Health Benefits Glossary of Terms

Below is a glossary of health benefit terms that are frequently used during the open enrollment benefits season.

Co-insurance: The percentage of costs of a covered health care service an employee pays after they've paid their deductible.

Co-payment: The fixed dollar amount that the covered employee pays for medical services.

Deductible: The fixed dollar amount the employee pays for covered health care services before their insurance plan starts to pay. Plans usually require separate limits per person and per family.

Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Health savings account (HSA): A savings account that allows employees to set aside pre-tax money specifically for qualified medical expenses. By utilizing these untaxed funds, employees can effectively reduce their out-of-pocket healthcare costs by covering deductibles, co-payments, co-insurance, and other eligible 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. With the exception of preventive care, covered employees must meet the annual deductible before the plan pays benefits. The advantage of HDHPs is that they 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 an 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: A network of doctors, clinics, hospitals, and other providers who have an agreement to care for their members. When it comes to in-network health providers, health plans cover a larger portion of the cost compared to providers who are out-of-network.

Out-of-network: These are doctors, clinics, hospitals, and other providers that do not participate in that health plan's network. The provider is not contracted with the health insurance plan to accept negotiated rates. This means that patients will typically pay more or the full amount for the service they receive from their providers.

Out-of-pocket limit: The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and 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 annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

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