

# Benefits Glossary Addendum

## Alphabet Soup of Benefits Terminology



### **ACA: Affordable Care Act**

A Federal law that requires everyone to have medical insurance coverage. This law also sets minimum essential coverage requirements as well as affordability requirements for employers with 50 or more employees.

### **COBRA: Consolidated Omnibus Budget Reconciliation Act**

Applies to employers with 20 or more employees. Requires post-employment benefit continuation to be offered for qualifying loss of coverage reasons not related to gross misconduct. Separating employee pays an administration fee on top of premiums to continue qualifying health related coverage for fixed periods defined by the Act.

### **EAP: Employee Assistance Program**

A program designed to assist an employee with various personal needs from mental health or substance abuse to will preparation and identity theft. Programs vary greatly by offering.

### **EPO: Exclusive Provider Organization**

A physician network that allows covered individuals to see any physician within the assigned network without referral. Typically, EPO's do not cover out of network services.

### **ERISA: Employee Retirement Income Security Act**

A Federal law that defines plan requirements for group benefit and retirement plans

### **FSA: Flexible Spending Account: Section 125 Plan**

There are 3 types that apply to this term:

- **Medical Expense Reimbursement** – Pre-Tax dollars with max set by plan can be set aside to pay for out-of-pocket health care related expenses. Some funds may roll over to next plan year to a cap with excess forfeited, but some plans any leftover funds at end of plan year are forfeited
- **Dependent Care** – Up to \$5,000 pre-tax dollars can be set aside to pay for dependent care expenses. Note: Funds left over at end of plan year are forfeited
- **Pre-Tax Premiums or Premium Only Plan (POP)** – Set up by a plan to allow for employee portion of premium cost share (payroll deductions) to be deducted on a before tax basis from payroll.

### **HDHP: High Deductible Health Plan**

Covered participants must meet a set dollar amount in medical expenses before the healthcare plan starts covering expenses. Typically, a deductible must be met then the HDHP plan starts covering expenses. Participants on an HDHP plan are eligible to participate in an HSA plan.

### **HIPAA: Health Insurance Portability & Accountability Act**

A Federal law that defines coverage levels for plans including privacy requirements for medical providers and employers.

### **HMO: Health Maintenance Organization**

A physician network that requires participants to use a provider in the HMO network only and typically must start with a Primary Care Physician (PCP) who coordinates extended care.

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### **HRA: Health Reimbursement Arrangement**

Employers may choose to set up a group health insurance plan with high deductibles then contribute to an HRA on the employee's behalf to reduce the out-of-pocket expense for the employee. Employees cannot contribute to the HRA, funds are not portable, do not typically earn interest and are not invested. Qualified medical expenses such as co-pays, deductibles and maximum out of pocket limits are examples of costs the employer may choose to fund through an HRA.

### **HSA: Health Savings Account**

This is an investment account where funds can be deposited on a before-tax basis to pay for out-of-pocket health expenses. Employee must be participating in a qualified High Deductible Health Plan to take advantage of an HSA plan. IRS sets limits each year, and the employee keeps the money in this account year to year with no forfeitures. Money can also be used to pay for health costs after retirement.

### **POS: Point of Service Plan**

A combination of the HMO and PPO type plan that allows an employee to seek service from an in-network provider. Sometimes a POS plan may require the assignment of a Primary Care physician.

### **PPO: Preferred Provider Organization**

A physician network that allows individuals to use any of the plan's preferred providers within the network without referral. Typically, a PPO allows for out of network services with higher employee out of pocket expense.

### **SBC: Summary of Benefits Coverage**

A plan summary document, defined by Federal Regulations, that must be provided to all employees eligible to participate in a group medical insurance plan.

### **SBD: Summary Plan Description**

A plan document provided to plan participants for each enrolled benefit plan. This is typically an addendum to the certificate of coverage booklet provided by the group insurance carrier for each plan.

### **SMM: Summary of Material Modifications**

A notice to plan participants that ERISA requires when an employer makes material changes to a group benefit plan.

### **TPA: Third Party Administrator**

A vendor the employer selects to administer group benefits plans. Commonly used for health, FSA, and retirement plans.