Common terms and acronyms associated with Labor Management Benefits Committee (LMBC)

ACA – Affordable Care Act, enacted in 2010. Employers with 50 or more employees must offer coverage which meets a minimum value and affordability standard.

Annual Open Enrollment – The annual period in which employees can make changes to their benefit elections, add/drop dependents, etc. without experiencing a qualified event. This period typically runs for 2-3 weeks and starts in May. Changes made within this enrollment period are effective July 1. See qualified status change/qualified life event definition for options outside of the annual open enrollment period.

ASO – Administrative Services Only. Under the City's self-funded plans, we fund/pay our own claims but hire a third-party administrator to process claims and provide customer service related to claims payment. The City receives invoices from the ASO vendors and we send money to release claims payments to providers. This keeps protected medical information outside of the City's benefit office.

CAL – Current Appropriation Level. CAL Target is the extrapolation of a bureau's current discretionary and overhead budget to the budget year. The CAL Target is determined by taking a bureau's current revised budget, subtracting out one-time expenses, and applying City Consumer Price Index (CPI) inflation factors.

CBO – City Budget Office

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985. A federal law which allows plan participants to continue healthcare coverage with their employer after a qualified loss of coverage for a period of time and at their own cost. For example, if an employee leaves City employment, they may have access to 18 months of continued coverage if they pay the full cost of the premium.

COE – Center of excellence. A team, a shared facility, or an entity that provides leadership, best practices, research, support, or training for a focus area.

Coinsurance – The percentage of costs you pay for covered health care services after you've paid your deductible.

Copayment – A copayment, or copay, is a pre-determined flat dollar amount you pay each time you have a specified health care service. For example, Kaiser requires that you pay a $10 copayment for each primary care office visit, regardless of the type or level of services provided during the visit.

Covered Expenses – Expenses that are eligible for reimbursement under a plan. The amount of reimbursement depends on the Plan's provisions.

Deductible – The amount of covered expenses you must pay each year before a plan begins to contribute toward expenses. At the City, the deductible is an annual amount you must meet each plan year. You pay the full cost of services until you reach the deductible amount, but in some situations, only a copay is required (and you do not need to meet the deductible first); see each plan description for details.

EAP – Employee Assistance Program. Free, confidential, short-term counseling services offered to employees and their dependents. Additional services such as legal and financial consultation, work-life assistance and crisis intervention services may also be provided by EAP. Services are provided by an outside vendor partner and the City pays a per employee, per month (PEPM) for coverage.

Emergency Services – Emergency medical services transport as well as health care items and services furnished in an emergency department of a hospital, including all ancillary services routinely available to the emergency department (to the extent they are required for the stabilization of a member, performed within the capabilities of the staff and facilities available at the hospital, when such further medical examination and treatment are required to stabilize a member).

Exclusions – Medical services that are not covered by the health plan.

FSA – Flexible Spending Account. City offers a healthcare FSA and dependent care FSA. Both plans allow employees to elect an annual amount they want deducted, pre-tax, from their paycheck to help pay for qualified expenses for themselves and IRS tax dependents. Healthcare FSA qualified expenses include out of pocket costs (not fully covered by healthcare coverage) such as copays, deductibles, coinsurance, and other IRS eligible expenses. Dependent care FSA qualified expenses include daycare coverage for tax dependents and other IRS eligible expenses.

Fully-insured Medical Plan – A health plan purchased by an employer directly from an insurance company. Kaiser is an example of a fully-insured medical plan where the City and employees are charged the full cost of the annually set premium.

HIPAA – Health Insurance Portability and Accountability Act of 1996. This law protects an individual's personal health information, among other things. See the *Important Notices* section of this SPD for more details.

HMO – Health Maintenance Organization. A type of health insurance plan that generally limits coverage to care from providers who work for or contract with the HMO. This type of plan may require you to reside in its service area to be eligible for coverage.

HRA – Health Reimbursement Account or Health Reimbursement Arrangement. Mechanism which allows employers to reimburse employees and eligible dependents for qualified medical expenses. Also allows for balances to carry over from year to year.

IBNR/IBNP – Incurred but not reported, incurred but not paid. These terms are used interchangeably and are commonly seen when Aon, benefits consultant, presents information to the LMBC. IBNR accounts for claims which have transpired but the costs have not yet hit the health plan/insurer. The City's self-funded plans must include IBNR/IBNP in the reserve calculation to ensure these amounts are accounted for and the plan has sufficient funds to cover future claims.

In-network – A group of providers (physicians, dentists, other health care professionals) or health care facilities that contract with a health plan to offer services at negotiated rates.

LMBC – Labor Management Benefits Committee. Currently 20 members, with half represented by Labor appointment members and the other half appointment by Management. Committee is responsible for making plan recommendations which get presented to City Council for official approval annually.

Maximum Plan Allowance (MPA) – The maximum amount that the Plan will reimburse providers under the CityCore medical plan. For an *in-network provider*, the MPA is the amount the provider has agreed to accept for a particular service.

MHPAEA – Mental Health Parity and Addiction Equity Act of 2008, including later additions. This federal law prevents health plans from treating mental health and addiction differently than other medical services.

MSK – Musculoskeletal. Referring to the body's muscles, bones, joints, and connective tissues.

Out-of-Network – Physicians, hospitals and other health care providers and facilities that do not have an agreement with the plan to charge members discounted rates—these providers do not participate in a plan's network. Expenses incurred for services provided by out-of-network health professionals may not be covered (Kaiser), or may only be partially covered after a higher deductible and coinsurance (CityCore plans). You pay more when you use out-of-network providers.

Out-of-Pocket Maximum – The maximum amount you pay out-of-pocket every plan year; generally, this includes the deductible, coinsurance and copays related to medical coverage. Certain plans may also include pharmacy costs in the overall plan's out-of-pocket maximum. If you obtain both network benefits and non-network services, two separate out-of-pocket maximums apply. If you reach the out-of-pocket maximum in a plan year, the plan will pay 100% of eligible expenses for the remainder of the plan year.

PCP – Primary care physician or provider. A physician or provider who coordinates or helps a patient access a range of healthcare services. Some plans may require designation of a PCP for lower cost services.

PEPM/PMPM – Per employee per month, per member per month. This term is used when referring to costs the City pays for participants on a monthly basis.

Plan Design – Components that make up a medical plan, such as us copays, deductible, out of pocket maximums.

Plan Year – The plan year for the City's benefit plans is July 1 through June 30.

PPO – Preferred Provider Organization – Offers a contracted network of providers you can use for your medical care. It also allows you to seek medical care from out of network providers, typically at a higher out of pocket cost to you. The City offers self-insured PPO medical plans, see "self-insured medical plan".

Premium – The amount you pay for coverage each month. Also called a "contribution" or "premium share." Most full-time employees pay 5% of the total premium and the City pays 95%. COBRA/Retirees pay 100%.

Preventive Care Initiative – Non-represented employee's and employee's covered under a collective bargaining agreement enrolled in CityCore, CityNet or a Kaiser medical plan will be asked to seek a preventive health care screening at least once during a two (2) calendar year period to maintain the City's contribution level of 95% for full-time employees.

Qualified Status Change/Qualified Life Event – A change in your situation, such as marriage or birth of child, which make you eligible for a special enrollment period, allowing you to enroll in health insurance outside of the benefits annual open enrollment period. For example, if you report a birth event within 60 days of the date of birth, your new dependent can be added to your existing coverage. There may be additional opportunities such as FSA and life insurance.

RBC – Risk Based Capital. Formula used by the National Association of Insurance Commissioners to calculate a target capital level based on factors that reflect the level of financial risks faced by an organization. This formula utilizes key factors (underwriting/pricing risk, business risk, asset risk, and credit risk) which affect the level of uncertainty within a plan.

Renewal – Period of time in reviewing and revising components of benefits; restarting the benefit plan year.

Reserves – Also referred to as contingency reserves. Self-funded health plans set aside funds to absorb financial strain as a result of adverse scenarios. The primary reason for reserves is to pay active claims and provide sufficient funds to cover Incurred But Not Paid claims. The amount needed in the reserves is dependent upon the plan size, stop loss limits, and historical data related to large claims. At the City's current stop loss level of $1.2M, it is actuarily recommended to have 150% of the Risk Based Capital as a healthy reserve level. Amounts above 175% should be used to buy-down future rate increases and amounts below 125% should prompt the City to build up reserve levels over 1-2 years.

Self-insured Medical Plan – Claims are paid by the employer instead of by an insurance company in a self-insured plan. The CityCore and CityHD plans are self-insured. This means the City pays a third party administrator (currently Moda Health) to administer the plans and the City pays the costs (claims costs plus administration) directly out of the City's health fund.

Stop Loss – May also be referred to as reinsurance. It's insurance for insurance. Stop loss protects self-funded plans against claims, per individual, over the plan's threshold (currently $1.2M). When a single claim reaches the stop loss threshold, the City's carrier pays amounts above this limit in exchange for a Per Employee Per Month fee.

Utilization – Access and usage of health care services.