



Benefits Terminology: An Overview

Co-insurance

A percentage of a health care cost — such as 10 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 nonpreventative health expenses. Plans usually require separate limits per person and per family.

Formulary

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

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. An HMO will not pay for out-of-network services except in emergencies.

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, their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as bi-weekly, and deducted from his or her paycheck.



For a comprehensive list of health care terms and definitions, refer to this online **Glossary of Health Care Terms** from BCBSIL or go to the **Risk Management Health and Benefits Literacy** webpage.