My Insurance Benefits
Glossary of Terms and Definitions

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Version 1.0

My Insurance Benefits (Benefitplace™)

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Disclaimer

Some definitions are as defined by the federal *Bureau of Labor Statistics:* National Compensation Survey: Glossary of Employee Benefit Terms : U.S. Bureau of Labor Statistics (bls.gov) or *Healthcare.gov:* Glossary | HealthCare.gov

Version Control

The information contained within is documented jointly by Benefitfocus and ETF. Changes to this document are summarized in the table below.

Version	Describe reason for change, changes made and any other important items to note	Updates Made by	Date
1.0	Original Version, initial documentation release	Kari Navis, Karen Hinsdale	04/28/2025
1.1			
1.2			
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1. General Glossary of Terms & Definitions

Term	Definition
820 File	An 820 file, within the context of healthcare and electronic data interchange (EDI), is a transaction set used to transmit premium payment information from a plan sponsor (like an employer) to a health plan (insurance company). It provides details like payer and payee identification, bank account information, invoice numbers, adjustments, and payment amounts.
834 File	An 834 file refers to a benefit enrollment and maintenance protocol that must abide by HIPAA 5010 standards which dictate the standard file format for transmitting member data, benefit eligibility, dependent information, etc. It was developed by ANSI (American National Standards Institute) and used by many organizations to add, remove, or update member's enrollment information including new enrollments, dependent enrollments, adjustments to coverage, and termination.
Account Structure	Account structure includes the plans, carrier numbers, and offering that comprise how the account is built out within My Insurance Benefits (Benefitplace). See also Carrier Code, Carrier Identifier, Carrier Number.
ACORD/LIMRA File	The ACORN/LIMRA file type is an industry standard XML file that provides the means for carriers to transmit member demographic and benefit election information.
Active Enrollment	Active enrollment requires employees to choose an enrollment plan, regardless of their coverage from the previous year. If they do not elect benefits, they will receive only company provided plans, no coverage and/or the communicated default coverage depending on the organization's rules. See also Passive Enrollment.
Adjustment Deduction	Adjustment deductions are noted on the deduction file to communicate retros or refunds for a member or annuitant based on the timing of the change in coverage eligibility or qualifying life event. See also Retros.
Affordable Care Act (ACA)	The Affordable Care Act (ACA) law was enacted on March 23, 2010, and amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" refers to the final, amended version of the law. The law provides numerous rights and protections that make health coverage fairer and easier to understand, along with subsidies (through the "premium tax credit" and "cost-sharing reductions") to make it more affordable. The law also expands Medicaid to cover more people with low incomes.
Aggregate View	The aggregate view is an option in the HR Admin role that allows an HR Admin to see member information for all sponsors simultaneously, within their permission access.
Ancillary Benefits, Supplemental and/or Voluntary Benefits	Ancillary Benefits, Supplemental and/or Voluntary Benefits are terms that represent any benefit type other than major medical benefits such as dental, vision, life, disability benefits (short and long term) or other benefit programs that are either company provided and/or optionally selected (and paid for) by the employee.
Advanced Salary	Advanced salary is used as an alternate salary for salary-based benefits and rates.
Beneficiary	A beneficiary is a person or an organization that is designated by the policyholder to receive proceeds from a policy when the policyholder is deceased. The policyholder can name multiple persons and/or organizations as beneficiaries and designate allocation percentages for each beneficiary. Primary beneficiaries are the first to receive life

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	insurance proceeds if the policyholder passes away. Secondary beneficiaries receive proceeds if all primary beneficiaries are no longer eligible to receive benefits.
Benefit Detail Report (BDR)	The Benefit Detail Report (BDR) report shows cost and enrollment information for each covered person, including the option to display dependent information.
Benefit Element	A benefit element is used to group together one or more plans for a single benefit type. For example, an employer may offer a medical benefit that contains two medical plans – a PPO and an HMO. An eligible person can choose between these two plans. The plans included in a benefit element may or may not be offered by the same insurance carrier.
Benefit Offer	A benefit offering is a group of related benefit elements offered to an eligible person. In addition, benefit offerings include the following: Health Benefits, Life Benefits and Disability Benefits. Benefit dependency rules define how the benefit elements relate to each other.
Benefit Plan	A benefit plan is the actual product the carrier offers.
Billing Process	The billing process results in the creation of a sponsor specific invoice based on the data within My Insurance Benefits. It includes health and ICI related coverage charges and fees for all participating members and dependents through Certifi. This invoice is generated using the Certifi platform on a monthly basis and shows the premiums which need to be paid by the employer. The employer is responsible for deducting premiums and remitting payment to ETF on behalf of their employees. Within ETF, billing and invoicing can be used interchangeably. See also Certifi and Invoicing.
Business Configuration and Requirements Document (BCR)	The Business Configuration and Requirements Document (BCR) captures requirements for determining how the My Insurance Benefits (Benefitplace) platform should function to meet business needs. The BCR includes all carriers, plans, eligibility, and other details that are used to configure My Insurance Benefits (Benefitplace).
Business validations	Business validations ensure that the data and processes comply with business rules and requirements. These validations are aligned with the business logic and objectives, ensuring that the system operations adhere to established standards, policies, and regulations. Business validations often involve checking for compliance with industry standards, regulatory requirements, and internal policies.
Cancellation or Termination	The cancellation/termination end date rule determines which benefits will end following the employees' termination or cancellation without change reason or life event. Discontinuance of coverage for a subscriber member or dependent member
Carrier	A carrier is a large insurance organization (such as Blue Cross Blue Shield) that offers benefit programs to their various groups and members. The insurance carrier is the organization that Benefitfocus provides enrollment information to, and which provides coverage to the member and dependents.
Carrier Code, Carrier Identifier, Carrier Number	Carrier Code, Carrier Identifier or Carrier Number are defined as part of their account structure and is used to configure plans within My Insurance Benefits (Benefitplace). See also Account Structure.
Categories	Categories are employee groupings created on a per employer basis. Categories can be used to perform a variety of functions to meet an employer's organizational needs.

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	Understanding how categories function in the application is critical to understanding how benefits and enrollment rules are configured. Categories are a way of grouping employees for benefits assignment and/or billing purposes. Clients can use any category type they choose, but some common examples are Employee Status (Full Time, Part Time) and Location. A sponsor may have many categories. The employer can define the label for the category (called the Category Type) and the values for the category. Categories can be used in the following ways: Employee Benefit Eligibility, HR Administrator Permissions, Benefit Eligibility Rules, Open.
Census File	A census file contains only demographic information on the outbound file and is provided by the employer. It does not include benefit level information. For all ETF member organizations, ETA provides this information. See also Employer Transaction Application (ETA)
Certifi	Certifi is a component of the Insurance Administration System. It is a billing service contracted by Benefitfocus to generate monthly invoices for health and ICI premiums and fees for employers. Employers are responsible for reviewing and reconciling their invoice every month. See also Billing Process and Invoicing.
Change File	A change file provides the carrier with updates to only the member(s), whose enrollment, and/or demographic information has changed since the last time a full file was sent. The carrier will use this information to update their records as necessary.
Change Reason Profile (CRP)	A Change Reason Profile (CRP) is a collection of different life events. Benefit types that have the same rules across all life events within a CRP will be assigned the same CRP. If rules differ, then separate CRPs will be defined as needed. See also Qualifying Life Event (QLE).
Claim	A claim is a formal request by a policyholder to an insurance company for coverage.
Class	In My Benefits Place, the term class represents key criteria which determines how an employee is classified, and which may drive benefit eligibility and plan offers, i.e. Active / Retiree, Management / Non-Management, Salaried / Hourly, Active / COBRA, etc.
Closed-loop Payroll (CLP)	Closed-loop Payroll (CLP) allows a customer to compare benefit deductions from My Insurance Benefits (Benefitplace) against what was actually deducted for that benefit. The difference between the two creates a variance that can be applied to credit the employee or recoup lost premiums. *(Retiree & Inactive Only)*
COBRA (Consolidated Omnibus Budget Reconciliation Act)	Consolidated Omnibus Budget Reconciliation Act (COBRA) is Federal legislation that allows an individual, assuming they work for an insured employer group of 20 or more employees, to continue to purchase health insurance for up to 18 months if they lose their job or coverage is otherwise terminated. For more information, visit the Department of Labor. This term must always be capitalized.
COBRA Qualified Beneficiary	COBRA qualified beneficiary is an individual who is entitled to COBRA coverage because they were covered by a group health plan at least one day prior to experiencing a qualifying event.

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COBRA Qualifying Event	A COBRA qualifying event causes an individual to lose health coverage. There are seven types of qualifying events: • Termination (except in the cases of gross misconduct) • Reduction of hours • Death of employee • Divorce or legal separation from employee • Loss of dependent status • Medicare entitlement of employee • Employer bankruptcy
COBRA General Rights Notice (GRN)	A COBRA General Rights Notice (GRN) is a written summary of COBRA rights and obligations. This notice is provided to new plan participants within 90 days of when group health plan coverage first begins.
COBRA Specific Rights Notice (SRN)	Specific Rights Notice (SRN) is a written notice outlining COBRA rights and obligations, including election forms. SRNs must be provided to all qualified beneficiaries within 14 days of receiving notice of a qualifying event.
Combined Split Contract Deductions	Combined split contract deductions refers to health insurance deductions from two health plans for participants of the same family, which are combined leveraging the Retirement Administration System.
Coinsurance	Coinsurance is the percentage of the approved amount that a person is required to pay for covered health care services and/or prescription drugs. For example, the health plan may cover 80 percent, while the individual is required to pay 20 percent. Some plans require the individual to first pay the deductible before they are eligible to pay the plan copayment or coinsurance for covered healthcare services.
Consumer Directed Healthcare (CDH)	Consumer Directed Healthcare (CDH) engages the consumer with care decisions and corresponding financial consequences regardless of plan design, this includes things like Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA) See also Flexible Spending Accounts (FSA), Health Savings Accounts (HSA) and High Deductible Health Plan (HDHP).
Consumer Directed/Defined/ Driven Health Plan (CDHP)	Consumer Directed/Defined/ Driven Health Plan (CDHP) is a broad term incorporating several emerging healthcare strategies that heightens consumer awareness of the cost and use of healthcare services through plan design incentives.
Continuation of Benefits	Continuation of Benefits is a temporary extension of coverage under a plan for plan participants and certain family members for 18 or 36 months, at group rates. It is mandated for most employers to offer in situations where coverage for an employee might otherwise be terminated, such as with a voluntary or involuntary separation from employment, a reduction of hours worked, the death of an employee, or a divorce. The medical, dental, and the vision plans are all included under the continuation of benefits guidelines. However, individuals may continue only those plans in which he/she was enrolled on the date of the loss of eligibility.
Coordination of Benefits (COB)	Coordination of Benefits (COB) is a provision that applies to a person who is covered by more than one health plan. COB was established as a method by which two or more carriers or plans could coordinate their respective benefits to eliminate duplication of payment and assist patients to receive the maximum benefit to which they are entitled. It sets forth guidelines to determine which company will pay as primary insurer and

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	which will pay as secondary insurer when a working couple (or their dependents) have a claim that's covered by more than one group insurance policy. It states that in situations where double coverage exists, the insurer covering the employee who has the claim is automatically designated as the primary insurance company. The primary company must pay as much of the claim as its policy limits allow.
Copay	Copay is a set dollar amount an individual is required to pay for covered healthcare services and/or prescription drugs. For example, health insurance plan may require a $15 copayment for an office visit or brand-name prescription drug Some plans require the individual to first pay the deductible before they are allowed to pay the copayment or coinsurance for covered healthcare services.
Coverage Level	Coverage level (or tier) defines the family members that are covered under a health insurance policy, e.g., Employee only, Employee + Spouse, Employee + Child(ren), Employee + Family.
Critical Dates	Critical Dates are applied when a future dated update or action is needed according to the configuration, but no action is expected to be taken by the EE, HR, or BF admins to trigger the update.
Cybersecurity Event	Cybersecurity event is a violation or imminent threat of violation of computer security polices, acceptable use policies, or standard security practices. Events impact, or have the potential to impact, the confidentiality, availability, or integrity of computer systems and data.
Data Exchange Dashboard	The data exchange dashboard can be found on the tools and reporting tab in the HR administrator role. This tool shows clients exactly when their files are sending to carriers and gives them details of which members were sent.
Data validations	Data validations are technical checks to ensure the accuracy, completeness, and integrity of the data being entered or processed. These validations focus on the data format, data type, and data consistency, ensuring that the data conforms to predefined rules and constraints.
Deductible	The Deductible is the amount am individual owes for healthcare services before their health insurance or plan begins to pay. For example, if the deductible is $1,000, the plan won't pay anything until the individual has met the $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.
Deduction Based Payroll (DBP)	Deduction Based Payroll (DBP) is a process that when a member starts, changes, or ends their coverage, Benefitfocus calculates any retros and refunds that are need and sends those on the payroll file along with an ongoing deduction if needed. The employer can directly apply those amounts into their payroll system. *(UWHC and the Retiree & Inactive Only)*
Deduction Calendar	Deduction calendars define when payroll will deduct for enrolled benefits on a specific schedule.
Deduction Dashboard	The deduction dashboard is a tool within My Insurance Benefits. This dashboard is available to employers using Deduction-Based Payroll and allows them to update deductions on the upcoming deduction file. *(UWHC and the Retiree & Inactive Only)*
Deduction File	The deduction file is generated by My Insurance Benefits showing all new charges and adjustments. The deduction file includes three options: start, stop, and term. These

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	options indicate when a deduction starts, changes, or ends. Adjustments include retro charges or credits.
Deduction Hierarchy	ETF's deduction hierarchy determines the order deductions are taken from BPS so it's consistent for annuitants. It is necessary so multiple deductions are not applied at the same time when the annuity is not large enough to cover all deductions. The hierarchy flows in order of life, supplemental dental, vision, and health. Public Safety Officers Program deductions are also the last priority of the hierarchy although they are not related to the Insurance Administration System.
Deduction Types	Deduction types are included on the deduction file from My Insurance Benefits. There may be several line items that can roll up into a deduction. For example, Medical, Pharmacy, and Wellness Program are deduction types which contribute to health insurance.
Deferred Medicare	Deferred Medicare is the practice of delayed enrollment in Medicare because a person has other health coverage, such as through their employment. This can include delaying Part B of Medicare. When the person retires and they are 65 or older, they are advised to sign up for Medicare. A person must have creditable drug coverage to avoid paying a Part D late enrollment penalty.
Defined Contribution	Your employer may contribute a fixed amount of money, also called a defined contribution that you can apply toward your benefits. If your employer uses a defined contribution strategy, you will see the amount your employer is contributing toward you benefits in the *Shopping Cart*. Defined contributions work much like a gift card. Your employer contributes a specified amount toward your benefits, and each time you select a benefit, that amount is reduced from the total amount in your cart.
Dependent	A dependent is a member who is not the primary contract holder for coverage provided by an insurance carrier. Examples include the contract holder's spouse and/or children.
Dependent Verification	Dependent verification is an industry standard practice of requiring a member or annuitant to provide documentation to verify that a dependent is eligible for benefits. The types of documents can include birth certificates, marriage certificates, divorce decrees, etc. See also Document Verification Process.
Direct Bill	A direct bill is an invoice sent directly from an insurance carrier to the member who is responsible for paying the carrier directly.
Document Verification Process	Document verification is the process of reviewing member submitted documents against approved ETF standard approved document types to ensure the documents support enrolling or removing a dependent from coverage. See also Dependent Verification.
Dual Enrollment	Dual Enrollment is an election period where you are eligible to make elections or updates for two participation periods.
Dual Employment	Dual Employment is when a person is employed with two different WRS employers and may be offered benefits through both.
Effective Date	Effective Date is when benefits start for a member. Based on group setup, this can be updated when a coverage level change is made. Some carriers also have a transaction effective date, which includes the effective date of a termination as well.

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Electronic Data Interchange (EDI)	Electronic Data Interchange (EDI) is a set of standards for structuring information that is to be electronically exchanged between and within businesses, organizations, government entities and other groups. The standards describe structures that emulate documents, for example purchase orders to automate purchasing. The term EDI is also used to refer to the implementation and operation of systems and processes for creating, transmitting, and receiving EDI documents.
Emancipated Dependent	Emancipated dependent is when an individual is covered as a dependent on an active benefit and loses coverage due to a COBRA-qualifying event, that individual is eligible to enroll in COBRA. If the employee under which the dependent was covered is still covered under the active benefit, the canceled dependent is eligible to become the subscriber on his own COBRA policy. In this case, the individual is referred to as an emancipated dependent. Scenarios in which an emancipated dependent may be recognized are spouse dropped from coverage in a divorce, child who loses eligibility due to an age-out, or the family of an employee who is deceased.
Employee	The employee is the subscriber/policy holder. This is the person with the direct employment relationship with the company offering the benefits.
Employee Assistance Programs (EAPs)	Employee Assistance Programs (EAPs) programs provide structured plans, closely related to employee wellness programs, which typically deal with more serious personal problems than the essentially medical problems covered by wellness programs. EAPs can offer referral services, or referral services in combination with counseling services. Both the referral services and the counseling services may be supplied by company personnel, by an outside organization under contract, or by a combination of both.
Employee Detail Report (EDR)	The Employee Detail Report (EDR) is one of the most frequently accessed reports and displays comprehensive information specified for employees during the enrollment process. The report gives the employee a comprehensive report that includes the details specified for this employee during the enrollment process. Employers can choose whether they want to display employer contributions.
Employer Payment Application (EPA)	Employer Payment Application (EPA) is the tool employers will use to pay their invoice to ETF for health and income continuation insurance (ICI). Employers will continue to pay carriers directly for supplemental and life benefits. The tool connects with U.S. Bank's ePay application.
Employer Transaction Application (ETA)	Employer Transaction Application (ETA) allows employers to enter and update their employee data in two ways: through a file or via a user interface. Employers will use the ETA for insurance.
Enrollee	Enrollee, participant, member, subscribers, and dependents, all refer to people who are related to the Employee and/or are eligible for coverage and/or actively enrolled in coverage.
Enrollment Based Payroll (EBP)	Enrollment Based Payroll (EBP) is the process whereby, when a member starts, changes, or ends their coverage, the effective dates of those changes will be included on the payroll file. The employer will use those dates to calculate the appropriate amount of premiums that should be retroactively charged or refunded to a member, as well as the ongoing deduction amounts.
Enrollment Periods	Enrollment periods are pre-determined time spans during which you are allowed to perform certain tasks and functions in reference to your benefits.
ePay	ePay is the secure application employers will use to complete their payment to ETF. ePay is operated by US Bank.
Evidence of Insurability (EOI)	Evidence of Insurability (EOI) or SOH (statement of health) may be required for any amount over the guaranteed issue (GI). EOI typically includes a health questionnaire and/or physical examination done by a primary care physician. Based on the

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	questionnaire and/or physical examination, the insurer will approve or deny the request coverage amount. See also Guaranteed Issue (GI).
Exclusive Provider Organization (EPO)	Exclusive Provider Organization (EPO) is a type of plan that requires employees to use only the plan's providers in order to receive coverage.
Family and Medical Leave Act of 1993 (FMLA)	The Family and Medical Leave Act of 1993 (FMLA) is a labor law requiring larger employers to provide employees unpaid leave for serious health conditions, to care for a sick family member, or to care for a newborn or adopted child.
Flexible Benefit Plans	Flexible benefit plans are also known as cafeteria benefit plans. They are operated under provisions of Section 125 of the Internal Revenue Code. Section 125 allows employees to make a choice between cash (taxable) and noncash (nontaxable) benefits. The code permits companies providing flexible benefit plans to offer employees the following options: accident and health insurance plans, including healthcare spending accounts; group term life insurance and dependent coverage; disability benefits and accidental death and dismemberment plans; employee contributions to 401(k) plans or other thrift or savings plans (either pre-tax or after tax); dependent care assistance plans, including spending accounts; vacation days; and group legal services. Flexible benefit plans may be funded solely by the employer or through joint employer-employee contributions. Employers usually grant each employee credits to purchase benefits covered by the plan. Many plans include a core group of benefits (for example, life insurance coverage of $25,000) and allow employees to purchase additional levels of the core benefit as well as benefits not included in the core group. An example is the employer's offering an additional $20,000 in life insurance coverage.
Flexible Spending Account (FSA)	Flexible Spending Account (FSA) is an arrangement set up through the employer to pay for many out-of-pocket healthcare (medical, dental, vision, prescription drug, or other IRS approved expenses), dependent care and/or commuter expenses with tax-free dollars. These expenses can include things like insurance copayments and deductibles, and qualified prescription drugs, insulin and medical devices or daycare and parking fees. The individual decides how much of their pre-tax wages they want taken out of their paycheck and put into an FSA. The employer's plan sets a limit on the amount that can be contributed into an FSA each year. FSA funds not spent by the end of the plan year can't be used for expenses in the next year, unless the employer's FSA plan permits a grace period. This would permit funds to be used for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year. Note: Flexible Spending Accounts are sometimes called Flexible Spending Arrangements. See also Consumer Directed Healthcare (CDH) and Health Savings Account (HSA).
Formulary drugs	Formulary drugs are both generic and brand-name drugs approved by the healthcare provider. Drugs not approved by the healthcare provider are nonformulary drugs, for which enrollees receive less generous benefits, such as a higher copayment per prescription.
Full File	A full file provides the carrier with all member information every time the file is sent. The carrier will use this information to update their records as necessary.
Generic drugs	Generic drugs are drugs that are not under any patents. Once a drug's patent has expired, some plans provide more generous coverage for same-formula generic drugs

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	than for name-brand drugs; the practice is adopted as a cost containment measure.
Guaranteed Issue (GI)	Guaranteed Issue (GI) is the minimum, default amount of coverage that an employee can receive for life insurance benefits, generally. If an employee elects a coverage amount larger than the GI amount, then the employee is typically required to complete a Statement of Health (SOH) or Evidence of Insurability (EOI) to request coverage. The life insurer can decline to cover the employee for the amount over the GI. See also Evidence of Insurability.
Health Maintenance Organizations (HMOs)	Health Maintenance Organizations (HMOs) both insure and deliver health care. HMOs pay the cost of health care and hire or contract with health care providers to give the care. Those enrolled in an HMO prepay the cost of health care and obtain coverage only from providers affiliated with the HMO. Because the cost is largely prepaid, HMOs are not indemnity plans. Those enrolled in an HMO pay only nominal additional co-payment costs when receiving health care. HMOs therefore tend to emphasize preventive care to hold down the cost.
Health Reimbursement Account (HRA)	Health Reimbursement Account (HRA) is a specific type of fund account that can be combined with a healthcare plan to allow an individual to be reimbursed for approved out-of-pocket medical expenses. Employers allocate a set amount of money to the employee's account, and they can use this money to pay for their eligible medical expenses. The employer funds and owns the account.
Health Savings Account (HSA)	Health Savings Account (HSA) allow members to pay for qualified medical expenses with pre-tax dollars—meaning income-tax free—and save for retirement on a tax-deferred basis. HSAs are portable, able to earn interest and are eligible for rollover contributions. The HSA must be paired with a high-deductible health plan. Employees use the account to pay for qualified medical costs or save for future health expenses. Contributions are tax advantaged. Earnings and distributions for qualified medical expenses are tax-free. Withdrawals for non-medical expenses are treated very similarly to those in an IRA account in that they may provide tax advantages if taken after retirement age, and they incur penalties if taken earlier. See also Consumer Directed Healthcare (CDH), Flexible Spending Account (FSA) and High Deductible Health Plan (HDHP).
High Deductible Health Plan (HDHP)	A High Deductible Health Plan (HDHP) is a health insurance plan that has a high minimum deductible that does not cover the initial costs or all of the costs of medical expenses. Participating is an HDHP is a requirement for Health Savings Accounts (HSA) contributions. See also Consumer Directed Healthcare (CDH) and Health Savings Account (HSA).
History of Changes Report (HOC)	History of Changes Report (HOC) can be access by HR Administrators for an employee at any time. When creating the detailed report, users can display the changes to specific categories of information, such as personal (changes to address, personal e-mail, etc.), work (salary changes, work phone number, etc.) and carrier identifiers (billing number, account number, group number, etc.). Users can also customize the report to changes to one or more benefits.
HR Administrator	HR Administrator refers to anyone who is responsible for reviewing and/or executing certain processes within the platform and/or using information from the platform to validate, update, or execute work activities outside of the benefits platform. This could include HR Generalists, Payroll Analysts, Benefits Specialists, etc. The platform refers to all

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	administrators as Benefits Administrator as a generic naming convention that encompasses all roles and responsibilities.
Identity Proofing - Document Verification Process	The document verification process is the identity proofing process which a limited number of members will go through to further verify they are who they say they are as they login to My Benefits (the member portal) to reach My Insurance Benefits (Benefitplace). The process works involves a member taking a "selfie" and providing a picture of a physical ID, such as a driver's license. See also Socure, Identity Proofing and Referee Process.
Identity Proofing	Identity proofing is a process used to confirm members are who they say they are when they log into My Benefits (the portal) to reach My Insurance Benefits (Benefitplace). The initial process involves the member providing demographic information through an electronic form. See also Socure, Identify Proofing – Document Verification and Referee Process.
IMAX File	The iMax file is a daily file exchange used to communicate demographic and enrollment data across systems employers to the My Insurance Benefits platform. It is an XML file with UTF8 encoding.
Imputed Income	Imputed income works on the principle of adding value to cash or non-cash employee compensation to properly withhold employment and income taxes from wages. In other words, *Imputed income is the value of a service or benefit provided by employers to employees, which must be treated as income*. Unless specifically exempt, imputed income is taxed.
Individual Coverage Health Reimbursement Arrangement (ICHRA)	Individual Coverage Health Reimbursement Arrangement (ICHRA) is a company-funded health benefit where employers reimburse employees with pre-tax dollars through an HRA. These dollars help cover the cost of individual health insurance premiums and qualified medical expenses.
Initial Contribution	Initial or one-time contributions that are applied to the first available paycheck after the initial eligibility or open enrollment period.
Initial Enrollment, New Hire or Newly Eligible Enrollment	Initial Enrollment, New Hire or Newly Eligible Enrollment is a designated period of time in which newly hired, or newly eligible employees can make their initial benefit elections. The initial eligibility enrollment period may include a wait period.
In-network	In-network healthcare providers (e.g., specialists, hospitals, laboratories) have accepted contracted rates with the insurer. The insured person typically pays a lower price for using services within the network.
Integrated EOI	Integrated EOI providers permit the member to SSO over to the carrier's website to complete their EOI form.
Internal Limits	An internal limit applies to individual categories of care-for example, a $250-per-procedure deductible for inpatient surgery.
Interunit Billing	Interunit Billing is the payment method for the STAR sponsor group to pay their health and ICI invoice. The process is managed by DOA with STAR Finance to bill each agency their portion of the health and ICI premiums, and the payment to ETF is an accounting transaction rather than a billing transaction.
Invoicing Process	The invoicing process results in the creation of a sponsor specific invoice based on the data within My Insurance Benefits. It includes health and ICI related coverage charges and fees for all participating members and dependents through Certifi. This invoice is generated using the Certifi platform on a monthly basis and shows the premiums which

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	need to be paid by the employer. The employer is responsible for deducting premiums and remitting payment to ETF on behalf of their employees. Within ETF, billing and invoicing can be used interchangeably. See also Certifi and Billing Process.
Life Insurance	Life Insurance provides a lump-sum payment to a designated beneficiary or beneficiaries of a deceased employee. Companies may provide a basic amount of life insurance benefits, which may vary with an employee's age, income, and occupation. Companies also may allow employees to pay for additional amounts of coverage.
Long Term Care (LTC) Insurance	Long Term Care (LTC) Insurance provides long-term (more than 1 year) custodial care, home care, and nursing home care. Coverage may be extended to active employees, retirees, parents of active employees, and dependents of active employees and retirees. Premiums are generally, though not necessarily, paid by employees. These plans are separate from coverage for extended care facilities and home healthcare found in health insurance plans that provide post-hospitalization benefits for a limited period.
Long Term Disability (LTD)	Long-term disability (LTD) insurance pays a percentage of your salary, usually 50 to 60 percent, depending on the policy, once the short-term (STD) benefits expire (generally after three to six months). The benefits last until you can go back to work or for the number of years stated in the policy.
Mail-order drugs	Mail-order drugs are drugs that can be ordered through the mail. As a cost containment measure, some plans use mail-order pharmacies that typically provide a 3-month supply of maintenance drugs.
MCC File (Miscellaneous Changes and Credit File)	MCC File (Miscellaneous Changes and Credit File) is created by ETF and is used to provide retroactive adjustment transactions prior to the billing start date.
Medicaid	Medicaid is a health care program that assists low-income families or individuals in paying for long-term medical and custodial care costs. Medicaid is a joint program, funded primarily by the federal government and run at the state level, where coverage may vary.
Medical Expenditure Panel Survey (MEPS)	The Medical Expenditure Panel Survey (MEPS) is a set of large-scale surveys of families and individuals, their medical providers and employers across the United States. MEPS is the most complete source of data on the cost and use of health care and health insurance coverage.
Medicare	Medicare is a federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD) • Part A: (synonym hospital insurance): is administered directly by the federal government, is the way most people get their Medicare. Part A (Hospital Insurance) covers most medically necessary hospital, skilled nursing facility, home health, and hospice care. • Part B: (synonym medical insurance): Covers services and supplies that are medically necessary to treat your health condition. This can include outpatient care, preventive services, ambulance services, and durable medical equipment.

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	• Part C: (synonym Medicare Advantage (MA)): The part of Medicare policy that allows private health insurance companies to provide Medicare benefits. These Medicare private health plans, such as HMOs and PPOs. • Part D: (synonym prescription coverage): A United States federal-government program to subsidize the costs of prescription drugs and prescription drug insurance premiums for Medicare beneficiaries.
Medicare Dates	Medicare start date is three months after the month an individual turns 65. The Initial Enrollment Period lasts for seven months, starting three months before an individual turns 65. If the individual misses their seven month Initial Enrollment Period, they may have to wait to sign up and pay a monthly late enrollment penalty for as long as they have Part B coverage. Open enrollment for Medicare generally ends in early December.
Member	A member is a person that is covered for a benefit. The member may be an employee, a dependent child, the spouse of a terminated employee, the dependent of an employee that is no longer living, etc.
Most Generous Coverage	Insurers may offer tiered networks and provide the insured person with the most-generous coverage, lowest costs, for using the preferred provider(s). The insured person may also receive services from the other in-network providers.
My Benefits	My Benefits is the portal through which members and employers will access online ETF applications and systems, including My Insurance Benefits. In the future, members will also access My Pension Benefits through My Benefits.
MyWisconsin ID	MyWisconsin ID is the State of Wisconsin's identity solution that allows citizens the ability to securely access participating online state services and systems using a single user ID and password. The tool used in creating MyWisconsin ID is Okta. See also Okta.
Name Brand Drugs	Name brand drugs are drugs that once were, or still are, under patents.
New Hire Rules	New Hire Rules determine the initial eligibility enrollment period (initial enrollment) or designated period in which newly hired employees can make their initial benefit elections. The initial eligibility enrollment period consists of the wait period plus the extended enrollment period. Typically, when newly hired employees do not make elections during the initial eligibility period, they are considered late enrollees unless they are added with a qualifying change reason. New Hire Rules can be configured by plan, benefit, category, hire/other date or one value for all. There are 3 main components of New Hire Rules: • Wait Period – The amount of time that a new employee must wait before their benefits will become effective. • Effective Date Rule – The day of the month that benefits are effective once the wait period has been satisfied. • Grace Period – The span of time in which a new employee can elect benefits before they are considered late.
Off-cycle Enrollment Period	Off-cycle Enrollment Period applies when employees are not in an initial, open, or special enrollment period.
Okta	Okta is a tool the State of Wisconsin uses to create MyWisconin ID and provision member user accounts (email addresses connected to passwords), as the first step to login to My Benefits (the portal) to reach My Insurance Benefits (Benefitplace). See also MyWisconsin ID
Ongoing Deductions	Ongoing deductions are noted on the deduction file to communicate routine starts and stops of payment deductions for a member or annuitant.

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Open Enrollment (OE) and/or Annual Enrollment (AE)	Open Enrollment (OE) and/or Annual Enrollment (AE) is the designated period of time that generally occurs once a year, during which employees can make benefit election changes without using a life event. Open Enrollment periods typically apply to health benefits but can occur for all types of benefits. Various entrant rules apply. Coverage effective date is the beginning of the plan year. This is also referred to as Annual Enrollment. Open Enrollment periods typically apply to health benefits rather than life benefits. The application separates employees' current elections from their open enrollment elections, which allows Benefitfocus to continue to transmit updates to the current year's elections while the employer is in open enrollment. While updates to the current year's benefits are sent daily, open enrollment transactions are typically held until the end of the period so that they can be transmitted to the carrier in one large file.
Open Enrollment (OE) Insights	OE (Open Enrollment) Insights will be available on the lower right-hand side of the main landing page in the HR Administrator role. These insights include: • Enrollment activity by day • Total participation by benefit, benchmarked against current participation and the My Insurance Benefits (Benefitplace) standard • Actions taken by the Admin to support Open Enrollment • Metrics to measure utilization of decision support tools, such as Cost Estimator and Recommendations, and mobile These insights will enable HR Administrators to drive increased benefit enrollment participation as well as report on key utilization metrics.
Out of Pocket Maximum (OOPM)	Out of Pocket Maximum (OOPM) is the total amount that a member will have to pay towards medical services during a plan year. When this amount has been reached, the insurance carrier/plan will pay 100% of all remaining costs of medical services accrued during that plan year. This restarts every plan year.
Out Of Network (OON)	Out Of Network (OON) services and/or healthcare providers do not have contracted rates with the insurance carrier resulting in a higher cost to the insured person.
Participation Period or Plan Year	Participation Period or Plan Year is the timeframe for benefit to be in effect. A 12-month period of benefits coverage under an insurance plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your policy documents or contact your insurer.
Passive Enrollment	Passive enrollment allows employees to roll over their benefits from the previous year, without requiring them to assess their plan options or learn more about their benefits. Note: Contributory benefits are not plan mapped - for example: HFSA, DCFSA, HSA, Parking or Transportation.
Payment Based Deliverables	Payment Based Deliverables are high-level deliverables used for payment based on meeting goals outlined in the IAS contract.
Payroll Reconciliation File	The payroll reconciliation file is created by ETF to compare deductions calculated by My Insurance Benefits to the deductions that occurred in the payroll systems. It automatically creates future paycheck adjustments based on the variances detected. At scale, this feature helps reduce premium leakage and administrative burden.
Person OID	The member's person OID is a unique id that is specific to them within My Benefit Place. It displays in the top left corner of the member record and can be used to look up the member up in the database.
Point of Service (POS) Plan	Point of Service (POS) Plan is a type of plan that provides services through a network of participating healthcare providers. Services received within the network or through select

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	medical facilities generally provide more generous benefits than services received outside the network.
Pre-Go-Live Retros	Pre-Go-Live Retros represent a temporary challenge in conversion to IAS. A retro adjustment that is entered after go-live (7/1/2025) with a coverage effective date before go-live will need to follow a specific process because Certifi invoicing is not available prior to go live.
Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO) is a type of plan which provides coverage through a network of participating healthcare providers. Enrollees may receive services outside the network, but generally at higher costs. The additional costs may be in the form of higher deductibles, higher coinsurance rates, or both, or in the form of non-discounted charges from providers.
Premium	Premium is the amount a member pays to have the access to the insurance; typically, this is what is deducted from the employee's paycheck. This amount does NOT go towards the cost of medical treatment/services. This can change from plan year to plan year.
Preventive Services	Preventive Services are routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.
Primary Care Provider (PCP)	Primary Care Provider (PCP) is a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.
Qualifying Life Event (QLE)	A Qualifying Life Event (QLE) is a change in a member's situation — like getting married, having a baby, or losing health coverage — that can make the member eligible for a special enrollment period and allows the member to enroll in an insurance benefit outside the initial or open enrollment periods.
Qualifying Life Event Companion Guide	The Qualifying Life Event Companion Guide documents the change reason profile (CRP) that determines which set of life event rules will be used for the benefit element. For every benefit element, a profile must be selected to determine which set of life event rules are in effect. Each profile can support different life events and rules for how life events are enforced within the system. When members are off cycle (outside of their initial enrollment grace period or open enrollment), a list of qualifying life event is configured to govern when the member is eligible to make changes to benefits. The change reason profile is associated per benefit and contains all possible life events, and the permitted actions and date rules of each. See also Qualified Life Event. See also Change Reason Profile (CRP).
Rate Sheet	Rate Sheet is the documentation that explains how rates are calculated based on the total premium as well as the member and employer contribution split, if appropriate.
Referee Process	The Referee Process is an identity proofing process used to verify a member is who they say they are login to My Benefits (the portal) to reach My Insurance Benefits (Benefitplace) when they cannot succeed using the Socure identity proofing tool. This process involves interaction with an ETF Team Member. See also Socure, Idenfity Proofing – Document Verification, and Identity Proofing.

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Retirement Administration System (RAS)	Retirement Administration System (RAS) is an ETF application that Employer Services Bureau staff will use to update the payment sources and categories for members with insurance coverage. It is the system of record for retiree payment and connects with legacy applications like AcSL and BPS.
Retro Adjustment (Retros)	A Retro adjustment is made when the coverage effective date is changed outside the normal billing and payment cycle, usually in a prior invoice or payroll period. This typically results in a financial transaction where an employer or annuitant is charged or credited so funds received align to the adjusted coverage effective date. See also Adjustment Deduction.
Retroactive Payroll	The Retroactive payroll feature identifies members who require a retroactive transaction to be made to "catch up" their payroll deductions, such as when a member takes a leave of absence or initiates a life event that impacts prior pay periods.
Salary	Salary amount is provided by the employer on the iMax file and is used for benefit calculation and rates. Must be sent as annual, non-reduced earnings.
Service Area	Service Area is a geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may end your coverage if you move out of the plan's service area.
Short-term disability (STD)	Short-term disability (STD) is a benefit in which pays a percentage of the individual's salary, usually 50 to 60 percent, depending on the policy beginning after the wait period, for up to 3 months.
Social Security Act of 1935	Social Security Act of 1935 provides income benefits for retired workers and unemployment insurance.
Socure	Socure is the tool ETF will use to prove that members are who they say they are when they log into My Benefits (the member portal) to reach My Insurance Benefits (Benefitplace). See also Identity Proofing - Document Verification, Identify Proofing and Referee Process.
Special Enrollment Period	Special Enrollment Period is when an employee initiates a life event or other qualified change to make changes to his benefits.
Sponsor	Each employer has their own unique system instance or "sponsor" which represents their benefits offers and contains their employees.
Stabilization Period	Stabilization period is the period of time post Go Live when the Implementation and Production Support Teams are work together to stabilize the customer experience.
Subscriber	A subscriber is a member (i.e., enrolled person) who is the policyholder (also called the contract holder). For example, a subscriber might be an employee that has elected Employee plus Family coverage. While the employee and his dependents are members, the employee is a subscriber; the dependents are not. The subscriber may not always be an employee. For example, an employee's spouse may become a subscriber when she elects COBRA coverage while the employee does not elect COBRA coverage.
Summary of Benefits and Coverage (SBCs)	Under the law, insurance companies and group health plans will provide consumers Summary of Benefits and Coverage (SBCs) which is a concise document detailing, in plain

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	language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year, and within seven business days of requesting a copy from their health insurance issuer or group health plan.
Summary Plan Description (SPD)	Summary Plan Description (SPD) is a document that explains the fundamental features of an employer's group health plans, including eligibility requirements, contribution formulas, vesting schedules, benefits calculations and distribution options.
Targeted Messaging	Targeted Messaging is a feature that allows administrators to create and send on-demand, scheduled or event-driven messages to specific groups of employees based on data in My Insurance Benefits (Benefitplace).
Termination	Termination is the voluntary or involuntary end of employment. All group offered benefit coverage will be cancelled (excluding COBRA). This is NOT the same as a "Cancellation" of coverage.
Third Party Administrator (TPA)	Third Party Administrator (TPA) is an individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.
Upid (Unique External Person ID)	Upid (Unique External Person ID) is a unique system assigned ID within My Benefit Place which acts as a key or alternate identifier to SSN or Employee ID.
Traditional fee-for-service plan	Traditional fee-for-service plan is a type of plan that finances, but does not deliver, healthcare services; the plan allows participants the choice of any provider, without affecting reimbursement. Employers pay premiums to a private insurance carrier to provide a specific package of health benefits. Some employers may choose to self-fund a fee-for-service plan, in which case the employer, as opposed to an insurance company, assumes responsibility for payment of all eligible benefits.
Variance Manager	Variance Manager is a tool within of My Insurance Benefits which is used to identify and approve variances detected in My Insurance Benefits. Employers will send a file with the actual deductions which is then compared with the amounts My Insurance Benefits expects. Any variances are flagged for review. *(Retiree & Inactive Only)*
Voya	Voya is the company that administers COBRA for Benefitfocus for all available coverages. Voya administers all COBRA-related tasks based on termination of coverage within My Insurance Benefits (Benefitplace) directly with the member or their dependents. Voya acquired Benefitfocus in 2022.
Wellness programs	Wellness programs are programs which provide a structured plan, independent from health insurance that offers employees two or more of the following benefits: smoking cessation programs, exercise or physical fitness programs, weight control programs, nutrition education, hypertension tests, periodic physical examinations, stress management programs, back-care courses, and lifestyle assessment tests.
Your Benefits at a Glance (BaaG)	Your Benefits at a Glance (BaaG) provides members with a summary of all the benefits in which they are enrolled. The feature provides options to view additional details about each benefit, update existing benefits or to shop for additional benefits.