2025

BENEFITS GUIDE

HORTON

A Marsh & McLennan Agency LLC Company

The City of Hobart

Benefits Guide

Our Promise

We are committed to providing our greatest assets – our people – with comprehensive and affordable benefits. Our 2025 Employee Benefits offerings deliver maximum options and flexibility. This guide will help you understand the full range of health and wellness benefits that will be available. After reading through the enclosed information, be sure to use this guide as a benefits resource you can reference throughout the year.

This guide includes a quick reference directory of telephone numbers and websites for all of our providers. We encourage you to access these sites to learn more about the plans and make the best choices possible.

Protect your Health, Life & Well-Being

Table of Contents

Medical Insurance

About the Medical Insurance

Choosing the right health insurance plan is important for you and your family. The following are some of the basic reasons you should obtain health coverage.

- Health insurance gives you a sense of security knowing that a sudden illness or serious injury will not drain your bank account, or worse, your retirement savings. Health insurance protects your financial future by helping pay for expensive doctor visits and treatments.

- Seeing doctors who are in-network with your health insurance plan also gives you the advantage of receiving care with lowered costs. When doctors are in-network, you have access to lower rates negotiated by the insurance company, meaning you owe less than if you did not have insurance.

- Health insurance covers many preventative services without you having to pay a deductible or copayment. Preventative care is intended to prevent or catch diseases and other health problems before they become serious. Preventative services that are covered in full include various health screening and immunizations

- Having health insurance will also help you pay for prescription drugs through reduced fees or copays.

Who is Eligible?

Full-time employees who work a minimum of 40 hours and their family members are eligible to enroll in the benefits described in this guide. *Children can remain covered up to age 26 for all lines of coverage.*

When are you Eligible?

Newly Eligible Employees: Benefits are effective as follows:

Medical: Full-time date of hire

Voluntary Dental: First of the month following 30 days of employment

Basic Life: Full-time date of hire

Voluntary Life: Full-time date of hire

Annual Open Enrollment:

You may make changes to your benefit elections during your open enrollment period (December 2-December 13, 2024) for an effective date of January 1st.

Qualified Change in Status:

You may make benefit changes within 30 days of a qualified event. Qualified events include marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death, and change in residence due to an employment transfer for you or your spouse or changed in spouse's benefits, or employment status.

Note: ***Employee is responsible for notifying the Clerk Treasurer's Office of any changes within 30 days.***

Medical Insurance

Allied

***Full-Time employees and dependents are eligible to enroll in the medical plan effective full-time date of hire.** Employee must work 40 hours per week.*

COVERAGE	HSA $3,300		HSA $4,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Network	Aetna and Multiplan			
Annual Deductible				
Individual	$3,300	$6,600	$4,000	$8,000
Family	$6,000	$12,000	$8,000	$16,000
Out-of-Pocket Maximum				
Individual	$4,000	$12,000	$5,000	$16,000
Family	$8,000	$24,000	$10,000	$32,000
Coinsurance	100%	80%	100%	80%
Lifetime Maximum	Unlimited		Unlimited	
Physician & Services				
Primary Care Physician	100% after Ded.	80% after Ded.	100% after Ded.	80% after Ded.
Specialist Care Physician	100% after Ded.	80% after Ded.	100% after Ded.	80% after Ded.
Virtual Visits (through 1800.MD Only)	$40 Copay until Out-of-Pocket Maximum is met	N/A	$40 Copay until Out-of-Pocket Maximum is met	N/A
Preventative Care	100% after Ded.	80% after Ded.	100% after Ded.	80% after Ded.
Urgent Care	100% after Ded.	80% after Ded.	100% after Ded.	80% after Ded.
Hospital Services				
Inpatient	100% after Ded.	80% after Ded.	100% after Ded.	80% after Ded.
Outpatient	100% after Ded.	80% after Ded.	100% after Ded.	80% after Ded.
Emergency Room	$300 Copay after Ded.		$300 Copay after Ded.	

PRESCRIPTION COVERAGE	HSA $3,300		HSA $4,000	
	Retail (30-day supply)	Mail Order / Preferred Pharmacy (90-day supply)	Retail (30-day supply)	Mail Order / Preferred Pharmacy (90-day supply)
Generic	$0 after Ded.	$0 after Ded.	$0 after Ded.	$0 after Ded.
Preferred	$40 after Ded.	$80 after Ded.	$40 after Ded.	$80 after Ded.
Specialty	Contact Caremark Specialty		Contact Caremark Specialty	

See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources. To identify an in-network provider go to www.alliedbenefit.com.

Telemedicine

1.800MD

The doctor can see you now. Getting sick or having a minor health emergency is never planned. Getting in to see your doctor or having to go to urgent care or even the emergency room can be hard to schedule when you need it and expensive. With telemedicine, you have virtual access (via mobile device or computer) to board-certified doctors and licensed counselors, therapists, or psychiatrists. Telemedicine is a cost-effective and convenient alternative to traditional doctor's care and urgent clinics and costs less than visiting the emergency room.

- 24/7/365 access to board-certified doctors – no waiting room and no need to leave home
- Receive diagnosis, treatment instructions and if necessary, presciption(s) sent to your preferred pharmacy
- Clear cost-savings – the cost of a phone or online visit is usually the same or less than your primary care provider co-pay
- Scheduled appointments available
- Talk Therapy is available for such issues as depression, anxiety, trauma, and loss or relationship problems

Doctors can treat a variety of health conditions during a virtual visit, including:

*Remember, telehealth services are only available for minor, non-life-threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

Allergies	Fevers (age 3+)	Rashes	Stomachaches
Asthma/Bronchitis	Headaches	Shingles	Urinary Tract Infections
Colds/Flus	Nausea	Sinus Infections	
Ear Problems (age 12+)	Pink Eye	Sore Throats	

To get started call (800) 530-8666 or visit www.1800MD.com

1.800 MD™

A SUBSIDIARY OF ONE80 INTERMEDIARIES

DOWNLOAD APP

Available on the App Store

GET IT ON Google Play

HOW IT WORKS

Activate your Account

Using the group and member numbers located in the Member ID card received via email

Enter your Health Info

Including your personal information and pharmacy information

Request Consultations

With the tap of a button! Schedule an appointment if needed

Get the Help you Need

Our care coordination team will respond within 15 minutes of your request, and video consultations are scheduled within a two-hour span

INTRODUCING

The NEW 1800MD App

Telemedicine in the Palm of your Hands

The new 1800MD app gives quick and convenient access to our vast network of board-certified physicians.

Access your virtual healthcare information by downloading the app today!

- ☑ Easily request medical consultations
- ☑ Schedule doctor consultations when it's most convenient for you
- ☑ Select your preferred pharmacy for easy prescription pick-up
- ☑ Manage and confirm dependents
- ☑ View past virtual consultation history
- ☑ And much more!

www.1800MD.com

1.800.530.8666

Health Savings Account (HSA)—Lively HSA

What is a Health Savings Account?

A Health Savings Account (HSA) is a type of tax-free savings account that lets you save for current and future qualified medical expenses while reducing your pretax dollars. Using an HSA to pay for deductibles, copayments/coinsurance and other qualified medical expenses is another way to lower your overall health care costs. Specific requirements must be met to have an HSA. Any unused funds at the end of the calendar year will be rolled into the next calendar year.

Some details to keep in mind:

- In order to establish an HSA, you have to be covered by a High Deductible Health Plan. These types of plans have no co pays.
- The IRS sets an annual maximum amount that can be deposited into the account. Any unused funds will earn interest and roll over from year to year. These funds belong to you — if you leave your job, you take the money in the account with you.
- As long as funds are withdrawn for qualified medical expenses, they will be tax-free. If funds are taken for other expenses, you will pay income tax and a 20% penalty on the withdrawal.
- The owner of the HSA account is responsible to keep records on all withdrawals. Keep all receipts for medical expenses paid for with HSA money in case you are audited.

Who is eligible for a HSA?

- Must be enrolled in a high-deductible health insurance plan (HDHP).
- Do not have another first-dollar medical coverage, or enrolled in Medicare, or Tricare.
- Is not covered by another health plan that is not a HDHP.
- Cannot be claimed as a dependent on someone else's tax return.

Contributions and Out-of-Pocket Limits for Health Savings Accounts and HDHPs

	2025	2024	Change
HSA Contribution Limit (employer + employee)	Self-only: **$4,300** Family: **$8,550**	Self-only: **$4,150** Family: **$8,300**	Self-only:**+$150** Family: **+$250**
HSA Catch-up Contributions (Age 55 or older)	**$1,000**	**$1,000**	**No Change**

Source: IRS, Revenue Procedure 2022 — 24.

** Please visit www.thehortongroup.com/limits for the most current IRS approved limits.*

2025 Employer Annual HSA Contribution		
	Employee Only	**EE + SP or EE + CH or Family**
HSA $3,300	**$1,000 ($250 in January, April, July & October)**	**$2,000 ($500 in January, April, July & October)**
HSA $4,000	**$1,300 ($325 in January, April, July & October)**	**$2,600 ($650 in January, April, July & October)**

Life Insurance and AD&D

Standard

The City of Hobart provides and pays for Group Life and AD&D Insurance for all full-time employees. The beneficiary you designate will receive the Life Insurance benefit. Contact Human Resources to update your beneficiary info.

Full-Time employees are covered effective the full-time date of hire. Employee must work 40 hours per week.

Employee Life Insurance	
Amount	$20,000
Accidental Death & Dismemberment	
Amount	$20,000
Benefit Reduction	• To 65% or original amount at age 70 • To 45% or original amount at age 75 • To 35% of original amount at age 80
Travel Assistance	
Service available to insureds and their families traveling 100 or more miles from their primary residence and include: • Medical Evacuation/Return Home* • Return of Mortal Remains* • Traveling Companion Assistance* • Much More* *Carrier must be contacted prior to services rendered	

See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources.

Voluntary Dental Insurance

Delta Dental of IN

The goal is to deliver affordable protection for a healthier smile and a healthier you. Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider. For complete coverage details, please refer to the Summary Plan Description (SPD).

Full-Time employees and dependents are eligible to enroll in the Voluntary Dental plan the first of the month following 30 days of employment. Employee must work 40 hours per week.

Coverage	Low Option			High Option		
	Delta Dental PPO	Delta Dental Premier	Non-Participating Dentist	Delta Dental PPO	Delta Dental Premier	Non-Participating Dentist
Annual Deductible—Does Not Apply to Preventive Services						
Individual	$50	$50	$50	$50	$50	$50
Family	$150	$150	$150	$150	$150	$150
Calendar Year Maximum	$1,000 per person			$2,000 per person		
Preventive Care Services						
Routine Oral Exams	No Charge*	No Charge**	No Charge***	No Charge*	No Charge**	No Charge***
Routine Cleanings	No Charge*	No Charge**	No Charge***	No Charge*	No Charge**	No Charge***
Sealants (per tooth)	No Charge*	No Charge**	No Charge***	No Charge*	No Charge**	No Charge***
X-Rays	No Charge*	No Charge**	No Charge***	No Charge*	No Charge**	No Charge***
Basic Services						
Fillings (one surface)	50%*	50%**	50%***	No Charge*	No Charge**	20%***
General Anesthesia	50%*	50%**	50%***	No Charge*	No Charge**	20%***
Simple Extractions	50%*	50%**	50%***	No Charge*	No Charge**	20%***
Scaling & Root Planting (per quadrant)	50%*	50%**	50%***	No Charge*	No Charge**	20%***
Major Services						
Single Crowns	No Coverage	No Coverage	No Coverage	40%*	40%**	50%***
Dentures	No Coverage	No Coverage	No Coverage	40%*	40%**	50%***
Orthodontia Lifetime Maximum (up to age 19)	No Coverage			40% up to a lifetime Max of $1,000		50% up to a lifetime Max of $1,000

See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources. To identify an in-network provider go to www.deltadentalin.com.

*You will not be "balance billed" for charges exceeding Delta's PPO Allowance

**You will not be "balance billed" for charges exceeding Delta Dental's maximum plan allowances (MPAs)

***You are responsible for charges exceeding Delta Dental's maximum plan allowances (MPAs)

Voluntary Life Insurance and AD&D

Standard

In addition to the base life insurance plan offered by your company, your employer also offers you the opportunity to "buy-up" more insurance coverage. Please consider this option if you need more coverage for yourself or your dependents.

Full-Time employees and dependents are eligible to enroll in the Voluntary Life AD&D plan effective full-time date of hire. Employee must work 40 hours per week.

	Employee	Spouse	Child(ren)
Amount	Choice of $10,000 increments Not to exceed six times your annual earnings	Choice of $5,000 increments Not to exceed 100% of employee Additional Life coverage	Choice of $5,000 increments Birth to 25 Years old– Choice of $5,000 or $10,000 Not to exceed 100% of employee Additional Life coverage
Minimum Amount	$10,000	$5,000	$5,000
Maximum Amount	$500,000	$250,000	$10,000
Guarantee Issue Amount*	**$100,000**	**$25,000**	**$10,000**
Benefit Reduction	To 65% of original amount at age 70 To 45% of original amount at age 75 To 35% of original amount at age 80		N/A
Accidental Death & Dismemberment (AD&D)	AD&D coverage provides additional benefits following an accidental death or certain bodily injuries. AD&D is a separate election from Voluntary Life.		

See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources.

***Guarantee Amounts listed above are available without evidence of insurability when you are first hired and become eligible for benefits.**

Open Enrollment Evidence of Insurability (EOI) Rules: medical questionnaire completion, review and approval required for first time enrollees (non-new hires), election increases and first time spouse elections. Employees who are already enrolled can increase their current election by one or two increments of $10,000 as long as the final amount does not exceed the Employee Guarantee Issue limit ($100,000) without needing to complete EOI. Spouses who are already enrolled can increase their current election by one or two increments of $5,000 as long as the final amount does not exceed the Spouse Guarantee Issue limit ($25,000) without needing to complete EOI. Child(ren) who are already enrolled can increase their current election by one increment of $5,000 as long as the final amount does not exceed the Child(ren) Guarantee Issue limit ($10,000) without needing to complete EOI.

Franciscan HEALTH
EMPLOYEE ASSISTANCE PROGRAM

SUPPORT FOR LIFE'S JOURNEY

- **7 LICENSED THERAPISTS**
- **14 LOCATIONS** TO CHOOSE FROM
- **FACE TO FACE, VIRTUAL AND TELEPHONIC VISITS AVAILABLE**
- **6 FREE CONFIDENTIAL** COUNSELING SESSIONS FOR EMPLOYEES AND FAMILY MEMBERS

NEED SOME SUPPORT?
MAKE A CONFIDENTIAL
CALL TO EAP FOR HELP
1-800-747-7262 or
1-219-662-3730

ARE YOU or a FAMILY MEMBER

- Feeling Stressed?
- Having relationship problems?
- Wanting to improve your relationships with others?
- Concerned about the drinking or drug use of yourself or a loved one?
- Is your child…
  - Having a school problem?
  - Having Behavior issues?
  - Coping with divorce?

CLIENT COMMENTS:

EAP has been a positive experience for me. • I have learned so much and I am better. My therapist made a big impact on my life. • I don't know where I would be without EAP.

LOCATIONS:

Chesterton • Crawfordsville • Crown Point • Dyer • Hammond • Hobart • Indianapolis • Lafayette Michigan City • Munster • Olympia Fields • Rensselaer • Mishawaka • Mooresville

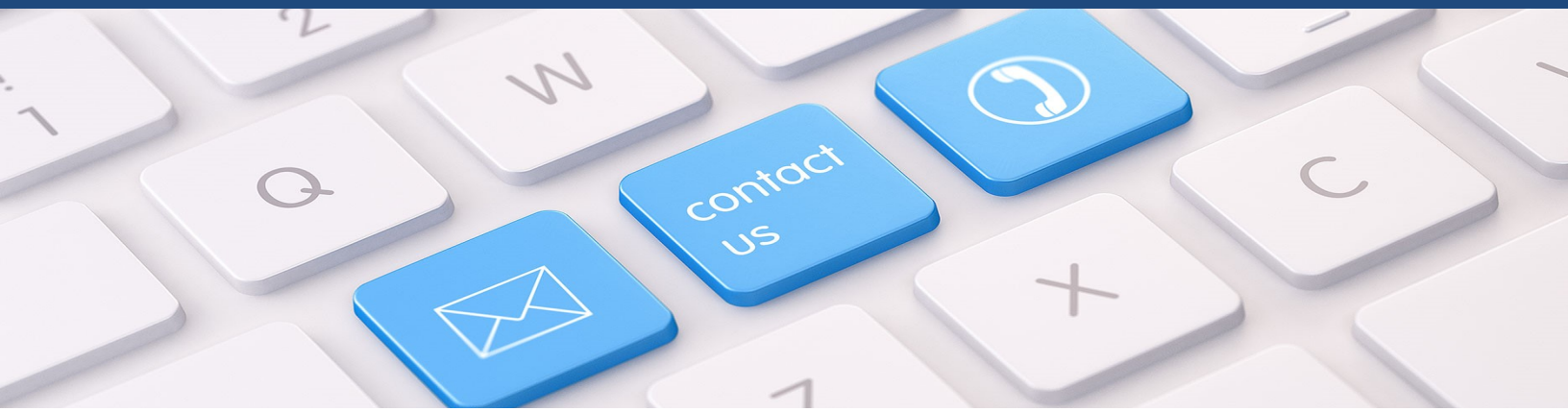
2025 Costs

2025 Medical Monthly Contributions				
Tier	HSA $3,300		HSA $4,000	
	With Health Screen	Without Health Screen	With Health Screen	Without Health Screen
Employee Only	$13.50	$52.00	$13.50	$52.00
Employee + Spouse	$25.00	$100.00	$25.00	$100.00
Employee + Child(ren)	$22.50	$70.00	$22.50	$70.00
Employee + Family	$37.50	$125.00	$37.50	$125.00

2025 Dental Monthly Contributions		
Tier	Low Plan	High Plan
Employee	$15.71	$35.18
Employee + Spouse	$35.87	$81.22
Employee + Child(ren)	$40.70	$82.17
Employee + Family	$63.47	$129.51

2025 Voluntary Life AD&D Monthly Costs	
Age Band	Employee & Spouse Rate per $1,000
Under 30	$0.070
30-34	$0.070
35-39	$0.090
40-44	$0.160
45-49	$0.300
50-54	$0.450
55-59	$0.760
60-64	$1.290
65-69	$2.270
70-74	$3.550
75-79	$5.860
80+	$9.570
Child Rate Per $1,000	$0.18
AD&D Rate Per $1,000	
$0.020	

Contact Information



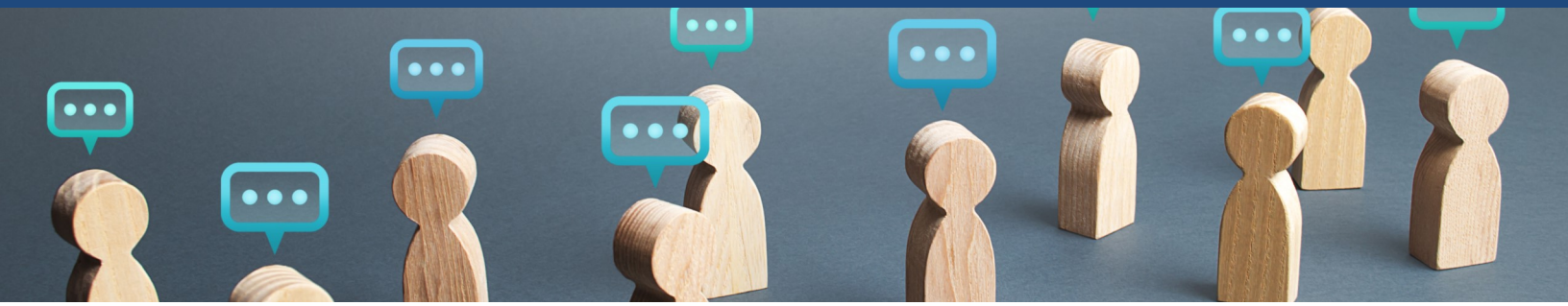
Benefit	Carrier	Phone	Website
Medical	Allied	866-455-8727	www.alliedbenefit.com
Prescriptions	Caremark	866-885-4944	www.caremark.com
Telemedicine	1 800 MD	800-530-8666	www.1800MD.com
Health Savings Account (HSA)	Lively	800-733-6632	www.livelyme.com
Group Life	Standard	800-628-8600	www.standard.com
Voluntary Dental	Delta Dental of IN	800-524-0149	www.deltadentalin.com
Voluntary Life	Standard	800-628-8600	www.standard.com
Employee Assistance Program (EAP)	Franciscan Health	800-274-7262	www.francisicanhealth.org

Customer Service/Billing/Benefit Questions at the Horton Group:
Nicole Walsh Senior Client Service Representative Phone: 708-845-3192 Fax: 708-845-3001 Email: nicole.walsh@thehortongroup.com

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have questions about your Guide, contact Human Resources.

Company hereby consents to The Horton Group's use of Company's logo for proposals or other documents designed by The Horton Group for the benefit of Company. Company's consent to The Horton Group's use of Company's logo shall remain in effect until Company withdraws such consent by sending written notice via email to The Horton Group at info@thehortongroup.com.

Employee Benefits Terminology



Health Care Benefits: Health Care Benefits provide preventive and protective coverage for medical, dental, vision, and prescription drugs for employees and their qualified dependents.

Medical care plans provide services or payments for services rendered in the hospital or by a qualified medical care provider.

BALANCE BILLING: When out-of-network providers bill 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. An in-network provider cannot balance bill you for the covered services.

BENEFICIARY: A designated person who is the recipient of proceeds from an insurance policy.

BIOMETRIC SCREENING: Usually a series of Body Mass Index (BMI) measurements and blood tests (e.g. pressure, cholesterol, and glucose) used to gauge an individual's overall health.

COINSURANCE: The percentage the plan or you pay for a covered service or supply. For example, the plan may pay 80 percent while you pay 20 percent.

COPAYMENT (COPAY): A copay is a flat-dollar amount you pay for specific covered services upon each visit to the provider. It is not impacted by the plan deductible, coinsurance, or out-of-pocket maximum.

DEDUCTIBLE: The amount you pay each year before the plan begins to pay coinsurance.

DEPENDENT: Relative of an employee who may be eligible for benefits' coverage if they meet certain criteria. Many benefits plans offer coverage to spouses, domestic/civil union partners, and children up to age 26 who are totally or substantially reliant on their parents for support, thereby defined as "dependent children."

ELIGIBLE EXPENSE: This is the amount on which payment is based for covered medical services; may also be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

ELIMINATION PERIOD: The period of time before you're eligible to receive benefits. Also known as the "waiting period."

EMPLOYEE CONTRIBUTION: The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

EVIDENCE OF INSURABILITY (EOI): The documentation of the good health condition of the insurance beneficiary and his/her dependent's health in order to be approved for coverage. It is only required in certain circumstances.

EXPLANATION OF BENEFITS (EOB): After you receive medical services, your insurance will provide you with an EOB. It will outline details regarding how your insurance processed your medical claim, including what portion of the charges your insurance paid and what portion, if any, you are responsible for paying.

FLEXIBLE SPENDING ACCOUNT (FSA): An FSA is a tax-advantaged account that lets you put money aside on a pre-tax basis to pay for a wide range of health and/or dependent care expenses (as defined by the IRS) not covered by your plan that you incur during the plan year.

Unlike the HSA, any unused funds remaining after the plan year ends will be forfeited.

FORMULARY: A medical plan's formulary is a preferred brand-name drug list of the most cost-effective outcome-based drugs. You pay less when using a drug on the plan's formulary list.

HEALTH SAVINGS ACCOUNT (HSA): An HSA is a tax-advantaged savings account for high-deductible health plan (HDHP) participants that lets you put money aside on a pre-tax basis to pay for a wide range of health care expenses (as defined by the IRS) not covered by your plan. Unused money remaining in the account at the end of the plan year rolls over to be used the next year. Please refer to IRS Publications 502 and 969 for complete details on eligible expenses.

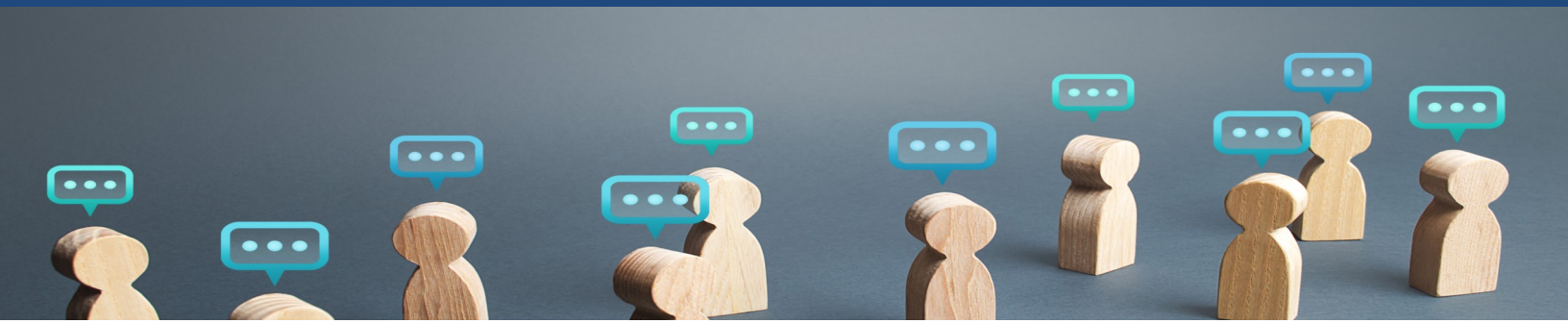
HSA CONTRIBUTION: This refers to a contribution, or "deposit," an employee may make to his/her HSA or a deposit made by the company to the HSA of an employee participating in the HDHP.

HIGH-DEDUCTIBLE HEALTH PLAN: A plan that provides competitive health insurance along with a tax-advantaged health savings account (HSA) that lets you decide how to spend your health care dollars. Essentially, you pay a lower premium in exchange for a higher deductible, much like car insurance.

HIPAA: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: HIPAA is a legal requirement that regulates how organizations must handle Protected Health Information (PHI).

IN- AND OUT-OF-NETWORK PROVIDERS: The facilities, providers, and suppliers a health insurance carrier contracts with to provide medical services at a pre-negotiated discount. You generally pay less out of pocket when you use in-network providers. Benefit plans develop networks by contracting with doctors, hospitals, labs, etc., who have agreed to provide health care services to members at negotiated rates. You generally pay less out-of-pocket when you use in-network providers.

Employee Benefits Terminology



INSURED: Person(s) covered under the medical plan to receive treatment and services. Includes primary insured (usually the employee) and their designated dependents.

INSURER: The company that underwrites and assumes the insurance risk for your medical plan. Also known as "insurance carrier."

MAXIMUM DOLLAR LIMIT: The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while the ensured is enrolled in the health plan. Plans can have a yearly or lifetime maximum dollar limit. The most typical maximum limit is a lifetime amount of $1 million per individual.

MEDICALLY NECESSARY: Medical services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine and are covered under your medical plan.

OUT-OF-POCKET MAXIMUM: The maximum amount you will pay out of pocket for covered medical expenses per calendar year, including your deductible. After your share of covered expenses reaches this annual limit, the plan pays 100% for eligible network services and supplies for the remainder of the calendar year.

POLICY HOLDER: A person or group in whose name an insurance policy is held.

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN: A type of health plan that contracts with doctors, hospitals, labs, and other health care providers to create a network of participating providers. You generally pay less when you use providers that belong to the PPO network. You may use providers that fall outside of the plan's network at an additional cost. This type of plan typically has higher premiums and a lower deductible than a high-deductible health plan (HDHP).

PREMIUM: The contracted amount that must be paid for a health insurance plan by covered employees, by their employer, or is shared by both. A covered employee's share of the annual premium is generally paid periodically, such as bi-weekly or monthly, and deducted from his or her paycheck.

PREAUTHORIZATION: A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called prior authorization, prior approval or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost

PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM: The maximum amount you will pay out of pocket for covered prescription drug expenses per calendar year. After your share of covered prescription drug expenses reaches this annual limit, the plan pays 100 percent for eligible prescription drugs for the remainder of the calendar year. The prescription drug out-of-pocket maximum is separate from the medical out-of-pocket maximum.

PRESCRIPTION DRUG PLANS: Provide coverage for outpatient prescription drugs. Prescription drugs dispensed during a hospital stay are covered as hospital miscellaneous charges.

Name-brand drugs — These are drugs that once were or still are, under patents.

Generic drugs — These are drugs that are not under patent. Once a drug's patent has expired, some plans provide more generous coverage for same-formula generic drugs than for name-brand drugs. The practice is adopted as a cost-containment measure.

Mail-order drugs — These are drugs that can be ordered through the mail. As a cost-containment measure, some plans use mail-order

PRE-TAX DEDUCTION: Payments deducted from your gross pay before Medicare, Federal, and State taxes are calculated, thus reducing your taxable wages and tax liability.

PRIMARY CARE PHYSICIAN (PCP): A physician who directly provides or coordinates a wide range of medical services for a patient. Primary Care Physicians include Medical Doctors, Doctors of Osteopathic Medicine, Internists, Family Practitioners, General Practitioners, OB/ GYNs, and Pediatricians. The opposite of a specialist.

PROVIDER: A physician, healthcare professional or healthcare facility, certified or accredited as required by state law and mentally fit.

QUALIFYING LIFE EVENT (QLE): A change in your life that allows you to make changes to your benefits' coverage outside of the annual open enrollment period. These changes include a change in marital status (marriage, divorce, death of spouse), a change in the number of eligible children (birth, adoption, death, aging-out), and a change in a family member's benefits eligibility under another plan (losing a job, Medicare or Medicaid eligibility, etc.).

REASONABLE AND CUSTOMARY (R&C) CHARGES: 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 R&C amount sometimes is used to determine the allowed amount.

SPECIALIST: A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. The opposite of a Primary Care Physician (PCP). For example, a Dermatologist is considered a specialist.

SUMMARY PLAN DESCRIPTION (SPD): An important document that tells plan participants what the plan provides and how it works.

WELLNESS: Wellness refers to a healthy state of being. Many employers have wellness programs that encourage and sometimes incentivize employees to become more physically and mentally fit.

HORTON

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