

**Health Pass** <sup>SM</sup>  
WE'VE GOT YOU COVERED

*The* **ABC's**

*An Administrative Guide To*  
**Your Insurance Plan**



**We've Got You Covered** <sup>SM</sup>

# WELCOME

Thank you for choosing HealthPass!

We know a lot of time, effort, and thought went into the decision to select the best possible health plan for you and your employees. HealthPass is an easy way to offer your employees a choice of affordable health insurance and for you to control your costs through our defined contribution method.

We want you to know that we're always working hard to keep it easy for you to administer our plans. We strive to provide you with excellent service. Our goal is to offer the area's most flexible health plan, while keeping HealthPass simple to use, simple to understand and simple to administer.

**With HealthPass, We've Got You Covered.**

**Health Pass** <sup>SM</sup>  
WE'VE GOT YOU COVERED



**A****UPDATING OR CHANGING INFORMATION**

All enrollment and information changes should be sent to HealthPass, not the individual carriers. Changes sent to the carriers will not be updated. (Refer to page 6)

**Employer Information Updates**

Use the HealthPass Notice of Election Form or submit a request on company letterhead, signed by an authorized contact or officer, to make changes to the following group information at any time:

- Address
- Group Contact Name
- Phone / Fax Number
- Email

**Employee Information Updates**

Use the HealthPass Enrollment/Change Form to make changes to the following employee information at any time:

- Name
- Address
- Phone Number

*It is very important that HealthPass has accurate and current information for the group and employees at all times.*

**B****RESOURCES WEBSITES**

<a href="http://www.healthpass.com">www.healthpass.com</a>	HealthPass
<a href="http://www.ghi.com">www.ghi.com</a>	Group Health Incorporated
<a href="http://www.glic.com">www.glic.com</a>	Guardian
<a href="http://www.healthnet.com">www.healthnet.com</a>	Health Net
<a href="http://www.hipusa.com">www.hipusa.com</a>	HIP
<a href="http://www.perfectny.com">www.perfectny.com</a>	PerfectHealth
<a href="http://www.healthadvocate.com">www.healthadvocate.com</a>	Health Advocate

Use the HealthPass website, as well as the carrier websites, as a tool for you and your employees. You can search for providers, print forms check claim status and/or view drug formulary lists. To make administration easier, you can access your account online to review employee information, make changes, or pay your bill.

**MATERIALS**

The best resource for materials is the HealthPass website. If you are unable to locate what you need, you can link to the

individual carrier website or contact each carrier directly. For guidance, call HealthPass Member Services at 888.313.7277. Assistance is also available with the following:

- Claim forms
- Pharmacy Mail Order information
- Drug Formularies
- Summary of Benefit Plan designs
- Carrier Contact information
- ID Cards

**Health Advocate** is an advocacy and assistance service, which addresses many of the concerns members routinely confront when accessing healthcare and health insurance services. All employees enrolled in HealthPass medical plans, as well as their spouse, domestic partner, children, parents and parents in-law are eligible. Contact a Health Advocate at 866.695.8622 for help with:

- Claim resolutions
- Finding the best doctors and hospitals
- Locating and researching all current treatments for a medical condition
- Scheduling appointments with hard to reach specialists
- Eldercare issues

*Note: COBRA / NYS Continuation-of-Coverage members are not eligible for Health Advocate.*

**C****ADDING EMPLOYEES AND DEPENDENTS**

The initial open enrollment is the period in which you first offered HealthPass to your employees. All eligible employees were permitted to enroll. Annual open enrollment will occur each year at the same time; all eligible employees may enroll or renew. Enrollment/Change Forms should be submitted 10 days prior to the enrollment or renewal effective date.

## STEP 1: VERIFY ELIGIBILITY

### NEW EMPLOYEES

Use the same Enrollment/Change Form that was originally used to enroll all new employees. Apply the same criteria used to define a full-time employee that was previously applied.

*Group level requirements, such as hours worked to be full time and waiting period can only be changed at the group's annual open enrollment.*

### EMPLOYEES WHO PREVIOUSLY WAIVED COVERAGE

Employees who previously waived coverage may enroll in HealthPass during your group's open enrollment or due to certain qualifying events. A qualifying event is a change in an employee's status, which allows the employee to enroll outside the open enrollment period.

#### Qualifying Events - Employees

##### *Involuntary Loss of Coverage*

If an employee, employee's dependent or eligible domestic partner loses health coverage provided by another source, and that loss arises due to no fault of their own, they are eligible to enroll in HealthPass. A HIPAA certificate must be provided to substantiate the request.

Examples:

- Death or divorce of a spouse or eligible domestic partner
- Loss of employment by a spouse under whose health plan the employee and dependents were covered

##### *Exhaustion of COBRA or NYS Continuation-of-Coverage*

If a new employee is currently covered by COBRA or NYS Continuation-of-Coverage from their previous employer, the employee is eligible to enroll in HealthPass at one of the following:

- Upon satisfaction of your company's waiting period

- Upon expiration of COBRA or the continuation period
- At your company's next annual open enrollment

##### *Change from Part-Time to Full-Time Status*

Follow the procedure to enroll a new employee in Step 1. The selected waiting period applies from the date of the change to full-time status.

### DEPENDENTS

Dependents of an employee are eligible for coverage if they fall into one of the following categories:

- A legal spouse or eligible domestic partner
- Any unmarried child (natural, step or adopted) under 19 years of age
- A legally appointed dependent (must meet criteria established under Section 152 of the U.S. Internal Revenue Service Code)
- Any unmarried child (under 25) if a full-time student in an accredited college or university and financially dependent on the employee
- An unmarried, dependent child over age 19, incapable of self-sustaining employment due to mental or physical handicap, in which the disability existed prior to the age at which dependent coverage would otherwise terminate. A physician must certify the dependent's condition.

Dependents must have a qualifying event to be added outside an open enrollment period. Documentation must be provided to verify the qualifying event has occurred.

Dependents and/or domestic partners must enroll with the same carrier and benefit design as the employee. After a dependent is added, coverage remains in effect until the end of the month or year during which they become ineligible, or the date of their marriage. Domestic Partner coverage is only available through select HealthPass carriers. (Employees should refer to their Certificate of Coverage for specific information).

## Qualifying Events - Dependents

- Adoption
- Birth of a Child
- Involuntary Loss of Coverage
- Marriage
- New Stepchildren

## STEP 2: DETERMINE THE EFFECTIVE DATE

### NEW EMPLOYEES

A new employee's coverage will become effective on the 1<sup>st</sup> day of the month that follows the completion of the waiting period.

Example:

Waiting period:	30-day
Hire Date:	May 16
End of Waiting Period:	Jun 15
Effective Date:	July 1

### EMPLOYEES WHO PREVIOUSLY WAIVED COVERAGE AND HAVE A QUALIFYING EVENT

- Employee must enroll within **30 days** from the date of the qualifying event
- Coverage will take effect the 1<sup>st</sup> of the month following the date of the qualifying event

### DEPENDENTS WITH A QUALIFYING EVENT

The effective date of coverage is the 1<sup>st</sup> of the month following the date of eligibility.

For a birth or adoption, coverage will begin as of the date of the event. For example, a couple will pay family premium from January 1 for a baby born on any day in January.

***HealthPass and/or the insurance carriers may request documentation or proof of employee status and verification at any time. Failure to provide requested documentation may result in termination of coverage.***

### REHIRES

Employees rehired within 12 months are eligible to enroll on the 1<sup>st</sup> of the month

following the date of rehire provided the group treats all rehires consistently.

## STEP 3: HELP AN EMPLOYEE DETERMINE THEIR COVERAGE

1. Have the employee identify doctors and hospitals they wish to access. Go to [www.healthpass.com](http://www.healthpass.com) and search the carrier provider directories to determine which carrier best suits their needs. (Health Advocate can assist 866.695.5062)

2. If an employee's provider does not participate with a given network, consider a plan with out-of-network benefits.

3. Show the employee their out-of-pocket premium costs, if any, for the available plan designs.

4. Determine whether the employee would consider a plan that requires referrals to see specialists, or if they want a non-referral plan.

5. Consider the importance of the following: office visit copay costs, whether or not to have a hospital copay, in-network or out-of-network deductible amounts, embedded Rx cards and their features, coinsurance levels and maximum out-of-pocket costs. These cost features and varying levels of benefits may be factors that reduce plan premiums.

6. Be sure to think about an appropriate plan choice not only for the employee, but for any current or future dependents they may have.

**Once a plan is selected, it cannot be changed until the next annual open enrollment.**

Ultimately, the decision rests with each employee to choose a plan he/she feels the most comfortable with, based on current and future needs.

Consult your broker for further assistance with making an informed choice or contact Member Services at 888.313.7277 or [memberservices@healthpass.com](mailto:memberservices@healthpass.com).

## STEP 4: COMPLETE AND SUBMIT AN ENROLLMENT/CHANGE FORM

An Enrollment/Change Form is included in your Welcome Kit or you can obtain forms by contacting HealthPass.

- Visit [www.healthpass.com](http://www.healthpass.com)
- Email [mbrscvs@healthpass.com](mailto:mbrscvs@healthpass.com) OR [memberservices@healthpass.com](mailto:memberservices@healthpass.com)
- Call 888.313.7277 to have forms forwarded to you

It is important that every section of the Enrollment/Change Form be completed. If the Prior Coverage section is not adequately completed, your employee may be subject to the pre-existing condition exclusion. (Refer to page 8)

- Submit completed Enrollment/Change Forms to [forms@healthpass.com](mailto:forms@healthpass.com), or fax to 888.354.7277.
- Send Enrollment/Change Forms via mail to:  
HealthPass  
4409 Parkbreeze Court  
Orlando, Florida 32808

HealthPass must receive the Enrollment/Change Form within **30 days** in which the employee is eligible. *If we are not notified within 30 days of the qualifying event, we will be unable to enroll the employee, and the employee will not be eligible again until your group's next open enrollment.*

### DEPENDENTS

HealthPass must receive the Enrollment/Change Form within **30 days** of the date from which the dependent is eligible. All appropriate documentation must be submitted with the Enrollment/Change Form for qualifying events.

#### Event

#### Documentation Required

Adoption.....copy of adoption certificate

Birth of a Child.....copy of birth certificate

Student Status Change.....carrier student verification form or documentation from accredited institution

Marriage.....marriage certificate

New Stepchildren.....court order or marriage certificate

Involuntary Loss of Coverage.....HIPAA certificate of prior coverage

## WHAT AN EMPLOYEE WILL RECEIVE AT HOME

As a member of HealthPass, each enrolled employee will receive the following materials from their selected health plan:

- An identification card
- A Certificate of Coverage that provides benefit details and new member information, including how to use their health plan and obtain care

## D

## TERMINATING AN EMPLOYEE, DEPENDENT GROUP COVERAGE

### EFFECTIVE DATE

The effective date of the termination is the last day of the month in which the employee or dependent loses eligibility. HealthPass must be notified of any termination(s) within 30 days of the last date of eligibility.

### HOW TO TERMINATE AN EMPLOYEE

1. Complete a HealthPass Enrollment/Change Form.
2. Submit the HealthPass Enrollment/Change Form to [forms@healthpass.com](mailto:forms@healthpass.com), fax to 888.313.7277 or send via mail to:

HealthPass  
4409 Parkbreeze Court  
Orlando, FL 32808

3. Notify terminating employee of COBRA or NYS Continuation-of-Coverage option within 14 days of the Qualifying Event.

Certain guidelines for Section 125 plans have conditions regarding whether an employee or dependent(s) can voluntarily

terminate health insurance coverage. If your company has a Section 125 plan, we suggest you have the termination request approved by your Section 125 administrator prior to sending the Enrollment/Change Form to HealthPass.

## HOW TO TERMINATE YOUR GROUP

HealthPass must receive a written request on company letterhead to terminate the group coverage within 30 days of the requested termination date. An authorized officer of the company must sign the letter.

E

## COBRA & NYS CONTINUATION-OF- COVERAGE

### FEDERAL COBRA AND NYS CONTINUATION-OF-COVERAGE

Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and New York State Insurance Law (Section 3221(m) and Section 4305 (e)) require that covered employees or dependents that lose coverage due to a qualifying event be offered the right to continue health coverage at their own expense, subject to the group's terms and conditions, with certain exceptions (see New York State Insurance Law).

When an employee is no longer eligible for coverage due to a qualifying event, under federal law the employee and any dependents may have a right to continue group coverage.

Federal law requires employers with 20 or more employees to notify employees and their dependents of their COBRA rights.

New York State Insurance law requires employers with 2 to 19 employees to offer NYS Continuation-of-Coverage, which follows similar guidelines as COBRA.

COBRA/NYS Continuation-of-Coverage enrollees must continue on the initial plan selection. Subscribers residing outside the coverage area **cannot** change plan designs mid-contract year.

## QUALIFYING EVENTS

### ***Termination of Employment***

A terminated employee is eligible for COBRA/ NYS Continuation-of-Coverage

### ***Divorce***

If an employee and their spouse divorce, the spouse is no longer eligible as a dependent but is eligible for COBRA/ NYS Continuation-of-Coverage as of the 1<sup>st</sup> of the month following the divorce date.

### ***Loss of Dependent / Student Status***

Dependents who reach age 19 or who lose full-time student status are eligible for COBRA / NYS Continuation-of-Coverage

### ***Death***

Dependents covered under the policy of an employee who passes away are eligible for COBRA / NYS Continuation-of-Coverage

## NOTIFICATION OF COBRA & NYS CONTINUATION-OF-COVERAGE

Once the employee or qualified beneficiary\* is terminated and notified of their COBRA / NYS Continuation-of-Coverage rights within 14 days of the qualifying event, covered employees and their covered dependent(s) must follow this timeline to elect COBRA/ NYS Continuation-of-Coverage.

1. Elect COBRA / NYS Continuation-of-Coverage within 60 days after receiving their COBRA/ NYS Continuation-of-Coverage election notice from the employer or the qualifying event, whichever is later.

*HealthPass is unable to enroll an individual if the Enrollment/Change Form is not received within the 60-day period*

2. Pay all retroactive premiums within 45 days from the date of election. A 2% administrative fee must be added to the premium.

***Coverage will not be activated until initial premium is received.***

After that, the employee will be billed monthly to their specified address.

Premium is due on the 1<sup>st</sup> day of the month with a 30-day grace period. Failure to render payment in a timely fashion will result in termination of coverage.

COBRA / NYS Continuation-of-Coverage will last up to 18 months after the qualifying event. Eligible dependents may have up to 36 months of coverage due to the following qualifying events:

- Death of the employee
- Divorce or legal separation
- The employee becoming Medicare eligible
- Loss of Dependent / Student Status

An employee may receive up to 29 months of COBRA/ NYS Continuation-of-Coverage if the employee is deemed disabled under the Social Security Act.

*If the group policy is cancelled, COBRA/NYS Continuation-of-Coverage cannot be offered through HealthPass.*

*\*A qualified beneficiary is any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the spouse or domestic partner of a covered employee, or the dependent child of a covered employee or domestic partner; or any child born to, or placed for adoption with, a covered employee or domestic partner.*

#### **HEALTHPASS COBRA ADMINISTRATION SERVICES**

You may purchase an additional service from HealthPass that alleviates the need to track and follow the above timeframes. With HealthPass COBRA Administration, once an employee or dependent is terminated we will automatically generate all necessary notifications and track the process from beginning to end. HealthPass will directly bill the subscriber for the initial premium and subsequent payments. Renewal paperwork will be mailed directly to the COBRA enrollee.

#### **You can enroll in HealthPass COBRA Administration Services anytime during the plan year and use the HealthPass Notice of Election Form at renewal.**

For additional information, contact your broker, HealthPass Member Services (888.313.7277) or refer to our website at [www.healthpass.com](http://www.healthpass.com).

#### **F COORDINATION OF BENEFITS**

##### **MEDICARE-REACHING AGE 65**

An employee becomes eligible for Medicare (a federal program) at age 65. If the employer has employees who are Medicare eligible and has fewer than 20 total employees, Medicare will be the primary payer for those employee claims. If the employer has 20 or more employees, the employer plan becomes the primary payer of those employee claims.

Carriers may require completion of a Coordination of Benefits Form for determination as to the primary and secondary payer.

#### **G MAIL ORDER PHARMACY**

##### **MAIL ORDER PHARMACY ADMINISTRATION**

Each HealthPass carrier offers a mail order pharmacy program. The pharmacy program provides discounts for mail order medications. All GHI plans are mandatory mail order for maintenance medications. Refer to the HealthPass Pharmacy Options Flyer for more information.

##### **HOW MUCH IS SAVED**

###### *GHI & Health Net*

When a member uses the mail order pharmacy program to order a 90-day supply of a generic drug, brand name drug on the formulary or brand name drug not on the formulary, the member will only pay 2 months copay. For example, with a \$10/\$20/\$40 drug card, the total cost for a 90-day supply of a generic drug is \$20 not

\$30 (2 months copay x \$10.00 = \$20.00).  
Member saves 33% or \$10.00.

### *HIP*

If a HealthPass member orders a 90-day supply of a generic drug or brand name drug on the formulary, the member will pay 50% of the total copay. For example, with a \$10/\$20/\$40 drug card, when a member orders a 90-day supply of a brand name drug on the formulary, the total cost would be \$30.00 (3 months copay x \$20.00 = \$60.00). Members save 50% or \$30.00.

HealthPass members who order a brand name drug NOT on HIP's formulary, pay the total copay amount regardless of the quantity, they order. For example, with a \$5/\$15/\$35 drug card, the total cost for a 90-day supply of a brand name drug NOT on HIP's formulary would be \$105.00. (3 months copay at \$35.00).

### *PerfectHealth*

Since there are no copays for prescriptions with the PerfectHealth plans, employees use the Express Scripts discount card. When a member uses the mail order pharmacy program with their Express Scripts discount card, they will save an average of 14% - 29% off retail pharmacy prices.

### **HOW TO ENROLL**

#### *GHI*

Members can access Express Scripts  
website: [www.expressscripts.com](http://www.expressscripts.com) or call  
877.534.3682.

#### *Health Net*

Members can access Express Scripts  
website: [www.expressscripts.com](http://www.expressscripts.com) or call  
866.265.9458.

#### *HIP*

Members can access Express Scripts  
website: [www.expressscripts.com](http://www.expressscripts.com) or call  
800.820.6976.

#### *PerfectHealth*

Members can access Express Scripts  
website: [www.expressscripts.com](http://www.expressscripts.com) or call  
877.680.4502.

## **H**

## **BILLING**

### **ABOUT YOUR BILL**

- HealthPass is a prepaid plan. The cost of coverage is due on the 1<sup>st</sup> day of each month of coverage. If your payment is late, your group is at risk of being charged a reinstatement fee or terminated.
- It is your responsibility to review, verify and submit any adjustments or corrections to HealthPass to ensure that your billing is accurate. Mail or fax changes to HealthPass as they occur. If you identify a billing discrepancy, you must notify us within 30 days of the due date in order to rectify.
- Billing reconciliation requests will be completed and forwarded to the group within 30 days.
- Your HealthPass bill will be mailed on the 10<sup>th</sup> day of the month prior to the month of coverage. The bill will be based on the enrollment data in our system at that time. Any additions, terminations or changes sent to HealthPass that are not reflected on your bill will be included on the next month's invoice.
- All changes or credits due will appear on the bill generated after the request is processed. Credit requests must be presented within 30 days, as HealthPass cannot accommodate any retro-activity beyond this period.
- HealthPass will directly bill employees on COBRA or NYS Continuation-of-Coverage to their home address. Those premiums will not be not be included on your monthly charges.

## PREMIUM PAYMENTS

- Premiums are due the 1<sup>st</sup> day of the month of coverage.
- Payment must be made with a company check, money order or bank check for group premiums. HealthPass does not accept personal checks except for payment of COBRA/ NYS Continuation-of-Coverage. Payment can also be made each month via Electronic Funds Transfer (EFT). The EFT application is included in the Welcome Kit, or call 888.313.7010 to set up EFT.

Full payment must be made to keep your group policy active. Partial payment is insufficient and may result in termination.

## LATE PAYMENTS & TERMINATION

- If your payment is not received by the 1<sup>st</sup> day of the month of coverage, your group is late and a 30 day grace period begins.
- If you have not paid in full by the end of the 30 day grace period, your group policy will be terminated back to the last day of the month for which we received full payment. As the employer, you may be responsible for any unpaid claims for your employees.
- If your group policy is terminated, you may be able to reinstate within 5 days of termination by paying the full amount due plus a reinstatement fee. There will be no lapse in coverage with a full reinstatement. ***Please note that we are only able to allow 1 reinstatement per 12 months.***

If HealthPass does not receive, a request to reinstate your group within 5 days from the termination, your group can only be activated as “new business”. All new business documentation will be required. In that event, no payments will be made for claims incurred after the termination date

and before the new group is activated. If the break in coverage is greater than 63 days there may be a waiting period for pre-existing conditions. You will also be required to pay the most current rates and cannot enroll with the prior carrier(s).



## HIPAA

## THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 and applies to all employer health plans with 2 or more eligible participants who are current employees. HIPAA addresses nondiscrimination, enrollment rights and notices, health coverage certificates and restrictions on pre-existing conditions.

1. Employer health carriers may no longer establish eligibility rules for medical coverage based on health status factors. This means that evidence of insurability cannot be used to determine a late entrant’s acceptance into the plan. All eligible applicants will be accepted into the plan provided the enrollment is requested within the 30-day timeframe of becoming eligible to enroll or at the annual open enrollment date.

2. Special enrollments were established to allow certain employees and/or dependents to enroll in a plan for medical coverage without waiting until the company’s next annual enrollment. Employees who become enrolled through special enrollment cannot be subjected to a pre-existing condition exclusion longer than 12 months, and must be given credit for their prior coverage as long as the break in coverage is not more than 63 days from the person’s enrollment date.

## COMMON TERMS TO KNOW

**Annual Maximum:** The maximum amount of money a given plan will pay towards a particular benefit in a calendar year.

**Brand Name:** Drugs that may still have patent protection so they can only be produced by the originating pharmaceutical company or those companies licensed by the originating company. This category of drugs is generally listed on the health plan's formulary.

**Certificate of Creditable Coverage:** Evidence of employee's coverage under the contract between the employee and prior insurance carrier. A member will need to provide this documentation to their new carrier to prove prior coverage and facilitate claims processing.

**Coinsurance:** A policy feature in which the insurer and the insured share costs incurred, usually after the deductible is met, according to a defined percentage split.

**Copay:** The flat dollar amount a member must pay to an in-network provider at the time services are rendered.

**Cost Sharing:** A plan in which employees share a larger portion of the cost of services through copays, deductibles, and coinsurance.

**Deductible:** The portion of eligible expenses that an individual or family must pay during the calendar year before the plan will begin to pay for covered services.

**Domestic Partner:** A non-legal spousal relationship. Domestic partners may be same-sex or opposite-sex partners. State and local laws may affect such relationships.

**Durable Medical Equipment (DME):** Specialized equipment that aids in

maximizing physical independence, i.e. prosthetics. These items can withstand repeated use and are intended to serve a medical treatment purpose. A plan physician or plan provider must prescribe DME.

**Eligibility:** Conditions that must be met to qualify for coverage under a plan.

**Explanation of Benefits (EOB):** Documentation from the insurance carrier received after a service was rendered. The EOB explains what services the insurance company covered.

**Exclusive Provider Organization (EPO):** A preferred provider organization that does not provide coverage for care performed outside the PPO's network or facilities. EPOs generally do not require a referral to seek care from an in-network specialist. Member has more responsibility in managing care.

**Effective Date:** The date in which insurance coverage is activated with HealthPass. A 1<sup>st</sup> of the month effective date is available to all new and renewing groups, 15<sup>th</sup> of the month coverage is available **only** to new groups.

**Flexible Spending Account:** An employer sponsored benefit that enables employees to contribute a percentage of their salary, on a pre-tax basis, up to the plan limits. Monies contributed can be used to pay for qualified expenses including medical costs that are not covered by health insurance, as well as childcare, care for elderly or disabled dependents, and work related transportation.

**Formulary:** A list of medication that is eligible for coverage under the carrier's pharmacy benefits program.

**Generic:** Are drugs that no longer have, or never had patent protection and are generally referred to by their chemical names.

**Health Maintenance Organization (HMO):** Highly managed in-network

healthcare that may require referrals.  
Physicians are prepaid.

**Health Reimbursement Arrangement:** An employer sponsored and funded benefit where a specified amount of money is set aside by the employer to reimburse each enrolled employee's out-of-pocket medical expenses. These medical expenses may include deductibles, copays and prescription drugs as well as dental and vision services. The funds contributed to the HRA are tax-free for the employees.

**Health Savings Account (HSA):** A tax-favored savings account only available to the employees covered under a qualified high deductible health plan. The account can be used to pay for routine medical, dental, prescription drugs, eyewear and other IRS qualified medical expenses.

**High Deductible Health Plan (HDHP):** A high deductible health plan that meets the IRS requirements to allow for use with an HSA.

**HIPAA Certificate:** A document issued from your insurance carrier upon termination, or upon request, to prove evidence of coverage.

**In-Network Plan:** A benefit design in which the member must stay within the chosen carrier's network of doctors and providers in order for services to be covered.

**In-Network Provider:** A provider who accepts an insurance carriers' allowance as payment in full for covered services.

**In & Out-of-Network Plan:** A benefit design in which the member can either stay within the chosen carrier's network of doctors and providers or go outside of the network and have services covered subject to a deductible and coinsurance.

**Maintenance Medication:** A prescription drug that is taken on a regular basis to treat chronic conditions, which have duration of use greater than 30 days.

**Non-Preferred Brand:** Drugs are generally placed on the non-preferred list only when there is a preferred drug that offers the same therapeutic benefit or there is an approved generic available.

**Open Enrollment:** The 30-day period prior to renewal in which employees have the opportunity to examine their insurance coverage and keep their existing benefits or choose another HealthPass benefit option for the coming year.

**Out-of-Network Provider:** Providers with whom an insurance carrier has not contracted for services. A deductible and coinsurance will apply and you will generally be responsible for a larger share of the costs of services than if you utilized an in-network provider. If the out-of network provider charges more than the allowance, the member will be responsible to pay the difference between the allowance and the provider's charge, in addition to any applicable deductible and coinsurance amount.

**Out-of-Pocket Maximum:** The maximum dollar amount per calendar year of expenses payable by an employee for covered medical services. (Includes deductible and coinsurance)

**Over the Counter (OTC):** Any drug that can be purchased without a prescription. (HSA funds may be utilized)

**Point of Service (POS):** Highly managed healthcare that allows for in and out-of network benefits.

**Pre-Certification:** Certain covered services must be pre-certified by contacting the insurance carrier for approval prior to treatment. Failure to obtain advance approval for these services may result in a reduction of benefits and/or payments. Pre-certification can include either hospital admissions and/or medical services. Please consult the certificate of coverage to find out which benefits need to be pre-certified.

**Pre-Existing Condition:** A pre-existing condition is any disease, symptom, or condition that was present on the 1<sup>st</sup> day of coverage and for which medical advice or treatment was recommended or received during the six-month period prior to the enrollment date. Generally, a condition is not considered pre-existing if a member has continuous prior health insurance.

**Preferred Provider Organization (PPO):**

Allows for in and out-of-network benefits, physicians are reimbursed on a discounted fee schedule. Similar to an EPO with an attached out-of-network benefit.

*\*HealthPass reserves the right to change or modify information included in this document at any time.*



**888.313.7277**  
**[www.healthpass.com](http://www.healthpass.com)**