Employee benefits lingo 101

Knowing benefits is part of your job, but it's not necessarily a part of your employees' jobs. So words you take for granted, such as "copayment," "deductible" and "premium," might be completely lost on the people who need this information.

This glossary doesn't cover everything your employees need to know about health insurance and supplemental insurance—but it's a start. Keep hard copies and a digital download of this glossary on hand to distribute to your team.

Ready to put this knowledge into action? Contact your Aflac benefits advisor or visit Aflac.com/business.

Aflac®

Employee benefits glossary

You know it's important to take control of your health, but insurance can feel as confusing as it is essential. Demystify the basic lingo of insurance with this glossary. If you want to learn more, visit HealthCare.gov's glossary for more than 200 additional terms.

Annual limit, lifetime limit: The most an insurance policy will pay in a year for your care. A lifetime limit is the most an insurance policy will pay over your lifetime. Both annual and lifetime limits for health insurance were banned by the Affordable Care Act. Many dental insurance plans do have an annual or lifetime limit, though, as dental insurance is not health insurance.

Claim: A payment request that you or your health care practitioner sends to your insurance carrier. If you are being treated by a practitioner who is out of network, you'll most likely have to file a claim yourself. If you're being treated in network, your health care practitioner is likelier to file the claim.

Coinsurance: The percentage of the total cost of a service that you pay. If your insurance plan has 30% coinsurance, that means you'll pay 30% of all costs after you've met the deductible.

Copayment (aka copay): What you pay for a particular service. If your insurance plan has a $30 copayment for a visit with a specialist, you'll pay $30, even though the real cost of that visit is higher—the insurance carrier pays the rest. Depending on your plan, you might pay the real cost of all services until you've met your deductible.

Deductible: How much you need to pay before insurance kicks in. So if you have a $1,000 deductible, you may pay $1,000 out of pocket before your insurance starts to cover anything. Depending on your policy, some things might be covered before you hit your deductible.

Drug list (aka formulary): A list of prescription drugs that an insurance plan will cover. Most plans sort drugs by price category.

EPO (aka exclusive provider organization): An insurance plan that pays only for providers who are in the EPO's network. If you have an EPO, you may need to choose a primary care physician, but you won't necessarily need a referral to see other types of practitioners. EPOs are a lot like HMOs, although HMOs are more common.

High-deductible health plan (aka HDHP): An insurance plan with a higher deductible than many other plans. For 2022, the IRS considers a plan with a deductible of at least $1,400 for an individual or $2,800 for a family to be a high-deductible health plan.[1]

HMO (aka health maintenance organization): An insurance plan that pays only for providers who are in the HMO's network. If you have an HMO plan, you'll need to select a primary care physician, and that physician will need to give you a referral before your insurance will cover other types of practitioners. Compared with PPOs and POS plans, HMOs give you less freedom in choosing your practitioners, but they usually cost less.

Network, out of network: A group or list of practitioners who agree to an insurance carrier's payment structure. If you choose a provider who is in network, the cost is usually lower for you. If you choose a provider who is "out of network," that means he or she has not agreed to your insurance carrier's payment structure, which usually results in higher prices for you.

Open enrollment: The time each fall when you can enroll in a new health insurance plan. Exact open enrollment dates vary by state, but all states include November in their open enrollment periods. You can't enroll in health insurance outside of this time unless you have a qualifying life event.

POS plan (aka point of service plan): An insurance plan that pays a bigger portion of the bill when you see a practitioner in its network. Out-of-network practitioners are covered at a lower rate. A POS plan gives you more freedom in choosing your practitioners than an HMO does but less freedom than a PPO does.

PPO (aka preferred provider organization): An insurance plan that shoulders a bigger percentage of the bill when you see a practitioner who is in network. Out-of-network practitioners are covered at a lower rate. You don't need to have a primary care physician with a PPO, and you don't need a referral to see another practitioner. Compared with an HMO, a PPO gives you more freedom in choosing your practitioners, but it usually costs more.

Preauthorization (aka prior authorization, prior approval or precertification): Approval you get from your insurance carrier for a specific service before you actually get the service. Health care practitioners are the ones who file for preauthorization, but you may need to work with them and your carrier to move forward with the service.

Premium: What you pay every billing period to be insured. For insurance that you get through your job, you probably pay the premium through a payroll deduction.

Primary care provider: A practitioner who leads your health care. HMOs and EPOs usually require that you have a primary care provider; PPOs and POS plans don't require one. Regardless of your insurance, you can have a primary care provider as the starting point for all your health care needs. This person is usually a physician—most often an internal medicine doctor or a family medicine doctor—but can also be a nurse practitioner or a physician assistant.

Qualifying life event: A life or situational change that allows you to enroll in health insurance outside of the open enrollment period. Examples include losing your health insurance, moving to a different area, having a household change (such as getting married or divorced) or becoming a U.S. citizen.

Rider: An add-on to your insurance policy that gives you benefits beyond the main policy. Riders usually cost you more money than the basic policy, but in exchange you get additional coverage.

Specialist: A health care practitioner who specializes in a certain kind of medicine. Depending on the type of insurance you have, you might need to see a primary care provider to get a referral before a visit to a specialist would be covered. Some types of practitioners (such as gynecologists) can be both a specialist and a primary care provider.

Supplemental insurance: A type of insurance that helps you pay for costs that aren't typically covered by health insurance. It usually pays you directly instead of paying providers.

[1] HealthCare.gov. "High Deductible Health Plan (HDHP)." Accessed 9.10.2021.