Frequently Used Terms

The language of health insurance can be confusing. Keep this list of common terms handy as you explore your open enrollment materials; it will help you understand and choose the plan that's right for you.

- **Coinsurance:** The percentage you pay for care or prescriptions after you've reached your deductible. Your plan pays the remaining percentage until you reach your out-of-pocket maximum, or OPM. Then your plan takes over and pays 100% of your costs for the rest of the plan year. Your coinsurance percentage may vary based on the plan you select.
- **Combination flexible spending account:** For employees with a high-deductible health plan, an account that can be used in combination with an HSA to set aside pre-tax dollars for eligible dental and vision expenses.
- **Copayment/copay:** A fixed dollar amount you pay for care or prescriptions, usually at the time of service.
- **Covered charges:** Within the guidelines of the plan, medically necessary services and supplies provided by or under the direction of a physician.
- **Deductible:** The amount of money you pay out of pocket for care and prescriptions before your plan begins to pay benefits. The deductible may not apply to all services, like preventive care.
- **Dependent:** An eligible child or spouse you elect to cover on your health plan or flexible benefits.
- **Dependent care flexible spending account (DCFSA/ Dependent care FSA):** A benefit that lets you set aside pre-tax dollars to help pay for childcare and dependent care expenses. You may open a DCFSA if you have a child under the age of 13 or if you can claim on your taxes a dependent adult who is mentally or physically unable to care for themselves. Contributing to a DCFSA reduces taxable income and spreads the benefits of pre-tax dollars throughout the year, helping you save 30% or more on your dependent care costs.
- **Eligible employee:** A permanent full-time employee, permanent part-time employee, or an employee of a participating unit who has worked an average of 30 hours or more per week during a 12-month period, as defined by the Patient Protection and Affordable Care Act of 2010.
- **Embedded deductible:** For those with family coverage, how the deductible is met so no one family member contributes more than the single deductible amount to the family deductible.

  For example: The Washington Plan has a single deductible of $5,500 and a family deductible of $11,000. If you have family coverage and one of your family members reaches the $5,500 deductible/OPM, the plan will then begin to pay 100% of their covered healthcare and prescription costs for the remainder of the plan year. Then, if a different family member or members reach the additional $5,500 remaining deductible of $11,000, the plan will pay 100% of covered healthcare and prescription costs for all covered family members for the remainder of the plan year.
- **Emergency services:** Evaluation and treatment of an emergency medical condition.
- **Excluded services:** Healthcare services your health plan doesn't pay for or cover.
- **Health reimbursement account (HRA):** An employer-funded account that members can use to be reimbursed for certain medical, pharmacy, dental, and vision expenses.
- **Health savings account (HSA):** A triple tax-advantaged savings account that allows those enrolled in a high-deductible health plan to set aside funds to pay for covered medical, prescription, dental, and vision expenses. You can also use your HSA to save and invest long term. The funds in your account roll over year to year, and the money is yours to keep, even if you change jobs or retire.

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- **Health screening:** A regular measurement of your most important health numbers: your blood pressure, your cholesterol levels, and your body mass index (height and weight). An incentive is provided for completing the annual screening at a State-sponsored event or by submitting a form signed by your doctor at your yearly preventive exam.
- **Incurred:** To become liable for. A "charge incurred" is a cost you owe because you received a service or prescription on the listed date.
- **Medical flexible spending account (FSA):** An account that allows you to set aside pre-tax dollars to pay for out-of-pocket medical, prescription, dental, or vision expenses. You may use the account to pay for deductibles, copayments, and other costs not covered by insurance. Only State employees who select a low-deductible health plan for coverage may elect a medical FSA.
- **Member:** Any employee, spouse, or dependent who is insured under the State of South Dakota's health insurance plan.
- **In-network:** In-network healthcare providers have contracted with our insurance company to accept discounted rates. Out-of-network providers have not agreed to the discounted rates. You will pay much less at in-network doctors, hospitals, and pharmacies.
- **Network:** The doctors, hospitals, pharmacies, and other providers and suppliers your health plan contracts with to provide care and services.
- **Non-covered charges:** Charges for services and supplies that are not covered under the health plan. Examples of non-covered charges include exercise equipment, gym memberships, and cosmetic surgery. Consult your plan for more information.
- **Non-primary care practitioners:** Specialists — such as dermatologists, oncologists or cardiologists — who are not considered primary care practitioners.
- **Out-of-network:** Out-of-network healthcare providers have not contracted with our insurance company to accept discounted rates. You will pay much less at in-network doctors, hospitals, and pharmacies.
- **Opt out:** When you choose not to participate in your employer health plan. State of South Dakota employees must provide acceptable proof of coverage in an alternate group health plan in order to opt out.
- **Out-of-pocket maximum:** The most you have to pay out of pocket in a plan year. After you spend this amount on deductibles, copays and coinsurance, the plan pays 100% of your health care costs.
- **Premium:** The amount taken from each paycheck to pay for your health insurance coverage.
- **Prescription drugs:** Medications that, by law, require a prescription from a medical provider.
- **Prescription drug coverage:** Coverage built in to your health plan to help pay for your prescription medications.
- **Preventive care/services:** Care received to prevent illness and disease rather than treat it. Examples of preventive care include routine cancer screenings, well-child care, and immunizations.
- **Primary care practitioners (PCPs):** General and family practice doctors, internists, OB/GYNs, pediatricians, nurse practitioners, and physician assistants.
- **Proof of coverage:** A document from a health plan insurer stating that you have health insurance coverage.
- **Provider:** A physician, nurse practitioner, clinical nurse specialist, or physician assistant who provides, coordinates, or helps a patient access a range of health care services.
- **Self-funded health plan:** A health plan is self-funded when the employer pays the medical and pharmacy claims, rather than the health insurance company. The South Dakota State Employee Health Plan is a self-funded plan.
- **The beneFIT well-being program:** A wellness program offered as a benefit to State of South Dakota employees. Tools and resources are provided to help improve your overall well-being, with focuses on physical, mental, social, emotional, and financial health.