Health Benefit Terms Glossary

Co-insurance. A percentage of a health care cost —such as 20 percent—that the covered employee pays after meeting the deductible.

Co-payment. The fixed dollar amount —such as $25 for each doctor visit —that the covered employee pays for medical services.

Deductible. A fixed dollar amount that the covered employee must pay out of pocket each calendar year before the plan will begin reimbursing for expenses. Plans usually require separate limits per person and per family.

Formulary. A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than higher-cost brand-name drugs.

Health savings account (HSA). HSAs may be opened by employees who enroll in a high-deductible health plan. Employees can put money in an HSA up to an annual limit set by the government using pre-tax dollars. Employers may also contribute funds to these accounts within the prescribed limit. HSA funds may be used to pay for medical expenses whether or not the deductible has been met, and no tax is owed on funds withdrawn from an HSA to pay for medical expenses. HSAs are individually owned and the account remains with an employee after employment ends.

High-deductible health plan (HDHP). An HDHP features higher annual deductibles than traditional health plans, such as a preferred provider organization (PPO) or health maintenance organization (HMO) plan. With the exception of preventive care, employees must meet the annual deductible before the plan pays benefits. HDHPs, however, may have significantly lower premiums than a PPO, HMO or other traditional plan.

Health reimbursement arrangements (HRAs). Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

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

Out-of-network. A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-of-pocket limit. The most an employee could pay during a coverage period (usually one year) for his/her share of the costs of covered services, including co-payments & co-insurance.

Premium. The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Adapted from a glossary on the web site of the U.S. Office of Personnel Management.