

UNDERSTANDING HEALTHCARE

A Plain-Language Glossary

Common terms to help you understand your coverage, care, costs, and next steps.

Healthcare doesn't come with a roadmap.

SurePath Health helps people understand the system around their care so they can ask informed questions, prepare for what comes next, and move forward with greater clarity and confidence.

How to Use This Guide

Healthcare words can sound straightforward while carrying very specific meanings. Use this glossary when reviewing plan information, preparing for a call or appointment, comparing a bill with an Explanation of Benefits, or deciding what question to ask next.

- Start with the term you encountered, then read why it matters in practice.
- Use the helpful question as a starting point; adapt it to your situation.
- Write down the name of the person you spoke with, the date, and any reference or confirmation number.
- When possible, request important explanations, decisions, and approvals in writing.

Important Note

This guide provides general educational information and is not medical, legal, financial, or insurance advice. Terms, processes, coverage rules, rights, and costs can vary by health plan, provider, employer, program, state, and individual situation. Always confirm how a term applies to you with the appropriate healthcare provider, health plan, benefits administrator, attorney, or other qualified professional. In an emergency, call 911 or seek appropriate emergency care.

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Glossary

Terms are listed alphabetically. Category labels show where each term most often appears, although many terms overlap more than one part of healthcare.

A

Advance Directive MANAGING CARE

A legal document that records your wishes for medical care if you are unable to communicate or make decisions for yourself.

Why it matters: It helps your loved ones and healthcare team understand and follow your preferences.

Helpful question or next step: Ask where the completed document should be stored and who should receive a copy.

Allowed Amount COSTS & COVERAGE

The maximum amount a health plan recognizes for a covered service. It may also be called the negotiated rate, eligible expense, or payment allowance.

Why it matters: Your deductible or coinsurance is often calculated from this amount—not the provider’s original charge.

Helpful question or next step: Ask your plan for the allowed amount and your estimated responsibility before non-emergency care.

Ambulatory Surgery Center PLACES OF CARE

A facility where certain surgeries and procedures are performed without an overnight hospital stay.

Why it matters: The facility and each clinician involved may have separate network status and charges.

Helpful question or next step: Confirm the center, surgeon, anesthesia provider, and other involved professionals are in network.

Appeal APPROVALS & ACCESS

A formal request asking a health plan to reconsider a decision, such as denying coverage or payment.

Why it matters: A denial is not always the final answer, but appeals usually have specific steps and deadlines.

Helpful question or next step: Request the denial reason, appeal instructions, deadline, and documents needed in writing.

B

Balance Billing BILLS & CLAIMS

When a provider bills you for the difference between its charge and the amount your health plan allows. Federal and state protections may limit this in some situations.

Why it matters: The amount may be substantial, especially when out-of-network care is involved.

Helpful question or next step: Before paying, compare the bill with your EOB and ask whether surprise-billing protections apply.

Benefits COSTS & COVERAGE

The healthcare services, medications, supplies, and other forms of care included in your health plan's coverage.

Why it matters: Having a benefit does not mean every service is automatically covered or free. Network, medical necessity, authorization, limits, and cost-sharing rules may still apply.

Helpful question or next step: Ask whether the specific service is a benefit under your plan and what requirements, limitations, and costs apply.

Benefit Limits COSTS & COVERAGE

Restrictions on how much, how often, or for how long a health plan will cover a particular service, treatment, or item.

Why it matters: A service may be covered but limited to a certain number of visits, days, treatments, or dollar amount within a defined period.

Helpful question or next step: Ask what limit applies, how much of the benefit you have already used, when the limit resets, and whether an exception can be requested.

Brand-Name Medication PRESCRIPTIONS

A medication sold under a specific product name by a manufacturer.

Why it matters: A health plan may place a brand-name drug on a different coverage tier or require a higher cost than an available generic.

Helpful question or next step: Ask whether a generic, preferred alternative, or coverage exception is appropriate for you.

C

Care Coordinator MANAGING CARE

A person who helps organize parts of a patient's care, such as appointments, referrals, services, or communication among providers.

Why it matters: The role and level of assistance vary by organization, benefits, and condition.

Helpful question or next step: Ask exactly what the coordinator can handle and what still remains your responsibility.

Care Navigator MANAGING CARE

A person who helps patients move through a particular healthcare organization, health plan, program, or condition-specific care process.

Why it matters: The navigator's role, employer, and level of support can vary, and they may not address every part of your healthcare journey.

Helpful question or next step: Ask what the navigator can help with, who employs them, and which responsibilities will remain with you or your caregiver.

Care Plan MANAGING CARE

A written outline of health goals, treatments, medications, services, responsibilities, and follow-up needs.

Why it matters: It can help multiple people understand what is happening and what comes next.

Helpful question or next step: Ask for an updated copy after a major visit, hospitalization, or change in treatment.

Case Manager MANAGING CARE

A professional—often a nurse or social worker—who may help assess needs and connect a person with services, resources, or care planning.

Why it matters: A provider, hospital, employer, or insurer may assign a case manager, and each role may have a different scope.

Helpful question or next step: Ask who employs the case manager, what support is available, and whether participation affects coverage.

Claim BILLS & CLAIMS

A request for payment sent to a health plan after a healthcare service or item is provided.

Why it matters: How the claim is coded and processed affects what the plan pays and what you may owe.

Helpful question or next step: Track the service date, provider, claim number, status, and any requested follow-up.

Claim Denial BILLS & CLAIMS

A health plan's decision not to pay all or part of a claim.

Why it matters: Denials can occur for many reasons, including missing information, coding issues, network rules, or lack of required authorization.

Helpful question or next step: Find the exact denial code and reason before deciding whether the provider should correct the claim or you should appeal.

Clinical Trial MANAGING CARE

A research study involving people that evaluates a medical treatment, test, device, or approach.

Why it matters: The study sponsor and your health plan may cover different parts of the care.

Helpful question or next step: Ask which costs are research-related, which are routine care, and who is responsible for each.

Coding BILLS & CLAIMS

The use of standardized codes to describe diagnoses, services, procedures, and supplies on healthcare claims.

Why it matters: An incomplete or incorrect code can affect coverage, payment, and your bill.

Helpful question or next step: If a claim is denied or a bill seems wrong, ask the provider to review the codes submitted and the supporting record.

Coinsurance COSTS & COVERAGE

The percentage of the allowed amount you pay for a covered service, often after meeting your deductible.

Why it matters: A percentage can produce very different costs depending on the allowed amount.

Helpful question or next step: Ask for the allowed amount—not only the coinsurance percentage—when estimating your cost.

Continuity of Care APPROVALS & ACCESS

An arrangement that may allow you to temporarily continue receiving care from a current provider when your health plan or the provider's network status changes.

Why it matters: Changing providers during active treatment could disrupt care, but eligibility, time limits, covered services, and costs vary.

Helpful question or next step: Ask whether you qualify for continuity-of-care protections, how to apply, and what coverage and cost-sharing will apply during the approved period.

Coordination of Benefits COSTS & COVERAGE

The process used to decide which health plan pays first when a person has more than one source of coverage.

Why it matters: Claims may be delayed or denied if the plans do not have current information about other coverage.

Helpful question or next step: Confirm which plan is primary and respond promptly to requests to update coverage information.

Copayment (Copay) COSTS & COVERAGE

A fixed amount you pay for a covered healthcare service or prescription, such as \$30 for an office visit.

Why it matters: Copays may vary by service, provider type, drug tier, or place of care and may not apply to every expense.

Helpful question or next step: Check whether the copay applies before or after the deductible and whether other charges may be added.

Covered Service COSTS & COVERAGE

A healthcare service or item included in your plan's benefits when its rules and requirements are met.

Why it matters: Covered does not necessarily mean free; deductibles, copays, coinsurance, limits, or authorization rules may still apply.

Helpful question or next step: Ask both "Is this covered?" and "What rules and costs apply in my situation?"

D

Deductible COSTS & COVERAGE

The amount you pay for certain covered services during a plan year before the health plan begins paying its share.

Why it matters: Plans may have separate deductibles, and some services may be covered before the deductible is met.

Helpful question or next step: Confirm which deductible applies and how much you have already met.

Discharge Plan MANAGING CARE

Instructions and arrangements for what should happen after leaving a hospital or other care setting.

Why it matters: A safe transition may depend on medications, equipment, follow-up appointments, transportation, home support, or warning signs.

Helpful question or next step: Before leaving, ask who is responsible for each next step and whom to contact if something changes.

Drug Tier PRESCRIPTIONS

A level in a health plan's prescription list used to determine coverage rules and what you pay for a medication.

Why it matters: Lower tiers often cost less, while higher tiers may have higher costs or additional requirements.

Helpful question or next step: Ask which tier applies, what you will pay, and whether preferred alternatives exist.

Durable Medical Equipment (DME) MANAGING CARE

Reusable medical equipment intended for use over time, such as a wheelchair, walker, hospital bed, or oxygen equipment.

Why it matters: Coverage may depend on medical-necessity documentation, approved suppliers, rental rules, or prior authorization.

Helpful question or next step: Ask whether the item is rented or purchased and which in-network supplier must be used.

E

Emergency Department PLACES OF CARE

A hospital department equipped to evaluate and treat serious or potentially life-threatening conditions.

Why it matters: Emergency care can involve separate hospital, clinician, imaging, laboratory, or ambulance claims.

Helpful question or next step: After care, keep the discharge instructions and compare every related bill with its EOB.

Exclusion COSTS & COVERAGE

A service, item, condition, or situation a health plan states it does not cover.

Why it matters: An exclusion is different from a service that is covered only when certain requirements are met.

Helpful question or next step: Ask the plan to point you to the exact exclusion in the governing plan document.

Explanation of Benefits (EOB) BILLS & CLAIMS

A statement from your health plan showing how a claim was processed, including charges, plan discounts, payments, and the amount you may owe. It is not a bill.

Why it matters: The EOB helps you check whether a provider bill matches the plan's decision.

Helpful question or next step: Compare the service date, provider, codes, and patient responsibility before paying a bill.

F

Facility Fee/Charges BILLS & CLAIMS

A charge for services provided in a hospital-owned or facility-based setting, separate from the professional's charge.

Why it matters: The same type of visit may cost more in a hospital outpatient setting because a facility fee is added.

Helpful question or next step: Ask whether both a professional fee and a facility fee will be billed.

Formulary PRESCRIPTIONS

The list of prescription medications a health plan covers and the rules or cost tiers that apply.

Why it matters: Formularies can change, and a listed medication may still require authorization, step therapy, or quantity limits.

Helpful question or next step: Check the exact drug name, dose, form, tier, restrictions, and preferred pharmacy.

Flexible Spending Account (FSA) COSTS & COVERAGE

An employer-sponsored account that allows you to set aside pre-tax money to pay for eligible healthcare expenses.

Why it matters: FSA funds can help lower your taxable income, but contribution, spending, rollover, and reimbursement rules apply.

Helpful question or next step: Ask which expenses qualify, how to submit claims, and how much of your balance must be used before the plan's deadline.

G

Generic Medication PRESCRIPTIONS

A medication with the same active ingredient as an approved brand-name medication and evaluated to meet applicable standards.

Why it matters: Generics often cost less, but coverage and individual clinical considerations can vary.

Helpful question or next step: Ask your clinician or pharmacist whether a generic is appropriate and what it will cost under your plan.

H

Health Savings Account (HSA) COSTS & COVERAGE

A tax-advantaged account available to eligible people enrolled in a qualifying high-deductible health plan and used for qualified medical expenses.

Why it matters: Eligibility, contribution, and spending rules apply; the money generally remains in the account from year to year.

Helpful question or next step: Confirm current rules with your benefits administrator, plan, or tax professional.

Healthcare Proxy MANAGING CARE

A person legally authorized to make healthcare decisions for you if you cannot make or communicate them yourself. The term and requirements may differ by state.

Why it matters: Choosing and documenting the right person can reduce uncertainty during a crisis.

Helpful question or next step: Discuss your preferences with the person and confirm that your documents meet your state's requirements.

HIPAA (Health Insurance Portability and Accountability Act) MANAGING CARE

A federal law that establishes standards for protecting certain health information and governs how covered healthcare organizations may use or share it.

Why it matters: HIPAA protects the privacy of your health information, but it does not prevent all appropriate communication or apply to every person, organization, or type of health data.

Helpful question or next step: Ask what authorization or documentation is needed if you want a caregiver, family member, or other trusted person to receive information or communicate on your behalf.

Home Health Care PLACES OF CARE

Certain skilled healthcare services provided in a person's home, such as nursing, therapy, or medical social services.

Why it matters: Coverage generally depends on eligibility, the type of service, documentation, and an approved agency.

Helpful question or next step: Ask what services, visit frequency, agency, and patient costs have been authorized.

Hospice Care PLACES OF CARE

Care focused on comfort and quality of life for a person with a serious illness who meets the program's eligibility requirements.

Why it matters: Hospice may include clinical care, medications, equipment, emotional support, and caregiver support related to the terminal illness.

Helpful question or next step: Ask what is included, what is not, who provides after-hours help, and how other treatments are handled.

I

In-Network COSTS & COVERAGE

A provider, facility, pharmacy, laboratory, or supplier that participates in your specific health plan's network and has agreed to the plan's contracted payment terms.

Why it matters: Using in-network services generally lowers your costs, but an in-network facility does not guarantee that every professional or service involved in your care is also in network.

Helpful question or next step: Verify network status with both your health plan and the provider using the exact name of your plan and ask whether anyone else involved may bill separately.

Inpatient PLACES OF CARE

A hospital status based on a formal admission order, not simply the number of hours spent in the hospital or whether you stay overnight.

Why it matters: Status can affect coverage, cost sharing, and eligibility for certain follow-up services.

Helpful question or next step: Ask, “Am I admitted as an inpatient, or am I receiving outpatient observation services?”

Itemized Bill BILLS & CLAIMS

A detailed bill from the provider and/or facility listing the individual services, supplies, medications, and charges included in the total.

Why it matters: It can reveal duplicate, unfamiliar, or incorrect charges that are hidden in a summary bill.

Helpful question or next step: Request an itemized bill and compare it with your records and EOB.

M

Mail-Order Pharmacy PRESCRIPTIONS

A pharmacy service that sends eligible medications to you, often in larger supplies.

Why it matters: Your plan may offer different prices or require mail order for some maintenance medications.

Helpful question or next step: Check delivery timing, refill procedures, temperature-control needs, and what to do if a shipment is delayed.

Medical Necessity APPROVALS & ACCESS

A plan standard used to decide whether a healthcare service or item is appropriate and eligible for coverage under the plan’s rules.

Why it matters: A clinician’s recommendation does not automatically guarantee that a health plan will consider the service medically necessary or covered.

Helpful question or next step: Ask which criteria were applied and what clinical documentation is required.

Medical Record MANAGING CARE

The documented history of care, which may include visit notes, diagnoses, test results, medications, procedures, and communications.

Why it matters: Accurate, accessible records help support continuity of care, claims, authorizations, and appeals.

Helpful question or next step: Review important records for accuracy and ask how to request a correction or amendment.

Medication Reconciliation MANAGING CARE

The process of comparing medication lists to identify differences, duplications, omissions, or needed changes during transitions in care.

Why it matters: Medication problems can occur when a person moves between providers, facilities, or home.

Helpful question or next step: Bring a current list—including doses, supplements, allergies, and how medications are actually taken—to each transition or major visit.

N

Network COSTS & COVERAGE

The group of providers, facilities, pharmacies, laboratories, and suppliers that have contracted with a specific health plan to provide covered services under agreed-upon terms.

Why it matters: A network describes the plan’s overall group of participating healthcare professionals and organizations.

Helpful question or next step: Ask whether each provider and facility involved is in network for your exact plan—not simply whether they “accept” your insurance.

Network Exception APPROVALS & ACCESS

Permission from a health plan to receive certain care from an out-of-network provider under specified terms, sometimes because appropriate in-network care is unavailable.

Why it matters: Approval does not always mean the service will be priced exactly like in-network care.

Helpful question or next step: Get the approval, covered services, dates, provider, and cost-sharing terms in writing before care.

O

Observation Status PLACES OF CARE

An outpatient hospital status used while clinicians evaluate whether a person should be admitted or discharged, even if the person stays overnight. This varies by health plan and facility.

Why it matters: Observation and inpatient status may result in different coverage and costs.

Helpful question or next step: Ask about your status, how it affects your benefits, and whether the status changes during the stay.

Out-of-Network COSTS & COVERAGE

A provider, facility, pharmacy, or supplier that does not participate in your specific health plan's network.

Why it matters: Your plan may pay less or nothing, and the provider may bill more than the plan's allowed amount, subject to applicable protections.

Helpful question or next step: Ask for a written cost estimate and whether an in-network option or network exception is available.

Out-of-Pocket Maximum COSTS & COVERAGE

The most you pay during a plan year for covered services that count toward the limit. After you reach it, the plan generally pays 100% of covered in-network benefits for the rest of that plan year.

Why it matters: Premiums, noncovered services, and some out-of-network amounts usually do not count.

Helpful question or next step: Confirm which expenses count and whether your plan has separate individual, family, in-network, or out-of-network limits.

Outpatient PLACES OF CARE

Care received without formal inpatient admission, including many office, clinic, emergency, surgery, and hospital observation services.

Why it matters: The setting and status can affect which benefits apply and how services are billed.

Helpful question or next step: Ask where the service will be performed and whether hospital outpatient or facility fees apply.

P

Palliative Care PLACES OF CARE

Specialized care focused on relief of symptoms, stress, and the practical impact of a serious illness. It can be provided alongside treatment intended to cure or control the illness.

Why it matters: It may support quality of life, communication, and care planning for patients and families.

Helpful question or next step: Ask what services are available, who qualifies, and how the care is covered.

Patient Portal MANAGING CARE

A secure online system that may provide access to appointments, messages, test results, visit notes, medication lists, and bills.

Why it matters: Portals can help organize information, but records may be spread across multiple health systems.

Helpful question or next step: Download important records and do not assume every provider can see information in another organization's portal.

Patient Responsibility BILLS & CLAIMS

The portion of a healthcare charge the health plan says you may owe after processing a claim.

Why it matters: It may include a deductible, copay, coinsurance, noncovered amount, or other cost.

Helpful question or next step: Compare the EOB and bill; if they differ, ask the plan and provider to explain why before paying.

Peer-to-Peer Review APPROVALS & ACCESS

A discussion in which a treating clinician speaks with a clinician working for or on behalf of the health plan about a coverage decision.

Why it matters: It may help clarify clinical information but is not available for every decision and does not replace all appeal rights.

Helpful question or next step: Ask whether it is available, who must request it, the deadline, and what happens if the decision remains unchanged.

Power of Attorney MANAGING CARE

A legal document authorizing another person to act for you in specified matters. Healthcare and financial authority may require different documents depending on state law.

Why it matters: The authority granted depends on the document's wording and when it becomes effective.

Helpful question or next step: Confirm the document fits the intended purpose and applicable state requirements.

Precertification APPROVALS & ACCESS

A term some health plans use for advance review or confirmation of treatment before certain services. It is often used similarly to prior authorization, but plan definitions vary.

Why it matters: Precertification may be required even when a service is a covered benefit.

Helpful question or next step: Ask what approval is required, who submits it, and whether both the facility and professional services are included.

Premium COSTS & COVERAGE

The amount paid regularly—often monthly—to keep health coverage active.

Why it matters: Paying the premium does not eliminate other costs such as deductibles, copays, and coinsurance.

Helpful question or next step: Know the due date, grace-period rules, and how coverage could be affected by a missed payment.

Primary Care Provider (PCP) PLACES OF CARE

A clinician who serves as a main point of contact for routine care, prevention, and coordination of health concerns.

Why it matters: Some plans require a designated PCP or referrals from the PCP before specialist care.

Helpful question or next step: Check your plan's rules and make sure the correct PCP is listed in its system.

Prior Authorization APPROVALS & ACCESS

Advance approval a health plan may require before covering a medication, test, procedure, service, or item.

Why it matters: Approval may prevent a coverage denial, but it is not a guarantee of payment or a substitute for verifying other benefit rules.

Helpful question or next step: Ask whether it was submitted, what exactly was approved, the authorization number, effective dates, and your estimated cost.

Provider PLACES OF CARE

A person or organization that provides healthcare services or supplies, such as a clinician, hospital, laboratory, therapist, pharmacy, or equipment company.

Why it matters: Different providers involved in one episode of care may bill separately and have different network status.

Helpful question or next step: Ask who will participate in your care and which separate bills to expect.

R

Referral APPROVALS & ACCESS

A direction or authorization for a patient to see another provider or receive a service, often from a primary care provider.

Why it matters: Some plans require a referral for coverage, while others do not; a referral is not the same as prior authorization.

Helpful question or next step: Confirm the correct provider, number of visits, effective dates, and whether separate authorization is also required.

Release of Information MANAGING CARE

Written permission allowing specified health information to be shared with particular people or organizations.

Why it matters: Privacy rules can prevent family members or helpers from receiving information without appropriate permission.

Helpful question or next step: Specify who may receive information, what may be shared, for what purpose, and how long the permission lasts.

S

Second Opinion MANAGING CARE

An evaluation by another qualified clinician about a diagnosis, treatment recommendation, or care plan.

Why it matters: It may confirm the plan, identify alternatives, or help you feel more prepared to decide.

Helpful question or next step: Check coverage, referral or authorization requirements, and whether records or images should be sent in advance.

Skilled Nursing Facility (SNF) PLACES OF CARE

A facility providing short-term skilled nursing or rehabilitation services that require licensed clinical professionals.

Why it matters: Coverage depends on the plan, eligibility criteria, medical need, network, authorization, and length-of-stay rules.

Helpful question or next step: Ask what must occur for coverage, how many days are approved, what you will owe, and what discharge options are being planned.

Specialist PLACES OF CARE

A clinician with focused training in a particular area of medicine or type of care.

Why it matters: Your plan may require a referral, authorization, or use of an in-network specialist.

Helpful question or next step: Confirm the specialist's network status and whether tests, procedures, or facility services require separate approval.

Specialty Medication PRESCRIPTIONS

A medication that may require special handling, administration, monitoring, or distribution and is often high cost.

Why it matters: Coverage may involve a specialty pharmacy, prior authorization, a specific benefit, or manufacturer and plan support programs.

Helpful question or next step: Ask which benefit covers it, where it must be obtained, what approvals apply, and what your full cost will be.

Specialty Pharmacy PRESCRIPTIONS

A pharmacy that dispenses and supports certain complex or specialty medications.

Why it matters: Your plan may require you to use a specific specialty pharmacy, and delivery or refill coordination can take time.

Helpful question or next step: Confirm enrollment steps, shipping schedule, refill timing, storage instructions, and whom to contact about delays.

Surprise Medical Bill BILLS & CLAIMS

An unexpected bill that may occur when out-of-network care is involved despite a patient seeking care at an in-network facility or in an emergency. Legal protections apply in many—but not all—situations.

Why it matters: You may have rights that limit what you owe.

Helpful question or next step: Do not assume the bill is correct; compare it with the EOB and ask the plan or appropriate assistance resource about applicable protections.

T

Transition of Care MANAGING CARE

The movement from one provider, setting, level of care, or health plan to another.

Why it matters: Information, medications, equipment, appointments, and responsibilities can be lost or delayed during a transition.

Helpful question or next step: Create a written next-step list identifying what must happen, by when, and who owns each task.

U

Urgent Care PLACES OF CARE

A setting for timely evaluation of health concerns that need prompt attention but may not require an emergency department.

Why it matters: Services, hours, capabilities, and costs vary, and not every urgent care center is in every plan's network.

Helpful question or next step: Verify network status and understand when symptoms require emergency care instead.

Utilization Review APPROVALS & ACCESS

A process used by a health plan or healthcare organization to assess whether care meets specified coverage or clinical criteria.

Why it matters: The review can affect authorization, continued services, level of care, or payment.

Helpful question or next step: Ask what decision is being reviewed, which criteria are used, the timeline, and your appeal rights.

About SurePath Health

SurePath Health is an independent healthcare guidance and education company. We help individuals and families better understand, manage, and move through the practical, non-medical side of healthcare—including coverage, approvals, bills, records, coordination, and next steps.

Healthcare doesn't come with a roadmap. We created one.

Reference Sources

Definitions were developed in plain language with reference to public educational materials from HealthCare.gov, the Centers for Medicare & Medicaid Services (CMS), and MedlinePlus. Because rules and definitions may change or vary, readers should verify information with the organization responsible for their specific coverage or care.