Glossary for health plan provisions for private industry workers in the United States, 2024

April 2025

This glossary is updated to reflect changes in the National Compensation Survey. Information is applicable to estimates published as of this glossary's release date. Prior versions of the glossary are available on the Annual Summaries of Benefit Coverage page. Information on survey concepts, data sources, design, and calculation are available in the Handbook of Methods: National Compensation Measures.

Healthcare benefits

Healthcare benefits provide preventive and protective medical, dental, vision, or prescription drug coverage to employees and their families. Employer sponsored plans may provide coverage for individuals, dependents, or families.

Medical care

Medical care plans provide services or payments for services rendered in hospitals or by qualified medical care providers, such as hospitals, specialists, or laboratories.

Catastrophic coverage. These plans protect against large medical expenses, but plan participants are responsible for routine medical expenses. They have low monthly premiums and higher deductibles, compared to traditional health plans.

Coinsurance. This form of medical cost sharing requires plan participants pay a stated percentage of medical expenses after the deductible amount, if any, is paid. After the deductible and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits, up to the maximum allowed charges. Participants may be responsible for any charges in excess of what insurers determine to be “usual, customary, and reasonable.” Coinsurance rates may differ between services received from an approved provider and those received from providers not on the approved list. In addition to overall coinsurance rates, rates may also differ for different types of services.

Copayments. The predetermined dollar amount that plan participants must pay when services are received before any remaining charges are paid by the plan. For hospital room and board benefits, the copayment can vary based on salary or length of stay.

Coverage limits. Limits may be set in terms of dollar or day ceiling on benefits, a requirement that plan participants pay a percentage of costs (coinsurance), or a requirement that participants pay a specific amount (deductible or copayment) before reimbursement begins or services are rendered. For example, participants pay a $250 copayment for hospital room prior to service and plan participants cover the remaining costs.

Deductible. The deductible is a dollar amount that plan participants pay during the benefit period—usually a year—before the insurer starts to make payments for covered medical services. Plans may have both individual

and family deductibles. Some plans have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may vary between services received from an approved provider (that is, a provider with whom the insurer has a contract or an agreement specifying payment levels and other requirements) and those received from providers not on the approved list or as part of a different tier of benefits. Some deductibles vary based on other factors (aside from plan network), such as employee length of service, salary range, or enrollee age. Additionally, some preventative services are free from deductible requirements, due to the Affordable Care Act.

Health Reimbursement Arrangement (HRA). HRAs may be available with medical plans and are funded solely by the employer to reimburse employees for any qualified medical expenses.

Health Savings Account (HSA). HSAs are used in combination with high deductible health plans to pay for current and future medical expenses, from pretax contributions. Additionally, HSAs may earn tax-free interest and unused contributions roll over from year to year. HSAs are controlled by the employee, although both employees and employers may contribute to them.

High deductible health plan (HDHP). These plans typically feature higher deductibles and lower insurance premiums than those of traditional (nonhigh deductible) health plans. Normally plans include catastrophic coverage to protect against large medical expenses, but plan participants are responsible for routine out-of-pocket expenses up until they meet the plan deductible.

Internal Revenue Service (IRS) minimum deductible amount allowed for single coverage HDHP plans

Year	Amount (1)
2015 – 2017	$1,300
2018 – 2019	$1,350
2020 – 2022	$1,400
2023	$1,500
2024	$1,600
Footnotes: (1) In the NCS, HDHPs are determined based on the individual deductible amount. Source: Internal Revenue Service (IRS)	

In-network. Healthcare providers (e.g., specialists, hospitals, laboratories) that have accepted contracted rates with the insurer are considered in-network. Plan participants typically pay a lower price for using services within the network.

Maximum out-of-pocket expense. The annual dollar amount limit that plan participants are required to pay out of pocket, in addition to the plan deductible. Until it is met, the insurer and participants share in the cost of covered expenses. Once reached, covered expenses are fully reimbursed for the rest of the plan year.

Most-generous coverage. Plans may provide more than two tiers of benefits which provide participants with options when selecting services. The network that provides the lowest out-of-pocket cost for services (deductible, copayment, or coinsurance) provides the most generous coverage.

Out-of-network. For services received outside the network, healthcare providers with contracted rates typically carry a higher cost to plan participants.

Overall limits. Restrictions that apply to all or most benefits under the plan, as opposed to selected individual benefits. An example of an overall limit is a $300-per-year deductible that must be paid before medical expenses become eligible for reimbursement. Another example is an 80-percent coinsurance that applies to all categories of care except outpatient surgery.

Self-insured plan. Employers directly assume the responsibility for payment of eligible benefits. Some self-insured plans bear the entire risk, while other self-insured plans protect employers from large costs through the purchasing of stop-loss coverage. Some self-insured employers contract with insurance carriers or third-party administrators for claims processing and other administrative services; other self-insured plans are self-administered.

Outpatient prescription drugs

Prescription drug plans include both stand-alone drug plans and prescription drug benefits included as part of a medical care plan. Outpatient prescription drugs dispensed during a hospital stay are covered as hospital miscellaneous charges.

Brand-name drugs. These are drugs marketed under a proprietary, trademark-protected name that once were, or still are, under patents.

Formulary drugs. These are both generic and brand-name drugs approved by the healthcare provider. They are a list of drugs compiled by health plans, third-party insurers, or governments and may be dispensed or reimbursed. Some formularies are closed (restricted) formularies where only those drug products listed are reimbursed by health plans or third-party insurers. Other formularies can be open (unrestricted) or may have restrictions limiting the use of non-formulary drugs (drugs not on the list) such as higher copayments or coinsurance. Drugs not approved by the healthcare provider are nonformulary drugs, for which plan participants receive less generous benefits, such as a higher copayment per prescription.

Generic drugs. These are drugs that are not under any patents and are comparable to a brand-reference listed drug product in dosage form, strength, route of administration, quality and performance characteristics, and intended use. Generic drugs are usually cheaper than brand name drugs and most plans provide more generous coverage for generic drugs than for brand name drugs as a cost containment measure.

Mail-order drugs. These are drugs that can be ordered through the mail. As a cost containment measure, some plans use mail-order pharmacies that typically provide a 3-month supply of maintenance drugs.