Insurance Contract Rules/ Definitions:

Exclusions: Insurance companies may exclude certain services or diagnosis from a policy. For instance, if you believe there may be a need for, as an example: home equipment, ambulance services, mental health, rehabilitation services, etc. ask your plan for specific benefits information on those types of services you know you may need.

Contracting with providers, such as physicians and hospitals, means your insurance company may or may not contract with the physician, hospital or others that provide you with care. Be sure and know who all your providers of care are and ask any new insurance company if they contract with your providers. If they don't it could be more out of pocket expense for you.

Portability: If you have had "creditable" health insurance for 12 straight months, with no lapse in coverage for 63 days or more, a new group health plan cannot implement the pre-existing condition exclusion. It must cover your medial problems as soon as you enroll in the plan. Proof of previous creditable health insurance is required.

Pre-Existing Condition: If you have had a break in coverage (usually more than 30 days), your new insurance could impose waiting periods before they will start to cover your pre-existing condition.
Note: they will not go back and pick up previous medical bills during your waiting period.

Wait Periods for Special Services: Even though you may be covered under a new policy there may be additional waiting periods for special needs. For example, there may be a 12-month waiting period for transplant services. Talk to your insurance company about any special needs you may have.

Referrals: In HMOs and other managed care policies, a referral is usually necessary to see any practitioner or specialist other than your primary care physician (PCP), if you want the service to be covered. The referral is obtained from your PCP, who may require a telephone or office consultation first.

The term "referral" can refer both to the act of sending you to another doctor or therapist, and to the actual paper authorizing your visit.

Pre-Authorization/Certification: Certain medical care requires the approval of a treatment plan by your insurance company before care is given. If approval is not given, payment can be denied. Approvals can be verbal or a written statement indicating they agree to pay for medical treatment. In most cases a pre-authorization or certification number is assigned and is used during billing.