10 Health Insurance Terms You Should Know

Health insurance is one of the most valuable benefits your employer provides, yet it can be easy to take it for granted until you really need it. Understanding how your coverage works—before you're sorting through a stack of medical bills—puts you in a much stronger position. Whether you're enrolling in a plan for the first time, comparing options during open enrollment or simply trying to make sense of a recent claim, a little familiarity with the key terms and concepts can go a long way. The more informed you are, the better equipped you'll be to make the most of your benefits throughout the year and avoid costly surprises.

With many terms, definitions and concepts, the modern health insurance system can be complex and difficult to navigate. This article provides 10 terms you should know and what they mean.

1. Premium

Your premium is the amount you pay, typically deducted from each paycheck, to keep your health coverage active—whether you use it or not. It's usually the first cost you see when comparing plans, but it shouldn't be the only one.

Plans with higher premiums generally come with lower out-of-pocket costs like copays and deductibles, while lower-premium plans often mean higher costs when you do need care. Consider your expected healthcare needs for the year when deciding which balance makes the most sense for you.

2. Copayment

A copay is a fixed dollar amount you pay for a specific covered service or prescription, typically at the time of the visit or when you fill a prescription. For example, a primary care visit might have a $25 copay. The amount varies by plan and service type. As a general rule, higher-premium plans tend to have lower copays, while lower-premium plans tend to have higher copays. If you visit the doctor frequently, a plan with lower copays may save you money in the long run.

3. Coinsurance

Coinsurance is the percentage of covered medical costs you are responsible for after meeting your deductible. Unlike a copay, which is a flat fee, coinsurance is based on the total cost of the service. For example, with a 20% coinsurance rate on a $1,000 procedure, you pay $200, and your insurer pays the remaining $800. Coinsurance applies until you reach your out-of-pocket maximum.

4. Deductible

Your deductible is the amount you must pay out of pocket for covered services before your insurance begins sharing the cost. For example, if your deductible is $1,000 and you receive a $1,500 bill, you pay the first $1,000, and you would split the remaining $500 with the plan, depending on the coinsurance rate.

Many preventive services are covered before you meet your deductible. Generally, higher-deductible plans carry lower monthly premiums, and vice versa.

5. Out-of-Pocket Maximum

The out-of-pocket maximum (OOPM) is the most you will ever pay for covered, in-network services in a given plan year. Once you reach this limit, your insurance covers 100% of covered costs for the rest of the year.

Your OOPM typically includes your deductible, copays and coinsurance. Premiums and out-of-network expenses generally do not count toward it. At the start of a new plan year, your OOPM resets.

6. Prior Authorization

Prior authorization is the required approval your doctor must obtain from your insurer before certain services, procedures or medications are covered. It confirms that the care meets your plan's coverage guidelines.

Common services requiring prior authorization include the following:

- Specialty or high-cost prescription drugs
- Imaging tests such as MRIs or CT scans
- Planned surgeries or extended hospital stays

Emergency care generally does not require prior authorization, but follow-up treatment sometimes does. Check your benefits documents to understand what requires approval in advance.

7. Preventive Care

Preventive care refers to routine services that help detect or prevent illness before it becomes more serious. Most plans cover a standard set of preventive services at no cost to you—meaning no copay, coinsurance or deductible applies. Common covered services include annual physicals, vaccinations, and screenings for conditions such as high blood pressure, diabetes and certain cancers.

Taking advantage of covered preventive care is one of the best ways to protect your health and avoid higher costs down the road.

8. Explanation of Benefits

An Explanation of Benefits (EOB) is a summary from your insurer showing what a provider billed, what your plan covered and what you may owe. It is not a bill, but it is worth reviewing carefully. Checking your EOB helps you catch billing errors (such as duplicate charges), track your deductible and out-of-pocket progress, and understand why a service was or wasn't covered. If something doesn't look right, contact your insurer or the provider's billing office promptly.

9. Network

Your plan's network is the group of doctors, hospitals and healthcare providers that have agreed to discounted rates with your insurer. Using in-network providers is one of the easiest ways to keep your costs manageable. Out-of-network care often comes with significantly higher costs and little to no coverage. Always verify a provider's network status before scheduling an appointment to avoid unexpected bills.

10. Formulary

A formulary is your health plan's list of covered prescription medications, also called a prescription drug list. Medications are organized into tiers, with lower tiers (typically generics) costing less and higher tiers (brand-name or specialty drugs) costing more. Some medications may be covered at a higher percentage, while others require a lower copay or coinsurance rate.

If a drug you need isn't on your plan's formulary, talk to your doctor. There may be a covered alternative, or your doctor may be able to request an exception.

The Bottom Line

Navigating health insurance doesn't have to be overwhelming. When you understand the basics—what you're paying, what's covered and what to expect when you need care—you're in a much better position to use your benefits wisely. Take time to review your plan documents, verify provider network status before appointments, and don't hesitate to ask questions when something isn't clear.

Being an informed consumer is one of the best things you can do for both your health and your wallet. Contact your healthcare provider to learn more.

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