HEALTH BENEFITS GLOSSARY OF TERMS

The following is a glossary of commonly used health benefit terms.

- **DEDUCTIBLE:** A fixed dollar amount that the covered employee must pay out-of-pocket each calendar year before the plan will begin reimbursing for non-preventive health expenses. Plans usually require separate limits per person and per family.
  - ◊ ***Embedded Deductible:*** Each covered family member only needs to satisfy his or her individual deductible prior to receiving plan benefits. Benefits are payable for the entire family once family deductible has been reached. This applies to ***non-HSA plans***.
  - ◊ ***Aggregate Deductible***: Each covered family member's deductible amounts are applied toward the family deductible accumulation. Once the family deductible has been met, the entire family's deductible is considered met regardless of the individual amounts applied to the deductible. Individual deductible does not apply unless single coverage was elected. This applies to most ***HSA plans***.
- **COINSURANCE:** A percentage of healthcare cost, such as 20%, that the covered employee pays after meeting the deductible.
- **COPAY:** The fixed dollar amount, such as $25 for each doctor visit, that the covered employee pays for medical services. In some cases a deductible may also apply.
- **FORMULARY:** A list of prescription drugs covered by the health plan, structured in tiers with lower copays for generics than for brand name and specialty drugs.
- **HEALTH SAVINGS ACCOUNT (HSA):** HSAs may be opened by employees who enroll in a qualified high deductible health plan (HDHP). 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funds may be used to pay for medical expenses whether or not the deductible has been met, and no tax is owed on funds withdrawn from an HSA to pay for medical expenses.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):** A 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, covered 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 plans. **The IRS increased the <u>minimum</u> HDHP deductible from $1,650/$3,300 (single/family) to $1,700/$3,400 (single/family) beginning 1/1/2026.**
- **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:** Preferred Provider Organization **(PPO)** plans 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. Heath Maintenance Organization **(HMO)** plans typically do not cover non-emergency services received out-of-network.
- **OUT-OF-POCKET LIMITS:** 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 copayments and coinsurance.
- **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.

Please refer to your Summary of Benefits and Coverage (SBC) for official plan details. *Source: SHRM.*

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