What to Ask the Insurance Company and Common Insurance Terms

To avoid any misunderstandings, have the insurance company put everything in writing for you. Also, write down the name of the person as well as the day and time that you spoke to the representative. If you need more answers, ask for a supervisor or a case manager.

CONTACT PERSON

- Who should I speak with regarding a high risk pregnancy?
- Is there a certain person in the insurance company who is knowledgeable about congenital heart defects or heart surgeries? (Get his/her full name and phone number.)
- Will I have a case manager who will follow me through my pregnancy? Will the baby have a separate case manager? How do I contact him or her?

ENROLLMENT

- When do we need to enroll the baby to ensure coverage? (VERY important - make sure to follow all of your insurance company requirements to ensure coverage.)

CHOOSING A HOSPITAL/SURGEON

- What hospitals and surgeons are in my plan?
- What if the hospitals in my plan do not have experience with the type of procedure my child needs?
- If my insurance plan does not allow me to choose the hospital at which I would like to deliver the baby and/or have the surgery performed, how can I appeal this policy?

COSTS

- What would be my maximum out-of-pocket cost for the year? (Including the deductible, co-pays, coinsurance, and any other costs)

OTHER COVERAGE

- Does my plan cover any Home Health visits for the baby, if needed?
- Would the cost of transporting the baby to the hospital be covered, if needed?

PRECERTIFICATION OR PREAUTHORIZATION

- Do I need preauthorization for the needed procedure or surgery?
- Do I need to get pre-certified before entering the hospital to deliver the baby?
- How do I get preauthorization?
- When is preauthorization needed? (Before delivery, before procedure, etc.)
- If a different treatment is deemed necessary, do we need preauthorization for the new procedure?
- Do we need preauthorization for the baby's transport, if needed.

TRAVEL BENEFITS

Travel costs are sometimes paid for heart transplants, but not other heart surgeries. If your child is having a surgery other than a heart transplant, but is a candidate for a transplant, see if your child will be eligible for travel benefits. Speak to a supervisor, or someone in management to get a definitive answer.

- If we decide to travel (or if there is no local hospital that can perform the procedure) will travel costs be reimbursed?
- If my child is having a heart transplant, will he be eligible for travel reimbursement?
- If my child is a candidate for a heart transplant, but we choose a different procedure, will he qualify for the travel reimbursement?
- What is the maximum reimbursement?
- What travel expenses are reimbursed? (airfare, hotel, etc.)
- What is the procedure for getting travel reimbursement?

Common Insurance Terms

Benefit: Amount payable by the insurance company to a claimant, assignee, or beneficiary when the insured suffers a loss.

Certificate of Coverage - A document issued to a member of a group health insurance plan showing evidence of participation in the insurance.

Creditable Coverage or Prior Qualifying Coverage - The number of months you had health insurance in place before your current or new policy became effective. Creditable coverage must be counted towards any preexisting condition exclusion in either an individual or group policy.

Claim - A notification to your insurance company that payment is due under the policy provisions.

COBRA: Federal legislation that lets you, if you work for an insured employer group of 20 or more employees, continue to purchase health insurance for up to 18 months if you lose your job or your coverage is otherwise terminated.

Co-Insurance: Co-insurance refers to money that an individual is required to pay for services, after a deductible has been paid. In some health care plans, co-insurance is called "co-payment." Co-insurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

Co-Payment: Co-payment is a predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some HMOs require a $10 "co-payment" for each office visit, regardless of the type or level of services provided during the visit. Co-payments are not usually specified by percentages.

Coverage - The scope of protection provided by an insurance contract which includes any of the listed benefits in an insurance policy.

Denial - An insurance company decision to withhold a claim payment or preauthorization. A denial may be made because the medical service is not covered, not medically necessary, or experimental or investigational.

Deductible: The amount an individual must pay for health care expenses before insurance (or a self-insured company) covers the costs. Often, insurance plans are based on yearly deductible amounts.

Dependents: Spouse and/or unmarried children (whether natural, adopted or step) of an insured.

Effective Date: The date your insurance is to actually begin. You are not covered until the policy's effective date.

Exclusions: Medical services that are not covered by an individual's insurance policy.

Explanation of Benefits (EOB): The insurance company's written explanation to a claim, showing what they paid and what the client must pay. Sometimes accompanied by a benefits check.

Grace Period - The length of time (usually 31 days) after a premium is due and unpaid during which the policy, including all riders, remains in force. If a premium is paid during the grace period, the premium is considered to have been paid on time.

HIPAA: A Federal law passed in 1996 that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care. Full name is "The Health Insurance Portability and Accountability Act of 1996."

Lifetime Maximum Benefit (or Maximum Lifetime Benefit): the maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

Maximum Dollar Limit: The maximum amount of money that an insurance company (or self-insured company) will pay for claims within a specific time period. Maximum dollar limits vary greatly. They may be based on or specified in terms of types of illnesses or types of services. Sometimes they are specified in terms of lifetime, sometimes for a year.

Medically Necessary - A drug, device, procedure, treatment plan, or other therapy that is covered under your health insurance policy and that your doctor, hospital, or provider has determined essential for your medical well-being, specific illness, or underlying condition.

Miscellaneous Expenses: Ancillary expenses, usually hospital charges other than daily room and board. Examples would be X-rays, drugs, and lab fees. The total amount of such charges that will be reimbursed is limited in most basic hospitalization policies.

Network: A group of doctors, hospitals and other health care providers contracted to provide services to insurance companies' customers for less than their usual fees. Provider networks can cover a large geographic market or a wide range of health care services. Insured individuals typically pay less for using a network provider.

Out-of-Plan (Out-of-Network): This phrase usually refers to physicians, hospitals or other health care providers who are considered nonparticipants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

Out-of-Pocket Costs: The amounts the covered person must pay out of his or her own pocket. This includes such things as coinsurance, deductibles, etc.

Out-of-Pocket Limit: The maximum coinsurance an individual will be required to pay, after which the insurer will pay 100% of covered expenses up to the policy limit.

Pre-Admission Authorization: A cost containment feature of many group medical policies whereby the insured must contact the insurer prior to a hospitalization and receive authorization for the admission.

Pre-existing Condition - Any illness or health condition for which you have received medical advice or treatment during the six months prior to obtaining health insurance. Group healthcare policies cover preexisting conditions after you have been insured for 6 months, and individual policies cover preexisting conditions after you have been insured for 1 year. Creditable coverage must be counted towards any preexisting condition exclusion in either an individual or group policy.

Premium: The monthly amount you or your employer pays in exchange for insurance coverage.

Preferred Provider Organizations (PPOs): You or your employer receive discounted rates if you use doctors from a pre-selected group. If you use a physician outside the PPO plan, you must pay more for the medical care.

Primary care physician: Usually your first contact for health care under a health maintenance organization (HMO) or point-of-service (POS) plan. This is often a family physician, internist, or pediatrician. A primary care physician monitors your health, treats most health problems, and authorizes referrals to specialists, if necessary.

Provider: Provider is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.

Reasonable and Customary Fees: The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the provider will reduce the charge to the amount that the insurance company has defined as reasonable and customary.

Second Opinion: It is a medical opinion provided by a second physician or medical expert, when one physician provides a diagnosis or recommends surgery to an individual. Individuals are encouraged to obtain second opinions whenever a physician recommends surgery or presents an individual with a serious medical diagnosis.

Stop-loss: The dollar amount of claims filed for eligible expenses at which point you've paid 100 percent of your out-of-pocket and the insurance begins to pay at 100%. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of co-insurance.

Waiting Period: A period of time when you are not covered by insurance for a particular problem.

References:
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Healthinsurance.org - http://www.healthinsurance.org/insterms.html#benefit
InsWeb - http://www.insweb.com/learningcenter/glossary/health-a.htm
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