.

Explanation of benefits

Every time you use your health insurance your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

BENEFIT TERMINOLOGY

Health care FSA

Funded through pre-tax payroll deductions, a health care flexible spending account (FSA) is a cost-savings tool that allows you to pay for qualified health care-related expenses with pre-tax dollars.

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts. (These are typically "Tier 1" drugs in medical plans.)

High-Deductible health plan (HDHP)

A HDHP is a type of health insurance plan that typically offer lower premiums in exchange for higher deductibles. The deductible, which is the amount you must pay out of pocket for covered medical expenses before your insurance begins to pay, is higher for HDHPs compared to HMO plans. These plans allow individuals to pay a lower monthly premium and instead cover more of their medical expenses through out-of-pocket expenses/deductibles.

Health savings account (HSA)

An employer- and employee-funded savings plan that reimburses you for qualified out-of-pocket medical expenses. Funded through pre-tax payroll deductions by the employer and employee, HSAs are only available to people enrolled in a qualified high-deductible health plan. Unspent balances aren't forfeited; they roll over and accumulate over time.

In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx

The medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

Medically necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine.

Member health statement

Every time you use your health insurance your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount").

BENEFIT TERMINOLOGY

Negotiated rate

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Network

The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic. (These are typically "Tier 3" drugs in medical plans.)

Non-preferred provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-pocket maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment allowance

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

BENEFIT TERMINOLOGY

Preauthorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs. (These are typically "Tier 2" drugs in medical plans.)

Preferred provider

A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Prescription drugs

Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.

Prescription drug coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty (Tier 4).

Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.

Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and your employer, though there are insurance benefits the employer pays for entirely, while there are others that you pay for yourself.

Premium (Medical)

The amount that is paid for your medical coverage. You and your employer share this cost, which is paid monthly to the insurance carrier.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

BENEFIT TERMINOLOGY

Prior approval/authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider

A physician, health care professional or health care facility, certified or accredited as required by state law.

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

Special enrollment period

Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Open Enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.

BENEFIT TERMINOLOGY

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescription can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Urgent care

An illness or injury serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wellness

Wellness refers to a healthy state of being.

Click here to watch a video about benefits terms.