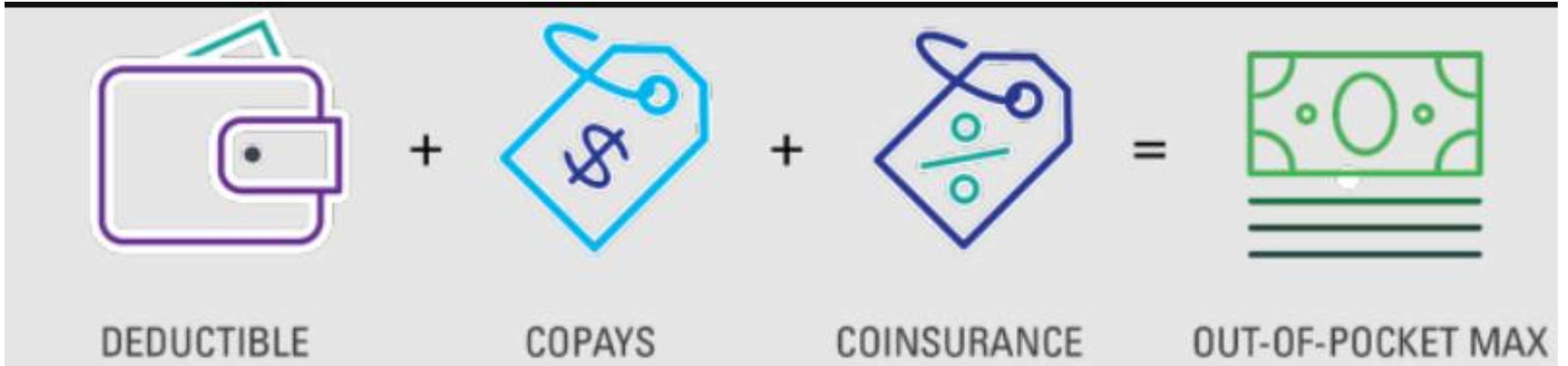
Terms To Know

Waiting Period

Team Members (full-time and part-time) have 14 days from their event date (hire or job change date) to access the enrollment link in their Ally inbox and complete enrollment.

Beginning June 28, 2021, Team Members who are eligible for benefits (full-time and part-time) will have a 30-day waiting period from their event date (hire or job change date) before benefits start. Benefits will be effective on the first day of the first full 14-day pay period after the 30-day waiting period expires.



You pay the full cost for all non-preventive medical expenses before you meet your deductible.

This is a fixed amount you pay for a covered health service, usually at the time you receive the service.

Once you meet your deductible, you and JOANN will share your expenses until you meet your out-of-pocket maximum.

The most you pay during a plan year (Feb 1 – Jan 31) before your plan starts to pay 100% for covered essential health benefits.

Beneficiary

A beneficiary is the person or persons you designate to receive benefits from any insurance policies you may hold.

Bi-Weekly Premium

This is the amount you pay bi-weekly for your plan, regardless of if you use any services. *Your premiums do not contribute to your out-of-pocket maximum.*

Co-insurance

This is a percentage of a health care cost that you pay after meeting your deductible.

Co-payment

This is a fixed dollar amount. Co-payments only apply to office visits for PPO1 and PPO2, and Urgent Care and Emergency Room visits for all PPO plans. Co-pays do not apply to your deductible.

Dependent

A Dependent is an individual who is the son, daughter, stepson, or stepdaughter of the employee. This also includes legally adopted children of the employee and a child who is lawfully placed with the employee for legal adoption by the employee, and includes an eligible foster child, defined as an individual who is placed with the employee by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction. A Dependent may also be a Spouse, Domestic Partner, or Child of a Domestic Partner.

Flexible Spending Account (FSA)

An FSA is a tax-advantaged account that lets you use pre-tax dollars to pay for eligible medical expenses. A health care FSA may not be combined with an HAS and funds in this account must be used each plan year. Funds will be lost if they are not used. You must re-enroll each year for coverage to continue. If you are enrolled in an FSA account, you cannot have access to a Health Savings Account (HSA), for example through a spouse's plan.

Health Savings Account (HSA)

You can open an HSA if you are enrolled in the Consumer Choice Plan (a high-deductible health plan). Team members can put money into an HSA up to an annual limit set by the government, using pre-tax dollars. HSA funds may be used to pay for medical expenses whether the deductible has been met, and no tax is owed on funds withdrawn from an HSA to pay for medical expenses.

In-network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Plans cover a greater share of the cost for in-network providers than for providers who are out-of-network.

Out-of-network

The plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but you will pay more out-of-pocket to use these providers than providers who are in-network.

Out-of-Pocket Maximum

You pay out-of-pocket costs in addition to your bi-weekly premiums when you incur claims. There is one combined out-of-pocket amount for both medical and prescription plans. Once you have met your out-of-pocket maximum, the plan will pay the full cost of your medical and prescription expenses until the end of the plan year.

Qualifying Life Events (QLE)

Qualifying life events are events in your life that have an impact on your insurance needs or change what health insurance plans you qualify for. The qualifying event triggers a special enrollment period that makes you eligible to enroll in coverage.

Loss/Gain Coverage – Examples include losing health insurance for any reason except for not paying premiums, losing eligibility (Medicaid, Medicare, or a Children's Health Insurance Program), turning 26 and losing coverage through a parent's plan, and loss of job-based coverage. Documentation stating dependent coverage status change needs to be provided.

Birth/Adoption – Birth certificate or adoption certificate needs to be provided.

Divorce/Dissolution of DP – Divorce or dissolution decree needs to be provided.

Marriage/Domestic Partnership – Marriage certificate or court document needs to be provided.