EMPLOYEE QUICK GUIDE / 01

Know what you pay. Know where to check.

Your plan documents and Summary of Benefits and Coverage (SBC) explain the actual coverage. This guide helps you recognize the terms and ask useful questions before enrollment or care.

Premium

The amount paid to keep coverage active, often shared by the employer and employee. A payroll deduction is generally part of the premium—not a payment toward the deductible.

Deductible

The amount you may pay for covered services before the plan begins sharing certain costs. Some services may be covered before the deductible, and separate medical or prescription rules can apply.

Copay

A set amount for a covered service, such as an office visit or prescription, when the plan uses that cost-sharing arrangement.

Coinsurance

Your percentage of the allowed amount for a covered service. For example, 20% coinsurance on a $200 allowed amount is $40, assuming the deductible and other plan rules have been satisfied.

Out-of-pocket maximum

A limit on your cost sharing for covered in-network care during the applicable plan year, subject to plan rules. Premiums, noncovered care and many out-of-network costs do not count toward this limit.

Before selecting a plan

Compare the employee premium, likely services, prescriptions, networks and worst-case covered cost sharing. A lower premium alone does not tell you which plan fits your needs.

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Check the network. Then check the service.

Use the exact plan network

Carrier names are not enough. Ask whether the clinician, facility and service are in the network for the specific plan you are considering. Verify with the insurer and provider before planned care.

Review prescriptions

Check the formulary, preferred pharmacies, drug tiers, prior authorization and any specialty-drug rules. A medication covered under one plan may have different costs or requirements under another.

Understand preventive care

Many plans cover qualifying in-network preventive services without cost sharing, but the service, eligibility, coding and plan rules matter. Diagnostic testing or treatment during a visit may be billed differently.

Ask about referrals and approval

A referral and prior authorization are different. Confirm what the plan requires before scheduled care. An authorization does not by itself guarantee payment for every billed item.

Check family deductibles

Some family plans track individual and family amounts differently. Ask how one person's expenses count, when the plan begins paying and whether the plan year resets January 1 or on another date.

Five details to save

Exact plan/network name • Member services number • Provider confirmation • Prescription coverage information • Date and reference number for important insurer conversations.

Use the Benefits 101 library for deeper explanations: benefit-experts.com/benefits-101/.

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An EOB explains a claim. It is not a bill.

The Explanation of Benefits (EOB) shows how the health plan processed a claim. A provider bill asks for payment. Compare them before paying an amount you do not understand.

Match the basics

Check the patient, provider, service date and claim number. Confirm that the services shown were received.

Follow the amounts

The billed charge is what the provider submitted. The allowed amount is the amount recognized under the plan's rules. The EOB then shows adjustments, plan payment and any patient responsibility.

Illustration: an allowed amount of $500

If $100 applies to the remaining deductible, $400 remains. At 20% coinsurance on that $400, the employee share is $80 and the plan share is $320. Total employee responsibility in this simplified example is **$180** ($100 + $80).
Actual claims depend on benefits, network status, accumulators and other rules.

Read remarks and reason codes

A denial, pending-information request or noncovered service needs an explanation. Check whether the provider needs to correct information or whether the plan needs records.

Ask before assuming the result is final

Call member services using the number on your card. Request the reason, next step and any appeal deadline. Keep copies and reference numbers. Follow the plan's formal appeal instructions when appropriate.

Privacy: Use the insurer's or administrator's secure channel for claim documents. Avoid sending diagnosis or detailed claim information through a general website contact form.

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Life changes need an enrollment step.

A marriage, new child or loss of other coverage may create enrollment rights, but a life event does not automatically update your benefits. Contact the plan administrator promptly.

Employer plan deadlines

For specified HIPAA special enrollment events, employer group plans generally allow at least 30 days to request enrollment. Medicaid/CHIP-related events generally have a 60-day window. Confirm the qualifying event, documents and effective date with your plan.

Marketplace and payroll elections are separate

Individual Marketplace special enrollment rules differ. A permitted pre-tax payroll election change is also a separate question. Do not assume one deadline or approval resolves all three.

My plan contact: _____ Phone: _____
Event / date: _____ Request deadline: _____
Documents needed: _____ Coverage effective date: _____

Questions for enrollment

What is my paycheck cost? Are my providers and medications covered? Who am I enrolling? Have I completed every required step? Where can I find confirmation of my elections?

Official sources and further reading

HealthCare.gov: Summary of Benefits and Coverage
HealthCare.gov: out-of-pocket maximum
CMS: how to read an EOB
DOL: special enrollment
HealthCare.gov: Marketplace special enrollment

Reviewed September 19, 2026. General education; actual coverage, costs and enrollment rights depend on plan terms and applicable rules. Contact your plan for individual decisions.