League

Glossary

CANADA

A

Accidental Insurance

Provides benefits coverage if you are injured as a direct result of an accident.

Accidental Death and Dismemberment (AD&D)

AD&D provides coverage for death or dismemberment resulting directly from accidental causes. Provides benefits in the event of loss of life, limbs or eyesight as the result of an accident.

B

Beneficiaries

Beneficiaries are the person (or people) who will receive the proceeds of your life insurance policy when they pass away. Beneficiaries can be close family members or friends.

Benefits

Medical benefits refer to the perks, protections, and services that are included in your health insurance plan.

C

Carrier

If you are asked to "check with your carrier", that simply means you should check with your insurance company.

Claims

A health insurance claim is essentially an invoice that your provider sends to your health insurance company for the services you received.

Critical Illness

A type of insurance that pays you a lump sum if you are diagnosed with a life-altering illness such as cancer, heart attack, stroke, Multiple Sclerosis or Parkinson's Disease.

D

Dispensing fee

The charge for the professional services provided by a pharmacist when dispensing a prescription (not applicable in Quebec).

E

Employee Assistance Program (EAP)

A confidential, short term, counseling service for employees with personal problems that affect their work performance. EAPs can help with things like stress, substance abuse, marital and family issues, preventative health and more.

Extended Health Insurance

Your insurance that provides protections for hospital and medical expenses not covered by government programs and other health care expenses, such as prescribed drugs, medical appliances, ambulance, private nursing, etc.

H

Health Spending Account (HSA)

A benefit that provides reimbursement for a wide range of health-related expenses, over and above regular benefit plans. HSA's are administered in accordance with Canada Revenue Agency guidelines. Money spent from this account is tax exempt!

L

Life Insurance

Insurance providing for the payment of benefits upon the death, whether by accident or otherwise, of the life insured.

P

Paramedical

Services covered under the paramedical coverage are typically services provided by professionals, not in the public health system. Services include chiropractor, physiotherapy, massage therapy, naturopathy, acupuncture and more.

Premium

A health insurance premium is a fixed cost you pay your insurer to keep your health insurance plan.

Primary Care Provider (PCP)

PCPs are doctors (can be called family doctors, internists or general practitioners) who are your first point of entry to the health care system.

Provider

You probably hear this term a lot. "Provider" is used to refer to a physician, healthcare professional, or healthcare facility.

Q

Qualifying Life Event

A magical moment or event in your life that allows you to change their benefits selections from a previous enrollment period, or otherwise. These can include marriage, the birth of a child, or a gender transition, for example.

S

Short-Term Disability

Short-term and Long-term disability (STD & LTD) insurance pays you a percentage of your salary for a specified amount of time if you become ill or injured and cannot perform the duties of your job.

League

Glossary

UNITED STATES

A

Active Enrollment

Active enrollment: indicates that employees have to complete their new open enrollment elections. Active enrollment requires employees to choose an enrollment plan, regardless of their coverage from the previous year.

Allowed Amount

The maximum amount a plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

B

Balance Billing

Balance billing is a term used for the amount a doctor charges after your insurance company pays the negotiated rate for a service, device, or drug. You usually are balance billed when you've gone out-of-network.

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Child dependent

A child dependent is an individual 25 years of age or younger who is your biological child, step-child, legally adopted child, foster child, or legal ward. If you are legally responsible for another individual and have questions about their eligibility, please help@league.com and we'll help you determine if they are eligible to enroll.

Claims

A health insurance claim is essentially an invoice that your provider sends to your health insurance company for the services you received.

Coinsurance

A coinsurance is a varying amount that you pay when you receive care and is calculated as a percentage of the allowed amount for a service. How this works with your deductible: Typically, coinsurance doesn't kick in until you've met your deductible.

Commuter Reimbursement Account

An account that allows you to set aside pre-tax dollars to put towards eligible transportation and parking expenses.

Copay

One of the ways you share in your medical costs. You pay a flat fee for certain medical expenses (e.g., $10 for every visit to the doctor), while your insurance company pays the rest. Copays may apply before or after the deductible has been met.

D

Deductible

A deductible is the dollar amount you pay out-of-pocket for covered services before your health insurance plan begins to pay for your care.

Dependents

Dependents are individuals who must be financially dependent on you. Usually, eligible dependents include your spouse, your domestic partner, children under 26.

Diagnostic Care

Diagnostic care involves treating or investigating a health issue. It may include treatment for specific symptoms, risk factors, ongoing care, and lab or other tests needed to manage or treat a medical issue or health condition.

Domestic partners

Domestic partnerships are same-gender or opposite gender couples who are registered with any state or local government department registry. Your insurance carrier may extend benefits to domestic partners. Benefits provided to domestic partners may be subject to additional or different tax treatment under Federal or state law. Please consult your tax or legal professional to learn more about how Federal and state law will be applied in connection with this election.

H

Health Savings Account (HSA)

A health savings account (HSA) is a long-term saving account you can set up to pay for health care expenses. Think of it kind of like a retirement account, but for medical expenses. You can contribute pre- or post-tax to your HSA – up to $3,500 ($7,000 for a family plan) in 2019 – and use that money to pay for qualified medical expenses throughout the year. If you choose the Lavender plan, your employer will contribute ($1000 - single, and $1500 - family), which are included in the overall contribution limit for 2019.

High-Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible). A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

I

In-Network Provider

A health care professional, hospital, or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their way.

N

Network

A network is made up of the providers (doctors) and suppliers Members' health insurer has teamed up with to provide healthcare services.

O

Open Enrollment

The yearly period when employees can enroll in the employer's health insurance plans. An annual enrollment period is typically 6-12 weeks prior to the plan year. This process typically lasts 1 to 4 weeks and tends to positively correlate with the size of the company.

Out-of-Network Provider

A health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers.

Out-of-pocket maximum

Your out-of-pocket max is the most you could pay for covered health care in a calendar year aside from your premiums. Once you've met your out-of-pocket maximum, your plan will begin to pay 100% of in-network charges.

P

Preferred Provider Organization (PPO)

PPO plans, or "Preferred Provider Organization" plans, are one of the most popular types of plans in the Individual and Family market. PPO plans allow you to visit whatever in-network physician or healthcare provider you wish without first requiring a referral from a primary care physician.

Premium

A health insurance premium is a fixed cost you pay your insurer to keep your health insurance plan.

Preventive Care

Preventive care focuses on evaluating your current health, concentrates on disease prevention, and is a great way to help you stay healthy. It's part of routine physical care such as checkups, annual wellness visits, most immunizations, and preventive screening tests. Preventive care visits are no-cost for most members.

You might hear different names for preventive care visits, including well-care visit, well-child visit, well-adult visit, annual physical exam, and annual wellness visit.

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S

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.