

# Important Terms

**We know that benefits can be confusing, especially with all of the terms that are used to describe them. To help you better understand your options, we put together a listing of commonly used benefit terms used throughout this Guide.**

**Coinsurance** — percentage of covered expenses you pay after the plan's applicable deductible.

**Consumerism features** — choices you make to save money, such as using network providers instead of out-of-network providers, or requesting a generic drug instead of a brand-name drug alternative.

**Contributions** — the amount that is deducted from your paycheck to pay for your share of benefits.

**Copayment** — the fixed dollar amount you pay to the provider for some services, such as office visits and prescription drugs.

**Deductible** — the amount you pay each calendar year before the plan reimburses you for covered expenses.

**Exchange** — another name for the Health Insurance Marketplace that has been available since October 1, 2013 to help individuals and small employers compare and purchase health insurance.

**Health Assessment** — online questionnaire that you complete to help you identify potential health risks.

**Health Care Reimbursement Account (HCRA)** — a company-funded account that can be used to pay for a portion of your deductible or coinsurance. (Only available with the Health Care Reimbursement Account Plan).

**Health Insurance Marketplace** — a way for individuals and small employers to compare and purchase health insurance.

**In-network** — service received from a participating medical, dental or vision care network provider. Also, can be used to define the level of benefits paid when you use a network provider.

**Out-of-network** — service received from a provider that does NOT participate in the applicable Aetna, MetLife and/or EyeMed networks.

**Out-of-pocket maximum** — maximum expense limit you are responsible for paying such as your deductible, coinsurance, and copays in a given plan year - this does not include your contributions. After this limit is reached, the plan reimburses 100% for most remaining covered medical expenses (excluding prescription drugs and the amount above the reimbursement level.).

**Primary care physician (PCP)** — the network doctor, generally a family practice, internist or pediatrician, you choose to provide care for you and to help you coordinate your overall health care, and make referrals to specialists, when appropriate.

**Reasonable and Customary (R&C) Charges (for Dental Plan)** — the negotiated fee your network dentist and the insurance provider have agreed on to perform certain services. If you visit an out-of-network provider, you will be required to pay any charges that exceed the R&C charge.