

# HEALTH INSURANCE

## SHOPPER'S GUIDE



KANSAS  
DEPARTMENT  
OF INSURANCE

**VICKI SCHMIDT, COMMISSIONER**  
[insurance.kansas.gov](http://insurance.kansas.gov)



# TABLE OF CONTENTS

INDIVIDUAL MAJOR MEDICAL COVERAGE	01
OTHER TYPES OF INDIVIDUAL POLICIES	02
WHAT IS NOT COVERED UNDER AN INDIVIDUAL POLICY?	03
PURCHASING AN INDIVIDUAL POLICY	05
GROUP HEALTH INSURANCE	06
GROUP PLAN FEATURES	07
JOINING / LEAVING A GROUP HEALTH PLAN	09
HEALTH MAINTENANCE ORGANIZATIONS AND MANAGED CARE ORGANIZATIONS	11
DISCOUNT HEALTH PLANS	13
KANSAS PROMPT PAY ACT	14
APPEAL A CLAIM DENIAL	15
FILING A CONSUMER COMPLAINT	15
INDEPENDENT MEDICAL REVIEW	16
GLOSSARY OF HEALTH INSURANCE TERMS	17

# IMPORTANT BENEFITS OF MAJOR MEDICAL COVERAGE

## MAJOR MEDICAL EXPENSE

**Deductible** – The dollar amount that you must pay each year before the policy will begin to pay. If you purchase a policy that covers a spouse or dependents be sure to understand how the deductible works.

**Coinsurance** – The percentage of costs you pay after you have met your deductible.

**100% payment** – The insurance company will pay 100% of eligible expenses after you have reached the maximum out-of-pocket limit. The 100% payment is for covered expenses only and will be paid until the end of the calendar year.

## MATERNITY & NEWBORN COVERAGE

Childhood immunizations for children ages 0 - 72 months. Deductibles and copays do not apply. Automatic newborn coverage under a "family" plan for the first 31 days. To continue coverage, the policy or contract may require that notification of birth and payment of a specific premium is required in order to have the coverage continue beyond that 31 days. The policy must pay for the mother to stay at the hospital for at least 48 hours for a vaginal delivery or 96 hours for a cesarean birth.

Coverage for a newborn adopted child from the moment of birth if petition for adoption is filed within 31 days of birth. Coverage for birth mother if child is adopted within 90 days of birth.

## PREVENTIVE AND ROUTINE CARE

Coverage for services related to the diagnosis, treatment and management of osteoporosis.

Examples: routine screenings for diseases, including mammograms, pap smears, and prostate cancer screenings. See the following website for the complete list of required preventive benefits per federal law [www.uspreventiveservicestaskforce.org/uspstf](http://www.uspreventiveservicestaskforce.org/uspstf).

Services provided by health care providers other than a primary care physician, including (but not limited to): APRN nurses, optometrists, dentists, psychologists, podiatrists, and social workers.

## PRESCRIPTION DRUGS AND SUPPLIES

Examples include:

- Coverage of certain off-label drugs when used for treatment of cancer.
- Coverage for orally-administered drugs to treat cancer.
- Diabetic supplies (including needles) used for diabetes management and outpatient self- management training and education (when prescribed by a health care professional).

## OTHER REQUIRED COVERAGE

Examples include:

- Coverage for breast reconstruction following a mastectomy.
- Access to routine coverage of health care services upon a diagnosis of cancer and upon acceptance into a phase I, phase II, phase III, or phase IV clinical trial for cancer.
- Coverage of general anesthesia for dental care for children younger than five, people with severe disabilities and people with a medical or behavioral condition requiring hospitalization.
- Every health plan on the health insurance marketplace must provide all of the essential health benefits required by state and federal law.

Federal law requires a summary of benefits page be included with your policy, which outlines what is and is not covered under the policy, details what costs you will incur under the policy, a glossary of terms with standardized definitions, and a list of providers included in the plan (list may be internet-based).

# OTHER TYPES OF INDIVIDUAL POLICIES

## Hospital Indemnity

Hospital indemnity insurance supplements your existing coverage by helping pay expenses for hospital stays. Depending on the plan, hospital indemnity insurance gives you cash payments to help you pay for the added expenses that may come while you recover. Typically, plans pay based on the number of days of hospitalization.

Even if your medical insurance covers most of your hospitalization, you can still receive payments from your hospital indemnity insurance plan for extra expenses while recovering.

## Critical Illness

Critical illness insurance provides additional coverage for medical conditions like heart attack, stroke, or cancer. These conditions often incur greater than average medical costs and critical illness policies pay out cash to help cover those expenses.

## Short-Term Limited Duration

Short-term limited duration insurance is primarily designed to fill gaps in coverage that may occur when transitioning from one plan or coverage to another. This type of coverage is exempt from the definition of individual health insurance coverage under the Affordable Care Act but is subject to the state mandate. Effective September 1, 2024, short-term limited duration plans are limited to three months and one extension.

## Catastrophic Plans

A catastrophic health insurance plan covers essential health benefits, but has a high deductible. This means it provides coverage in case you have an accident or serious illness. Premiums for catastrophic plans may be lower than traditional health insurance plans, but deductibles are usually much higher.

In the marketplace, catastrophic plans are available only to people under 30 or to someone who has received “hardship exemption.” Marketplace catastrophic plans cover three annual primary care visits and preventive services at no cost. After the deductible is met, they cover the same set of essential health benefits that other marketplace plans offer. People with catastrophic plans are not eligible to receive subsidies or tax credits to help with the cost of their health insurance.

# WHAT IS NOT COVERED UNDER AN INDIVIDUAL POLICY?

Every policy has services and products that are not covered. The following are commonly excluded services: cosmetic surgery (except in the case of a mastectomy), hearing aids, weight-loss surgery, and long-term care, among other services. Refer to your policy for all exclusions and limitations.

## Medical Necessity

Every major medical policy excludes coverage for treatment that is not “medically necessary.” This provision allows insurance companies to determine, if the treatment received was medically necessary.

If your doctor says a treatment was medically necessary but the insurance company's doctor says it was not, you should appeal the decision within the company according to the appeals process outlined in your policy.

If you do not receive a satisfactory result, please contact the Kansas Department of Insurance for assistance at 785-296-3071.

## Hospital Prior-Authorization

Most health plans require you to tell them before you check into the hospital for nonemergency services. This is referred to as prior-authorization, pre-certification or pre-admission approval.

The insurance company reviews the medical necessity for your hospitalization and either approves or disapproves the length of stay. Prior-authorization does not guarantee the insurance company will pay your bills; it is merely a confirmation that the proposed service is medically necessary and that the setting is appropriate.

The company will also review the following before approving your claim:

- Whether coverage is in force when the services are performed
- Discrepancies in the information received for the prior-authorization as compared to your actual medical records
- Whether other limitations or exclusions of the policy are applicable

The instructions about prior-authorization should be clearly spelled out in your policy. The number you or your doctor can call will be shown there, too. Often this phone number is also included on your medical ID card, along with your policy number and any personal identification number.

The patient is responsible for making sure prior-authorization is completed prior to admission. If your doctor's office fails to make the call on your behalf, you can be held responsible for the entire cost of the hospital stay. If time permits, get the approval in writing.

Be sure the company's notice makes it clear what exactly has been approved for coverage.

## **Determining How Much You Pay**

Health insurance companies will decide how much to charge you for your health insurance based on the following four factors: your age, where you live, tobacco use, whether you are looking for coverage for yourself or for your family.

No other factors can be used to determine how much to charge you for health insurance, including your health condition or gender.

## **Free-Look Provisions**

Once you receive your health insurance policy, you are entitled to a 10-day free look at the policy (30 days for policies purchased on the Federally Facilitated Marketplace). This free-look period begins the day you receive the policy. Be sure to keep a record of when the policy arrived. If you are dissatisfied for any reason, you can return the policy within the allotted timeframe and be refunded, no questions asked. Use the free-look period to make sure the policy provides the benefits you expected and check for limitations and exclusions.

## **Rate Increases**

Companies cannot increase premiums for an individual policyholder unless they increase premiums on all people with the same policy. This means your premium cannot be raised because you had a lot of claims or high claims against your plan. There are no state laws regarding when notice of a rate increase must be sent, but most companies usually give written notice before implementing a rate change. Check your policy to find out the specific notification requirements of the company.

# PURCHASING AN INDIVIDUAL POLICY

Individual health insurance coverage can be purchased on the Health Insurance Marketplace, or through insurance companies and/or insurance agents off the Marketplace.

## Marketplace Coverage

Individual health insurance policies can be purchased by visiting [www.healthcare.gov](http://www.healthcare.gov) or calling 1-800-318-2596. The Marketplace allows you to see all plan options available to you.

Tax credits and subsidies are available to individuals who qualify, but these are only available to you if you buy your plan on the Marketplace.

All Marketplace health insurance plans cover the essential health benefits outlined in federal law, and all are considered “qualified health plans.”

If you need help enrolling in coverage through the Marketplace, ask your agent if they are licensed to sell health insurance and can help you identify a plan that fits your needs. If your agent is not licensed, you can also find assistance through health insurance navigators and Certified Application Counselors (CAC).

## Coverage off the Marketplace

There are several options on the Marketplace. However, plans purchased from the Marketplace are not eligible for any tax credits or subsidies.

## Grandfathered Health Plans

Any individual health policy purchased on or before March 23, 2010, may be considered “grandfathered.” Grandfathered plans are health insurance plans that are exempt from certain changes required under the Affordable Care Act. A health plan must disclose to its policyholders if it considers itself to be “grandfathered.”

### Grandfathered Health Plans

MUST	End lifetime limits on coverage, end arbitrary cancellations and rescissions of coverage, cover adult children up to age 26, provide a Summary of Benefits and Coverage, and not require longer than 90 days waiting period for group coverage
DO NOT	Cover preventive care for free, and guarantee your right to appeal



# GROUP PLAN FEATURES

Most employer-based health plans are major medical plans. The employer likely pays a portion of the premium, and the employee pays the rest. Sometimes the cost of coverage is deducted from the employee's pay before a paycheck is issued. A group health insurance policy in Kansas may cover groups as small as two people.

There are important features of group plans to keep in mind:

- When you join your employer's health plan, your employer is the policyholder and you are the member or a certificate holder.
- As the policyholder, the employer does not need the consent of the plan participants to change insurance companies, make changes to the plan, cancel the policy, or agree to new premiums or benefits.

## Fully-Insured Plans vs. Self-Insured Plans

Under a fully-insured plan, the employer purchases coverage from an insurance company. The insurance company assumes the risk to pay all health insurance claims. Fully-insured plans are regulated by the Kansas Department of Insurance.

Self-insured plans are set up by employers to pay the health claims of its employees. The employer sets aside funds for the health claims. The employer assumes the risk of providing the benefits and is obligated to pay claims. Self-insured plans may hire an insurance company as a third-party administrator to pay the claims and administer the plan. If you do not know what kind of plan you have, ask your employer or plan administrator.

Self-insured plans are regulated by the U.S. Department of Labor. States do not regulate these plans. This means federal, rather than state, laws govern requirements of specific benefits and protections in health insurance plans.

Beware that some fraudulent health plans may be described or offered as "self-insured" when, in fact, they are operating without state or federal approval. If a health insurance policy seems too good to be true, check with the Kansas Department of Insurance.

## Medical Necessity

Every major medical policy excludes coverage for treatment that is not "medically necessary." This provision allows insurance companies to determine if the treatment received was medically necessary.

If your doctor says a treatment was medically necessary but the insurance company's doctor says it was not, you should appeal the decision within the company according to the appeals process outlined in your policy.

## Hospital Prior-Authorization

Most health plans require you to tell them before you check into the hospital for nonemergency services. This is referred to as prior-authorization, pre-certification or pre-admission approval.

The insurance company reviews the medical necessity for your hospitalization and either approves or disapproves the length of stay. Prior-authorization does not guarantee the insurance company will pay your bills; it is merely a confirmation that the proposed service is medically necessary and that the setting is appropriate.

The company will also review the following before approving your claim: whether coverage is in force when the services are performed, discrepancies in the information received for the prior-authorization as compared to your actual medical records, whether other limitations or exclusions of the policy are applicable.

The instructions about prior-authorization should be clearly spelled out in your policy, including the number you or your doctor can call. This phone number is also included on your medical ID card, along with your policy number and any personal identification number.

The patient is responsible for making sure the prior-authorization review is completed prior to admission. If your provider fails to make the call on your behalf, you can be held responsible for the entire cost of the hospital stay. If time permits, get the approval in writing. Be sure the company's notice makes it clear what exactly has been approved for coverage.

## Other Cost-Control Features

Along with hospital prior-authorization, group health plans may also control medical expenses by requiring one or more of the following cost-saving measures: review of patient records to see if continued hospitalization is justified, a second surgical opinion on nonemergency surgery (at the insurance company's expense), and a review of patient records and denial of "unnecessary" expenses, including expenses related to experimental and investigative procedures and those judged not medically necessary.

# JOINING / LEAVING A GROUP HEALTH PLAN

Employers may have an employment waiting period that must be satisfied before you can enroll in their group health plan. This is often called a probation period. Employers are not allowed a waiting period of more than 90 days.

After this probation period, employees have an initial open enrollment period to enroll in benefits. New employees have 31 days from the end of the probation period to enroll in health insurance for themselves and their families.

## JOINING A GROUP HEALTH PLAN

**Late Enrollment** – If you do not enroll during your initial enrollment period and later decide that you/spouse/child would like to join the plan, you will be a late enrollee and may have to wait until the next enrollment period.

**Special Enrollment Periods** – All health insurance plans must provide special enrollment periods which allow individuals and family members to join the plan when a qualifying event occurs.

All employees in large group plans (more than 50 employees included in the plan) have at least 30 days for special enrollment when one of the following occurs: the employee has new dependents because of marriage, birth or adoption, the court has ordered coverage for a spouse and/or minor child or the employees/dependents initially decided not to join the plan because they were insured under another employer-sponsored plan and then lost that coverage.

Federal and state laws provide important consumer protections for those who leave a group health plan or move from one job to another.

When you leave a group you usually have the opportunity to temporarily continue your group health benefits. When you have exhausted your temporary continuation benefits, you can convert your group plan to an individual health policy. This conversion policy is often a last resort option because of the limited benefits and high costs associated with this kind of coverage. If you lose employer-sponsored coverage, you may find better options for individual coverage on the Health Insurance Marketplace.

## LEAVING A GROUP HEALTH PLAN

**Kansas Continuation** – If you are leaving an insured group plan of fewer than 20 employees, or a large group plan under circumstances not protected under the COBRA (Consolidated Omnibus Budget Reconciliation Act) laws, you may be eligible for state continuation benefits.

**State Continuation** – Allows for 18 months of continuation of coverage if your group insurance coverage terminates for any reason except nonpayment of premium or fraud. You must have been covered under the group plan continuously for three months in order to be eligible, you pay the full cost for the coverage - both the employer's share and the employee's share, you have 31 days to apply for these continuation benefits, and at the end of the 18-month continuation period, you have 31 days to apply for an individual conversion plan.

**Federal Continuation (COBRA)** – If you are leaving a group of 20 or more employees, COBRA (Consolidated Omnibus Budget Reconciliation Act) laws apply. COBRA allows you to continue your group coverage for a limited time for yourself, your spouse and any dependent children.

Under COBRA, you must pay the full amount of the coverage plus a two percent administrative fee. You have 60 days to apply for COBRA benefits. Coverage may continue for 18 to 36 months, depending on the circumstances surrounding termination of coverage.

COBRA benefits are not available if your plan has been discontinued and not replaced. In some cases, the Kansas continuation benefits may apply.

Detailed information on COBRA is available from the U.S. Department of Labor’s Pension and Welfare Benefits Administration at 866-487-2365 or online at [www.dol.gov/general/topic/health-plans/cobra](http://www.dol.gov/general/topic/health-plans/cobra).

**Continuation of In-Patient Coverage** – If you are confined in the hospital or disabled for a specific condition when you lose your group health insurance coverage, you have the right to continuation of your coverage for an additional 31 days, or until you are discharged from the hospital.

**Affordable Care Act (ACA) Benefits Included in your Group Health Plan**

All group health plans, regardless of whether they are self-insured or fully-insured or grandfathered, must include the following reforms in their policies:

- End all lifetime and annual limits
- Health insurance policies cannot be rescinded, except in cases of fraud or intentional misrepresentation
- Extend coverage to dependents up to age 26
- Cover all persons, regardless of whether they have a pre-existing condition

**“Grandfathered” Health Plans**

Any group health policy sold on or before March 23, 2010, may be considered “grandfathered.” Grandfathered plans are health insurance plans that are exempt from certain changes required under the Affordable Care Act. Keep in mind that the date you joined the plan does not determine whether it is grandfathered. Plans lose this “grandfathered” status if the policy makes certain significant changes that reduce benefits or increase costs.

**Grandfathered Health Plans**

MUST	Disclose to its policyholders if it considers itself to be “grandfathered.” If you are unsure, check with your employer’s human resources department.
DO NOT	Cover preventive care for free, and guarantee your right to appeal.

# HEALTH MAINTENANCE ORGANIZATIONS AND MANAGED CARE ORGANIZATIONS

## Health Maintenance Organization

**Health Maintenance Organization (HMO)** – HMOs provide health services through a network of doctors, hospitals, laboratories, and other providers. The HMO pays your primary care provider a set monthly fee regardless of the amount of services they perform for patients. The fee does not increase in a month where the person might receive services in excess of that fee.

When you enroll in an HMO, you may be required to choose one of the doctors in the network as your primary care physician to manage all your health care. Then, when you need health care, you must first consult your primary care physician, who may then refer you to an HMO-approved specialist.

Except in some emergency situations, you must receive your care from providers within the HMO network. If you do not get approval from your primary care physician before you seek medical care, you may be required to pay out-of-pocket for the actual charges of those services.

## Managed Care Organizations

Managed care plans are health plans that use a network of doctors and other providers to offer comprehensive health coverage.

**Preferred Provider Organizations (PPO)** – A PPO is a group of doctors, hospitals and other health care providers who have agreed to provide services to members of a health plan. However, you do not have to choose a primary care physician if you enroll in a PPO. You may get care from providers outside the PPO network, though you will pay more for these services. You do not need a referral to see a preferred provider specialist.

**Point of Service (POS)** – Point of Service plans combine many of the characteristics of both HMOs and PPOs. Like an HMO, those enrolled in a POS plan choose a primary care physician to serve as their “point of service.” This physician then is responsible for referring the patient to any specialists they may need to see. Like a PPO, the patient is able to get care from physicians and specialists outside of the plan’s network, though there may be an additional cost to do so, and the patient may be responsible for taking care of any paperwork related to the visit. Plan costs stay low when you stay in-network, but the POS provides the option of going outside the network.

**Exclusive Provider Organization (EPO)** – Companies may provide exclusive provider organization (EPO) health insurance plans. EPO plans require some or all health care services to be administered by participating providers, except for emergency services. EPO plans may require a gatekeeper, an administrator who coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations.

## Consumer Protections

- The managed care plan must have enough doctors and hospitals in the plan so that you can get the care you need without unreasonable delay.
- The plan must notify you if your doctor, hospital, or other health care facility leaves the plan's network.
- You have a right to a list of all providers within your plan's network. This list may be located online.
- The plan must notify you if it refuses to pay for a health care service. It must include the reasons for the denial and instructions on how to appeal.
- The managed care plan must pay for your treatment if a medical emergency occurs. This must be provided regardless of whether prior authorization was obtained to provide the service and even if the emergency provider is out of your plan's network.

## DISCOUNT HEALTH PLANS

The Kansas Department of Insurance does not regulate discount health plans as they are **not health insurance policies**. Companies that offer or sell discount health plans are required to register with Kansas Secretary of State. If you have a consumer complaint related to discount health plans, please contact the Kansas Attorney General's Office at 785-296-3751. Discount health plans are not a replacement for health insurance. The promised discounts may be exaggerated or may not exist. Administrative fees and other hidden costs can eat up any savings you may receive with a discount plan. Avoid giving your credit card and checking account numbers to strangers selling discount plans over the phone or Internet.

### Before You Buy

It is important to understand the difference between health insurance and discount health or medical plans. **Discount health plans are not insurance.** These plans offer lower prices on services from doctors, pharmacists, etc., but only from the providers that accept these plans. Many health care providers do not accept discount plans.

# KANSAS PROMPT PAY ACT

The Kansas Health Care Prompt Payment Act establishes a framework for prompt payment of health insurance claims.

In general, an insurer has 30 days to pay a clean claim or to send a notice to the provider stating why the payment has been delayed or denied. Failure to comply with this portion of the act may result in the accrual of interest equal to one percent per month of the billed charges. The interest is payable to the provider, individual, or entity submitting the claim.

An insurer may request additional information on an unpaid claim, but must do so within the first 30 days. When the additional information is received, the insurer has 15 days to pay or deny the claim. Again, failure to comply with this portion of the act results in the accrual of interest equal to one percent per month of the billed charges.

## **Which insurance plans are covered?**

The law applies to fully-insured health plans, including plans offered by HMOs. Plans typically covered include individual or group major medical plans, hospital/surgical policies, and dental plans. Organizations such as third-party administrators paying claims for fully-insured plans must also comply with the act.

## **Which insurance plans are not covered?**

The law does not apply to any of the following types of health-related medical claims from: self-insured employer plans (including the Kansas State Employee Health Plan), Medicare and Medicare supplement policies, Medicaid, workers compensation, federal employee plans, vision or drug plans, disability income, medical claims paid by auto or homeowners insurance.

## **How to report slow payment?**

If your health insurance provider failed to comply with the timeline outlined above, you may file a complaint with the Kansas Department of Insurance. Information on how to file a complaint is found on the next page.

# APPEAL A CLAIM DENIAL

In some cases, your health care provider will file a claim on your behalf for services they render. In some cases, a claim filed by your provider may be denied by your health insurance company. If your claim is denied:

- The reason for the denial should be stated on your explanation of benefits. If you disagree, you may file an appeal with your insurance company.
- You may submit an appeal to the company. Check your policy for the company's appeal procedures. Your appeal should be in writing and may require information from your doctor.
- The company should be able to answer procedural questions over the phone about how to file an appeal.

## FILING A CONSUMER COMPLAINT

If you have tried unsuccessfully to resolve a claim dispute with your company or agent, you can file a complaint with the Kansas Department of Insurance by visiting [insurance.kansas.gov/complaint](https://insurance.kansas.gov/complaint), by calling 1-800-432-2484, or by email at [KDOL.Complaints@ks.gov](mailto:KDOL.Complaints@ks.gov).



## Limited Intervention

If a company insists your complaint or claim is not valid, the Department cannot require the company to make payment unless state insurance law has been clearly violated. In some cases, legal action is the only way to resolve a dispute over health insurance issues and legal obligations. You may want to talk to an attorney if your complaint cannot be resolved and it involves a significant amount of money.



# INDEPENDENT MEDICAL REVIEW

By law, Kansans are afforded the ability to appeal adverse decisions to a medical expert through an independent medical review (IMR). To be eligible two conditions must first be met:

1. Your health claim has been denied by a health insurance company because it was said to be experimental, investigatory, or medically unnecessary.
2. You have gone through your health insurance company's internal appeal process, per K.S.A. 40-22a09.

You have 120 business days from the date of the final decision by your health insurer to request an IMR from the Kansas Department of Insurance. The Department will need the following documents to begin the process:

- A letter summarizing your dispute, including copies of correspondence with your insurer, letters from your provider(s), medical records and documentation supporting your case.
- A completed IMR request form and medical release form. Contact the Department at 1-800-432-2484 to receive the form.

The Department will determine if your health claim is eligible for an IMR within 10 working days of receiving all necessary records. If your request is approved, the Department will have the IMR organization review.

A written decision by the IMR organization will be issued to you within 30 business days after submission. This decision is binding and comes at no cost to you.

## In Case of Emergency

If your care is urgent you may request an expedited IMR. If you have questions, call the Department at 1-800-432-2484 and ask for an IMR coordinator.

## Plans Not Eligible for Review

Some plans are not eligible for IMRs, including: Medicare, Medicare Supplement, Medicaid, federal employee plans, workers compensation, and self-insured employer plans.

# GLOSSARY OF HEALTH INSURANCE TERMS

**Allowed Amount** – Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance billing).

**Appeal** – A request for your health insurer or plan to review a decision or a grievance again.

**Balance Billing** – When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. Typically a preferred provider may not balance bill you for covered services.

**Coinsurance** – Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. The health insurance or plan pays the rest of the allowed amount.

**Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage** – A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent to the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

**Community Rating** – A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status, or other factors.

**Complications of Pregnancy** – Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus.

**Copayment** – A fixed amount (for example, \$25) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

**Cost Sharing** – The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

**Deductible** – The amount you owe for health care services before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan will not pay anything until you have met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

**Disease Management** – A broad approach to coordinate and manage the successful treatment of a specific disease with the goal of making more expensive inpatient and acute care unnecessary. Disease management includes the use of preventive medicine, patient counseling, education, and outpatient care. The process is intended to reduce health care costs and improve the quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition.

**Durable Medical Equipment (DME)** – Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

**Emergency Medical Condition** – An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

**Emergency Services** – Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

**Essential Health Benefits (EHBs)** – A set of health care service categories that must be covered by certain plans. EHBs must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Exclusive Provider Organization (EPO)** – Companies may provide exclusive provider organization (EPO) health insurance plans. EPO plans require some or all health care services to be administered by participating providers, with the exception of emergency services. EPO plans may require a gatekeeper, an administrator who coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations.

**Excluded Services** – Health care services that your health insurance or plan does not pay for or cover.

**Formulary** – A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

**Group Health Plan** – In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

**Guaranteed Issue** – A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guaranteed issue does not limit how much you can be charged if you enroll.

**Guaranteed Renewability** – A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. In Kansas, guaranteed renewal does not limit how much you can be charged if you renew your coverage.

**Habilitative Services** – Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Health Insurance Policy** – A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

**Health Savings Account (HSA)** – A health savings account available to taxpayers who are enrolled in a high deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you do not spend them.

**High Deductible Health Plan (HDHP)** – A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a Health Savings Account (HSA) or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

**Hospitalization** – Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

**In-Network Provider** – A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO, EPO or PPO). The provider agrees to the managed care organization's rules and fee schedules in order to be part of the network and agrees not to balance bill patients for amounts beyond the agreed upon fee.

**Individual Market** – The market for health insurance coverage offered to individuals other than in connection with a group health plan.

**Internal Review** – A review of the health plan's determination that a requested or provided health care service or treatment is not or was not medically necessary by an individual(s) associated with the plan.

**Major Medical Plan** – Provides the most comprehensive coverage for medical services either in or out of the hospital. Major medical plans typically require you to pay a deductible, copayments and coinsurance.

**Mandated Benefit** – A requirement in state or federal law that all health insurance policies provide coverage for a specific health care service.

**Medicaid** – A state-administered health insurance program for low-income families and children, pregnant women, the elderly, and people with disabilities. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state. In Kansas, Medicaid is known as KanCare.

**Medically Necessary** – Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

**Medicare** – A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (a permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

**Network** – The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

**Non-Preferred Provider** – A provider who does not have a contract with your health insurer or plan to provide services to you. You will pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

**Out-of-Pocket Limit** – The maximum amount you pay in one year when you add together your deductible, copayments and your share of co-insurance. This limit never includes your premium, balance billed charges or health care your policy does not cover. Some policies do not count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

**Prior-Authorization** – A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called “prior authorization,” “prior approval” or “precertification.” Your health insurance or plan may require pre-authorization for certain services before you receive them, except in an emergency. Prior-authorization is not a promise your health insurance or plan will cover the cost.

**Preferred Provider** – A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

**Prescription Drug Coverage** – Health insurance or plan that helps pay for prescription drugs and medications.

**Preventive Services** – Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

**Primary Care Provider** – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

**Qualified Health Plan** – Under the Affordable Care Act, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

**Rate Review** – A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

**Rehabilitation Services** – Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

**Rescission** – The retroactive cancellation of a health insurance policy. Insurance companies would sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

**Self-Insured** – Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered.

**Small Group Market** – The market for health insurance coverage offered to small businesses with between two and 50 employees.

**Special Enrollment Period** – A specific period during which a person may be eligible to enroll in coverage mid-year due to a specific qualifying event, such as marriage, birth, divorce or adoption.

**Specialist** – A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

**Waiting Period** – In job-based coverage, the time that must pass before coverage can become effective (cannot exceed 90 days) for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan. Also known as a “probation period.”





**KANSAS  
DEPARTMENT  
OF INSURANCE**

**VICKI SCHMIDT, COMMISSIONER**

1300 SW Arrowhead Road  
Topeka, KS 66604  
[insurance.kansas.gov](http://insurance.kansas.gov)  
[KDOL@ks.gov](mailto:KDOL@ks.gov)

Main: (785) 296-3071  
Hotline: 1 (800) 432-2484  
1 (877) 235-3151 (TTY/TDD)

