



Health Insurance Glossary

Basic Medical Plan: Provides coverage for hospital/surgical/physician services. Also referred to as the “first part” of an insurance plan.

Comprehensive Medical Insurance: The most common plan available under group health insurance. This type of plan combines both basic and major medical plans and pays for approved services after a deductible has been met.

Co-payment: A co-payment (co-pay) is a sum of money that you pay each time you receive a service or product from a healthcare provider. For example, you might be charged a \$15 co-payment for a visit to your physician while your insurance company will pay the balance. Check your plan to see the amount of co-payments and deductibles required.

The Consolidated Omnibus Budget Reconciliation Act (COBRA): This act states that employers who sponsor group health insurance plans must offer a continuation of coverage to employees and their families under certain circumstances (if hours of work have been reduced and thus employee no longer qualifies for health benefits, or if employment has been terminated for reasons other than gross misconduct). The employee has 62 days to accept or decline COBRA, and must pay the entire premium on a timely basis.¹

Deductible: Your deductible is the total amount of money you need to pay before your insurance plan begins paying its share of costs.

Explanation of Benefits (EOB): The EOB summarizes and explains the amounts approved and paid to healthcare providers, and also details why certain services were not covered or paid for.

Fee-for-service: A fee-for-service, or traditional, plan uses a method of charging in which a physician or other healthcare professional bills for each office visit or service provided.

Health Insurance Portability and Accountability Act (HIPAA): This act, also known as the Kennedy/Kassebaum Act, was enacted in 1996 to help ease the burden that “pre-existing condition clauses” in health insurance policies caused. HIPAA guarantees individual health coverage under certain circumstances when you lose group health coverage and prohibits group health plans from discrimination due to your medical condition. For more information on HIPAA, call 1-888-700-7010 or your factor distributor or HTC.

HMO: An HMO is an organization of healthcare personnel and facilities that provides a comprehensive range of health services to enrolled consumers/members. Healthcare providers receive a fixed sum of money paid in advance for a specified period of time for the services they provide. These health services include a wide variety of medical treatments and consultations, inpatient and outpatient hospitalization, home health service, ambulance service, and sometimes dental and pharmacy services. HMO stands for Health Maintenance Organization.

Lifetime Maximum: This represents the maximum costs the policy will cover during your lifetime. If your medical costs go over this limit, your insurance may no longer pay for factor or clinic visits, or any other type of medical services. Affects medical benefit but not pharmacy benefit.

Medicaid: A federally and state funded program for low-income people. Eligibility criteria will vary by state but are usually tied to income and assets.

Medical Insurance: Offers broad coverage of most medical expenses up to the maximum benefit, offered to both group and individual insurance plans. These plans usually have deductibles and co-payments.

Medicare: A federally funded medical insurance program for people age 65 and over, individuals with end stage renal disease, or those who qualify for Social Security disability.

POS Plan: A POS plan incorporates features of HMOs and PPOs. Patients are enrolled in an HMO but are offered the option to go outside the network for an additional cost. POS stands for Point of Service.

PPO: A PPO is a group of physicians and/or hospitals that contract with an employer to provide services to their employees. In a PPO, the patient may go to the physician of his or her choice – even if that physician does not participate in the PPO. Patients enrolled in this plan typically receive a lower benefit level, usually through higher deductibles and co-payments. PPO means Preferred Provider Organization.

Public payers: Public payers are funded by government entities and include Medicare, Medicaid, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), state sponsored hemophilia programs (i.e. Genetically Handicapped Persons Program, Children’s Medical Services, Children with Special Healthcare Needs) and state high-risk insurance pools.

Referrals: Referrals are a form of authorization by your managed care plan (HMO or POS) or primary care physician.

Supplemental Medical Insurance: Covers those expenses not otherwise covered by the basic medical plan. Covers services at a set percentage once the beneficiary has met the deductible designated by the policy.

Supplemental Security Income (SSI): Provides cash benefits to the aged, blind, and disabled, and can be applied for through your local Social Security office. Children with impairments that hinder them in school but which may not hinder them in later life are sometimes eligible for SSI. Examples of supplemental insurance include vision and prescription plans.

“Transition of care” benefit: This benefit allows you to continue seeing a physician for a diagnosis even after your plan changes. For example, if your current plan allows you to see your primary physician and you transition to a new plan to which your current physician does not belong, you may be covered for seeing your physician for a specific amount of time if your employer offers the “transition of care” benefit.

1. U.S. Department of Labor website. Available at: www.dol.gov/dol/topic/health-plans/cobra.htm. Accessed September 5, 2005.