Frequently Used Terms

Co-Insurance: Your share of the costs of covered health care service or prescription, calculated as a percentage (for example, 25%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. After you have reached your deductible, your health plan will pay a percentage of all eligible charges until you reach your out-of-pocket maximum. The percentage may vary based on the health plan selected.

Combination Flexible Spending Account: An account used with a health savings account (HSA) that provides pre-tax reimbursement for eligible dental and vision expenses until your health plan deductible has been met.

Co-Payment: A fixed amount (for example, $50) you pay for a covered health care service or prescription benefit, usually when you receive the service. The amount can vary by the type of covered health care service.

Covered Charges: Medically necessary services and supplies, if provided by or under the direction of a Physician. These services are subject to the limitations, exclusions, and other provisions of the Plan; payment by the Member of any applicable Deductible, Copayment, and Coinsurance specified for any service; and pre-authorization if applicable.

Deductible: The amount you owe for health care services or prescriptions your health insurance or plan covers before your health insurance or plan begins to pay. The Deductible may not apply to all services, such as preventive services.

Dependent: An eligible child or spouse that you elect to be covered on the health plan or flexible benefits.

Dependent Care Flexible Spending Account (DCFSA): A dependent care flexible spending account (dependent care FSA) is a benefit that lets employees set aside pre-tax dollars to help pay for dependent care. Contributing to a dependent care FSA reduces taxable income and spreads the benefits of pre-tax dollars throughout the year, helping you save 30 percent or more on your dependent care costs. Funds can be used to pay for childcare for children under age 13 when they're claimed as qualifying dependents. But the savings potential isn't limited to just childcare. They can also cover care for a disabled spouse or dependent of any age.

Eligible Employee: – A permanent full-time employee, permanent part-time employee, or an employee employed by a participating unit who has worked an 20 average of 30 hours or more per week during a 12-month standard measurement period, as defined by the Patient Protection and Affordable Care Act of 2010, as amended.

Embedded Deductible: The single deductible is embedded in the family deductible, so no one family member can contribute more than the single amount toward the family deductible.

> **For Example:** The Washington Plan introduces an embedded deductible, which is the way a deductible is met when two or more individuals are covered. If you have family coverage and one of your family members reaches the $5,500 deductible, the plan will then begin to pay 100% of covered healthcare and prescription costs for the remainder of that plan year for that family member.
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> Then, if a different family member (or combination of family members) reaches 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 of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health plan doesn't pay for or cover.

Health Reimbursement Account (HRA): An employer-funded account that reimburses members for certain medical, pharmacy, dental, and vision expenses

Health Savings Account (HSA): A type of savings account that enables members enrolled a High Deductible Health Plan to pay for covered medical, prescription, dental, and vision expenses with pre-tax dollars.

Health Screening: Healthy living includes regular screenings to measure your most important health numbers: your blood pressure, your cholesterol levels, and your body mass index (height and weight). Receive valuable information to keep you healthy today and help prevent serious health problems in the future. An incentive is provided for completing the health screening qualification through one of our screening events or by submitting a form signed by your doctor following an annual wellness preventive exam.

Incurred: A charge is deemed "Incurred" on the date the service or supply is provided.

Medical Flexible Spending Account (FSA): A type of pre-tax account that allows you to pay for out-of-pocket medical, prescription, dental, or vision expenses with pre-tax dollars. A Medical FSA helps you pay for costs including deductibles, copayments, and other costs that may not be covered by insurance.

Member: Any Employee, Spouse or Dependent who is insured under the Plan.

In-Network Provider: A provider who has a contract with your health plan and flexible benefit providers to provide services to you at a discount.

Network: The facilities, providers, and suppliers your health and flexible benefits plans have contracted with to provide health care services.

Non-Covered Charges: Charges for services and supplies that are not covered under the health plan. Examples of non-covered charges may include things like exercise equipment, marital counseling or cosmetic surgery. Consult your plan for more information.

Non-Primary Care Practitioners: Specialists such as dermatology, oncology, cardiology, etc. that are not defined as a Primary Care Practitioner.

Out-of-Network Provider: A provider who doesn't have a contract with your health plan or flexible benefit to provide services to you. Members will pay more to see a non-network provider for services.

Opt-Out: When you as the employee 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 of the State employee health plan.

Out-of-Pocket Maximum: The portion of payments for health services which is the responsibility of the Member, which shall include Deductible and Co-insurance.

Premium: The amount you pay every pay period for health insurance.

Prescription Drugs: Drugs and medications that by law require a prescription from a medical provider.

Prescription Drug Coverage: Coverage within your health plan to help pay for prescription drugs and medications.

Preventive Care/Services: Care received to prevent illness and disease. Preventive Care includes things such as routine cancer screenings, well-child care, and immunizations. The term "Preventive Care" also includes care and treatment designated or identified as such in federal regulations promulgated by the Department of Health and Human Services under the PPACA.

Primary Care Practitioners (PCP): General and family practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs.

Proof of Coverage: A document from a health plan insurer stating that an individual has health insurance coverage.

Provider: A physician (M.D.-Medical Doctor or D.O. Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, 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 benefits directly through its general assets or through a trust fund established for that purpose. 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 employees. Tools and resources are provided to help improve your overall well-being, focusing on physical, mental, social, emotional, and financial health.