Insurance Term Glossary

Understanding the basics

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The knowledge of insurance terminology can be important and may be especially helpful when reviewing, understanding, and communicating about your existing or future insurance coverage. There are many terms that may be unfamiliar when discussing health insurance. Below are some glossary definitions to help explain what some of these terms mean.

- *Coinsurance* is the percentage of costs of a covered health care service you pay after you've paid your deductible[1]
- *Copayment* is a fixed amount you pay for a covered health care service after you've paid your deductible[1]
- *Deductible* is the amount you pay for covered health care services before your insurance plan starts to pay[1]
- *Exclusions* or *excluded services* are health care services for which your insurance doesn't pay[1]
- A *formulary* is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits[1]
- *Generic drugs* are prescription drugs that have the same active-ingredient formula as a brand-name drug[1]
- *In-network* means providers or health care facilities that have contracted with your insurance company to participate in a plan[2]
- An annual *limit* is a cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan[1]
- *Medical exceptions* are requests that are granted when a plan sponsor determines that a drug is medically necessary[3]
- *Orphan drugs* are those intended for the treatment, prevention, or diagnosis of a rare disease or condition (one that affects fewer than 200,000 persons in the US or meets certain cost recovery provisions)[4]
- *Out-of-network* means that a doctor or physician does not have a contract with your health insurance plan provider[2]
- *Out-of-pocket* (OOP) costs are your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered[1]
- *Pharmacy benefit managers*, or PBMs, are companies that manage prescription drug benefits on behalf of payers[5]
- *Premiums* are the amount you pay for your health insurance every month[1]
- *Prior authorization* or *preauthorization* is approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan[1]
- *Quantity limits* are restrictions on the amount of medication that is covered by your plan on one prescription[6]
- *Specialty medications* are medications used to treat rare, chronic, or complex conditions[6]
- *Step edits* or *step therapy* are policies that require patients to try therapies in a particular order[6]
- *Tiers* are levels of coverage for prescription medicine. Each tier will have a different level of patient cost sharing[6]

These are just a few of the terms that often come up in discussions about health plans. The US federal government provides even more definitions at www.healthcare.gov/glossary to help further understand terminology surrounding insurance coverage.

References 1. Glossary. HealthCare.gov website. Accessed April 27, 2022. https://www.healthcare.gov/glossary/ **2.** Montgomery K. What an out-of-network provider means. Verywell Health website. Updated May 9, 2021. Accessed April 27, 2022. https://www.verywellhealth.com/out-of-network-1738597 **3.** Exceptions. Centers for Medicare and Medicaid Services website. Updated December 1, 2021. Accessed April 27, 2022. https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Exceptions **4.** Developing products for rare diseases & conditions. US Food and Drug Administration website. Updated December 20, 2018. Accessed April 27, 2022. https://www.fda.gov/industry/developing-products-rare-diseases-conditions **5.** Pharmacy benefit managers and their role in drug spending. The Commonwealth Fund website. Published April 22, 2019. Accessed April 27, 2022. https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending **6.** Formularies. HealthAffairs.org website. Published September 14, 2017. Accessed April 27, 2022. https://www.healthaffairs.org/do/10.1377/hpb20171409.000177/full/

Questions to Ask: Guiding a Discussion About Insurance Coverage

Asking questions can help you make a decision about which plan is right for you

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Understanding your insurance plan is important. Here are some questions to help guide a discussion about your health insurance.

Plan Coverage

- What type of plan is it?
- What is the premium for the plan?
- Does the plan cover all the services I need?
- Does the plan cover prescription drugs?
- Are referrals required, and if so, for which services?
- What is the total of my out-of-pocket costs, including medical and prescription copays, deductibles, and coinsurance?
- Am I covered if I get sick or need treatment out of state?
- Are laboratory testing services (lab work) included in the plan? What is covered?

Limitations

- What are the plan's exclusions or limitations?
- Are there annual limits on the number of visits for any particular service? (Ex: physical therapy and nursing home care is often limited to a certain number of visits per year)
- Is there a lifetime or yearly limit or cap?

Network

- Are my physicians in-network?
- Can I only see doctors in-network?
- What is the cost to see an out-of-network doctor?
- Are out-of-network benefits available? What percentage of the cost am I responsible for if I receive out-of-network care?

Here are some additional questions that people with rare conditions may consider:

- Is my medication covered under the major medical or pharmacy benefit?
- Do I have a choice of more than one specialty pharmacy?
- Is durable medical equipment covered?
- Do I need a referral to see a specialist?
- What services require prior authorization?
- Are home health services covered?

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