GLOSSARY OF HEALTH COVERAGE TERMS

YOUR voice. treatment. choice.

The glossary below can help you understand some of the words you may come across in communications from your health plan. Note that while this glossary has many commonly used terms, it is not a full list. These terms and definitions may not exactly match the terms and definitions in your health plan. If that is the case, your health plan's policy governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Appeal
A request for your health insurance company to review a decision that denies a benefit or payment.

Claim
A request for payment that you or your healthcare provider submits to your health insurer when you get items or services you think are covered.

Commercially insured
Having health insurance provided and administered by non-governmental entities.

Co-payment
A fixed amount ($20, for example) you pay for a covered healthcare expense after you've paid your deductible.

Deductible
The amount you pay for covered healthcare 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.

Denial
When your health insurance company notifies you that it will not cover the cost of your medication or treatment.

Drug list
A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits; also called a formulary (see below).

Eligible
Meeting the necessary conditions or requirements or having the necessary qualifications for a certain benefit.

Exception
A coverage determination that you, your doctor, or your representative may request from your health insurance plan to reconsider their coverage decision.

Exception letter
A formulary exception is a type of coverage determination that is used when a medication is not included on a health plan's formulary (list of drugs) or is subject to an NDC block. A Formulary Exception Request Letter is a written request asking that the restriction placed on a specific medication be released as it is medically appropriate and necessary for the patient's treatment. Out-of-network providers may seek a provider exception using this process, especially for patients being treated in the hospital.

External review
A review of a plan's decision to deny coverage for or payment of a service by an independent third party not related to the plan. If the plan denies an appeal, an external review can be requested.

Formulary
A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits; also called a drug list (see above).

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GLOSSARY OF HEALTH COVERAGE TERMS (CONT'D)

Grievance
A complaint that you communicate to your health insurer or plan.

Health coverage
Legal entitlement to payment or reimbursement for your healthcare costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

Letter of Medical Necessity
A letter written by your doctor explaining why the requested item or service is medically important for your treatment.

Medically necessary
Healthcare expenses or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine.

Out-of-pocket costs
Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, co-insurance, and co-payments for covered services plus all costs for services that are not covered.

Peer-to-peer review
A review between your doctor and your health insurance company in which your doctor explains why it is important for your prescription to be covered.

Plan
A benefit your employer, union, or other group sponsor provides to you to pay for your healthcare services.

Plan ID
A unique identifier that's a combination of numbers and/or letters. You can find a plan's ID below the plan name when you preview plans and prices.

Plan year
A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer.

Prescription drug coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription drugs
Drugs and medications that, by law, require a prescription.

Prior authorization
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.

To find additional terms and definitions, please visit:
https://www.healthcare.gov/glossary/

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