



2026 Massachusetts Employer Survey Instruction Booklet

Why the Massachusetts Employer Survey is Important

The Massachusetts Employer Survey (MES) is a study designed to understand employer-sponsored health insurance benefits in Massachusetts. Your participation provides policymakers and businesses with comprehensive insights into employer health insurance offerings, employee participation, and the overall landscape of employer-sponsored insurance in Massachusetts.

The survey collects information on employee demographics, the types of insurance employers offer, employee eligibility and enrollment, cost sharing, and the factors influencing employer decisions about plan offerings. Since most Massachusetts residents receive health insurance through their own employer or a family member's, evaluating the role of employers in the health insurance marketplace is critical to understanding access to coverage. The data will help identify trends in employer-sponsored health insurance, support evidence-based policymaking, and offer businesses valuable analyses for strategic planning and benchmarking purposes.

This study is conducted on behalf of the Center for Health Information and Analysis (CHIA), an agency of the Commonwealth of Massachusetts that provides objective and reliable data on the state's health insurance landscape to policymakers and the health care community. CHIA aims to promote a transparent health care system where reliable information supports improvement and helps organizations make informed decisions. To conduct this year's survey, CHIA is partnering with Market Decisions Research (MDR), an independent research firm located in Portland, Maine with extensive experience studying health insurance and employer practices. MDR employs a team of professional researchers dedicated to respecting your time and privacy while producing accurate and actionable data.

Your participation helps improve the stability and affordability of employer-sponsored health insurance. Your answers will be confidential, and the information collected in this study will not be presented or published in any way that identifies you or your business. You can see past results here: <http://www.chiamass.gov/massachusetts-employer-survey>.

Who Should Complete This Survey?

The person in your organization who is most familiar with employee health benefits should complete the survey. **For all questions in this survey, please provide your best available estimate for the numbers requested. You will not be able to skip any questions.** If there is a question you are unsure about, you may exit the survey and return to it once you have collected the appropriate information. If you do not have an answer for a particular question, you can select 'I don't know.'

At several points in the survey, you will have the option to provide an alternate contact if you are not able to provide the most accurate information to complete the survey.

If you would like additional information, please visit <https://mahealthsurveys.gov/mes-faq> to find answers to frequently asked questions and worksheets that will help you gather the information needed to complete the survey.

You can also contact the lead researcher, Dr. Brian Robertson, if you have additional questions or concerns. He can be reached at MAEmployerSurvey@marketdecisions.com.

How to Access the Survey

You can access the survey by visiting <https://mahealthsurveys.gov/mes>. You will need to enter the PIN provided to you in the invitation letter or email you received. If you cannot find your PIN, please contact MAEmployerSurvey@marketdecisions.com.

Please complete this survey using a desktop or laptop computer. You will not be able to access or complete the survey using a mobile device or tablet. If you prefer to complete a paper version of the survey, please contact Candace Walsh at cwalsh@marketdecisions.com to request a mailed paper copy.

You will be able to save, exit, and re-enter the online survey where you left off at any time using your PIN from the email or letter invitation you received.

Recommended Approach to Completing this Survey

First, we recommend reviewing this instruction book to familiarize yourself with the kinds of information you will need to complete the survey. Second, visit the survey website <https://mahealthsurveys.gov/instructions> and download/print the survey worksheet. Complete the worksheet with your organization's information. Finally, given the length and complexity of the survey, it would be difficult to take the survey on a mobile device. We recommend you complete this survey on a desktop or laptop computer. Following these steps will reduce the time it takes you to complete the survey and ensure your information is organized and accurate before you take the survey online.

Information Needed to Complete Survey

Employee characteristics: Number of employees working for your organization nationally and in Massachusetts, including those working remotely for a Massachusetts location. The survey is focused on full-time and part-time employees working on-site or remotely for your organization in Massachusetts and will exclude contract workers, volunteers, and temporary workers.

Benefits offered to employees: Types of employee benefits your organization offers. We will ask you about the types of benefits offered and how many employees are eligible and enrolled.

Health plans and plan characteristics: Type and number of health plans offered to employees. Plan characteristics include premium amounts, deductibles, out-of-pocket spending limits, high-deductible health plans, and cost-saving features.

Health plan enrollment in Massachusetts: Break out enrollment numbers by the coverage type – employee only, employee plus spouse, employee plus child, and employee plus spouse and child.

Health plan co-pays: Copayments and coinsurance after an employee has met the general annual deductible. We will ask for payment amounts for various services and prescription drug coverage.

Health care decision-making: Who in your organization makes decisions and what factors are important in shaping those decisions.

The Health Connector for Business: Awareness of offerings on the MA Health Connector for Business and whether your organization utilizes the Health Connector to purchase health insurance for your employees.

Organizations that DO NOT offer health insurance: Whether your organization has offered health insurance coverage to employees in the past and why your organization does not currently offer insurance.

Where to Find the Requested Information

Most of the health plan information that will be asked for in this survey is included in the **Summary of Benefits and Coverage (SBC)** provided by your health insurance carrier(s).

We are looking to collect information about your current health insurance benefits. We recognize you may be in the process of renewing or changing your organization's benefits. Please provide information about the benefits currently in effect, in which your employees are currently enrolled.

Survey Worksheet to Help Organize Information

A printable PDF worksheet is available to help you collect and organize the information needed to complete this survey. The worksheet is available at

<https://mahealthsurveys.gov/instructions>.

Instructions for Organizations That Do Not Offer Health Insurance

If your organization does **not** provide traditional group health insurance, you will still be asked to complete several key sections of this survey. These questions help us understand your workforce, the types of benefits you may offer in place of traditional coverage, and the factors influencing your decision not to offer insurance. Your responses are essential for building a complete picture of employer-sponsored health benefits across the state. Please note if your organization does offer health insurance through a professional employer organization (PEO), you will be asked to complete the survey as if your organization offers traditional group insurance directly.

Organizations without traditional health insurance coverage will be required to complete the following sections:

- **Section II – Number of Employees**
Provide information on your total workforce, including full-time, and part-time employees.
- **Section III – Benefits Offered to Employees**
Indicate any traditional and non-traditional benefits your organization provides, such as stipends, wellness programs, or other forms of support.
- **Section IIIA – Health Benefits Coverage**
Report whether you offer alternative health benefit arrangements, including Individual Coverage Health Reimbursement Arrangements (ICHRAs), Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs), or benefits offered through a Professional Employer Organization (PEO).
- **Section VII – Organizations That Do Not Offer Insurance**
Explain the primary reasons your organization does not offer traditional health insurance coverage.
- **Section IX – The Health Connector for Business**
Share your awareness of, experience with, or interest in the Health Connector for Business as a potential resource for offering employee coverage.

- **Section X – Employee Demographics**

Provide general demographic information about your workforce to help contextualize your organization’s benefit decisions.

Description of Survey Sections

Section II: Employee Characteristics

This section will help us understand the makeup of your organization’s workforce. You will be asked about the number of:

- Total United States employee count (applicable if you have employees outside of Massachusetts)
- Total count of full- and part-time employees
- Full- and part-time employees currently working on-site or remotely for your Massachusetts organization or establishment

Section III: Employee Benefits

This section gathers information about the benefits offered to employees in You will be asked about the:

- Benefits offered to employees

Section IIIA: Health Benefits Coverage

This section will help us understand how many employees in Massachusetts are currently eligible for and enrolled in employer health insurance plans. You will be asked about:

- Whether your organization offers health insurance to full- and/or part-time employees
- Whether your organization provides health insurance coverage through a Professional Employer Organization (PEO)
- Whether spouses and children are offered health insurance
- Full-time employees currently *eligible* for health insurance
- Part-time employees currently *eligible* for health insurance (if applicable)
- Full-time employees currently *enrolled* in health plans
- Part-time employees currently *enrolled* in health plans (if applicable)
- Whether your organization offers an Individual Coverage Health Reimbursement Arrangement (ICHRA) or Qualified Smaller Employer Health Reimbursement Arrangement (QSEHRA) in addition to group health insurance and who is eligible
- Potential penalties paid for not offering insurance
- Count of full-time equivalent employees in 2025

Section IV: Health Plan Characteristics

(Worksheet: Section IV. Health Plan Characteristics – Numbers and Types of Plans)

Information for this section can be found in the **Summary of Benefits** provided for each plan by your health insurance carrier(s). To minimize the time burden to complete this survey, we will

only ask about your five largest plans as defined by the number of employees enrolled. If you offer fewer than five plans, you will only provide information for the plans you offer. You will be asked about the:

- Type(s) of plan(s) offered (HMO, POS, PPO, Indemnity)
 - How many plans of each type are offered
- Identify your five largest plans by enrollment numbers
 - If you offer five or fewer plans, we will ask about each one.
 - If you have more than five plans we will ask about the five largest by enrollment.
- Insurance carrier(s) providing the plan(s)
- Deductibles for single coverage (in-network) on each plan
- Out of pocket spending limit for single coverage (in-network) on each plan
- For plans offered by your organization that qualify as high-deductible health plans (HDHPs):
 - Identify which HDHP plans include an HRA, HSA, or Both
 - Provide for each HRA and/or HSA
 - Employer annual contribution amount for employee only
 - Employer annual contribution to family coverage (if you cover spouses or children)
- Premiums (monthly plan premium, monthly employer contribution, and monthly employee contribution) for each plan by coverage level offered:
 - Employee only
 - Employee plus spouse
 - Employee plus dependent children
 - Employee plus spouse and dependent children
- Whether your plans include the following features:
 - Fully insured, self-funded with stop-loss coverage, or self-funded without stop-loss coverage (including level-funded plans)
 - Waives co-payment for chronic illness treatment and prescription drugs
- Contact with a pharmacy benefits manager (PBM)

Section V: Health Plan Enrollment

This section will ask you to provide the number of employees enrolled in your organization's health plan(s) by coverage type(s):

- Employee only
- Employee plus spouse
- Employee plus dependent children
- Employee plus spouse and dependent children
- Total plan enrollment (sum above the above coverage level enrollments)

Section VI: Health Plan Co-Pays

This section will ask for *co-payment* amounts and/or *co-insurance* percentages under your organization's **largest** plan after an employee meets their general annual deductible in the following areas:

- Primary care office visit
- Outpatient mental health visit
- Emergency department visit
- Inpatient hospitalization visit
- Generic prescription drug (Tier 1) (30-day supply)
- Preferred brand prescription drug (Tier 2) (30-day supply)
- Non-preferred brand prescription drug (Tier 3) (30-day supply)
- Lifestyle or specialty drug (Tier 4) (30-day supply)

Section VII: Organizations that do not Offer Health Insurance*

This section does not need to be completed if your organization offers health insurance. If your organization does not offer health insurance, you will be asked:

- If your organization has ever offered insurance and when it was last offered
- If rising premiums costs influenced your organization's decisions to stop offering health insurance
- Why your organization does not currently offer insurance benefits
- If your organization would consider offering health insurance in the future

***Please note if your organization utilizes a PEO, you will need to complete the survey as if you offer traditional health insurance.**

Section VIII: Health Care Decision Making

This section will ask you to provide:

- How your organization purchases health insurance
- Factors important to your health insurance decision-making
- Reasons your organization offers health insurance
- Strategies your organization uses to control health insurance costs
- Effective strategies in controlling your organization's cost of health insurance coverage
- Self-insured plans and reasons for providing or not providing this option to employees
- Changes in the costs of coverage and impacts of rising health insurance costs

Section IX: The Health Connector

Skip this section if your organization employs more than 50 people in Massachusetts. This section will ask you about your experience using the Health Connector, awareness of the Health Connector, and potential benefits.

Section X: Employee Demographics

This section will help us understand the makeup of your organization's workforce. You will be asked about the number of:

- Unionized employees
- Number of Massachusetts employees in each age category:
 - Under age 26
 - Ages 26 – 64
 - Ages 65 and older
- Number of Massachusetts employees in each income category:
 - Less than \$18/hour (\$37,440 per year)
 - Between \$18 and \$39/hour (\$37,440 to \$81,120 per year)
 - \$439/hour (\$81,120 per year) or more

Glossary of Terms

<p>Centers of Excellence (COE). Specialized medical programs or facilities, identified by the employer or health plan, that offer high-quality care for specific conditions or procedures such as cancer treatment, organ transplants, or orthopedic surgery. COEs are selected based on expertise, outcomes, and cost-effectiveness. Employees may receive enhanced benefits or lower out-of-pocket costs when using these designated centers.</p>
<p>Catastrophic Loss Coverage. See Stop-Loss Coverage.</p>
<p>Co-insurance. A fixed percentage of the total charge paid each time an enrollee uses services.</p>
<p>ConnectWell Rebate. A program offered through the Health Connector for Business that provides eligible employers with a rebate on their group health insurance premium contribution if they participate in qualifying wellness activities and meet employee participation requirements.</p>
<p>Conventional Plan. See Indemnity Plan.</p>
<p>Copayment (Copay). A fixed dollar amount paid each time an enrollee uses services.</p>
<p>Cost-Sharing. Out-of-pocket costs such as deductibles, copayments, and coinsurance.</p>
<p>Deductible. An amount that the enrollee must pay before most services are payable by the plan.</p>
<p>Dental Insurance. Coverage for routine dental care, such as exams, cleanings, and fillings, which may be provided as a standalone dental plan or as an embedded benefit within a health insurance plan. Coverage does not include situations where only medically necessary dental procedures (such as surgery for jaw injuries) are covered under a medical plan; to count as dental insurance, the plan must specifically provide routine dental benefits.</p>
<p>Direct Primary Care (DPC). An arrangement, typically outside of traditional health insurance, in which employees receive access to a set of primary care services through a membership or subscription paid by the employer or employee. DPC usually covers routine visits, preventive care, and basic lab work at no additional cost. It does not include specialist or hospital care, and is designed to provide more accessible and personalized primary care.</p>
<p>Disability Insurance. A benefit that provides income replacement for employees who are unable to work due to a qualifying short-term or long-term disability, typically covering a portion of lost wages during the period of disability.</p>
<p>Employee Assistance Programs (EAP). Confidential services provided to employees to assist with personal or work-related problems, such as counseling, mental health support, legal or financial advice, and referrals to community resources.</p>

<p>Employee Choice Model / Employee Choice Options. A set of options offered through the Health Connector for Business that allows employers to choose how employees select their health plans. Employers may choose a plan, a benefit level, or a carrier, and employees can then select from available plans within those parameters.</p>
<p>Employer Contribution. The amount an employer pays toward the cost of benefits. Most commonly refers to the employer’s share of health insurance premiums but may also refer to contributions to other benefits such as Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), or retirement plans.</p>
<p>Employee Contribution. The amount an employee pays toward the cost of benefits. Most commonly refers to the employee’s share of health insurance premiums, but may also refer to contributions to HSAs, FSAs, or other benefit programs.</p>
<p>Employer-Sponsored Retirement Plan. A retirement savings program offered by the employer, such as a 401(k), Simple IRA, or pension plan, which allows employees to save for retirement with potential employer contributions and tax advantages.</p>
<p>Exclusive Provider Organization (EPO). A health plan that only covers non-emergency care if it is from physicians and hospitals who have a contract with the health plan. A referral may not be needed to visit a specialist.</p>
<p>Fee-for-Service Plan. See Indemnity Plan.</p>
<p>Flexible Spending Account (FSA). An employer-established benefit program governed by Section 125 of the Internal Revenue Code that allows employees to contribute pre-tax dollars from their paychecks to pay for eligible health care expenses, such as copayments, deductibles, prescription drugs, and certain medical supplies; funds in an FSA are generally subject to a “use-it-or-lose-it” rule, meaning any unspent balance at the end of the plan year may be forfeited unless the plan includes a grace period or carryover provision.</p>
<p>Formulary. A list of drugs covered by the plan and their cost-sharing amounts.</p>
<p>Fully Insured. A funding arrangement for health insurance coverage in which coverage is underwritten by a health insurance carrier, the employer pays a premium to the carrier, and the carrier is responsible for paying enrollee claims, with no refunds if claims are lower than expected.</p>
<p>Full-Time Employee. A permanent employee who works, on average, 30 hours or more per week. Excludes temporary or seasonal employees, contract workers who are not employees of the organization, and volunteers.</p>
<p>Generic Drugs. Drugs that are no longer covered by patent protection and thus may be produced and/or distributed by multiple drug companies.</p>

GLP-1 Agonist Drugs. Commonly known as GLP-1 medications, these drugs mimic the GLP-1 hormone, which manages blood sugar levels in the body. They have been shown to be an effective drug for weight loss. Common trade names include Ozempic and Wegovy (semaglutide), Rybelsus, Trulicity, Victoza, and Mounjaro or Zepbound.

Health Connector for Business. A program within the Massachusetts Health Connector that serves small employers, allowing them to offer health insurance options to their employees through the state’s public exchange. Formerly known as “SHOP” or “Business Express”.

Health Insurance. A plan that helps pay for a broad range of medical services, such as doctor visits, hospital care, prescriptions, and preventive care, and does not include plans that cover only a single type of care (such as dental or vision only) or plans that provide limited or temporary coverage (such as short-term medical or hospital indemnity plans).

Health Maintenance Organization (HMO). A health plan that does not cover non-emergency services provided out of network and uses gatekeeping for specialist services. In network, cost-sharing is typically lower.

Health Reimbursement Arrangement (HRA). A medical care reimbursement arrangement sponsored and funded solely by an employer on a pre-tax basis. Employees use HRA funds for eligible medical expenses, and if the employer allows, unused balances may be carried over to the next year, but funds are not portable if the employee leaves the job.

Health Savings Account (HSA). A medical savings account that accompanies a high-deductible health plan, is owned by the individual, and can be maintained over multiple years. Employers and employees may contribute pre-tax funds that can be used for qualified medical expenses, though neither is required to contribute. Unlike a Flexible Spending Account (FSA), unspent HSA funds roll over year to year and remain with the employee even if they change jobs.

High-Deductible Health Plan (HDHP). For 2026, an HDHP is a health plan with a minimum annual deductible of \$1,700 for self-only coverage or \$3,400 for family coverage. The plan’s annual out-of-pocket limit (including deductibles, copayments, and other amounts, but not premiums) cannot exceed \$8,500 for self-only coverage or \$17,000 for family coverage. To qualify as an HDHP, a plan must meet both the minimum deductible and not exceed the out-of-pocket limit. Preventive care may be covered without applying the deductible.

Indemnity Plan. A health plan with no preferred provider networks. An employee faces the same cost-sharing regardless of which provider they choose. Also known as a conventional or fee-for-service health plan.

Individual Coverage Health Reimbursement Arrangement (ICHRA). An arrangement that allows employers to reimburse employees tax-free when they purchase their own health care, including non-group coverage. Funds assigned to an ICHRA may be used for premiums and cost-sharing, as well as some other health services and equipment.

Level-Funded Plan. A funding arrangement for health insurance coverage in which the employer pays a fixed monthly amount to an insurer or third-party administrator, which funds a reserve account to cover anticipated claims, administrative costs, and stop-loss coverage. The employer may receive a refund if actual claims are lower than expected. Level-funded health plans are considered a form of self-insurance.

Life Insurance. A benefit that pays a lump sum to designated beneficiaries upon the death of the insured employee, providing financial protection for dependents or other beneficiaries.

Massachusetts-Based Employee. An employee who currently works for your organization at any of its Massachusetts locations, including employees who are physically present for work at these locations as well as employees working remotely who are on the payroll at these locations.

Massachusetts Health Connector. A state-established public health insurance marketplace (or “exchange”) for Massachusetts that helps individuals and small employers compare and purchase health coverage. The Health Connector administers programs that provide access to qualified health plans and may offer subsidies or tax credits for eligible enrollees.

Narrow Network Plan. A plan that limits the number of providers who can participate or limits services to certain facilities, with networks more restrictive than a standard HMO network.

One Benefit Level. Your organization chooses a benefit level and employer contribution amount. Employees can choose among health plans offered by a range of health insurance carriers at that benefit level.

One Carrier. Your organization chooses a health insurance carrier and employer contribution amount. Employees can choose a health plan from that carrier at any benefit level.

One Plan. Your organization chooses a health plan and employer contribution amount. All employees can enroll in that plan.

Out-of-Pocket Limit. The maximum amount that an enrollee can be required to pay for their health care each year, after which the plan covers the entire cost of in-network care. Also known as out-of-pocket maximum.

Part-Time Employee. A permanent employee who works, on average, less than 30 hours per week. Excludes temporary or seasonal employees, contract workers who are not employees of the organization, and volunteers.

<p>Pharmacy Benefits Manager (PBM). A company that manages prescription drug benefits on behalf of health plans, employers, or other payers. PBMs negotiate drug prices, manage formularies, and process pharmacy claims.</p>
<p>Point-of-Service Plan (POS). A health plan with lower cost sharing for in-network services, but that requires a primary care gatekeeper for specialist or hospital visits.</p>
<p>Preferred Drugs / Non-Preferred Drugs. Preferred drugs are included on a formulary or preferred drug list, such as a brand-name drug without a generic substitute, while non-preferred drugs are not included on a formulary or preferred drug list, such as a brand-name drug with a generic substitute.</p>
<p>Preferred Provider Organization (PPO). A health plan that allows use of both in-network and out-of-network providers, with lower cost sharing for in-network services and no requirement for a specialist referral.</p>
<p>Premium. The amount paid, typically monthly, by the employer and/or employee to maintain health insurance coverage.</p>
<p>Premium Value Plan. A health plan offered through the Health Connector for Business that is designated as having lower-than-market-average premiums, providing employers and employees with more affordable coverage options.</p>
<p>Prior Authorization Requirements. A utilization management process used by health plans or pharmacy benefit managers that requires a provider to obtain approval from the insurer before a prescribed medication, procedure, or service will be covered. It is intended to ensure medical necessity and cost-effectiveness but can delay access to care and typically involves submitting clinical documentation for review.</p>
<p>Private Exchange. A marketplace created by a private company such as a consulting firm or insurer that allows employees from multiple organizations to choose from a larger number of health plans or insurance company options than one employer would generally provide.</p>
<p>Professional Employer Organization (PEO). An organization that enters into a co-employment relationship with an employer, handling administrative functions such as payroll, benefits, and human resources. Under a PEO arrangement, the PEO is the employer of record for insurance and benefits purposes.</p>
<p>Public Exchange. A government-established public health insurance marketplace (or “exchange”) where individuals and small employers can shop for health insurance plans. In Massachusetts, the public exchange is the Massachusetts Health Connector, which includes the Health Connector for Business program for employers (formerly known as “SHOP” or “Business Express”).</p>

<p>Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). An arrangement that allows small employers with fewer than 50 full-time equivalent employees to reimburse employees tax-free when they purchase their own health care, including non-group coverage. Funds assigned to a QSEHRA may be used for premiums and cost-sharing, as well as other qualified medical expenses. Employers offering a QSEHRA cannot also offer a group health plan to any employees.</p>
<p>Reference-Based Pricing. A payment arrangement in some indemnity health insurance plans where the plan pays a set amount for a medical service, and the enrollee pays the difference between what the plan pays and what the provider charges.</p>
<p>Reinsurance. See Stop-Loss Coverage.</p>
<p>Reimbursement for Childcare. A benefit in which the employer provides financial assistance to employees to help cover the cost of childcare, either through direct reimbursement, subsidies, or dependent care flexible spending accounts.</p>
<p>Self-Funding. See Self-Insurance.</p>
<p>Self-Insurance. A funding arrangement where claims are paid from an account funded by the employer, and the employer is financially responsible for paying claims, with the plan possibly administered by a third-party administrator. A plan can be partially self-insured up to a certain dollar amount, sometimes known as reinsurance or stop-loss coverage.</p>
<p>Small Business Tax Credit. A federal tax credit available to eligible small employers who purchase health insurance through the Health Connector for Business, pay at least half of the cost of employee premiums, have fewer than 25 full-time employees, and meet average wage requirements.</p>
<p>Specialty Drugs. Expensive drugs, such as biologics, that may be used to treat complex conditions, often given by injection or infusion and may require special handling.</p>
<p>Stop-Loss Coverage. An insurance product that limits an employer with a self-insured plan's liability for large claims or high-cost claimants. Also known as catastrophic loss coverage or reinsurance.</p>
<p>Student Loan Repayment Programs. Employer-provided benefits that help employees repay their student loans, which may include direct payments to lenders, matching contributions, or other forms of financial assistance toward outstanding educational debt.</p>
<p>Third-Party Administrator (TPA). An entity that contracts with an employer to administer benefits by paying claims, designing benefits, establishing provider networks, and coordinating other aspects of coverage.</p>

Tiered Network Plan. A health plan that organizes providers into tiers based on cost, quality, or other criteria. Enrollees pay lower cost-sharing amounts when using providers in preferred tiers and higher amounts for providers in less-preferred tiers.

Vision Insurance. Coverage for routine vision care, such as eye exams, glasses, and contact lenses, which may be provided as a standalone vision plan or as an embedded benefit within a health insurance plan. Coverage does not include situations where only medically necessary vision-related services (such as treatment for eye injuries or diseases) are covered under a medical plan; to count as a vision plan, the plan must specifically provide routine vision benefits.

Wellness Programs. Initiatives or resources offered by the employer or health plan to promote employee health and well-being, which may include activities, screenings, incentives, or educational resources focused on physical, mental, or emotional health.