Understanding Plan Structure and Health Care Terminology
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ACA = Affordable Care Act
The federal government has legal requirements for all insurance plans to cover most preventative procedures for individuals. The ACA guarantees that the person covered pays no copays, deductibles, or out of pocket expenses for basic preventative healthcare. A child under the age of 26 may be claimed on the insurance plan of the employee.
https://www.healthcare.gov/coverage/preventive-care-benefits/

COB= Coordination of benefits
When a person has more than one form of insurance coverage, the payment for all medical costs is shared by each form of insurance. In addition to their employer's insurance coverage, an individual may be covered through Medicare, a spouse's or parent's insurance, or have a supplemental form of insurance. Each form of insurance will share the costs of a medical expense and there are laws to ensure these forms of insurance coordinate benefits in order to cover the costs correctly.

EOB = Explanation of Benefits
A statement of benefits is sent to all covered employees. After a medical expense an EOB should be sent to explain what was covered for that expense, but the EOB is not a bill it is only an explanation.

HSA = Health Savings Account
A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your overall health care costs. HSA funds generally may not be used to pay premiums.

HDHP or QHDP = High Deductible Healthcare Plan or Qualifying High Deductible Plan
A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible). A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

For 2022, the IRS defines a high deductible health plan as any plan with a deductible of at least $1,400 for an individual or $2,800 for a family. An HDHP's total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) can't be more than $7,050 for an individual or $14,100 for a family. (This limit doesn't apply to out-of-network services.)

In-network and out-of-network
An insurance company makes agreements with physicians, hospitals, specialists, pharmacies, etc. to be covered under the plans offered by that insurance company. These in-network agreements negotiate the costs for different medical expenses at a reduced rate for people on that insurance plan.

When a person has medical expenses not in-network, then insurance companies have different rates to the person covered on the plan. This is due to the lack of negotiated agreement with that provider so the costs are higher to the insurance company.

Definitions of Benefit and Plan terms

Copays
For specific medical visits or procedures there may be a specific dollar amount paid for that visit or procedure.

Coinsurance
The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible. Let's say your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%

Deductible
The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

Out-of-pocket maximums
The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance for in-network care and services, your health plan pays 100% of the costs of covered benefits.

The out-of-pocket limit doesn't include: Your monthly premiums; anything you spend for services your plan doesn't cover; out-of-network care and services; costs above the allowed amount for a service that a provider may charge.

Premium or employee contribution
The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.