UNDERSTANDING THE BASICS OF YOUR BENEFITS

PREMIUM

The amount you pay for your health insurance or plan. This is typically on a monthly basis.

COPAYMENT

A copayment, also known as a "copay" is a fixed amount that you pay for a covered health care service after you've met your deductible. For example, your copay for a doctor's visit is $20. Your plan's allowed amount for the visit is $100. After you've met your deductible you pay $20 at the time of your visit. If you have not met your deducible, you pay the full $100.

COINSURANCE

The percentage of costs of a covered health care service that you pay after you've paid your deductible. For example, your plan's allowed amount for an office visit is $100 and your coinsurance is 20%. If you've paid your deductible, you pay 20% of $100, or $20. The insurance company pays the remaining $80. If you have not met your deductible, you pay the full $100.

DEDUCTIBLE

The amount you pay for covered health care services before your insurance plan begins to pay. The deductible may not apply to all services.

COST SHARING

The share of costs covered by your insurance that you pay out of your own pocket. The most common types of cost sharing include copayments, coinsurance and deductibles. Cost sharing does not include your premium payments, balance billing amounts for nonnetwork providers, or the cost of non-covered services.

OUT-OF-POCKET MAXIMUM

The total amount of money you have to pay for covered expenses in a plan year. After you spend this amount on deductibles, copayments and coinsurance, your plan covers 100% of the costs of covered benefits.

EOB

The Explanation of Benefits (EOB) is a statement you receive from your insurance company outlining the cost of the service provided and how much you may owe.

CLAIM

A request for payment that you or your health care provider submits to the health insurance company or plan for items of services that you believe to be covered.

PREVENTIVE CARE

Routine health care, including screenings, checkups, and shots that most plans must cover at no cost to you.

DIAGNOSTIC CARE

A test to figure out what a health problem may be. Diagnostic care is provided when you exhibit symptoms or a particular health history. Unlike most preventive care services, diagnostic care is subject to cost sharing.

NETWORK

The facilities, providers and suppliers your health insurance company or plan has contracted with to provide health care services. An in-network provider or health care service is provided in your plan's network. You will typically pay less by utilizing an in-network provider versus an out-of-network provider.

For more information and a full list of health insurance terms and definitions, visit the HealthCare.gov Glossary: healthcare.gov/glossary/