2025 GPC Health Care Plans: Key Terms to Know

When reviewing your benefits, it helps to understand key terms. Below are some common terms used to describe healthcare coverage. While you may have seen many of these terms before, reviewing them again will be helpful as you learn about your choices and make decisions for 2025.

ACCIDENT INSURANCE

Accident Insurance is a voluntary benefit program that complements your medical coverage and provides extra financial protection.

The plan provides cash benefits if you are injured in a covered accident. Payments are made directly to you and you can use your payment for any purpose you choose.

BRAND NAME DRUGS

Medications that are researched, developed, patented, produced and distributed by a pharmaceutical drug manufacturer.

CARE MANAGEMENT PROGRAM

A program offered through each medical plan carrier that is designed to help you improve and maintain your health — whether you are healthy, have moderate needs or would like support managing a chronic condition.

COINSURANCE

A defined percentage of health care costs that you pay.

COPAY

A flat dollar amount you pay for certain health care services.

COVERAGE TIERS

The coverage level you choose when enrolling in the GPC Medical, Dental and/or Vision Plan.

The GPC Medical and Vision Plans offer four coverage tiers:

- Employee-only
- Employee + child(ren)
- Employee + spouse
- Employee + spouse + child(ren)

The GPC Dental Plan offers two coverage tiers:

- Employee-only
- Employee + 1 or more

COVERED ADULT DEPENDENT

A dependent covered under the GPC Medical, Dental, Vision, Accident Insurance, Hospital Indemnity and/or Critical Illness Insurance Plans who is age 18 years or older as of January 1, 2025.

CHRONIC CONDITION

A condition that requires ongoing management over a long period of time. Examples of chronic conditions include, but are not limited to, diabetes, hypertension and heart disease.

CPT CODES

Standardized codes used by health care providers to describe medical, surgical or diagnostic services and procedures.

CRITICAL ILLNESS INSURANCE

Critical Illness Insurance is a voluntary benefit program that complements your medical coverage and provides extra financial protection.

The plan provides a lump-sum payment if you are diagnosed with a covered condition such as cancer, heart attack or stroke. Payments are made directly to you and you can use your payment for any purpose you choose.

DEDUCTIBLE

For the Value Plan: The amount of money you pay for covered services before the Plan will pay benefits for services received in any calendar year (January-December). The deductible does not apply to in-network preventive care.

If you have employee-only coverage, the Plan begins paying coinsurance once your costs reach the employee-only deductible. If you have employee + child(ren), employee + spouse or employee + spouse + child(ren) coverage, the Plan begins paying coinsurance once the total employee + dependent(s) deductible is met. The employee + dependent(s) deductible can be satisfied with expenses from one of your family members or any combination of your family members.

For the Savings Plan: The amount of money you pay for covered services before the Plan will pay benefits for services received in any calendar year (January-December). The deductible does not apply to in-network preventive care.

If you have employee-only coverage, the Plan begins paying coinsurance once your costs reach the employee-only deductible. If you have employee + child(ren), employee + spouse or employee + spouse + child(ren) coverage, the Plan begins paying coinsurance once the total employee + dependent(s) deductible is met. The employee + dependent(s) deductible can be satisfied with expenses from one of your family members or any combination of your family members.

For the Traditional Plan: The amount of money you pay for covered services before the Plan will pay benefits for inpatient or outpatient services received in any calendar year (January-December). The deductible does not apply to in-network preventive care, office, urgent care and emergency care visits or prescription drugs.

If you have employee-only coverage, the Plan begins paying coinsurance once your costs reach the employee-only deductible. If you have employee + child(ren), employee + spouse or employee + spouse + child(ren) coverage, the Plan begins paying coinsurance once the total employee + dependent(s) deductible is met. The employee + dependent(s) deductible can be satisfied with expenses from one of your family members or any combination of your family members.

For the Dental Plan: The amount of money you pay for covered services before the Plan will pay benefits. The deductible does not apply to routine and preventive care.

If you have employee-only coverage, the Plan begins paying coinsurance once your individual costs reach the employee-only deductible. If you have employee + 1 or more coverage, the Plan begins paying coinsurance once an individual satisfies the individual deductible. After three family members have satisfied their individual deductible, any additional covered family members do not need to satisfy the individual deductible for the Plan to begin paying coinsurance for services received.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

An account that can be used to save pre-tax dollars for eligible dependent care expenses — such as child care, summer day camps, adult day care or elder care — in a given calendar year (January-December). Funds contributed to the account are subject to the "use it or lose it" IRS rule, and any unused funds remaining in the account after March 15th of the following Plan Year will be forfeited.

DIAGNOSTIC SERVICE

A service prescribed by a doctor related to the diagnosis or testing of a particular condition.

DRUG QUANTITY MANAGEMENT

Drug Quantity Management (DQM) limits the quantity of a particular prescription to ensure it is administered and taken safely. For example, a 30-day supply of a medication that requires one pill, or dose, per day would be 30 pills. The supply would be expected to last until the next 30-day refill.

EXPLANATION OF BENEFITS (EOB)

An EOB, or Explanation of Benefits, is a document that summarizes your health insurance claim and helps you understand your out-of-pocket costs. It's not a bill, but rather an explanation of how the costs of services are shared between you and the medical plan carrier.

FORMULARY DRUGS

Drugs found on the Express Scripts Preferred Prescriptions® formulary. A formulary is a list of Federal Drug Administration (FDA)-approved, preferred brand-name and generic medications that have been reviewed based on medical appropriateness, safety and cost effectiveness for the Pharmacy Benefit Manager by an independent Pharmacy and Therapeutics Committee. The formulary covers an extensive list of drugs used to treat most medical conditions.

GENERAL PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

An account that can be used to save pre-tax dollars for eligible medical, dental and vision expenses in a given calendar year (January-December). Funds contributed to the account are subject to the "use it or lose it" IRS rule. Therefore, any funds remaining in the account above the maximum carryover limit after December 31, 2025, will be forfeited if not claimed on/or before March 31, 2025. You are only eligible for this account in 2025, if you are enrolled in the Traditional Plan or have waived GPC Medical Plan coverage.

GENERIC EQUIVALENT DRUGS

A drug that is not a brand-name drug, but by law must have the same ingredients at the same dose as a brand-name drug and is subject to the same quality and effectiveness standards as its brand-name counterpart.

GENERIC THERAPEUTIC ALTERNATIVE

A drug that has different ingredients than the brand-name drug but is designed to work like a brand-name drug or another generic drug in the same class of medicines.

HEALTH COACH

A nurse or other certified health professional employed by your medical plan carrier. These individuals can direct you to useful health resources, provide personal advice and counseling, and help you set health goals.

HEALTH SAVINGS ACCOUNT (HSA)

A bank account owned by you to save for current and future qualified health care expenses. Tax-free contributions can be made by you or GPC. The account and any remaining balance rolls over from year-to-year. Eligibility to open an HSA is only available with enrollment in the Value Plan or Savings Plan.

HINGE HEALTH

Hinge health is a free and voluntary, physical program for GPC Medical Plan Members who are impacted by musculoskeletal conditions.

Hinge Health provides virtual support ranging from information about treatment options to coaching and convenient exercise therapy to help reduce pain and improve mobility.

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity Insurance is a voluntary benefit program that complements your medical coverage and provides extra financial protection.

The plan provides a daily cash benefit if you are hospitalized, including stays for childbirth. Payments are made directly to you and you can use your payment for any purpose you choose.

IN-NETWORK

Providers that have contracted with your medical, dental and/or vision plan carrier and have agreed to provide services at negotiated, discounted rates. You will pay less when you use in-network providers.

LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

An account that can only be used to save pre-tax dollars for eligible dental and vision expenses (not medical expenses) in any calendar year (January-December).

Funds contributed to the account are subject to the "use it or lose it" IRS rule. Therefore, any funds remaining in the account above the maximum carryover limit after December 31, 2025, will be forfeited if not claimed on/or before March 31, 2025. You are eligible for this account if you are enrolled in the Value Plan or Savings Plan.

LIVONGO HEALTH FOR DIABETES MANAGEMENT

Livongo Health is a free and voluntary diabetes management program for GPC Medical Plan members who are impacted by this condition.

Livongo Health uses a combination of state-of-the-art technology and certified diabetes educators to help individuals manage diabetes.

LIVONGO HEALTH FOR HYPERTENSION MANAGEMENT

Livongo Health is a free and voluntary hypertension (high blood pressure) management program for GPC Medical Plan members who are impacted by this condition.

Livongo Health uses a combination of state-of-the-art technology and one-on-one coaching to help individuals better manage high blood pressure.

MEDICAL PLAN CARRIER

The health insurance company responsible for administering your medical coverage.

NEGOTIATED FEE SCHEDULE

Special discounted rates for in-network services as a result of your medical, dental and/or vision plan carrier contracting with doctors, facilities and other providers.

NON-FORMULARY DRUGS

Drugs not found on the Express Scripts Preferred Prescriptions® formulary. (See definition for formulary drugs.)

OMADA DIABETES PREVENTION PROGRAM

Omada is a free and voluntary program for GPC Medical Plan members who are at risk for developing diabetes.

Omada uses a combination of state-of-the-art technology, personalized care plans, one-on-one coaching and nutrition guidance to support individuals along their health improvement journey.

OPTUM BANK

A Federal Deposit Insurance Corporation (FDIC) insured bank that offers the Health Savings Account (HSA), which is only available by enrolling in the Value Plan or Savings Plan.

OUT-OF-NETWORK

Providers that are not contracted with your medical, dental and/or vision plan carrier to provide services at negotiated, discounted rates. You will pay more when you use out-of-network providers.

OUT-OF-POCKET MAXIMUM

For the Value Plan: The maximum amount of money you pay in any calendar year (January-December) before the Plan pays 100% of eligible costs.

Your annual deductible and coinsurance count toward satisfying the out-of-pocket maximum.

If you have employee-only coverage, the Plan begins paying 100% of eligible costs once your costs reach the employee-only out-of-pocket maximum.

If you have employee + dependent(s) coverage, the Plan begins paying 100% of eligible costs for an individual once the individual out-of-pocket maximum is met. If the total out-of-pocket maximum is met, the Plan will pay 100% of eligible costs for family members. The total out-of-pocket maximum can be satisfied with expenses from any combination of family members.

For the Savings Plan: The maximum amount of money you pay in any calendar year (January-December) before the Plan pays 100% of eligible costs.

Your annual deductible and coinsurance count toward satisfying the out-of-pocket maximum.

If you have employee-only coverage, the Plan begins paying 100% of eligible costs once your costs reach the employee-only out-of-pocket maximum.

If you have employee + dependent(s) coverage, the Plan begins paying 100% of eligible costs for an individual once the individual out-of-pocket maximum is met. If the total out-of-pocket maximum is met, the Plan will pay 100% of eligible costs for family members. The total out-of-pocket maximum can be satisfied with expenses from any combination of family members.

For the Traditional Plan: The maximum amount of money you pay in any calendar year (January-December) before the Plan pays 100% of eligible costs.

Your annual deductible, coinsurance and copays count toward satisfying the out-of-pocket maximum.

If you have employee-only coverage, the Plan begins paying 100% of eligible costs once your costs reach the employee-only out-of-pocket maximum. If you have employee-only coverage, the Plan begins paying 100% of eligible costs once your costs reach the employee-only out-of-pocket maximum.

If you have employee + dependent(s) coverage, the Plan begins paying 100% of eligible costs for an individual once the individual out-of-pocket maximum is met. If the total out-of-pocket maximum is met, the Plan will pay 100% of eligible costs for family members. The total out-of-pocket maximum can be satisfied with expenses from any combination of family members.

PRIMARY CARE PHYSICIAN (PCP)

The primary doctor typically responsible for coordinating all your medical care. The GPC Medical Plan does not require you to select a PCP.

PAYROLL CONTRIBUTIONS/PREMIUMS

The pre-tax amount you pay each payroll period for benefits coverage.

POINT-OF-SERVICE COST

The amount you pay to a provider when you receive a health care service.

PRESCRIPTION DRUG PRIOR AUTHORIZATION

Certain medications require approval before the prescription is filled to ensure the most cost-effective, appropriate medication is used to treat a condition.

PREVENTIVE CARE

Preventive care services include screenings, immunizations and other procedures that are designed to detect and treat medical conditions to prevent avoidable illnesses. Preventive care guidelines are based on recommendations by the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices. In-network preventive care services are covered at 100% under both medical plan options based on age, gender and/or risk status.

PROVIDER

Physicians, hospitals, nurse practitioners, chiropractors, physical therapists and other health professionals who provide health care services.

QUIT FOR LIFE® TOBACCO CESSATION PROGRAM

A tobacco cessation program offered by GPC free of charge to all employees and their adult dependents age 18 years or older. The program provides confidential, one-on-one coaching and resources to support people in quitting tobacco.

REASONABLE AND CUSTOMARY (R&C)

The average fee charged by health care providers with similar training and experience in the same geographic area in which the service is obtained. If an out-of-network provider's charges exceed R&C expenses, the individual receiving the service is responsible for that part of the charge that exceeds this limit. Fees paid to satisfy R&C charges do not apply toward the out-of-pocket maximum.

SAVINGS PLAN

One of three medical plan options available under the GPC Medical Plan in 2025. This plan has the opportunity to open a Health Savings Account (HSA) to save for current or future health care expenses.

STEP THERAPY

Through Step Therapy, the safest, lowest-cost prescription drug available to treat a certain condition is tried first. Progression to higher-risk medications occurs only if medically necessary.

TOBACCO-FREE

Tobacco-free is defined as someone who has not smoked, chewed or in any manner used tobacco products of any kind (cigarettes, pipes, cigars, snuff, dipping tobacco, chewing tobacco or other smokeless tobacco products) more than two times per month during the last 180 days prior to Annual Enrollment or if you and/or your covered adult dependents are tobacco users but will enroll in and complete the Quit for Life® Tobacco Cessation Program.

TRADITIONAL PLAN

One of three medical plan options available under the GPC Medical Plan in 2025.

TRANSCARENT SURGERY CARE PROGRAM

Transcarent offers high-quality, non-emergency surgical care for Medical Plan members that covers surgery costs at 100% for members of the Traditional Plan and at 100% for members of the Savings and Value Plan after the annual deductible has been met.

VALUE PLAN

One of three medical plan options available under the GPC Medical Plan in 2025. This plan has the opportunity to open a Health Savings Account (HSA) to save for current or future health care expenses.

VIRTUAL VISITS

Virtual Visits allow you to see a doctor from your mobile device or computer, any time of day or night.