**Benefits Terms Glossary**

**Annual Benefits Salary** – Used to determine employees' medical contributions, Child Care Benefit eligibility, Life Insurance coverage and Long-Term Disability (LTD) coverage amounts. Annual Benefits Salary is calculated as of July 1 each year and is the greater of a) the base salary in effect on July 1; or b) the prior 12 months' gross compensation, plus additional and private practice compensation, to June 30.

**Annual Deductible** – The amount you pay for Covered Health Services each year before the Plan begins to pay for non-preventive expenses.

**Appeal of Claim** – If you have a claim for a benefit which is denied in whole or in part, you must receive a written explanation of the reason for the denial. Under ERISA, you have the right to appeal the denial of a claim and have the denial decision reconsidered.

**Coinsurance** – Cost-Sharing between you and the Plan for Eligible Expenses for certain Covered Health Services, where you are required to pay a percentage of the cost. For example, a 90/10 coinsurance plan with a $400 deductible requires you to pay 10% of the covered costs after the Annual Deductible has been met, while the Plan will be responsible for the remaining 90%.

**Copay** – A fixed amount you pay when you receive a healthcare service. The amount can vary by the type of Covered Health Service. Typically you pay a copay for a visit to an in-network provider’s office. For example, the $30 you pay for a physician’s office visit. The medical plan pays the balance of the cost. Your in-network medical copays for the Choice Plus plans accumulate toward your in-network out-of-pocket maximum.
Cost of Living Adjustment (COLA) – An adjustment made to income in order to adjust benefits to reflect the effects of inflation.

Cost Sharing – The share of plan costs that you pay out of your own pocket. This generally includes Annual Deductibles, Coinsurance and Copays, but does not include premiums or the cost of services that are not eligible.

Covered Health Services – Health services, including supplies, which are determined by the Plan to be provided for the purpose of preventing, diagnosing or treating sickness, injury, mental illness, substance use disorders or their symptoms. Covered services are listed in the SPD.

Deductible – If you have a claim, the deductible is the amount you pay each year before the Plan begins to pay for non-preventive expenses. Copays do not accumulate toward your deductible.

Eligible Expenses – Charges for Covered Health Services rendered, or supplies furnished by a certified health professional under the Plan. Eligible Expenses may be subject to Cost Sharing and/or annual or lifetime maximums as specified by the terms of the Plan. Eligible Expenses for services rendered by In-Network providers are limited to the network negotiated charge. For Out-of-Network Benefits, Eligible Expenses are limited to 190% of the Medicare MAC.

Evidence of Insurability (LTC, Life and LTD) – Documentation of insurability by an applicant for insurance. Usually this requires completing a form with your medical history.

Exclusion(s) – A health condition or service not eligible for coverage under the healthcare plan.

Explanation of Benefits (EOB) – A statement provided by a health insurer to the plan participant that explains how their claim was paid. The EOB typically includes the date of service, type of service rendered, Eligible Expense, amount paid by the Plan and the balance to be paid by the plan participant. If applicable, it will also provide any reason(s) the service or supply was not covered by the Plan.
Guaranteed Issue – A feature of certain insured benefits that permits you to enroll regardless of health status, age, gender or other factors that might predict the use of the benefit.

Imputed Income – The value of an employer-sponsored benefit or service that is considered by the IRS as compensation and added to an employee's taxable wages in order to properly withhold income and employment taxes from the wages. Examples of Imputed Income include:

- Educational assistance above the excluded amount
- Employer contributions for the coverage of same-sex domestic partners and their children

In-Network – Refers to providers or facilities that are part of UHC’s Choice network with which it has negotiated and contracted, to provide a discount for services rendered. Individuals pay less when using an In-Network provider.

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

Multi-Source Brand – Prescription drugs that are available in both the brand name and generic form.

Network – The group of physicians, hospitals and other providers who are contracted with UHC to provide services to health plan participants at lower-priced, negotiated rates. (See In-Network and Out-of-Network)

Non-Duplication – A provision in health plans specifying that benefits will not be paid for amounts reimbursed by other plans. This typically applies to a plan participant who is eligible for benefits under more than one plan (e.g., covered under spouse's plan).

Non-Preventive Drugs – Prescription medications that are designed and intended to treat a specific condition. If either a therapeutic class or specific drug is not defined as a Preventive Drug, then it is considered a Non-Preventive Drug.
Open Enrollment – The annual period in which employees can select from a choice of benefits programs with an effective date of January 1 of the following year.

Out-Of-Network Benefits – Covered Health Services provided by non-network providers. Individuals usually are responsible for additional Out-of-Pocket Costs if they use an out-of-network provider. Eligible Expenses for out-of-network services are indexed to 190% of the Medicare MAC.

Out-of-Pocket Costs – Expenses for medical services that are not reimbursed by the Plan. Out-of-Pocket Costs include Annual Deductibles, Coinsurance, and Copays for Covered Health Services, costs above the Eligible Expense and costs for services that are not covered under the Plan.

Out-of-Pocket (OOP) Maximum – The maximum amount a patient must pay for Covered Health Services during a plan year. The in-network OOP Maximum includes the Annual Deductible and medical and prescription drug Copays and Coinsurance. The out-of-network maximum does not include medical or prescription drug copays. The OOP Maximum does not include premiums, payments made for noncovered services or charges above Eligible Expenses.

Precertification – A process where UHC is contacted before certain services are provided, to determine if it is a Covered Health Service. Precertification is not a guarantee your health plan will cover the cost of the services (also called prior authorization, preauthorization or prior approval). This means those services require you to obtain authorization from your medical plan before you receive them. It is your responsibility to obtain precertification prior to receiving medical services. If you are receiving services from an in-network provider, generally your physician will obtain this authorization on your behalf. Note: If you go out-of-network, it is your responsibility to obtain precertification.

Pre-Tax Contribution – A contribution which is made before federal and/or state taxes are withheld.

Preventive Care – Medical care that focuses on health maintenance, such as annual physicals, certain screening tests and child immunization programs.

Preventive Drugs – Prescription medications that are designed to prevent individuals from developing a health condition.
Qualified Life Status Change – A change to benefits eligibility that is recognized by the IRS and allows an employee to make a change to certain benefits during the calendar year. After the initial enrollment as a new hire, or after annual Benefits Open Enrollment, employees are only able to change benefits for the remainder of the calendar year if they experience a Qualified Life Status Change.

Self-Insured Plan – Columbia University’s medical and prescription benefits are "self-insured." Columbia University does not pay "premiums" to each of the insurance carriers. The University pays employee healthcare claims, plus an administrative fee to UHC.

Single-Source Brand – Drugs that do not have a generic equivalent.

Specialty Medication – Drugs that require special handling, administration or monitoring.

Summary Plan Description (SPD) – A document that explains the fundamental features of an employer’s employee benefits plan, including eligibility requirements and the schedule of benefits.

University Network ID (UNI) – Your UNI, usually consisting of your initials plus an arbitrary number, is the key to accessing computer services and electronic resources at Columbia. You will use it to gain access to benefits information.

Vesting – A permanent right of ownership. You are always 100% vested in your Voluntary Retirement Savings Plan contributions.