Employee Benefits' Glossary & Acronyms

Employee Benefits Acronym

The following is a list of commonly used acronyms in the employee benefits industry.

-A-

- ADA – Americans with Disabilities Act
- AD&D – Accidental Death and Dismemberment
- ADB – Accidental Death Benefit
- ADEA – Age Discrimination in Employment Act
- ADL – Activities of Daily Living
- ADR – Alternative Dispute Resolution
- APL – Automatic Premium Loan
- APS – Attending Physician's Statement
- Archer MSA – Archer Medical Savings Account
- ART – Annually Renewable Term (also known as YRT – Yearly Renewable Term for life insurance)
- ASO – Administrative Services Only
- AVF – Amendment Verification Form

-B-

- BOR – Broker of Record

-C-

- CDHC – Consumer-Driven Health care
- CDHP – Consumer-Driven Health Plan
- CFR – Code of Federal Regulations
- CHAMPUS – Civilian Health and Medical Program of the Uniformed Services (now TRICARE)
- CLU – Chartered Life Underwriter
- CMS – Centers For Medicare & Medicaid Services (formerly HCFA)
- COB – Coordination of Benefits
- COC – Certificate of Coverage
- COLA – Cost-of-Living Adjustments
- COBRA – Consolidated Omnibus Budget Reconciliation Act
- CPT – Current Procedural Terminology

-D-

- DB – Defined Benefits
- DC – Defined Contributions
- DCAP – Dependent Care Assistance Program
- DCTC – Dependent Care Tax Credit
- DEI – Diversity, Equity, & Inclusion
- DFVC Program – Delinquent Filer Voluntary Compliance Program
- DHMO – Deductible Health Maintenance Organization
- DME – Durable Medical Equipment
- DO – Doctor of Osteopath
- DOB – Date of Birth
- DOS – Date of Service
- DOL –Department of Labor
- DOMA – Defense of Marriage Act
- DRGs – Diagnostic Related Groups
- DX – Diagnosis Code

-E-

- EAP – Employee Assistance Program
- EBSA – Employee Benefits Security Administration (formerly PWBA)
- EDI – Electronic Data Interchange
- EEO – Equal Employment Opportunity
- EEOC – Equal Employment Opportunity Commission
- EFAST – ERISA Filing Acceptance System
- EFT – Electronic Funds Transfer
- EGTRRA – Economic Growth and Tax Relief Reconciliation Act
- EIC – Earned Income Tax Credit
- EOB – Explanation of Benefits
- EOC – Evidence of Coverage
- EOI – Evidence of Insurability
- EOMB – Explanation of Medical Benefits
- EPO – Exclusive Provider Organization
- ERD – Equal Rights Division
- ERISA – Employee Retirement Income Security Act
- ESRD – End Stage Renal Disease

-F-

- FCRA – Fair Credit Reporting Act
- FEHBP – Federal Employees Health Benefits Program
- FICA – Federal Insurance Contributions Act
- FLSA – Fair Labor Standards Act
- FMLA – Family Medical Leave Act
- FSA – Flexible Spending Arrangement (or Account)
- FUTA – Federal Unemployment Tax Act

-G-

- GI – Guaranteed Insurability Benefit
- GLBA (or GLB)– Gramm-Leach Bliley Act (also known as the Financial Services Modernization Act of 1999)
- GTL Insurance – Group Term Life Insurance
- GUL – Group Universal Life Insurance

-H-

- HCE – Highly Compensated Employee
- HCFA – Health Care Financing Administration (now CMS)
- HCFA-1500 – claim form used by medical professionals
- HCR – Health Care Reform
- HCTC – Health Coverage Tax Credit
- HDHC – High-Deductible Health Coverage
- HDHP – High-Deductible Health Plan
- Health FSA – Health Flexible Spending Arrangement (or Account)
- HHS – Department of Health and Human Services
- HIAA – Health Insurance Association of America
- HIPAA – Health Insurance Portability and Accountability Act
- HMO – Health Maintenance Organization
- HRA – Health Reimbursement Arrangement
- HSA – Health Savings Account

-I-

- IDEA – Individuals with Disabilities Education Act of 1997
- ICD-9 – International Classification of Diseases, 9th edition
- IME – Independent Medical Exam
- IPA – Independent Practice Association
- IPS – Investment Policy Statement
- IRA – Individual Retirement Account
- IRC – Internal Revenue Code
- IRS – Internal Revenue Service

-J-
- JCAHO – Joint Commission on Accreditation of Healthcare Organizations
- JGTRRA – Jobs and Growth Tax Relief Reconciliation Act

-L-
- LCSW – Licensed Clinical Social Worker
- LG – Large Group
- LHSO – Limited Health Service Organization
- LTC – Long-Term Care
- LTD Plan – Long-Term Disability Plan

-M-
- MCO – Managed Care Organization
- MSN – Medicare Summary Notice
- Medigap – Medicare supplemental insurance
- Med Supp – Medicare supplemental insurance
- MET – Multiple Employer Trust
- MEWA – Multiple Employer Welfare Arrangement
- MHPA – Mental Health Parity Act
- MIB – Medical Information Bureau
- MIS – Management Information Systems
- MSA – Medical Savings Account
- MSP – Medicare Second Payer

-N-
- NAIC – National Association of Insurance Commissioners
- NAMCR – National Association of Managed Care Regulators
- NCQA – National Committee for Quality Assurance
- NICB – National Insurance Crime Bureau
- NHCE (or Non-HCE) – Non-Highly Compensated Employee
- NMHPA – Newborns' and Mothers' Health Protection Act
- NNL –
- Non-par – Non-participating provider

-O-
- OBRA – Omnibus Budget Reconciliation Act of 1993
- OCHI – Office of Consumer Health Insurance
- OCR – Office for Civil Rights
- OHCA – Organized Health Care Arrangement
- OMB – Office of Management and Budget
- OPM – Office of Personnel Management (for federal employee benefits)
- OTC Drug – over-the-counter drug

-P-
- Par – Participating Provider
- PBM – Pharmacy Benefit Management
- PCE – Pre-existing Condition Exclusion
- PCP – Primary Care Physician
- PDA – Pregnancy Discrimination Act
- PEO – Professional Employer Organization
- PFFS – Private Fee For Service (alternative form of Medicare)
- PHI – Protected Health Information
- PHSA – Public Health Service Act
- POA – Power of Attorney
- PHO – Physician Hospital Organization
- PMPM – Per Member Per Month
- POP – Premium-Only Plan
- POS – Point of Service
- PPA – Preferred Provider Arrangement
- PPO – Preferred Provider Organization
- PTO – Payment, Treatment and Operations
- PWBA – Pension and Welfare Benefits Administration (now EBSA)

-Q-
- QDRO – Qualified Domestic Relations Order
- QMB – Qualified Medical Beneficiary
- QMCSO – Qualified Medical Child Support Order

-R-
- RBC – Risk Based Capital
- RFP – Request For Proposal
- ROC – Review Oversight Committee
- RTW – Return to Work (date for disability coverage)

-S-
- SAR – Summary Annual Report
- SB – Summary of Benefits
- SBC – Summary of Benefits and Coverage
- SBJPA – Small Business Job Protection Act
- SEP – Simplified Employee Pension
- SHIP – Senior Health Insurance Program
- SLOB – Separate Line of Business
- SMM – Summary of Material Modifications
- SNF – Skilled Nursing Facility
- SOBC – Summary of Benefit Changes
- SPD – Summary Plan Description
- SPDA – Single-Premium Deferred Annuity
- SPIA – Single-Premium Immediate Annuity
- SSA – Social Security Administration
- SSM –
- SSDI – Social Security Disability Insurance

-T-
- TPA – Third Party Administrator
- TPL –
- TPPP – Third Party Prescription Program
- TRICARE – triple option benefit plan for military families (formerly CHAMPUS)

-U-
- UB04 –billing form used by hospitals
- U&C (R&C or UCR) – Usual Customary, Reasonable and Customary, Usual Customary and Reasonable
- UR – Utilization Review
- URAC – Utilization Review Accreditation Commission
- USC – United States Code
- USERRA – Uniformed Services Employment and Re-employment Rights Act

-V-
- VEBA – Voluntary Employees' Beneficiary Association
- VFC – Voluntary Fiduciary Correction Program
- VHSP – Voluntary Health Service Plan

-W-

- WHCRA – Women's Health and Cancer Rights Act
- WP – Waiver of Premium For Disability Benefit
- WPHCP – Women's Principle Health Care Provider

-Y-

- YTD – Year-to-Date
- YRT – Yearly Renewable Term Insurance (also known as ART – Annually Renewable Term Insurance)

Open Enrollment Glossary of Terms

Open enrollment is the time of year reserved for you to make changes to your benefit elections, and unfamiliar terms can make this process confusing. Use these definitions of common open enrollment terms to help you navigate your benefits options.

Coinsurance – The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Consumer-driven (also known as consumer-directed or consumer choice) Health Care (CDHC) – Health insurance programs and 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. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are common examples of CDHC plans.

Copayment – A flat fee that you pay toward the cost of covered medical services.

Covered Expenses – Health care expenses that are covered under your health plan.

Deductible – A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependent – Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

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. Most funds must be used by the end of the year, as there is only a limited carryover amount.

Health Management Organization (HMO) – A type of health insurance plan that usually limits coverage to care from doctors who work for or 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 – Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Inpatient – A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary (or medical necessity) – Services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

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.

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.

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) – The highest out-of-pocket amount paid for covered services during a benefit period.

Preferred Provider Organization (PPO) – A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Premium – The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Primary Care Physician (PCP) – A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance – The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances.

Health Insurance Terminology: Plan Types & Network

Managed Care

Managed care is a commonly used term, but what does it really mean and how does it apply to your health plan? This flyer defines managed care and several other terms related to this complex concept.

Managed Care Basics

Managed care – A system of delivering health care that is characterized by contractual arrangements with selected providers (doctors, hospitals, laboratories, etc.), ongoing quality control and utilization review programs, and financial incentives for members to use providers and procedures covered by the plan. It is a broad term that encompasses a variety of different types of organizations.

Managed health care plan – An organization that integrates finance, management and delivery of health care services using a contracted, organized provider network which delivers health care services to the plan's members. These providers typically either share some financial risk with the plan, or have financial incentives to deliver quality, cost-effective services to plan members.

Accreditation – Professional review and certification of a health plan's quality standards.

Grievance procedure – A specific procedure that allows health plan members to express complaints and seek remedies.

Independent review organization – An independent entity or organization that is retained by a private health plan, or state or federal agency, to review member appeals of coverage denials based on medical necessity.

Service area – the geographic area serviced by a health plan or insurance carrier, as approved by state regulatory agencies. In- and out-of-area services are defined below.

In-area services – Health care services received within a health plan's authorized service area.

Out-of-area services – Medical services or treatment given to an HMO member outside the geographical service area of his HMO. Coverage for out-of-area services is generally limited to emergency care.

Plan Types and Characteristics

Health maintenance organization (HMO) – A managed care organization that provides, offers or arranges for coverage of designated health services for plan members for a fixed, prepaid premium. Patients must choose doctors, hospitals and other health care providers from the plan's provider list in order to be fully covered. Emphasis is placed on preventive care and cost management. HMO models vary and are defined below.

Closed panel HMO – An HMO that provides coverage only for services received by health care providers who contract with the plan. Member care is usually performed by a "gatekeeper" physician who is the patient's initial contact for medical treatment, referrals and coordination of care. Physicians only see members of a single plan. Under certain circumstances, coverage will be granted for non-network providers (e.g., for out-of-area emergencies or when referrals are required to supply the necessary expertise). Also called *closed access plan* or *gatekeeper model.*

Group model HMO – A type of HMO in which the plan contracts with one or more independent practice groups to provide services to plan members. Contracts can be either exclusive (the group can only treat that plan's members) or non-exclusive (the group is free to contract with other plans and provide services to other individuals).

Independent practice association (IPA) model HMO – An HMO in which the plan contracts with individual independent physicians and physician groups to provide services in their own private offices. IPA physicians are free to contract with multiple HMOs and health plans at once, and to see any individual patients they choose.

Network model HMO – An HMO in which the plan contracts with one or more independent physician practice groups to provide services to plan members. These contracts are always non-exclusive, meaning that the physicians or practice groups are free to contract with other health plans or provide services to patients who are not members of a particular plan.

Open panel HMO – A health maintenance organization that contracts with individual physicians who work out of their own offices and perform services for plan members on a part-time basis.

Staff model HMO – An HMO in which physicians and other providers are employed and paid salaries directly by the HMO, and work exclusively in the HMO's facilities.

Open access – A managed care concept in which members are allowed to "self-refer" themselves to participating physicians for specialty care without a referral from a primary care physician or authorization from the plan.

Point-of-service (POS) plan – A fairly new form of managed care plan which allows the patient to see either in-network specialists without a referral, or out-of-network providers, but the patient is required to pay more out of pocket when seeking

these services. While coverage for in-network services or in-network referral services may be close or equal to 100 percent, in-network services without a referral and out-of-network services are usually subject to deductibles, copayments and coinsurance.

Preferred provider organization (PPO) – A managed care plan in which the network of doctors and hospitals provides services to plan members at discounted rates. Unlike HMOs, most PPOs do not use a primary care physician to oversee patients' overall care, allowing members to consult specialists or out-of-network providers whenever they wish. Coverage is usually less for out-of-network providers. PPOs usually do not exercise tight management over medical care.

Providers and Provider Networks

Credentialing – A managed care plan's process of reviewing a provider applicant's background and current professional standing before contracting with the provider. Plans usually require providers to conform to specific criteria for initial and ongoing participation in the plan.

Network – A selected group of physicians, hospitals, laboratories, and other health care providers and facilities that contract with a health plan to provide health care services to that plan's members.

Non-participating provider – A health care provider who has not contracted with a particular insurance carrier or health plan to provide health care services to its members. Also known as *out-of-network provider.*

Out-of-network services – Treatment obtained from a non-participating provider. Out-of-network services typically require the member to pay higher deductibles, copayments and coinsurance than in-network services, or services may not be covered at all.

Participating provider – A health care provider who has contracted with a particular insurance carrier or health plan to provide health care services to its members. Also known as *in-network provider.*

Primary care physician (PCP) – A physician who is responsible for monitoring and coordinating a patient's overall health care, and refers the patient to appropriate specialists when necessary. Many managed care plans require members to choose a PCP (usually a family practitioner, internist pediatrician, or obstetrician/gynecologist) as part of their strategy to increase quality of care and control costs.

Referral – A physician's or health plan's recommendation for a covered person to receive care from a different physician or facility.

Health Care Cost Management

Case management – The medical management process wherein health plans identify patients with specific or chronic health conditions, and interact with their physician(s) to ensure that these individuals receive medically necessary and appropriate health care services.

Case manager – A health care professional (e.g., nurse, doctor or social worker) who works with patients, physicians, other health care providers and health plans to help determine medically necessary and appropriate health care for certain individuals with specific or chronic health conditions.

Disease management – The process of identifying and evaluating patients with chronic diseases, using interventions designed to promote ongoing management and prevent worsening of the disease.

Medical cost management – Processes and procedures used by health plans to control how members use health care services.

Medical necessity – A health plan's evaluation of health care services to determine if they are medically appropriate and necessary to meet health care needs, are consistent with the diagnosis or condition, are rendered in a cost-effective manner and are consistent with national medical practice guidelines.

Pre-admission certification – A cost containment feature of many group health plans whereby a review of the need for inpatient hospital care is completed prior to actual admission. The review is usually performed by a case manager or health plan representative (typically a nurse), and is based upon pre-established criteria. The goal of such reviews is to ensure that inpatient care is medically necessary, appropriate and cost-effective. Also called *prior authorization, pre-admission review, or pre-admission authorization.*

Second surgical opinion – A cost containment technique to help patients and health plans determine the medical necessity of a particular procedure, or whether an alternative treatment method is appropriate.

Utilization – The extent to which a particular group uses a particular health plan or program.

Consumer-Driven Health Care: Health Insurance Terminology

Consumer-driven or consumer-directed health care (CDHC) is designed to allow you to have more power over your health coverage and options. CDHC plans are becoming increasingly popular and truly put you, the consumer, in the driver's seat. Feel more confident about controlling your health coverage with the most common CDHC terms defined below.

Archer medical savings accounts (Archer MSAs) – These tax-deductible medical savings accounts are available on a limited basis to self-employed individuals and employees of certain small employers. The MSA has been used less frequently since the creation of the more favorable Health Savings Account (HSA) plan option.

Coinsurance – The amount or percentage that you pay for certain covered health care services under your health plan.

Consumer-driven or consumer-directed health care (CDHC) – Health insurance programs and plans that are intended to make you more informed about your health. Under these plans, you have more control over your health care dollars and may use health care services more efficiently, so these plans tend to be more affordable. These medical plans also offer reduced premiums in exchange for higher deductibles. Plus, they offer incentives and tools to manage health care decisions and costs, including Web tools to make decisions about health care plan choices, education information about health care, preventive coverage at little or no cost, disease management programs and the use of care coaches. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are common examples of CDHC plans.

Consumerism – A marketplace trend that empowers and supports individuals in their use of health care services by allowing increased flexibility, credible prices and quality health care information to make informed decisions.

Cost sharing – Provisions within a health care plan that require you to pay for a portion of your health care services in the form of copayments, deductibles and coinsurance.

Covered expenses – Health care expenses that are covered under your health plan.

Deductible – Before benefits are available through a health plan, you must pay a specific dollar amount out-of-pocket. Under some plans, the deductible is waived for certain services such as preventive care.

Defined contribution health plan – These plans are an employer-provided CDHC arrangement intended to encourage the efficient use of health care by fixing employer contributions at a certain level, rather than promising a specific benefit regardless of cost.

Flexible spending account (FSA) – An account that allows you to save tax-free dollars to pay for qualified medical and/or dependent care expenses. Both and you can contribute to the account. Health insurance is not required to open an FSA. You determine how much you want to contribute to the FSA at the beginning of the plan year. Any funds left in the account at the end of the plan year are forfeited back to the employer.

Generic drug – A term used to describe an identical or medically equivalent option to a brand name medication. Generic medications are sold significantly cheaper than their branded counterparts, though they are chemically identical, and share the same dosage form, safety, strength, quality, performance and intended use.

Health reimbursement arrangement (HRA) – An account in which employers deposit pre-tax dollars for each of their covered employees. Employees can then use this account as reimbursement for qualified health care expenses. If there are funds left over in the account at the end of the plan year, they can be carried over into the next year; however, this type of account is not transferable from employer to employer.

Health savings account (HSA) – This is a medical savings account that can consist of both employer and employee contributions, and is used to pay for eligible medical expenses. Contributions are taken directly from your paycheck, before taxes, and placed in an account. After age 65, you can use your funds for non-health-related expenses without facing a penalty; however, any HSA withdrawals for non-medical expenses are subject to income taxes. Unlike an HRA, leftover funds can be rolled over from year to year, and the account stays with you regardless of whether you change employers. An HSA must be used with a qualified high-deductible health plan (HDHP) that covers catastrophic health care expenses after the deductible.

High-deductible health plan (HDHP) – An HDHP is a qualified health plan that gives you more control over your health care spending by offering lower monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans also allow you to open a tax-advantaged health savings account (HSA).

Medical expense reimbursement plans (MERPS) – These plans (also known as MRPS, Section 105 Plans or Direct Reimbursement Plans) are arrangements through which employers reimburse employees for uninsured medical expenses that are not paid for by the employer's major medical plan. For instance, an HRA describes a certain type of MERP.

Out-of-pocket maximum (OPM) – This is the most you will generally pay for covered services during a benefit period. Both the deductible and the coinsurance apply towards meeting the OPM, but copayments may not apply. Under some plans, the deductible and OPM may have the same dollar limit.

Premium – The amount you pay monthly for a health plan in exchange for coverage. Keep in mind health plans with lower premiums typically have higher deductibles.

Preventive care – Health care services that are for prevention, not for the treatment of active diseases or illnesses. This type of care focuses on wellness, health promotion and other initiatives that reduce the risk of future illnesses or injuries such as routine physical exams, mammograms or colon cancer screenings.

Qualified medical expense – These generally include expenditures for medical care that you may be able to deduct on your income taxes. The IRS imposes strict guidelines on claims for medical care, so check their guidelines for allowable expenses not reimbursed by insurance or another source.

Health Insurance Terminology: Facilities & Care Types

Health insurance benefits can be confusing. Where do I go for urgent care? What is the difference between long-term care and custodial care?

In order to get the most out of your employer-sponsored health insurance benefits, and to be sure that you are getting the most cost-effective care, it is important to understand the terms you will find in your plan booklet.

Health Care Facilities Defined

Ambulatory setting – institutions such as surgery centers, clinics or other outpatient facilities that provide outpatient health care services.

Approved health care facility or program – a facility or program that is licensed, certified or otherwise authorized according to the laws of the state to provide health care, and which has been approved by a health plan as described in the contract.

Extended care facility – a nursing home or nursing center that is licensed to operate in accordance with all applicable state and local laws and that provides 24-hour nursing care. These facilities offer skilled, intermediate or custodial care, or any combination of these types of care.

Facility – a physical location where health care services are provided, such as a hospital, clinic, emergency room or ambulatory care center.

Home health agency (HHA) – a state and federally certified facility that is approved to provide health care services in the home.

Hospice – a facility or program that is primarily designed to provide pain relief, symptom management and supportive services for the terminally ill and their families.

Intermediate care facility – a facility that is licensed by the state and provides nursing care to patients who require a degree of care that is less than would be received in a hospital or skilled nursing facility, but more than room and board.

Long-term care facility – usually a state licensed facility that provides skilled nursing services, intermediate care and custodial care.

Nursing home – a licensed facility that provides general nursing care to chronically ill patients who are unable to care for themselves and their daily living needs. Also referred to as a long-term care facility.

Outpatient surgical center – a health care facility, separate from a hospital, that provides pre-scheduled outpatient surgical services. Also called a freestanding outpatient surgical center or day-surgery center.

Skilled nursing facility – a facility either freestanding or part of a hospital, which provides rehabilitation and medical care that is less intense than would be provided in a hospital.

Sub-acute care facility – an intermediate care facility which provides care for patients too ill to be released to long-term care or their homes, but not so ill that they require ongoing hospitalization.

Treatment facility – any residential or non-residential facility that is authorized to provide treatment for mental health conditions or substance abuse.

Urgent care center – a health care facility whose primary purpose is the provision of immediate, short-term medical care for minor but urgent medical conditions. Serves as an alternative to the hospital emergency room.

Types of Care Defined

Activities of daily living (ADL) – everyday living functions and activities performed by individuals without assistance, including walking, dressing, personal hygiene and eating.

Acute care – skilled medical care provided by medical and nursing personnel in order to restore a person to good health.

Adult day care – a type of care (usually custodial) for individuals who require assistance with various activities of daily living while their primary caregivers are absent.

Aftercare – patient services required after hospitalization or rehabilitation.

Ambulatory care – care given on an outpatient basis.

Ancillary care – additional services (other than room and board) performed relating to a specific incident of care. Includes services such as x-rays, lab work, radiology, and anesthesia.

Behavioral health care – assessment and treatment of mental illness or substance abuse disorders.

Custodial care – care primarily to meet a patient's personal needs, such as bathing, dressing, eating, or taking medicine. Can be provided by medical or non-medical personnel, but must be administered according to a doctor's order.

Emergency services – services provided for an unforeseen acute illness or injury that requires immediate medical attention.

Home health care – skilled or unskilled care provided in an individual's home, usually on a part-time basis. Examples include part-time skilled nursing care, speech therapy, physical or occupational therapy, part-time services from home health aides or assistance with household chores.

Hospice services – services provided to the terminally ill and their families.

Intermediate nursing care – health or medical care that is occasional or rehabilitative, ordered by a physician and performed by skilled medical personnel.

Long-term care – care provided to people with chronic diseases or disabilities who need assistance with daily activities for an extended period. Includes a wide range of health and social services provided under the supervision of medical professionals.

Office visit – services provided in a physician's office.

Outpatient services – care received in a hospital or ambulatory care center that does not require an overnight stay.

Preventive care – proactive, comprehensive care emphasizing prevention, early detection, and early treatment of conditions. Generally includes routine physical exams, immunizations and well-person care.

Primary care – basic or general health care, traditionally provided by family practice physicians, pediatricians or internal medicine practitioners.

Respite care – temporary health or medical care designed to provide a short rest period for a caregiver of a chronically or terminally ill person.

Secondary care – medical services provided by doctors who do not have first contact with patients, such as urologists, cardiologists and so on.

Specialty care – services delivered by a health care provider who has received advanced training in a specific field of medicine. Specialty care also includes care provided in specialty facilities and emergency care.

Tertiary care – health care services provided by highly specialized providers, such as neurosurgeons, thoracic surgeons and intensive care units. These services often require highly sophisticated technologies and facilities.

Disability Insurance Glossary

Active, full-time employee: An individual must work for the employer on a regular basis in the usual course of the employer's business to be considered an active, full-time employee and thus be eligible for coverage. Usually, a minimum number of hours of regular work are specified.

Benefit percentage: The percentage of the insured's pre-disability income, up to an overall maximum benefit amount, that will be the amount payable to the insured upon disability.

Benefit period: The longest period of time for which benefits are payable for continuous disability.

Definition of total disability: Arguably the most important provision in the disability contract. The definition of total disability is used to determine an employee's eligibility for benefits.

Own occupation: A definition of disability which states that as long as the insured is unable to perform the duties of his or her regular occupation(s) at the time of disability, the insured will be considered eligible to receive the full benefit under the policy.

Any occupation: An insured will be considered disabled only if he or she is unable to work in any occupation for which he or she is qualified by education, training or experience.

Disability: An individual's physical or mental inability to perform the major duties of his or her occupation because of sickness or injury.

Elimination or waiting period: The period of time between the date the disability commences and the beginning of the benefit payment period. It is the period during which an employee must be disabled before payment of benefits begins.

Evidence of insurability: Group disability coverage is generally sold as a "guaranteed issue" policy, which means that evidence of insurability is not required. However, under certain circumstances (e.g., late enrollment or a high benefit maximum), an employee must provide medical or financial information as proof of insurability.

Exclusions: Certain conditions and causes that are not covered by the policy. These are listed in the policy. For example, a plan will typically exclude coverage for disabilities resulting from war, participation in a riot, commission of a felony or a self-inflicted injury.

Injury: Accidental bodily injury that occurs while a policy is in force.

Lifetime disability benefit: A benefit that is payable for the lifetime of the insured if he or she is continuously and totally disabled before a specified age (e.g., 45 or 55).

Limitations: Specific provisions included in the group disability policy that limit coverage in certain situations. For example, often only limited benefits are payable for disabilities caused by mental illness and pre-existing conditions.

Maximum benefit period (benefit duration): The maximum length of time for which benefits are payable under the plan as long as the employee remains continuously disabled.

Maximum monthly benefit: The highest dollar amount a disabled employee can receive on a monthly basis under the long-term disability policy.

Minimum monthly benefit: The minimum amount paid as a monthly benefit after reductions for other income benefits (see below).

Other income benefits (benefits integration): While disabled, an insured may be eligible for benefits from other sources. Benefits payable under the group long-term disability plan may be offset by other sources of disability income (Social Security, workers' compensation or other disability benefits).

Partial or residual disability: An insured's physical inability to perform some, but not all, of the duties of his or her regular occupation due to sickness or injury.

Pre-disability earnings: The amount of an employee's wages or salary that was in effect and covered by the plan on the day before the disability began.

Pre-existing condition limitations: Most plans exclude or reduce disability benefits for any illness or injury for which an employee received medical treatment or consultation within a specified time period before becoming covered under the plan.

Presumptive disability: The presumption that the insured is totally disabled, even if still at work, if sickness or injury results in the total and complete loss of sight in both eyes, hearing in both ears, power of speech or use of any two limbs. The elimination period is waived from the date of the loss and the total disability benefits are payable while such loss continues until the end of the benefit period.

Recurrent disability provision: A plan's recurrent disability provision is designed to protect an employee who tries to return to work but becomes disabled again from the same or a related cause. If this happens within a certain period of time, the employee is considered disabled from the original disability. That means disability payments will continue without a break. This provision helps protect people. It encourages an employee to return to work without fear of losing coverage.

Residual coverage: Disability coverage that pays for a portion of a covered person's salary when they are able to work, but limited in their abilities because of the covered disability. For example, residual coverage may pay if a covered person is diagnosed with multiple sclerosis and can only work part time because of their condition.

Return-to-work provision: To encourage employees to return to work as soon as they become physically able, an additional incentive is provided for a certain period of time. Typically, the employee can receive up to 100 percent of pre-disability earnings based on a combination of disability benefits and return-to-work earnings.

Sickness: A sickness or disease, including a pregnancy, which is first diagnosed and treated while the policy is in force.

Total disability: The physical or mental inability to perform the major duties of one's occupation because of sickness or injury.

Waiting period (for plan enrollment eligibility): To be eligible for coverage under a group insurance policy, an employee must have worked a certain number of continuous days as an active, full-time employee. Employees without the required days of employment are in the waiting period. Another type of waiting period is the time between when a disability occurs and when payments from the disability insurance policy begin.

Waiver of premium: When a covered person becomes disabled and eligible for coverage, they no longer have to pay for the coverage. Paying the plan's cost (premium) is stopped (waived). And they pay no disability premium payments as long as they are receiving payments from the plan.

Health Care Reform: Common Terms

There are a growing number of acronyms used in health care reform-related materials today.

ACA: The Affordable Care Act. Used to refer to the final, amended version of the health care reform legislation.

Accountable Care Organization (ACO): A group of doctors who work together to manage patient care. Health care reform law offers incentives for doctors to form Medicare ACOs starting in 2012.

Annual limits-Under health care reform, annual limits on essential health benefits for plans that begin on or after September 23, 2010 must be at least $750,000. Beginning September 23, 2011, the limit is $1.25 million and for September 23, 2012, it is $2 million. Reform does not allow annual minimum dollar limits for most plans beginning starting in 2014.

"Cadillac" Tax: A tax on health plans that cost more than $10,200 per year for single coverage or $27,500 for family coverage. This 40 percent excise tax begins in 2022.

CDC: The Centers for Disease Control and Prevention.

CHIP: The Children's Health Insurance Program. Program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.

DOL: United States Department of Labor.

EBSA: Employee Benefits Security Administration. A division of the DOL responsible for compliance assistance regarding benefit plans.

ERRP: The Early Retiree Reinsurance Program. A temporary program created under health care reform to provide coverage to early retirees.

Employer mandate: This applies to employers with 50 or more full-time employees.

•If an employer does not offer health coverage to full-time (30+ hours) employees and any full-time employee receiving premium assistance from the federal government, the employer must pay $2,000 for each full-time employee minus 30.

•If an employer offers coverage, and any full-time employee receives federal premium assistance, the employer must pay the lesser of: ◦ $3,000 for each employee receiving federal premium assistance, or $2,000 per employee for each full-time employee minus 30.

Essential health benefit: These are benefits that health care reform requires plans to cover:

•ambulatory patient care

•emergency care

•hospitalization

•laboratory services

•maternity and newborn care

•mental health and substance abuse

•pediatric services, including oral and vision care

•prescription drugs

•preventive and wellness care and chronic disease management

•rehabilitative and habilitative care and devices

Exchange: A state or federal insurance marketplace where individuals or small businesses can purchase health insurance.

FPL: Federal poverty level. A measure of income level issued annually by HHS and used to determine eligibility for certain programs and benefits.

FLSA: The Federal Fair Labor Standards Act. Amended by PPACA to incorporate health care reform-specific provisions.

Grandfathered status: Health plans that existed on March 23, 2010 may be "grandfathered". These plans do not have to comply with all Patient Protection and Affordable Care Act (PPACA) provisions. Plans can make routine changes without losing grandfathered status. Plans can lose their status if they reduce benefits or increase employee costs too much. Employers can switch insurance companies and change from administrative services only (ASO) to fully-insured without losing grandfathered status.

HCERA: The Health Care and Education Reconciliation Act of 2010. Enacted on March 30, 2010, to amend and supplement PPACA.

HCR: Health care reform.

HHS: United States Department of Health and Human Services.

HIF (Health insurance fee): A new $8 billion annual tax on health insurance companies starting in 2014. The tax will grow to $14.3 billion a year by 2018 and rise with inflation after that. The tax will be based on each company's market share.

Individual mandate: All U.S. citizens and legal residents must have "minimum essential" health coverage in 2014 according to health care reform law. If they do not, they will pay a tax penalty until 1/1/2019.

IRO: An independent review organization. An organization that performs independent external reviews of adverse benefit determinations.

MLR: Medical loss ratio. Refers to the claims costs and amounts expended on health care quality improvement as a percent of total premiums. This ratio excludes taxes, fees, risk adjustments, risk corridors and reinsurance. The MLR cannot exceed 80-85% of premiums or it must be refunded to the customer or employer.

Minimum essential coverage: All U.S. citizens and legal residents must follow health care reform's rule called the individual mandate. This rule requires people to maintain health coverage that offers essential health benefits.

Minimum value: Under health care reform, a health plan provides minimum value if it pays at least 60 percent of the allowed cost of services.

NAIC: The National Association of Insurance Commissioners.

National Committee on Quality Assurance (NCQA): An independent, nonprofit group that reviews the quality of managed care plans.

OCIIO: The Office of Consumer Information and Insurance Oversight. A division of HHS responsible for implementing many of the health care reform provisions.

PCE: Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.

PCIP: The Pre-existing Condition Insurance Plan. A temporary high-risk insurance pool that provided coverage to eligible individuals until 2014.

PPACA: The Patient Protection and Affordable Care Act. Enacted on March 23, 2010, as the primary health care reform law.

QHP: Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Rescission: Health plans cannot retroactively cancel coverage. The only exceptions are for fraud or false statements. Thirty days advance notice must be given before coverage ends.

SHOP Exchange: The Small Business Health Options Program. A program that each health insurance exchange must create to assist eligible small employers when enrolling their employees in qualified health plans offered in the small-group market

U.S. Preventive Services Task Force: A panel of doctors who review scientific evidence and suggest what preventive care services health plans should cover.

W-2 reporting: Employers must report the value of employer health coverage on each employee's W-2. Employee contributions to flexible spending accounts and health savings accounts are excluded.

ERISA GLOSSARY: Key Terms Defined

Administrative Services Only (ASO). An arrangement in which an insurance company is paid a fee to provide claims paying assistance to a self-funded plan, such as claims adjudication, forms and enrollment, and perhaps arranging for stop loss insurance, but does not assume any insurance risk to plan participants or beneficiaries.

Beneficiary. A person designated by a participant, or by the terms of an employee benefit plan, who is, or may become entitled to a benefit specified in the plan document.

Church plan. A church plan is defined as a plan established and maintained by a church or a convention or association of churches that is exempt from tax under Tax Code section 501(a). When a plan meets this definition, it will be exempt from meeting a range of ERISA obligations. Organizational tax structure will often make a big difference. For example, if a church member dies and donates a grocery store to the church, the church-owned grocery store will not automatically become exempt from ERISA.

Employer. An employer is generally any person for whom an individual performs or did perform any service, of whatever nature, as an employee. In the ERISA context, the term "employer" refers to any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan. The IRS uses strict rules designed to evaluate the level of control that an employer exerts over an individual to direct activities in determining whether or not a genuine employment relationship exists between the two parties. If employment exists, the employer is obliged to discharge specific employer duties, particularly as relates to wage payment and remitting tax.

ERISA. The *Employee Retirement Income Security Act of 1974* (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. ERISA gives employers a framework of laws where it can sponsor an employee benefit program, typically on a tax favored basis and in a manner that often helps the employer derive advantages from plan sponsorship. In exchange, the Employer agrees to operate the plan for the "exclusive benefit" of plan participants.

Except where Congress allows states to regulate insurance, ERISA reserves to the federal system the exclusive right to regulate inside the zone of employee benefits. States thereby lack the power to directly regulate employer benefit programs. States do retain authority to design insurance policies that will affect employers who choose to buy such policies because the employer will generally become subject to the terms and conditions of coverage as specified in the insurance policy

ERISA Preemption. Preemption arises when a state-law or rule duplicates, supplements, or supplants a function reserved inside the ERISA zone of authority. If a conflict arises, a challenge may ensue where a court must assess whether the state law or rule exceeded its authority. In some cases, the court may find that no conflict exists by ruling that ERISA would permit a state to engage in the particular type of regulating activity.

Excepted benefits: These are benefits offered separately or that are not part of a health plan. Excepted benefits might be dental, vision, long-term care or disability income.

Fiduciary. ERISA defines a person or entity as a plan fiduciary if that person: (1) exercises any discretionary authority or discretionary control respecting management of the benefits plan, or disposition of its assets; or (2) has any discretionary authority or discretionary responsibility in the administration of the benefits plan.

Fiduciary Duties. ERISA imposes legal duties on fiduciaries that incorporate principles from the law of "trusts."
Key responsibilities include:

- Acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them;
- Carrying out their duties prudently;
- Following the plan documents (unless inconsistent with ERISA); and
- Paying only reasonable plan expenses.

ERISA imposes a range of civil and criminal penalties for fiduciary failures.

Governmental Plan. A plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. A governmental plan is not subject to ERISA, but many non-ERISA plans still elect to use ERISA style materials (such as a document that resembles an SPD) in order to help explain benefit operations to participants.

MEWA or "*Multiple Employer Welfare Arrangement*." MEWA is defined in ERISA as an employee welfare benefit plan (typically providing medical, surgical, or hospital care benefits or benefits), to the employees of two or more un-related employers. MEWAs are avoided if the two or more employers are members of the same "control group." In other words, if they are related in a manner that satisfies IRS control group rules then the arrangement will be treated as a single employer. On the other hand, when organizations are un-related (e.g. related only by minority share ownership) have employees participating in one health plan, the arrangement will be considered a MEWA (*multiple employer* welfare arrangement).

- ERISA specifies that the preemption of state laws that normally protects self-insured plans from state insurance laws does *not* apply in the case of MEWAs. This subjects a self-funded MEWA to state laws that would not otherwise apply and that are often difficult, if not impossible for a self-funded plan to meet. MEWAs would additionally remain subject to ERISA requirements.

The **Mental Health Parity and Addiction Equity Act of 2008** is a law that makes benefits under Mental Health and Substance Use Disorder coverage the same as benefit limitations under a person's medical/surgical coverage.

Participant. Any employee, or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

Plan Document. A written instrument under which the plan is established and operated. In the ERISA context the plan document represents a type of enforceable contract executed between the employer and eligible workforce members that dictates how the benefit plan functions.

Plan year. This defined ERISA term refers to a consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year, or otherwise. *Plan year is **NOT** synonymous with an insured client's policy year and the two dates cannot be used interchangeably.*

Plan year specifically refers to the year that is designated as the plan year in the plan document of a group health plan, and that is used as the date governing the plan's Form 5500 filings. Note: In special cases where the client lacks any plan materials (e.g. a plan document does not designate a plan year or if there is no plan document), there are "default rules" the government uses to deduce the plan year which are especially relevant in the Health Care reform context.

Accordingly, where a plan *FAILS* to define its plan year, the plan year will be construed by using the following:

(1) The deductible or limit year used under the plan;
(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;
(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or
(4) In any other case, the plan year is the calendar year.

Summary Plan Description. An ERISA required document that includes a "plain language description" of important features of the plan. ERISA mandates an array of elements that must be included and disclosed in order for a document to be considered a bona fide SPD. For example, when employees begin to participate in the plan, eligibility terms, procedural requirements, and detailed explanations about how to file a claim for benefits. Participants must be informed of material changes either through a revised Summary Plan Description or in a separate document called a Summary of Material Modifications.

Welfare Benefit Plan. Any plan, fund, or program established or maintained by an employer or by an employee organization, for the purpose of providing its participants (or their beneficiaries), through the purchase of insurance (or otherwise), (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services. (NOTE: ERISA also applies to pension and retirement programs, but for the sake of the "welfare benefits definition", the above named-programs are distinguished from benefits intended as retirement or pension programs.)

DENTAL: Key Terms Defined

Bitewing X-rays: X-rays taken of the crowns of teeth to check for decay.

Bonding: A process to chemically etch the tooth's enamel to better attach (or bond) composite filling material, veneers or plastic/acrylic.

Bridge: A non-removable dental solution used to replace missing teeth.

Brush biopsy: Brush biopsy is a painless procedure used to gather cells in the mouth. The dentist uses a small brush to take a tissue specimen, which is then sent to a laboratory for analysis to determine the presence of pre-cancerous or early stage cancerous cells. Laboratory results are used to determine the need for further procedures.

Cap/crown: The portion of a tooth covered by enamel. Also a dental solution that covers the entire tooth and restores it to its original shape. Cap usually refers to a crown for a front tooth.

Cosmetic dentistry: Any dental treatment or repair that is done solely to improve the appearance of the teeth or mouth.

DDS: Doctor of Dental Surgery or DMD, Doctor of Dental Medicine. These are educational degrees given to dental school graduates. Some dental schools identify their graduates as DMDs, while other schools confer a DDS. The degrees are the same.

Dental hygienist: A dental professional specializing in cleaning teeth by removing plaque, calculus and diseased gum tissue. The dental hygienist acts as the patient's guide in establishing a proper oral hygiene program.

Denture: A removable appliance used to replace teeth. A complete denture replaces all of the upper teeth and/or all the lower teeth.

Enamel: The hard, calcified (mineralized) portion of the tooth that covers the crown. Enamel is the hardest substance in the body.

Filling: Material used to fill a cavity or replace part of a tooth. Can be composite (tooth colored plastic resin or porcelain) or amalgam (metallic).

Fluoride: A chemical compound used to prevent dental decay, used in fluoridated water systems and/or applied directly to the teeth.

Gingivitis: An inflammation or infection of the gingiva (gum tissue); the initial stage of gum disease

Impacted tooth: An unerupted or partially erupted tooth that's positioned against another tooth, bone or soft tissue so that complete eruption (reaching its normal position) is unlikely.

Implant: An artificial device, usually made of a metal alloy or ceramic material, which is placed within the jawbone as a means to attach an artificial crown, denture or bridge.

Local anesthetic: An injection given in the mouth to numb the areas where a tooth or area needs a dental procedure. Often referred to as Novocain.

Molars: The broad, multicusped back teeth, used for grinding food. Molars are the largest teeth in the mouth. In adults there are 12 molars (including the four wisdom teeth, or third molars), three on each side of the upper and lower jaws.

Oral surgery: The removal of teeth and the repair and treatment of other oral problems, such as tumors and fractures.

Orthodontics: A specialized branch of dentistry that corrects the misalignment of teeth and restores the teeth to proper alignment and function. There are several different types of appliances used in orthodontics, one of which is commonly referred to as braces.

Overbite: A condition in which the upper teeth excessively overlap the lower teeth when the jaw is closed. Dentists can correct overbites with orthodontics.

Panorex: An extraoral full-mouth X-ray that records the teeth and the upper and lower jaws on one film.

Periodontal disease: The inflammation and infection of gums, ligaments, bone and other tissues surrounding the teeth. Gingivitis and periodontitis are the two main forms of periodontal disease. Also called gum disease or pyorrhea.

Plaque: A film of sticky material containing saliva, food particles and bacteria that attaches to the tooth surface both above and below the gum line. When left on the tooth, plaque can promote gum disease and tooth decay.

Preventive treatment: Any action taken by the patient, assisted by the dentist, hygienist and the office staff that serves to prevent dental or other disease. Sealants, cleanings and space maintainers are examples of preventive treatment.

Quadrant: The dental term for the division of the jaws into four parts, beginning at the midline of the arch and extending toward the last tooth in the back of the mouth. There are four quadrants in the mouth. Each quadrant generally contains five to eight teeth.

Retainer: A removable dental appliance, usually used in orthodontics, that maintains space between teeth or holds teeth in a fixed position until the bone solidifies around them.

Root canal: The hollow part of the tooth's root. It runs from the tip of the root into the pulp.

Root planning: The process of scaling and planning exposed root surfaces to remove all calculus, plaque and infected tissue.

Sealant: A composite material used to seal the decay-prone pits, fissures and grooves of children's teeth to prevent decay.

Temporomandibular joint (TMJ): The connecting hinge mechanism between the upper jaw and the base of the skull.

Temporomandibular joint (TMJ) syndrome: The problems associated with TMJ, usually involving pain or discomfort in the joints and ligaments that attach the lower jaw to the skull or in the muscles used for chewing.

Treatment plan: In dentistry, a list of the work the dentist proposes to perform on a patient based on the results of the dentist's X-rays, examination and diagnosis. Dentists often present more than one treatment plan to give the patient options.

Usual, customary or reasonable (UCR): The amount paid to a health care professional for a service based on the typical charges for that service within a specific geographical area.

Veneer: An artificial filling material, usually plastic, composite or porcelain, used to provide an aesthetic covering over the visible surface of a tooth. Most often used on front teeth.

Wisdom teeth: The last of the three molar teeth, also called third molars. There are four third molars, two in the lower jaw and two in the upper jaw, one on each side. Some people are born without third molars.