Paradigm Precision

2022

BENEFITS GUIDE

WELCOME

TO ANNUAL ENROLLMENT!

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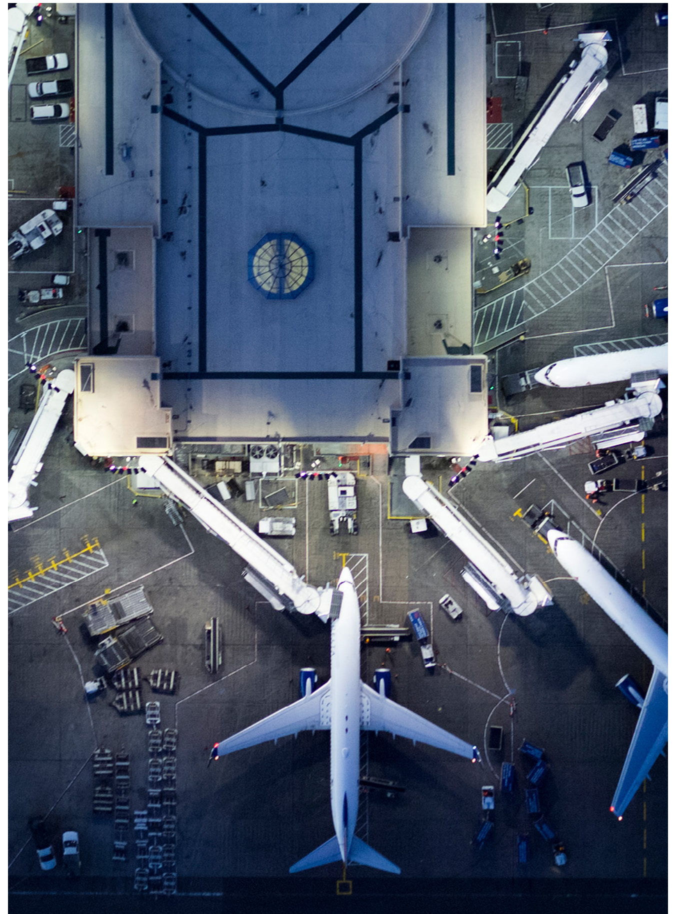


Paradigm Precision appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefit plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

This guide is not your only resource, of course. Anytime you have questions about benefits or the enrollment process, you can contact your human resources representative. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD) at myparadigmbenefits.com

What's NEW for 2022!

At Paradigm Precision, we are committed to providing a world-class work environment for our people—our greatest asset. A key aspect of that commitment is our investment in a well-rounded benefits package.

Each year, Paradigm evaluates our benefits with a focus on providing a cost-effective, competitive package. We believe your health is important and we continue to invest in wellness resources for all employees. Our goal is to provide offerings that continue to evolve and meet the needs of you and your family.

For 2022, we are pleased to provide you with access to a comprehensive, quality benefits package that offers flexibility and security. As you may be aware, health care costs continue to increase. We worked closely with our broker to maintain our current quality benefit offerings and competitive employee pricing for you.

Open enrollment begins on Monday, October 18th and ends on Friday, November 5th. This year we are having an **ACTIVE ENROLLMENT**, meaning that you must login to ADP at www.workforcenow.adp.com to confirm your benefits, even if you are not making changes for the 2022 plan year. Be sure to confirm your HSA elections again, even if you are not making any changes.

New this year, a $40.00 per month vaccine surcharge will be added to your monthly contribution for all employees who have not received the COVID-19 vaccine.

Members enrolled in the Buy-Up Plan OR changing medical plans will receive a new Cigna medical ID card in the mail prior to January 1st. Some design features on the Cigna Medical/Prescription plans are changing:

Core HSA Medical Plan:

- The annual in-network deductible will increase from $2,500 to $3,000 for Employee Only and from $5,000 to $6,000 for Employee + Dependents.
- The annual deductible will change from non-embedded to embedded. (please refer to the glossary for the definitions of embedded and non-embedded deductibles)
- The in-network out-of-pocket maximum will increase from $5,000 to $6,000 for Employee Only and from $10,000 to $12,000 for Employee + Dependents.
- The Prescription tier structure will change from 3-tiers to 4-tiers.
- The out-of-network deductible will increase from $5,000 to $8,000 for Employee Only and from $10,000 to $16,000 for Employee + Dependents.

Buy Up Medical Plan:

- The in-network annual deductible will increase from $2,500 to $5,000 for Employee Only and from $5,000 to $10,000 for Employee + Dependents
- The in-network out-of-pocket maximum will increase from $3,750 to $7,000 for Employee Only and from $7,500 to $14,000 for Employee + Dependents.
- The in-network coinsurance will decrease from 80% to 70% (what the plan pays)
- The out-of-network deductibles will increase from $5,250 to $8,000 for Employee Only and from $10,500 to $16,000 for Employee + Dependents
- The out-of-network coinsurance will decrease from 60% to 50% (what the plan pays)
- The out-of-network out-of-pocket maximum will increase from $9,750 to $10,000 for Employee Only and from $19,500 to $20,000 for Employee + Dependents
- The Prescription tier structure will change from 3-tiers to 4-tiers
- The Prescription Deductible will increase from $100/$200 (Employee Only / Employee + Dependents) to $400/$800 (Employee Only / Employee + Dependents)

What is staying the same for 2022

Life of Coverage	Carrier
Medical	Cigna (plan and employee contribution changes)
Pharmacy	Welldyne (plan changes)
Dental	Anthem (employee contribution changes)
Vision	EyeMed
Life/Voluntary Life	Reliance Standard
Short Term and Long Term Disability	Reliance Standard
Critical Illness and Accident	Reliance Standard
Pet Insurance	Nationwide
Enrollment Platform	ADP

Qualifying life events

It is your responsibility to notify human resources within 30 days of the qualifying life event. Failure to do so may result in an inability to change your benefit election(s).

Here are some examples of qualifying life events:

- Birth, legal adoption or placement for adoption.
- Marriage, divorce or legal separation.
- Dependent child reaches age 26.
- Spouse or dependent loses or gains coverage elsewhere.
- Death of your spouse or dependent child.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or the state children's health insurance program.

MEDICAL

Cigna	Core HSA Medical Plan		Buy Up Medical Plan	
Annual Deductible	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Employee-Only	$3,000	$8,000	$5,000	$8,000
Employee + Dependents	$6,000	$16,000	$10,000	$16,000
Type of Deductible:	Embedded Medical & Rx		Embedded Medical & Rx	
Coinsurance	80%	50%	70%	50%
Out-of-Pocket Maximum				
Employee-Only	$6,000	$10,000	$7,000	$10,000
Employee + Dependents	$12,000	$20,000	$14,000	$20,000
Are there any copays BEFORE the deductible?	No		Yes Rx only	
Does the annual deductible apply to my prescriptions?	Yes		No Rx Deductible $400/$800	
Rx Out-of-Pocket Maximum Employee-Only Employee + Dependents	Combined with Medical		$1,000 $3,000	
Retail Rx Copays	$10 / $40 / $60 / 20% up to $125	not covered	$10 / $40 / $60 / 20% up to $125	not covered

Effective Jan. 1, 2022

	Core HSA Plan	Buy Up Medical Plan
Medical and prescription biweekly employee payroll contributions		
Employee	$49.64	$147.33
Employee + spouse	$104.24	$309.40
Employee + child(ren)	$94.31	$279.93
Family	$148.92	$442.00
Medical and prescription weekly employee payroll contributions		
Employee	$24.82	$73.67
Employee + spouse	$52.12	$154.70
Employee + child(ren)	$47.16	$139.96
Family	$74.46	$221.00

Employees can elect the medical and prescription drug plan without enrolling in the dental or vision plan.

Buy Up Plan: Employee contributions will increase by 9% from the prior plan year.

Core HSA Plan: Employee contributions will remain the same from the prior plan year.

TELEMEDICINE

What is Telemedicine?

Telemedicine allows you to speak with a doctor 24 hours/365 days a year via your phone, computer or tablet. Like doctors and facilities, not all telemedicine vendors are in your carrier's network. Whether you use the medical and pharmacy insurance offered by your employer or choose coverage elsewhere, it is important you know what telemedicine resources are available.

How Does it Work?

- Request a visit with a doctor 24 hours a day, 365 days a year - on your computer, phone or tablet
- Request a voice call or video call
- All physicians are board certified
- If the doctor believes medication is warranted, they can write a prescription
- Access services... at home, at work (when permitted), while traveling domestically or internationally, in the middle of the night, etc.

Treatment Includes:

- Allergies
- Bronchitis
- Cough/Cold
- Diarrhea
- Migraine/Headaches
- Rash
- Seasonal Flu
- Sinus Problems
- Sore Throat
- Stomach ache

Looking for Cost Savings?

$$$$ Telemedicine

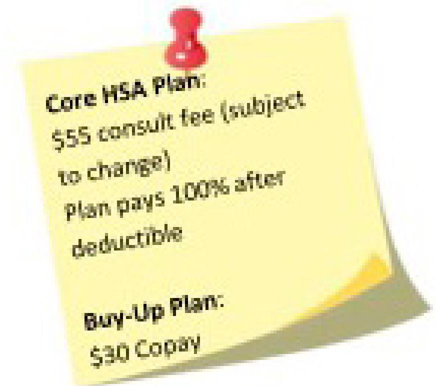
$$$$ Primary Care

$$$$ Urgent Care

$$$$ Emergency Room

In-Network Telemedicine Provider:

Conditions treated by:
Licensed and
Certified Providers



TIP! Choose other care for EMERGENCIES & anything that needs a hands-on exam, needs a test, cancer or other complicated conditions, chronic conditions, sprians/broken bones or injuries requiring bandaging, etc.

BENEFITS ACCOUNTS

Health Savings Accounts, or HSA's, are like personal savings accounts, but the money in them can only be used for IRS qualified medical expenses including medical, dental and vision expenses. You - Not your employer or insurance company - own and control the money in this account. Note to self: the money you deposit is not taxed.

Your employer contributes $500 for employee-only coverage & $1,000 for Employee + Dependent(s).
A portion of these funds is earned by completing wellness incentives.

Who can set up a Health Savings Account?

To be eligible for and contribute to an HSA, you must:

- ✓ Be enrolled in a qualified High-Deductible Health Plan (HDHP)
- ✓ Not be claimed as another person's tax dependent
- ✓ Those enrolled in the Medicare CANNOT contribute to an HSA. (if you are collecting Social Security, you are likely enrolled in Medicare. If you are unsure, contact the Centers for Medicare Services at 1-800-MEDICARE or access www.medicare.gov and then check "Your Enrollment Toll")
- ✓ Not be enrolled in a general-purpose Flexible Spending Account (FSA), but a limited purpose FSA may be available to you.

Who can set up a Health Savings Account?

HSA's Are Triple Tax Free!

All contributions are tax free to you, regardless of sources. That means withdrawals for qualified expenses are tax free and interest accumulates in your account tax free.

You Own Your HSA!

Unused funds rollver from year to year and belong to you. Use the funds to pay for the qualified expenses or let the money grow. Your account is portable to you and you are in control of the expenditures.

TIP!

For 2022, the IRS limits are $3,650 for individuals and $7,300 for family coverage. You are responsible for knowing the rules and keeping accurate records (save your receipts!). You will receive annual form 1099SA and 5498SA from the bank in order to report your contributions, earnings, and distributions on your individual tax return.

DENTAL

Aside from protecting your smile, dental care ensures good oral and overall health. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body--including your heart. Understanding and choosing dental coverage will help protect you and your family from high costs and dental disease and surgery.

Dental Benefits	CORE Dental Plan	BUY-UP Dental Plan
Network Name	**Anthem Dental Complete**	**Anthem Dental Complete**
Calendar Year Maximum	$1,000 (applies to Level 1, 2, 3)	$1,500 (applies to Level 1, 2, 3)
Calendar Year Deductible	$50 Ind. / $150 Family (applies to Level 2 & 3)	$25 Ind. / $75 Family (applies to Level 2 & 3)
Level 1 Coverage: Preventive Care	Deductible Waived Covered at 100%	Deductible Waived Covered at 100%
Level 2 Coverage: Basic Care	Deductible, then you pay 20%; Carrier pays 80%	Deductible, then you pay 20%; Carrier pays 80%
Level 3 Coverage: Major Care	Not Covered	Deductible, then you pay 50%; Carrier pays 50%
Level 4 Coverage: Orthodontia (Children only, to age 26)	Not Covered	50% (Lifetime Max - $1,500)
Out of Network:Coverage Limits	90th Percentile	90th Percentile

When you schedule regular preventive checkups, your dentist can detect problems early. This can help avoid more costly and complex procedures, like crowns and root canals, down the road. In fact, for each dollar spent on preventive services, it is estimated that $50 or more is saved on more expensive procedures.

Effective Jan. 1, 2022

	Buy-Up Plan	Core Plan
Dental biweekly employee payroll contributions		
Employee	$9.89	$2.31
Employee + spouse	$21.06	$4.80
Employee + child(ren)	$23.13	$5.83
Family	$36.76	$8.99
Dental weekly employee payroll contributions		
Employee	$4.95	$1.16
Employee + spouse	$10.53	$2.40
Employee + child(ren)	$11.57	$2.92
Family	$18.38	$4.49

Employees can elect the medical and prescription drug plan without enrolling in the dental or vision plan.

VISION

Routine eye exams will help you maintain your vision as well as detect various eye problems and concerns about your overall health. Obtaining vision insurance is a way to make sure you can continue enjoying good health as well as the sight around you.

Vision Benefits	In-Network	Out-Of-Network
Routine Eye Exam (every 12 months)	$10 Copay	Reimbursed up to $45
Single Vision Lenses (every 12 months)	$25 Copay	Reimbursed up to $30
Bifocal Lenses (every 12 months)	$25 Copay	Reimbursed up to $50
Contacts Instead of glass lenses (every 12 months)	80% of balance over $130 Allowance	Up to $105 Allowance
Contact Lens Fitting & Follow-Up (every 12 months)	$60 Copay, then 15% Discount	Up to $105 Copay
Frames (every 24 months)	20% of balance over $130 Allowance	Reimbursed up to $70

Visit the EyeMed custom virtual fair here and enter the password “GZ34K33N”

Effective Jan. 1, 2022

	Vision Plan
Vision biweekly employee payroll contributions	
Employee	$0.66
Employee + spouse	$1.08
Employee + child(ren)	$1.08
Family	$1.74
Vision weekly employee payroll contributions	
Employee	$0.33
Employee + spouse	$0.54
Employee + child(ren)	$0.54
Family	$0.87

Employees can elect the medical and prescription drug plan without enrolling in the dental or vision plan.

LIFE INSURANCE

Basic Life and Accidental Death & Dismemberment (AD&D)

The premium for this benefit is paid 100% by your employer.

TIP!

Review and/or update your beneficiaries annually at open enrollment. A beneficiary is someone that would get your life insurance/AD&D payment in the event of you losing your life. You can have as many primary and contingent beneficiaries as you need or want. You can change your beneficiaries at any time.

Basic Life & AD&D	Benefit
Life Benefit	1X Base Annual Salary to maximum of $300,000
AD&D Benefit	Equal to Life Amount
Age Reduction Schedule	Reduces by 50% at age 70

Voluntary Life and Accidental Death & Dismemberment (AD&D)

This is an optional benefit that is paid entirely by you, the employee. This protection can be important not only for you, but for eligible dependents.

- No Evidence of Insurability needed if you are enrolling under the guarantee issue…a true Open Enrollment!!
- Evidence of Insurability will be needed to enroll in any amount over the guarantee issue (unless you are newly eligible)!
- Any amount you are currently enrolled in will carry forward.
- You must purchase coverage for yourself in order to purchase coverage for your spouse and dependents

Voluntary Life & AD&D	Employee	Spouse	Child
Purchase Increments	$10,000	$5,000	$2,000
Max issue Amount	$500,000	$500,000 (not to exceed Employee Amount)	$10,000
Guaranteed Issue Amount	$150,000	$30,000	$10,000

DISABILITY INSURANCE

Short-Term Disability

Short-Term Disability (STD) coverage is designed to help you meet your financial needs if you are unable to work due to a non-occupational injury or illness. For working individuals, a disability is a medical condition that reduces your ability to perform your job duties, usually an injury or illness.

Short-Term Disability	Benefit
Plan Type	Employer Paid
Benefit	60%
Accident Benefits Begin	1st Day
Sickness Benefits Begin	8th Day
Duration of Benefits	12 Weeks

Long-Term Disability

Long-Term Disability (LTD) insurance protects workers in the event they become disabled for a prolonged period prior to retirement.

Long-Term Disability	Benefit
Plan Type	Employer Paid
Benefit	60%
Maximum Weekly Benefit	$7,500
Elimination Period	90 Days
Duration of Benefits	12 Weeks

TIP!

Currently, there are state-mandated disability insurance requirements in California, Hawaii, New Jersey, New York and Rhode Island. Speak with HR or reference your state's goverment web page for updates and changes.

Few More Things

Critical Illness Insurance & Accident Insurance

These coverages are voluntary and paid for by you, the employee.

Critical Illness:

Wellness Benefit-Members are provided a $50 per year benefit for completing certain routine wellness screenings or procedures.

Employees	Option of $5,000 to $50,000 in increments of $5,000, Guarantee Issue: $25,000
Spouse	Option of $5,000 to $50,000 in increments of $5,000, Guarantee Issue: $25,000. Has to be under age 70 and coverage terms at age 75.
Dependent Children	Coverage limited to 25% of employee approved Amount of Insurance to a Guarantee Issue and maximum of $12,500.

Group Accident:

Insurance is designed to help covered employees meet the out of pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to you based on the schedule of benefits. No health questions are required to elect coverage. Refer to the chart for a few examples.

Emergency Room visit	$150 benefit is payable to you
X-rays	$25 benefit is payable to you
Initial Hospital Admission	$500 benefit is payable to you
Concussion	$100 benefit is payable to you
Physical Therapy	$25 per session benefit is payable to you, 6 sessions max

Pet Insurance

Paradigm Precision offers you the opportunity to purchase Pet Insurance with Nationwide.

There are three simple ways to sign up:

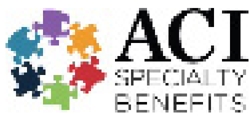
1. Go directly to the dedicated URL for your company: http://www.petinsurance.com/paradigmprecision This link is also available in ADP.
2. Visit PetsNationwide.com and enter your company name
3. Call 877-738-7874 and mention that you are an employee of Paradigm Precision to receive preferred pricing

Few More Things

Employee Assistance Program

Typical issues addressed include the following:

- Alcohol or substance abuse
- Smoking cessation
- Divorce/marital problems
- Depression and Anxiety
- Stress management
- Crisis intervention
- Childcare and Eldercare
- Eating disorders
- Gambling addiction
- Financial problems
- Legal problems



Are personal problems affecting your focus and performance at work? You are not alone. Personal problems can affect the lives of employees both at home and at work. When life's events become challenging, we would like to remind all employees about our Employee Assistance Program, or EAP.

- ✓ **Employees AND their family members can access the EAP**
- ✓ **Confidential!**
- ✓ **No Cost**

Face to Face

Unlimited telephonic assesment and referral included. Up to 3 Face-to-Face diagnostic and short-term problem resolution sessions.

How to Access the Program:

ACI Specialty Benefits **rsli@acieap.com** 855.775.4357 - Available 24/7/365.

Cigna Value Adds

Pre and Post Enrollment Line Support

Cigna makes it easy to be healthier.
Cigna offers so much more than your employer's medical coverage. From helping you answer health questions 24 hours a day to a virtual team of health and wellness coaches, we're here for you.

- **24/7/365 service**
  Whenever you need us, just call the toll-free number printed on the back of your Cigna ID card 24 hours a day, seven days a week, 365 days a year.
- **Health Information Line**
  Have a health question? You can talk with a clinician 24 hours a day, seven days a week.
- **Network of quality doctors**
  You can save money when you use a doctor, hospital or facility that's part of your plan's Cigna network. It's easy to find quality, cost-effective care right where you need it. You can find a doctor right on Cigna.com or on the myCigna® website or app once enrolled.
- **Preventive care covered 100% in-network**
  Getting and staying healthy is important. That's why certain preventive care services are totally covered when you use an in-network doctor.
- **Telehealth for 24/7 care**
  Cigna Telehealth Connection helps you get the care you need – including most prescriptions (when appropriate) – for a wide range of minor conditions. You can connect with a board-certified provider via video chat or phone, when, where and how it works best for you.
- **Cigna Veteran Support Line**
  This free hotline is available 24/7/365 to all veterans, their families and caregivers. No need to be a Cigna customer.

Cigna One Guide

Call a Cigna One Guide representative during preenrollment to get personalized, useful guidance. Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers to any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away. Don't wait until the last minute to enroll. Call **888.806.5042** to speak with a Cigna One Guide representative today.

Transition Of Care

With Transition of Care, you may be able to continue to receive services for specified medical and behavioral conditions with health care providers who are not in the Cigna network at in-network coverage levels. This care is for a defined period of time until the safe transfer of care to an in-network provider or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your medical plan. You must apply no later than 30 days after the effective date of your coverage.

Cigna's Omada Diabetes Prevention Program

Omada is a digital lifestyle change program designed to help you lose weight, gain energy, and reduce the risks of type 2 diabetes and heart disease. The program surrounds you with the tools and support you need to make lasting, meaningful changes to the way you eat, move, sleep, and manage stress—one small step at a time.

You'll receive the program at no additional cost if you or your covered adult dependents are enrolled in the company medical plan offered through Cigna, are at risk for type 2 diabetes or heart disease, and are accepted into the program.

Cigna's Your Health First® Chronic Condition Coaching Program

If you have a chronic health condition you'll develop a one-on-one relationship with a dedicated health coach, to help you:

- Manage a chronic health condition, ranging from asthma and low back pain to depression and coronary artery disease, among many others
- Make more educated decisions about your health and treatment options
- Obtain information and resources about your condition
- Save money on your medically related expenses
- Create a plan to help improve your health, based on your personal goals
- Understand medications and doctor's orders
- Identify the triggers that affect your condition
- Know what to expect if you need to stay in the hospital

Enrollment & Eligibility

All coverage effective **January 1, 2022.**

Coverage	Eligibility	Coverage Starts	Coverage Ends
Medical	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of the month that you or your dependents are no longer eligible; for children, on the last day of the month in which they turn 26.
Dental	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of the month that you or your dependents are no longer eligible; for children, on the last day of the month in which they turn 26.
Vision	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of the month that you or your dependents are no longer eligible; for children, on the last day of the month in which they turn 26.
Life & Disability Insurance	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For Life and AD&D, on the last day of the month after termination; for disability, on the date that you are no longer eligible. Dependent children are covered to age 19 or 23 if they are a full time student.
Critical Illness & Accident Insurance	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of active employment; for children, on the day in which they turn 26. This policy is portable on date of term.
Pet Insurance	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of active employment. This policy is portable on date of term. You can enroll or term this coverage at any time.

Account Type	Details
Health Savings Account (HSA)	Only for employees enrolled in the CORE HSA Medical Plan. Your employer contributes $500 for Employee-only coverage & $1,000 for Employee + Dependent(s) coverage.

Enrollment & Eligibility

Where can I enroll?

Log onto your ADP Workforce Now account to elect your benefits for 2022 during the annual open enrollment period.

Who can I add to my plan?

- Legally married spouse
- Natural or adopted children up to age 26
- Children under legal guardianship
- Stepchildren
- Domestic Partners
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

When can I make changes?

Generally, you may enroll in benefits, or make changes to your benefits, when you are first eligible or during open enrollment. However, you can make changes/enroll during the plan year if you experience a **qualifying event** (marriage, have a baby, divorce, lose other coverage, gain other coverage, etc.).

If you have a qualifying event, you must submit your changes **within 30 days of the event**, or you must wait until yearly open enrollment to make any benefits changes.

Required Notices

Annual Health Plan Notice Packet

CHIP Notice

Glossary of Insurance Terms

Open enrollment is the time of year reserved for making changes to your benefits elections. While it is extremely important to understand each plan before making a decision, it can also be challenging to navigate, and unfamiliar terms can make this process even more stressful. According to a recent workforce study1, two-thirds of employees feel that making sense of benefits is too complicated, and nearly three in four employees report there is some part of their coverage they don't understand.

Below is a quick and easy guide of frequently used employee benefits terms to help you navigate your benefits options and feel confident in your plan selection.

ALLOWED AMOUNT

Maximum amount on which payment is based for covered health care services. This may be called "maximum allowable coverage," "eligible expense," "payment allowance," or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

APPEAL

A request for your health insurer or plan to review a decision or a grievance again.

BALANCE BILLING

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

BENEFICIARY

A beneficiary is someone that would receive money or other benefits from the person insured. In life insurance, this is the person who would get your payments in the event you lose your life.

CLAIM

A health insurance claim is a bill for health care services that your health care provider turns in to the insurance company for payment.

COBRA

A federal law that can allow for temporary health coverage after employment ends, the loss of coverage as a dependent of a covered employee or another qualifying event. The individual will pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

1. Aflac. Aflac 2017 Workforces Report Employee Overview. Accessed August 16, 2019.

COINSURANCE

Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe.

CONSUMER DRIVEN HEALTH CARE (CDHC)

Health insurance plans that are intended to give you more control over your health care expenses. Under CDHC plans, you can use health care services more effectively and have more control over your health care dollars. CDHC plans are designed to be more affordable because they offer reduced premium costs in exchange for higher deductibles.

COPAYMENT

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

COVERED EXPENSES

Health care expenses that are covered under your health plan.

DEDUCTIBLE

The amount you owe for health care services that your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

DEPENDENT

An individual enrolled in the health plan as a qualified dependent of the subscriber and who meet eligibility requirements.

EMBEDDED DEDUCTIBLE VS. NONEMBEDDED DEDUCTIBLE

Embedded: A policy with a deductible for each person covered. Benefits kick in for a family member when they meet their individual deductible and for the whole family when at least two members do so. Embedded policies tend to have higher premiums to accommodate lower deductible options.
Nonembedded: A policy with a single, combined deductible for all covered individuals. No benefits begin for any covered individual until this deductible is met either by one member or a combination of several members. The nonembedded policy's higher deductible level carries a lower policy premium than embedded policies.

EVIDENCE OF INSURABILITY

Proof of good health, otherwise known as evidence of insurability (EOI), is an application process in which you provide information on the condition of your health or your dependent's health to get certain types of insurance coverages.

EXCLUSION

A provision within a policy that eliminates coverage for specific medical services or items.
Before 2014, individual health insurance policies frequently contained exclusions for pre-existing medical conditions. As a result of the Affordable Care Act, all new individual major medical policies have been guaranteed issue and pre-existing condition exclusions are no longer allowed.

EXPLANATION OF BENEFITS (EOB)

A statement from your health insurance plan describing the costs it covers for medical care or products received. The EOB is generated when your provider submits a claim for the services you received and provides clarification around the cost of the care received, money saved by visiting in-network providers and out-of-pocket medical expenses you are accountable for.

FLEXIBLE SPENDING ACCOUNT (FSA)

An account that allows you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year.

GRIEVANCE

A complaint that you communicate to your health insurer or plan.

HEALTH MAINTENANCE ORGANIZATION (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for/contract within a specified network. Premiums are paid monthly, and a small copay is due for each office visit and hospital stay. HMOs require that you select a primary care physician who is responsible for managing and coordinating all of your health care.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

An employer-owned medical savings account in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account as reimbursement for qualified health care expenses.

HEALTH SAVINGS ACCOUNT (HSA)

An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high-deductible health plans (HDHP).

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

A qualified health plan that combines very low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

IN-NETWORK COINSURANCE

The percent you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

INPATIENT VS. OUTPATIENT

Inpatient: A person who stays in a hospital or other healthcare facility while receiving medical care or treatment. For the purposes of healthcare coverage, health insurance plans require formal admittance into a hospital for a service to be considered inpatient.
Outpatient: A patient who receives medical treatment without being admitted to a hospital. Many surgical services, rehabilitation treatments, as well as mental health services, are available as outpatient services.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

MEDICARE

An insurance program administered by the federal government to provide health coverage to individuals aged 65 and older, or who have certain disabilities or illnesses.

MEMBER

You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

NETWORK

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

In-Network Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Out-Of-Network Health care you receive without a physician referral or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Preferred Provider A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great and you may have to pay more.

Non-Preferred Provider A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health plan has a "tiered" network and you must pay extra to see some providers.

OUT-OF-POCKET EXPENSE

Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

OUT-OF-POCKET MAXIMUM (OOPM)

Also commonly referred to as out-of-pocket limit. The most you pay during a policy period before your health insurance begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or care that your health insurance doesn't cover.

PHARMACY COVERAGE

Prescription Drugs A pharmaceutical drug, also known as prescription medication or prescription medicine, that legally requires a medical prescription to be dispensed. In contrast, over-the-counter drugs can be obtained without a prescription.

Generic Drugs Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts. The FDA (U.S. Food and Drug Administration) requires that generic drugs be as safe and effective as brand-name drugs.

Drug Formulary A list of prescription drugs, both generic and brand name, that are preferred by your health plan and that they have deemed as offering the greatest value. A committee of independent, actively practicing physicians and pharmacists maintain the formulary.

Drugs on a formulary are typically grouped into tiers. The tier that your medication is in determines your portion of the drug cost. A typical drug benefit includes three or four tiers.

Tier 1 Preferred generic drugs, lowest cost-sharing Tier 2 Non-preferred generic drugs
Tier 3 Preferred brand-name drugs
Tier 4 Non-preferred brand-name drugs
Tier 5 Specialty drugs, highest cost-sharing

BRAND NAME DRUGS ON THE FORMULARY These formulary drug lists have brand name prescriptions that have been tested and researched to be safe and effective, as well as less costly to both the insurance carrier and the member.

BRAND NAME DRUGS OFF THE FORMULARY These are brand name prescriptions not on the formulary. These are often most costly to purchase.

SPECIALTY MEDICATIONS Although the definition of specialty drugs continues to evolve, they can usually be defined by several common attributes. They are prescribed for a person with a complex/chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure, is progressive, and/or is debilitating or fatal if left untreated or under-treated. Usually, they treat rare or orphan disease indications and require additional patient education, adherence, and support beyond traditional dispensing activities. They can be difficult to administer, often given by injection or infusion and may require special handling, including temperature control. Typically, specialty drugs have a high monthly cost and potentially unique storage or shipment requirements and are not stocked at the majority of retail pharmacies.

POINT-OF-SERVICE PLAN (POS)

A managed care plan that is a hybrid of a HMO and PPO plan. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services.

PREFERRED PROVIDER ORGANIZATION (PPO)

A managed care organization of medical doctors, hospitals and other health care providers who have agreed with

an insurer or a third-party administrator to provide health care at reduced rates to the top insurer's or administrator's clients.

PREMIUM
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

PRIMARY CARE PHYSICIAN (PCP)
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

QUALIFYING EVENT
A change in your situation — like getting married or having a baby — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period.

SPECIALIST
A health care professional whose practices focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. Often, due to additional, advanced training this professional is certified by a specialty board.

SUBSCRIBER
Refers to the person or organization that pays for health insurance premiums, sometimes referring to the person whose employment makes them eligible for group health insurance benefits.

USUAL, CUSTOMARY AND REASONABLE (UCR) ALLOWANCE
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

90TH PERCENTILE
This means that 90% of the health care providers' fees will be covered in full. The carrier may cover a portion of the bill and the member may be balance billed the difference. Out-of-network (non-participating) providers are not limited in the amount they may balance bill.

This glossary includes many commonly used terms but is not a full list. These glossary terms and definitions are intended to be educational.

Paradigm Precision

All changes must be made by Friday, November 5th!

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.