MESH Collective provides this Healthcare & Benefits Glossary in order to help members understand medical bills, health insurance, virtual care, prescription savings, dental and vision discounts, other ways to access care, and many other items.

The most important feature is a clear distinction between insurance, non-insurance benefits, and discount programs. These can look similar to consumers, but they work very differently when someone needs care or receives a bill.

Each entry has a simple definition, a practical explanation where it is useful, and a category label to help people understand what type of product or service is being discussed.

How members should read the labels in the Glossary

INSURANCE

An insurance policy or plan that covers specified health costs under its terms. It may pay providers directly or reimburse covered costs. Deductibles, copays, coinsurance, exclusions, and other rules may apply.

NON-INSURANCE BENEFIT

A service, membership, or other benefit that may provide access to care, support, or assistance without being health insurance. What is included depends on the agreement.

DISCOUNT PROGRAM

A program that may help members obtain lower prices from participating providers or pharmacies. It generally does not pay the bill or guarantee that a service will be covered.

GENERAL HEALTHCARE TERM

A medical, billing, legal, or administrative term that helps members understand healthcare and their choices.

Important: A service being called a “benefit” does not automatically mean it is insurance. Likewise, a membership card, app, provider network, or discount card does not by itself establish that medical expenses are insured.

Understand the Difference: Insurance vs. Benefits vs. Discounts

1. Health insurance

Insurance helps pay for covered medical expenses under a policy or plan. Depending on the plan, it may cover office visits, hospital stays, prescriptions, tests, and other services.

Examples:

- Major medical health insurance
- ACA Marketplace health plans
- Employer-sponsored health insurance
- Dental or vision insurance
- Hospital indemnity insurance
- Specified-disease insurance

Remember: Not every insurance product provides comprehensive medical coverage. A limited-benefit policy may pay only a fixed amount or cover only certain events.

2. Non-insurance benefits

These services may help people access care, understand their options, or manage healthcare needs without serving as medical insurance.

Examples:

- Virtual care memberships
- Care navigation
- Medical bill assistance
- Employee assistance programs
- Direct primary care arrangements
- Healthcare education and resource libraries
- Provider-finding services

Remember: A non-insurance benefit may be useful even when someone has insurance. However, it may not pay the provider's bill or protect a person from large medical expenses.

3. Discount programs

Discount programs may help members obtain lower prices from participating providers, pharmacies, or other businesses.

Examples:

- Prescription discount cards
- Dental discount plans
- Vision discount plans
- Lab test discount programs
- Participating-provider discount networks

Remember: The member generally pays the discounted price directly. Participation, availability, prices, and restrictions can vary. A discount is not a promise that a provider will offer the lowest price available.

Questions Worth Asking

1. Is this product health insurance, a non-insurance benefit, or a discount program?
2. Who provides the service, and who is responsible for paying medical claims?
3. Does the product pay bills, reimburse eligible costs, or only provide access to services or lower prices?
4. Which providers participate, and can I confirm the price before receiving care?
5. Are there membership fees, service fees, copays, deductibles, or other charges?
6. What services are excluded or limited?
7. What happens if I need emergency care, hospitalization, surgery, or expensive medication?
8. Is there a written agreement that explains what I am buying?
9. Can the service be used alongside my existing insurance?
10. How do I cancel, renew, or file a complaint?
11.

A final reminder: A membership, app, discount card, navigation service, or virtual care program should not be treated as a replacement for comprehensive health insurance unless it actually provides qualifying coverage. Review the written terms and ask questions before enrolling.

Healthcare Glossary

Understand Your Options. Make More Informed Choices.

Healthcare has its own language. Understanding common terms can help you compare prices, understand your bills, ask better questions, and make informed decisions about your care.

Before you begin: Not every healthcare product is insurance. Some products help pay covered medical expenses, some provide access to services, and others offer discounts. Read each definition and its category to understand the difference.

Category key

- **[INSURANCE]** A policy or plan that covers certain costs under its terms.
- **[NON-INSURANCE BENEFIT]** A service or membership that provides access, support, or other benefits without being health insurance.
- **[DISCOUNT PROGRAM]** A program that may reduce the price of certain services or products.
- **[GENERAL HEALTHCARE TERM]** A medical, billing, legal, or administrative term.

A

Allowed Amount — [INSURANCE / GENERAL HEALTHCARE TERM]

The maximum amount a health plan recognizes for a covered service under its rules. This amount may be based on a contract, an approved fee schedule, or another payment method. It is not always the same as the provider's original price.

Ambulatory Care — [GENERAL HEALTHCARE TERM]

Medical care that does not require an overnight hospital stay. Doctor visits, outpatient surgery, and many tests are examples.

Annual Limit — [INSURANCE]

A limit on how much a plan will pay or how much a member may receive for a certain service or benefit during a year. The type of limit matters. Many ACA-compliant health plans cannot place annual dollar limits on essential health benefits, but other limits may apply to certain services or products.

Appeal — [INSURANCE / GENERAL HEALTHCARE TERM]

A request to review a decision, such as a denied claim, refused treatment authorization, or disputed bill. The steps and deadlines depend on the plan, provider, or law involved.

Association Membership — [NON-INSURANCE BENEFIT]

Membership in a group that may provide educational resources, services, negotiated offers, or access to participating vendors. Membership alone does not provide health insurance unless a separate, valid insurance arrangement exists.

Authorization — [INSURANCE / GENERAL HEALTHCARE TERM]

Permission that may be required before a plan will cover certain services. A provider may need to request this permission from the health plan. Authorization does not always guarantee payment.

Allowed Provider — [GENERAL HEALTHCARE TERM]

A provider who meets the participation or eligibility rules of a particular program or plan. Ask what those rules mean for the price you will pay.

B

Balance Billing — [INSURANCE / GENERAL HEALTHCARE TERM]

When a provider bills a patient for the difference between the provider's charge and the amount the provider received or was allowed to collect from a health plan. Whether this is allowed depends on the circumstances, contracts, and applicable law. Federal protections restrict many surprise bills for emergency care and certain other services.

Behavioral Health — [GENERAL HEALTHCARE TERM]

Care for mental health, emotional well-being, and substance use concerns. It may include counseling, therapy, psychiatric care, and other support.

Benefit — [GENERAL HEALTHCARE TERM]

A service, payment, discount, or other feature available through a plan or program. The word “benefit” does not automatically mean insurance coverage.

Benefit Limit — [INSURANCE / NON-INSURANCE BENEFIT]

A restriction on how much of a service or benefit is available. Examples include a set number of visits, a maximum payment, or a limit on how often a service can be used.

Billing Advocate — [NON-INSURANCE BENEFIT]

A person or company that helps review medical bills, identify possible errors, contact providers, or negotiate charges. Fees and results vary. Some services charge members, while others may earn fees from employers or other organizations.

Bundled Care — [GENERAL HEALTHCARE TERM]

A group of healthcare services offered together for one combined price or payment arrangement. A bundle may include a procedure, facility services, and follow-up care. Always ask what is included and what may cost extra.

Bundled Payment — [GENERAL HEALTHCARE TERM]

One payment intended to cover several related healthcare services. The payment arrangement between providers does not, by itself, determine how much a patient owes.

C

Cash-Pay Price — [GENERAL HEALTHCARE TERM]

The price a provider offers when a patient pays directly rather than using health insurance for that service. Ask whether the price includes all related fees, tests, supplies, and follow-up care.

Catastrophic Coverage — [INSURANCE]

Coverage designed to protect against very high healthcare costs. In the individual insurance market, catastrophic health plans have specific eligibility and benefit rules. Other plans may use the word “catastrophic” differently.

Claim — [INSURANCE]

A request for payment submitted to a health plan for healthcare services or supplies. A claim may be approved, denied, or paid in part.

COBRA — [INSURANCE / GENERAL HEALTHCARE TERM]

A federal law that may allow eligible workers and family members to continue certain employer-sponsored group health coverage after a qualifying event. The person continuing coverage generally pays the premium, including amounts previously paid by the employer, plus any permitted administrative fee.

Coinsurance — [INSURANCE]

The percentage of a covered medical bill you pay after meeting any applicable deductible. For example, if your coinsurance is 20%, you may owe 20% of the plan's allowed amount for a covered service, subject to the plan's rules.

Copay (Copayment) — [INSURANCE]

A fixed amount you pay for a covered service, such as $30 for a doctor visit. The amount may vary by service and plan.

Coordination of Benefits — [INSURANCE]

Rules used when a person has more than one health plan to determine which plan pays first and how the plans handle remaining costs. Having two plans does not mean every bill will be paid in full.

Cost Sharing — [INSURANCE]

The portion of covered healthcare costs you pay under your plan. It commonly includes deductibles, copays, and coinsurance.

Covered Service — [INSURANCE]

A healthcare service or supply that qualifies for benefits under a plan's terms. Coverage may depend on medical need, network rules, authorization, and other conditions.

Credentialed Provider — [GENERAL HEALTHCARE TERM]

A healthcare professional whose qualifications, licenses, training, or other credentials have been reviewed. Credentialing does not automatically mean the provider participates in your insurance plan.

Customary Charge — [GENERAL HEALTHCARE TERM]

A term sometimes used to describe a typical charge for a service in a certain area or setting. The meaning may vary by contract or program. It does not necessarily determine the amount a provider must accept.

D

Deductible — [INSURANCE]

The amount you must pay for certain covered healthcare services before your plan begins paying its share. Some services may be covered before you meet the deductible. Plans can also have separate deductibles for different types of coverage.

Denied Claim — [INSURANCE]

A claim the health plan refuses to pay in full or in part. Common reasons include missing information, lack of required authorization, or a service that does not meet the plan's coverage rules. A denial may be appealable.

Dental Discount Plan — [DISCOUNT PROGRAM]

A program that offers members access to reduced prices for certain dental services through participating dentists. It generally does not pay dental bills like dental insurance does.

Dental Insurance — [INSURANCE]

An insurance policy that helps pay for covered dental services according to its terms. It may have deductibles, annual maximums, waiting periods, coinsurance, and service-specific limits.

Dependent — [INSURANCE]

A person who qualifies for coverage under another person's health plan, such as an eligible child or spouse. Eligibility rules depend on the plan and applicable law.

Diagnosis — [GENERAL HEALTHCARE TERM]

The name of an illness, injury, or health condition identified by a healthcare professional.

Direct Primary Care (DPC) — [NON-INSURANCE BENEFIT]

An arrangement in which a patient pays a provider a recurring fee for an agreed set of primary care services. DPC arrangements generally are not health insurance and may not cover specialists, hospital care, or other major expenses.

Discount Card — [DISCOUNT PROGRAM]

A card or digital tool that may help you receive a lower price from participating providers or pharmacies. It is not the same as an insurance card.

Durable Medical Equipment (DME) — [INSURANCE / GENERAL HEALTHCARE TERM]

Medical equipment designed for repeated use, such as wheelchairs, walkers, or certain home oxygen equipment. Insurance payment depends on the plan's rules and medical requirements.

E

Emergency Care — [GENERAL HEALTHCARE TERM]

Medical care for a condition that may seriously threaten a person's health or requires immediate attention. Emergency coverage rules depend on the applicable plan and law. Call emergency services for a life-threatening emergency.

Employee Assistance Program (EAP) — [NON-INSURANCE BENEFIT]

An employer-sponsored program that may offer short-term counseling, referrals, work-life resources, or other support. It generally is not a replacement for health insurance or ongoing treatment coverage.

Employer-Sponsored Health Plan — [INSURANCE]

Health coverage offered through an employer. Depending on the arrangement, the employer may pay claims directly or purchase insurance from an insurer.

Essential Health Benefits — [INSURANCE]

A set of benefit categories that certain individual and small-group health plans must cover under federal law. The categories include hospitalization, prescription drugs, and preventive care, among others. Requirements vary by plan type and market.

Explanation of Benefits (EOB) — [INSURANCE]

A statement from your health plan showing how a claim was processed. It may list the provider's charge, the allowed amount, the plan's payment, and the amount you may owe. An EOB is generally not a bill.

Excluded Service — [INSURANCE]

A service or item the plan does not cover under its terms. You may have to pay the full price unless another arrangement applies.

F

Facility Fee — [GENERAL HEALTHCARE TERM]

A charge for the use of a healthcare facility, such as a hospital outpatient department. It may be separate from the professional fee charged by the doctor. Ask whether a quoted price includes both.

Fee-for-Service — [GENERAL HEALTHCARE TERM]

A payment method in which a provider receives payment for each service delivered. This differs from some arrangements that pay a set amount for a group of services or a period of time.

Formulary — [INSURANCE]

A list of prescription drugs covered by a health plan or its pharmacy benefit manager. Drugs may be grouped into tiers with different costs. A drug's presence on the list does not mean every prescription will be covered in every situation.

Front Door to Care — [NON-INSURANCE BENEFIT / GENERAL HEALTHCARE TERM]

A term for the first point where a person seeks help finding or accessing care. It may be a website, app, nurse line, care guide, or navigation service. It does not automatically mean the service provides insurance or clinical treatment.

G

Generic Drug — [GENERAL HEALTHCARE TERM]

A medicine approved as equivalent to a brand-name drug in active ingredient, strength, dosage form, and other required standards. Generic medicines often cost less, although prices vary.

Good Faith Estimate (GFE) — [GENERAL HEALTHCARE TERM]

An estimate of expected charges for certain healthcare items and services for people who are uninsured or self-pay. Eligible patients have federal rights to receive estimates in certain situations. The estimate may not include every service or unexpected charge.

Grace Period — [INSURANCE]

A period after a payment due date during which coverage may remain in effect under specified conditions. The rules depend on the plan and applicable law. A grace period does not always prevent a lapse in coverage.

Group Health Insurance — [INSURANCE]

Health insurance issued to cover a group, often through an employer or an eligible organization. Special legal rules may apply depending on the group and arrangement.

Guaranteed Issue — [INSURANCE]

A rule requiring an insurer to offer certain coverage without refusing an eligible applicant because of health status. The rule applies in specific markets and circumstances.

H

Health Benefit — [GENERAL HEALTHCARE TERM]

A service, payment, discount, or other offering intended to support health or access to care. Always check whether the offering is insurance, a non-insurance service, or a discount program.

Health Insurance — [INSURANCE]

A policy or legally recognized coverage arrangement that helps pay for covered medical expenses under its terms. Coverage may include limits, exclusions, cost sharing, and rules for using providers.

Health Maintenance Organization (HMO) — [INSURANCE]

A type of health plan that generally uses a network of providers and may require a primary care provider or referrals for certain services. Emergency and other legal protections may apply outside the network.

Health Reimbursement Arrangement (HRA) — [EMPLOYER HEALTH BENEFIT]

An employer-funded arrangement that reimburses eligible healthcare expenses under specific federal rules. An HRA is not the same as a health insurance policy, though some HRA types are designed to work with qualifying insurance coverage.

Health Savings Account (HSA) — [HEALTHCARE FINANCIAL ACCOUNT]

A tax-advantaged account that eligible individuals can use to pay qualified medical expenses. Eligibility rules apply, including requirements related to health coverage. An HSA is not insurance and does not itself pay providers automatically.

High-Deductible Health Plan (HDHP) — [INSURANCE]

A health plan that meets applicable legal requirements for deductibles and other features. Some HDHPs allow eligible members to contribute to an HSA. A high deductible does not mean every service is subject to that deductible.

Hospital Indemnity Insurance — [INSURANCE]

A policy that pays a set cash benefit when covered events occur, such as a qualifying hospital stay. The payment may be made to the insured person rather than directly to the hospital. It is not a substitute for comprehensive health insurance.

I

In-Network Provider — [INSURANCE]

A provider or facility that has a contract with your health plan or its network. Using an in-network provider often lowers your costs, but the service must still meet the plan's coverage rules.

Indemnity Insurance — [INSURANCE]

Insurance that pays a specified amount or benefit when a covered event occurs, according to the policy. The payment may not match the actual medical bill.

Individual Health Insurance — [INSURANCE]

Coverage purchased by an individual or family rather than provided through an employer group plan. Marketplace plans are one type of individual health insurance.

Insurance Broker — [GENERAL HEALTHCARE TERM]

A licensed professional who helps people or organizations compare and obtain insurance products. Brokers may receive commissions or other compensation. Ask how the broker is paid and which products they can offer.

Insurance Premium — [INSURANCE]

The amount paid to keep an insurance policy in force. Premiums may be paid monthly or on another schedule. Paying the premium does not eliminate deductibles, copays, coinsurance, or other possible costs.

Insured Person — [INSURANCE]

A person covered by an insurance policy or plan.

Integrated Care — [GENERAL HEALTHCARE TERM]

Care in which different healthcare professionals or services work together to support a person's needs. The exact services included depend on the organization or program.

J

Joint Replacement — [GENERAL HEALTHCARE TERM]

Surgery to replace a damaged joint, such as a hip or knee, with an artificial joint. The total cost may include the surgeon, facility, anesthesia, implants, rehabilitation, and follow-up care.

Just-in-Time Care — [GENERAL HEALTHCARE TERM]

Care arranged when it is needed rather than through a regular, ongoing relationship with one provider. The term may be used informally and does not describe a specific insurance product.

K

Ketamine Therapy — [GENERAL HEALTHCARE TERM]

Treatment involving ketamine in certain clinical settings for specific conditions. Approval, evidence, risks, and coverage vary by use and setting. Confirm the clinician's qualifications, the treatment plan, and the full cost before proceeding.

Kidney Dialysis — [GENERAL HEALTHCARE TERM]

Treatment that helps remove waste and extra fluid from the blood when the kidneys cannot do so well enough. Coverage depends on the person's insurance and applicable program rules.

L

Lab Test — [GENERAL HEALTHCARE TERM]

A test performed on a sample such as blood, urine, or saliva to help assess health, diagnose a condition, or monitor treatment. Prices can vary between laboratories and locations.

Lab Test Discount Program — [DISCOUNT PROGRAM]

A program that may offer lower prices for selected laboratory tests through participating providers. Check whether the quoted price includes the collection fee, lab processing, and any required provider order.

Lifetime Limit — [INSURANCE]

A maximum amount a plan will pay over a person's lifetime for a specified benefit. Federal law generally prohibits lifetime dollar limits on essential health benefits in covered health plans, but other benefit limits may apply.

Limited-Benefit Insurance — [INSURANCE]

Insurance that pays benefits for a narrower set of events or services than comprehensive health insurance. Examples may include certain accidents, hospital indemnity, or specified-disease policies. It should not be assumed to cover routine or major medical expenses broadly.

Medical Bill Advocate — [NON-INSURANCE BENEFIT]

A person or company that helps review bills, question charges, contact billing departments, or seek payment arrangements. Some charge a fee, while others are paid by another party.

Medical Necessity — [INSURANCE / GENERAL HEALTHCARE TERM]

A standard used to decide whether a service is appropriate and needed for a person's health condition under applicable clinical or coverage rules. A provider's recommendation does not always mean an insurer will approve payment.

Medical Savings — [GENERAL HEALTHCARE TERM]

Money saved by comparing prices, using eligible discounts, selecting a lower-cost site of care, or reducing avoidable expenses. Savings are not guaranteed, and lower prices do not always mean services are equivalent.

Member — [GENERAL HEALTHCARE TERM]

A person enrolled in a plan, association, or service program. Membership does not automatically establish insurance coverage.

Member Cost — [GENERAL HEALTHCARE TERM]

The amount a person is expected to pay for a service. It may include a deductible, copay, coinsurance, excluded charges, or the full self-pay price.

Member Portal — [NON-INSURANCE BENEFIT / GENERAL HEALTHCARE TERM]

A website or app that allows members to view information, use services, manage appointments, or access resources. A portal is a tool, not insurance coverage by itself.

Mental Health Benefit — [INSURANCE / NON-INSURANCE BENEFIT]

A benefit that supports mental health care. It may be included in an insurance plan or offered separately through counseling services, employee assistance programs, or other arrangements. Check the exact services and limits.

Minimum Essential Coverage (MEC) — [INSURANCE / GENERAL HEALTHCARE TERM]

A term used in federal health coverage rules. It includes certain types of coverage recognized under the Affordable Care Act. A limited service membership or discount card should not be assumed to qualify as MEC.

N

Narrow Network — [INSURANCE]

A health plan network that includes a smaller group of providers than some other plans. It may offer lower premiums or other features, but fewer provider choices can make access and travel more important to consider.

Negotiated Rate — [INSURANCE / GENERAL HEALTHCARE TERM]

A price agreed upon between parties, such as an insurer and a provider. A negotiated rate may differ from the provider's listed price or a self-pay price.

Network — [INSURANCE / DISCOUNT PROGRAM]

A group of providers, pharmacies, facilities, or other businesses that participate in a particular plan or program. An insurance network and a discount-program network do not provide the same protections.

Network Discount — [DISCOUNT PROGRAM / INSURANCE]

A price reduction associated with using a participating provider. Under insurance, a negotiated rate can affect the amount used to calculate cost sharing. Under a discount program, the member may still have to pay the reduced price directly.

Non-Covered Service — [INSURANCE]

A service that a plan does not cover under its rules. The member may be responsible for the full charge unless another payment arrangement applies.

Non-Emergency Medical Transportation (NEMT) — [INSURANCE / NON-INSURANCE BENEFIT]

Transportation to or from healthcare services when a person does not need an ambulance. Some insurance or public programs cover certain trips, and other organizations may offer transportation assistance.

Non-Insurance Product — [NON-INSURANCE BENEFIT]

A service or arrangement that does not transfer medical-cost risk as health insurance does. Examples can include virtual care memberships, care navigation, provider discounts, and wellness resources. The exact legal classification depends on the product and its terms.

O

Observation Stay — [GENERAL HEALTHCARE TERM]

A hospital stay in which a patient is monitored or treated without being formally admitted as an inpatient. The classification can affect billing and coverage.

Open Enrollment — [INSURANCE]

A set period when eligible people can enroll in or change certain health plans. Dates and rules vary by plan type. Special enrollment opportunities may be available after qualifying life events.

Out-of-Network Provider — [INSURANCE]

A provider who does not have a contract with your health plan's network. Care from this provider may cost more or may not be covered, except where plan terms or laws provide otherwise.

Out-of-Pocket Costs — [INSURANCE / GENERAL HEALTHCARE TERM]

Money you pay yourself for healthcare. It may include premiums, deductibles, copays, coinsurance, and services that are not covered. Not all costs count toward an insurance plan's out-of-pocket maximum.

Out-of-Pocket Maximum — [INSURANCE]

The annual limit on what you pay for covered, in-network essential health benefits under many ACA-compliant plans. Premiums, non-covered services, and certain out-of-network costs generally do not count toward this limit.

Outpatient Care — [GENERAL HEALTHCARE TERM]

Care that does not require an overnight hospital stay. Examples include office visits, many diagnostic tests, and some surgeries.

P

Patient Navigation — [NON-INSURANCE BENEFIT]

Help finding providers, understanding care options, arranging appointments, or moving through the healthcare system. Navigation services do not automatically pay medical bills or guarantee that care will be covered.

Patient Responsibility — [GENERAL HEALTHCARE TERM]

The amount a patient owes after payments, adjustments, and applicable coverage rules are considered. Check the provider's bill and the insurer's explanation of benefits before paying a disputed amount.

Pharmacy Benefit Manager (PBM) — [GENERAL HEALTHCARE TERM]

A company that manages certain prescription drug benefits for health plans or other organizations. PBMs may negotiate with pharmacies and drug manufacturers, manage drug lists, and process prescription claims.

Physical Therapy — [GENERAL HEALTHCARE TERM]

Treatment that helps improve movement, strength, balance, or function after an injury, illness, or surgery. Coverage may depend on medical need, visit limits, referrals, or authorization.

Point of Service (POS) Plan — [INSURANCE]

A type of health plan that combines features of managed care and out-of-network options. Costs and referral rules depend on the plan.

Preauthorization (Prior Authorization) — [INSURANCE]

Approval a health plan may require before certain services, drugs, or procedures. Getting approval does not always guarantee that the plan will pay the claim.

Pre-Existing Condition — [GENERAL HEALTHCARE TERM]

A health condition that existed before a person applied for or started certain coverage. ACA-compliant individual and group health plans generally cannot deny coverage or charge more because of pre-existing conditions. Other products may have different rules.

Preferred Provider Organization (PPO) — [INSURANCE]

A type of health plan that uses a network of providers and often offers some coverage for out-of-network care at a higher cost. The plan's specific rules determine member costs and coverage.

Premium — [INSURANCE]

The amount paid to maintain an insurance policy. A premium is separate from most charges you may owe when receiving care.

Prescription Discount Card — [DISCOUNT PROGRAM]

A card or digital service that may provide lower prices on certain medicines at participating pharmacies. It generally is not insurance and usually does not pay the pharmacy bill for you. The discounted price may differ from your insurance price.

Prescription Drug Coverage — [INSURANCE]

Coverage that helps pay for eligible prescription medicines under a health plan's rules. Drug lists, pharmacies, prior authorization, and cost-sharing rules may apply.

Preventive Care — [INSURANCE / GENERAL HEALTHCARE TERM]

Services intended to prevent illness or detect health problems early, such as certain screenings and vaccines. Many covered preventive services are available without cost sharing in eligible ACA-compliant plans when requirements are met.

Primary Care Provider (PCP) — [GENERAL HEALTHCARE TERM]

A healthcare professional who helps manage routine care, common health concerns, and referrals when needed. Some health plans require members to select a PCP.

Provider — [GENERAL HEALTHCARE TERM]

A person or organization that delivers healthcare, such as a physician, therapist, laboratory, clinic, or hospital.

Provider Directory — [INSURANCE / DISCOUNT PROGRAM]

A list of providers participating in a plan or program. Directories may not always be up to date. Confirm participation and the expected price directly before receiving care.

Q

Qualified Health Plan (QHP) — [INSURANCE]

A health insurance plan certified to be offered through an applicable Affordable Care Act Marketplace and required to meet specified standards.

Qualifying Life Event — [INSURANCE]

A change in circumstances, such as losing certain health coverage, getting married, or having a child, that may allow someone to enroll in or change a health plan outside regular open enrollment. Eligibility and deadlines apply.

Quality of Care — [GENERAL HEALTHCARE TERM]

How well healthcare services support safe, effective, and appropriate outcomes. Quality can include patient safety, clinical results, communication, and patient experience.

Quote — [GENERAL HEALTHCARE TERM]

An estimate of the expected price for a service or product. A quote may be binding or nonbinding depending on the agreement. Ask what is included, how long the quote is valid, and what could change the price.

R

Reference-Based Pricing (RBP) — [INSURANCE / GENERAL HEALTHCARE TERM]

A payment method that sets a reference amount for certain healthcare services rather than relying only on traditional negotiated provider rates. It is often used in some self-funded health plans. It may lead to disputes if a provider charges more than the reference amount. The plan's rules and applicable protections matter.

Referral — [INSURANCE / GENERAL HEALTHCARE TERM]

A recommendation or formal direction to see another healthcare professional. Some insurance plans require a referral before they cover certain specialist visits.

Reimbursement — [INSURANCE / NON-INSURANCE BENEFIT]

Payment back to a person or organization for eligible expenses. The rules determine which expenses qualify, what proof is needed, and how much will be paid.

Renewal — [INSURANCE / NON-INSURANCE BENEFIT]

The process of continuing a policy, membership, or service for another period. Renewal may involve changes in price, coverage, services, or eligibility.

Rescue Medication — [GENERAL HEALTHCARE TERM]

Medicine used to treat sudden or severe symptoms. The appropriate medicine depends on the condition and a clinician's instructions.

Retail Clinic — [GENERAL HEALTHCARE TERM]

A healthcare clinic located in or near a retail setting, often offering basic services for common health concerns. Services, staffing, and prices vary.

Risk-Bearing Entity — [INSURANCE / GENERAL HEALTHCARE TERM]

An organization that is financially responsible for some or all covered healthcare costs under an insurance or risk-sharing arrangement. Whether an organization bears insurance risk depends on its actual legal and contractual role, not simply its name.

Routine Care — [GENERAL HEALTHCARE TERM]

Regular healthcare such as checkups, follow-up visits, and care for common health concerns. What counts as routine may vary by provider and plan.

S

Self-Funded Health Plan — [INSURANCE]

A plan in which an employer or another plan sponsor pays covered medical claims from its own funds instead of transferring the full claims risk to an insurance company. The sponsor may hire outside companies to administer the plan or purchase stop-loss insurance.

Self-Pay — [GENERAL HEALTHCARE TERM]

Paying directly for healthcare rather than asking health insurance to pay for that service. Self-pay prices and payment policies vary by provider.

Service Fee — [GENERAL HEALTHCARE TERM]

A charge for a particular service, such as a consultation, facility use, lab collection, or administrative work. Ask whether additional fees may apply.

Special Enrollment Period — [INSURANCE]

A period outside normal open enrollment when eligible people can enroll in or change certain health coverage after a qualifying event or under another permitted rule.

Specialist — [GENERAL HEALTHCARE TERM]

A healthcare professional with advanced training in a particular area, such as cardiology, orthopedics, or dermatology.

Specified-Disease Insurance — [INSURANCE]

A policy that pays benefits for a named disease or group of diseases, subject to the policy's terms. It does not generally replace comprehensive health insurance.

Stop-Loss Insurance — [INSURANCE]

Insurance that protects an eligible employer or plan sponsor against certain high claim costs in a self-funded health plan. It generally protects the plan sponsor rather than functioning as a member's separate medical insurance policy.

Surprise Billing — [INSURANCE / GENERAL HEALTHCARE TERM]

A bill that arises when a person receives certain services from an out-of-network provider without reasonably expecting it. Federal and state laws protect patients in many situations, but not every unexpected bill qualifies for protection.

Surgery Center — [GENERAL HEALTHCARE TERM]

A facility where surgical procedures are performed. Some centers are designed for outpatient procedures, while hospitals may provide inpatient and outpatient surgery.

T

Telehealth — [NON-INSURANCE BENEFIT / GENERAL HEALTHCARE TERM]

Healthcare delivered using technology, such as video visits, phone calls, or secure messaging. Telehealth may be covered by insurance or offered through a separate service. The price, provider availability, and scope of care vary.

Telemedicine — [GENERAL HEALTHCARE TERM]

The use of communication technology to provide clinical services remotely. It is often used similarly to telehealth, though definitions can differ by law or organization.

Third-Party Administrator (TPA) — [GENERAL HEALTHCARE TERM]

A company that performs administrative work for a health plan, such as processing claims, handling member questions, or managing enrollment. A TPA does not necessarily insure the plan or pay claims from its own funds.

Tiered Network — [INSURANCE]

A provider network divided into levels with different member costs. Providers in a lower-cost tier may have lower copays or coinsurance than providers in a higher-cost tier.

Total Cost of Care — [GENERAL HEALTHCARE TERM]

The combined cost of healthcare services for a person, group, or population over a period of time. It may include medical claims, prescription drugs, administrative expenses, and other defined costs.

Transparency in Coverage — [INSURANCE / GENERAL HEALTHCARE TERM]

Rules and practices intended to make certain health plan pricing and coverage information easier to access. Available information does not always make the final cost of a specific treatment easy to predict.

Treatment Plan — [GENERAL HEALTHCARE TERM]

A plan created by a healthcare professional that describes recommended care, medicines, follow-up, or other steps for managing a condition.

U

Urgent Care — [GENERAL HEALTHCARE TERM]

Care for health problems that need prompt attention but are not usually life-threatening emergencies. Costs and coverage depend on the provider, service, and insurance plan.

Usual, Customary, and Reasonable (UCR) — [INSURANCE / GENERAL HEALTHCARE TERM]

A pricing method that uses certain measures of typical charges to help determine a payment amount. Definitions and calculations vary by plan or arrangement. The result is not necessarily the amount a provider must accept as payment in full.

Utilization Management — [INSURANCE / GENERAL HEALTHCARE TERM]

Processes used to review healthcare services for medical need, appropriateness, or compliance with plan rules. These processes may include prior authorization and reviews of treatment requests.

V

Value-Based Care — [GENERAL HEALTHCARE TERM]

An approach that connects provider payment or performance measures to the quality, outcomes, or cost of care rather than paying only for each service delivered. The details vary by program.

Virtual Care — [NON-INSURANCE BENEFIT / GENERAL HEALTHCARE TERM]

Healthcare services delivered remotely through a website, app, phone, or video connection. Virtual care may be part of insurance coverage or sold as a separate membership or service. It does not automatically cover in-person care, prescriptions, emergency services, or hospital bills.

Vision Discount Plan — [DISCOUNT PROGRAM]

A program that may provide lower prices on eye exams, glasses, contact lenses, or other eligible services through participating providers. It generally does not pay vision expenses like vision insurance does.

Vision Insurance — [INSURANCE]

An insurance policy that helps pay for covered vision services or products according to its terms. Benefits may include eye exams, lenses, frames, or contact lenses, subject to limits and cost sharing.

Visit Limit — [INSURANCE / NON-INSURANCE BENEFIT]

A limit on the number of appointments or service visits available during a period. Check whether unused visits carry over and what happens when the limit is reached.

W

Waiting Period — [INSURANCE / NON-INSURANCE BENEFIT]

A period that must pass before certain benefits become available. Waiting periods depend on the product and applicable law. Different rules apply to different types of coverage.

Wellness Program — [NON-INSURANCE BENEFIT]

A program intended to support healthy habits through education, coaching, screenings, or other activities. It may be offered by an employer, insurer, or independent organization. It is not automatically medical insurance.

Workers' Compensation — [INSURANCE / LEGAL BENEFIT]

A system that may provide medical care and wage benefits for eligible work-related injuries or illnesses. Coverage and requirements depend on state law and the person's work situation.

X

X-Ray — [GENERAL HEALTHCARE TERM]

An imaging test that uses a small amount of radiation to create pictures of structures inside the body. The total price may include the image, the facility charge, and a professional reading fee.

Y

Yearly Out-of-Pocket Maximum — [INSURANCE]

The limit on certain eligible healthcare expenses you pay during a plan year. It generally applies to covered in-network services under qualifying plans. Premiums and many non-covered expenses do not count toward it.

Z

Zero-Cost Preventive Care — [INSURANCE / GENERAL HEALTHCARE TERM]

Certain preventive services that eligible health plans must cover without member cost sharing when federal requirements are met. The service, provider, and circumstances matter. A visit that includes additional diagnostic or treatment services may have separate charges.
