

Glossary of terms



APPEAL A request for your health insurer or plan to review a decision of denied coverage for a treatment/service, either the payment for services received or prior approval for a service. You have the right to appeal the denial or have it reviewed by a third party, called an Independent Review Entity (IRE).

BENEFITS The healthcare items or services covered under a health insurance plan. The health insurance plan's coverage documents will define which benefits are covered and which are outside of coverage or excluded from coverage.

BENEFITS INVESTIGATION An investigation of your insurance plan's coverage benefits to determine the extent to which medications are covered by your insurance plan and whether there are any prior authorization requirements.

CLAIM A request for payment that you or your healthcare provider (HCP) submits to your health insurance plan after you receive covered items or services.

CO-PAYMENT OR CO-INSURANCE The part of a medical bill that you must pay after the insurance company pays their part – essentially, the cost-sharing portion. Co-payments or co-pays refer to a set dollar amount the beneficiary must pay for a covered service. Co-insurance requires the beneficiary to pay a fixed percentage (rather than a set dollar amount) of expenses after the deductible amount is paid until the beneficiary reaches their out-of-pocket (OOP) maximum.

Note: co-pay amounts differ depending on whether the service or procedure was received by an in-network or out-of-network provider or facility.

Note: co-insurance percentage amounts may differ depending on whether the service or procedure was received by an in-network or out-of-network provider or facility.

DEDUCTIBLE A fixed amount of money you have to pay before your health insurance plan will begin to pay for any benefits.

OUT-OF-POCKET (OOP) LIMIT OR MAXIMUM The maximum amount you will be required to pay for covered services in a year, before the plan covers 100% of all costs. Generally, this includes the deductible, co-insurance, and co-payments (varies from plan to plan), but not premiums. Plans can set different out-of-pocket limits for different services, and some plans do not have out-of-pocket limits.

MEDICAL NECESSITY Reasonable, necessary, and/or appropriate treatment and services for your health condition based on established clinical standards of care.

OUT-OF-POCKET (OOP) COSTS The fees you pay out-of-pocket when you receive medical care – they may be a combination of deductibles, co-payments, and co-insurance. The Affordable Care Act (ACA) sets an annual limit on out-of-pocket costs, which includes deductibles, co-insurance, and co-payments, or similar charges, but it doesn't include premiums, or the cost of non-covered services.

Note: separate cost-sharing limits apply in Medicaid and CHIP, which include premiums.

PREMIUM A monthly or annual payment you make to your insurer to obtain and maintain insurance coverage. Premiums can be paid by employers, unions, employees, or individuals or shared among different payers.

PRIOR AUTHORIZATION An approval that an insurer requires before it will cover your prescription. If a prior authorization is not completed, you may pay more for the medication, or it may not be covered.

SPECIALTY PHARMACY A type of pharmacy that focuses on specialty medications for patients with complex and/or serious health conditions. Specialty pharmacy providers may provide home health or nursing services.

SUMMARY OF BENEFITS The ACA requires plans to offer this easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You'll get the "Summary of Benefits and Coverage" (SBC) when you shop for coverage on your own or through your job, renew or change coverage, or request a Summary of Benefits from the health insurance company.

Reference: Health Care and Insurance Related Terms, National Organization for Rare Disorders, 2025, <https://www.claimyourcare.org/wp-content/uploads/2025/03/Healthcare-Acronyms-Glossary-1.pdf>