LehrmanGroup
Health Insurance Brokers

Health Insurance FAQ From Lehrman Group
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What is a deductible and how does it work?

Typically, a deductible is the amount of money you must pay each year before your health insurance plan starts to pay for covered medical expenses. For example, with a $100,000 heart surgery bill, you would be responsible for paying the first $1,000. After this $1,000 deductible is met, the insurance company will pay a percentage of the bill in what is called the coinsurance.

What is coinsurance?

Coinsurance is a cost-sharing requirement where you are responsible for paying a certain percentage and the insurance company will pay the remaining percentage of the covered medical expenses after your deductible is met. For a health insurance plan with 20% coinsurance, once the deductible is met, the insurance company will pay 80% of the covered expenses while you pay the remaining 20% until your out-of-pocket limit is reached for the year. Typically, the out-of-pocket limit is the maximum amount you will pay out of your own pocket for covered medical expenses in a given year. For a plan with a $2,000 out-of-pocket limit, you will pay a $1,000 deductible and $1,000 coinsurance while the insurance company covers the remaining $98,000 of the heart surgery bill. Even if you are hospitalized again in the same year, the insurance company will pay 100% of your covered expenses within the limit of the lifetime maximum.

What are co-pays?

A co-payment or co-pay is a specific flat fee you pay for each medical service, such as $30 for an office visit, after which the insurance company often pays the remainder of the covered medical charges. Let's say you are not feeling well and went to see your doctor who charges $200 for the office visit. If your insurance plan has an office visit co-payment of $30, then you will only be responsible for the $30 and the insurance company will cover the remaining $170.

Do I have to meet my deductible before I see my doctor?

With some health insurance policies the answer is YES, but today, most health insurance plans do NOT require this. Most companies today offer plans wherein the deductible usually only applies while hospitalized or for more major procedures, such as CT scans or MRIs. Most plans today allow you to visit doctors and specialists, and fill prescriptions, with simply a co-pay.

What is "Out-of-Pocket-Maximum?"

This is the amount of money one would pay out of their own pocket towards their medical expenses in any given year. An out of pocket expense can refer to how much the co-payment, coinsurance, or deductible is. Also, when the term annual out-of-pocket maximum is used, that is referring to how much the insured would have to pay for the whole year out of their pocket, excluding premiums. Usually, your maximum out-of-pocket is never more than a couple of thousand dollars over and above your chosen deductible.

What is a network?

A network is a list of doctors, hospitals and other providers that have contracted, or agreed, with an insurance company to do business with the insurance company. The providers fees have been pre-negotiated, which means that the insurance company will not necessarily pay the doctor or hospital what your actual medical bills are, but will pay a lower amount. For example, when you have a gall bladder removed at a hospital, the hospital's charges, if you did not have health insurance, might be $10,000. But under the network pre-negotiated amount, the hospital may only receive $4,000 as payment in full. This saves you and the insurance company money. If you have a health insurance plan that utilizes a network and you use providers that are not part of the network, the amount of money that you would have to pay for those services will be considerably higher than if you had used providers that were in the network. Your insurance company will probably pay some part of those non-network bills, but you'll be paying a whole lot more. Always stay in your network if possible.

What's the difference between a Primary Care Physician (PCP) and a specialist?

A Primary Care Physician, or PCP, is the doctor you would go to on a regular basis, such as when you're simply not feeling well, or have an ear ache or the flu. A specialist is a doctor that your PCP might refer you to if the problem

you have requires a doctor with more experience in a certain area. For example, if you contacted your PCP complaining about chest pains, your PCP would most probably refer you to a heart doctor (a cardiologist) who would have more advanced equipment and training to help you.

What is a pre-existing condition?

A pre-existing condition is any health condition you have or have had prior to applying for a policy. For example, if you currently have had kidney stones at any time during your life, then kidney stones would be considered a pre-existing condition. Some insurance companies want to know about your pre-existing condition going back as far as your date of birth, but most insurance companies only look back ten years.

Will it prevent me from obtaining health insurance?

Sometimes yes, sometimes no. It will depend upon the condition you have or had, its severity, the cost of medications, and whether the insurance company thinks it will lose money by giving you a policy. Some pre-existing conditions will not exclude you from getting a policy; instead, the insurance company may issue a policy to you, but they might try to offer you the policy with a "rider" which is a clause in your policy that says the insurance company will cover you, but NOT give you coverage for your pre-existing condition. Some companies might offer you their policy with a rider that the company says you may ask them to remove after a certain length of time, such as two years, and other companies may make the rider permanent.

What are some common pre-existing conditions that prevent people from obtaining health insurance?

Alcoholism and drug abuse are usually two conditions that most insurance companies will turn you down for. Others include heart attack or other heart problems within the past five years or so, most companies will not take you if you are diabetic. Many companies will not accept you if you've had certain types of cancer EVER in your life, while other insurance companies won't care if the cancer was more than 20 years in the past. It's almost impossible to get health insurance if you are currently obese or pregnant. Having AIDS is always an automatic decline, as is a stroke in your recent past. Most companies won't care if you have controlled hypertension (high blood pressure) or controlled high cholesterol. But if you have BOTH at the same time, there are very few companies that will offer a policy to you.

What if I'm currently pregnant?

No insurance company will give you a policy while you are pregnant.

What kind of options are there for people that cannot obtain health insurance due to preexisting conditions?

There are some high quality guaranteed issue health insurance plans available today that will cover most pre-existing conditions after you've been on the policy a period of time, usually one year. These policies have some conditions you'd have to meet in order to get a policy, such as requiring that you are gainfully employed or a member of a certain association. We offer these policies. Click HERE to find more information about guaranteed issue health insurance plans.

What is an HMO?

A health maintenance organization (HMO) is a type of Managed Care Organization that provides a form of health insurance coverage that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract. Unlike PPO health insurance, care provided in an HMO generally follows a set of care guidelines provided through the HMO's network of providers. Under this model, providers contract with an HMO to receive more patients and in return usually agree to provide services at a discount. When you choose to become insured under an HMO plan, you must choose a doctor (who is contracted by the insurance company and called a PCP, or Primary Care Physician) and see that doctor for all of your health issues. If you end up needing to see a specialist, you'll need your PCP first and get a referral from him or her to see the specialist.

What is a PPO?

A Preferred Provider Organization is a form of managed care closest to an indemnity plan. A PPO negotiates arrangements with doctors, hospitals and other providers who accept lower fees from the insurer for their services. As a result, your cost-sharing will be lower than if you go outside the network of providers.

If you go to a doctor within the PPO network, you will pay a co-payment for certain services, such as $20 for a doctor and then your PPO insurance policy will pay the rest of the doctor's charges, no matter what they really amount to.

Another characteristic of PPOs is the ability to make self-referrals. PPO plan members can refer themselves to doctors of their choice, including specialists, as long as those providers are also part of your PPO network. With a PPO plan, you are allowed to see providers that are NOT members of the network, but in this case, your insurance company will only pay some of those charges, leaving you to pay the balance. If you have a PPO plan, in order to make it work well for you, you should always seek medical care from members of the PPO.

What is the main difference between an HMO and a PPO?

Most HMOs require you to select a specific doctor as your primary care physician, or PCP. This doctor is supposed to be your first "port-of-call" for most any medical condition, although exceptions are typically made for emergencies. As such, he or she will end up providing most of your medical care. Your choice of specialists and hospitals is usually limited to those already under contract with the HMO, and your primary care physician is the one who decides whether or not a referral to a specialist is actually necessary. One major benefit of an HMO is that maternity is a covered expense.

PPOs combine some of the characteristics of HMOs with the flexibility of traditional fee-for-service plans. PPOs offer a specific set of doctors and hospitals that the member can choose from to get discounted rates. These are called "preferred" or "in-network" providers. PPO members are free to see any in-network provider at any time. Members can also see doctors who are not in the network, but the co-insurance payment for those doctors will be higher. Maternity benefits are not usually included on PPO plans.

What is an HSA?

HSAs are confusing to most people, because the term HSA can be used in two ways. Some people call their HSA-qualifying health insurance plan an HSA. That phrase is actually incorrect. What those people actually have is an IRS-recognized qualifying high-deductible health insurance policy. The policy ITSELF is not an HSA, it's simply a health insurance policy with deductibles that qualify you to legally open an HSA (or Health Savings Account) which is very much like an IRA. One may not open an HSA at a bank or other financial institution unless one has the qualifying high deductible health insurance policy. The second way people use the term HSA relates to the actual

financial instrument known as the HSA, or Health Savings Account, which is recognized by the IRS in much the same way an IRA is recognized. If one has the accompanying HSA-qualified health insurance plan, one may also have an HSA. You are not required to open an HSA and put money into it if you have the insurance plan, but lots of people elect to go with the qualifying health plan simply because it allows them to sequester the HSA deposit amounts. You're allowed to put up to 100% of your deductible amount into an HSA account annually, but you don't have to. You don't even have to open an HSA account.

I'm currently pregnant. What should I do?

There are no health insurance companies that will give you a policy if you are pregnant. If you do not have any health insurance and you are pregnant, contact your local welfare office if your income is low enough to allow you to get on state assistance. If your income is too high to qualify, call all of the hospitals in your area and ask what types of pre-payment plans they offer. You may find that for the same amount of money you'd pay monthly for a health insurance plan that included maternity benefits, you can pay a provider up front on a monthly basis and come out almost even. You'll still need to contend with the doctor's (obstetrician) bills, however. Try to contact local obstetricians and explain your situation. You may find a sympathetic ear who will allow you to make payments to him/her.

How long do I have to wait before I can get pregnant?

That depends upon what your insurance policy says. Some, but very few, companies will let you apply for a policy as long as you are not pregnant when they issue you their policy. Then you can get pregnant as soon as you want. None of the insurance companies we represent work this way any longer. Most companies today make you wait at least one year after your policy goes into effect before they will pay for any maternity benefits, which means you may get pregnant after you've been on the policy for three months. Yet other companies say you must have their policy for 12 months before you can get pregnant (or at least expect them to pay your maternity bills), which would mean your pregnancy would not be a covered expense until you've been on the policy for 21 months.

What is a group/employer plan?

These types of plans are available to you through your place of employment if your employer offers this benefit. Most employers that offer their employees health insurance make you wait until 30 or 60 or 90 days after you've become employed before you can get on the plan. By state law (and some states may vary), benefits are a little different on group plans than they are on individual plans. For example, most individual plans do not include maternity benefits, but almost all group plans do. Mental health benefits are not usually covered very well on individual plans, but on most group plans, mental health benefits are treated like any other illness. Almost all group plans will cover your pre-existing conditions as soon as you become included on the plan, and with no waiting period. This means that if you have a heart condition and get a job that provides you with health insurance benefits, you could have a heart attack the day you become covered and those medical bills will be covered by the group insurance policy. By law, your employer is required to pay at least 50% of your monthly premium. Some employers may pay all of your premium, but they don't have to. Your employer is not required to pay any of your spouse or children's premium — most companies do not pay any of this amount, but some employers will.

What is a guaranteed issue health insurance plan?

Guaranteed Issue Health Insurance is just what it says -- if you apply for the policy, you will receive it, regardless of any pre-existing health conditions. But most of these policies are not considered major medical policies. They are considered mini medical policies. They will pay some of your bills, but not all. If you got very sick and your medical bills were in the hundreds of thousands of dollars, you'd probably have to pay a large amount of those bills. Most higher quality mini-medical plans (guaranteed issue TRUE health insurance plans, as opposed to simple medical discount plans, which are not insurance policies) will pay you around $1,000 per day when you are hospitalized (and more if you end up in an intensive care unit), for up to 30 to 100 days per year. They also will pay a pre-determined amount for a surgeon, but many times the amount paid to the surgeon may not be enough to pay his or her bill in full. Scrupulous insurance brokers will usually only offer these types of policies to those people who have severe pre-existing health conditions that would make it impossible to get a major medical health insurance plan. If you've had a heart attack or stroke or cancer in the recent past, you'll find it

literally impossible to get a major medical policy, such as a policy from a company like Blue Cross. If you find yourself in this position, a mini medical plan is better than nothing, and some of these plans are high quality plans and, if used "according to the rules" can pay a large percentage of your medical bills.

What is COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers with group health plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status (referred to as "qualifying events"). The qualifying event requirement is satisfied if the event is the death of a covered employee; the termination (other than by reason of the employee's gross misconduct), or a reduction of hours, of a covered employee's employment; the divorce or legal separation of a covered employee from the employee's spouse; a covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or a dependent child ceasing to be a dependent child of the covered employee under the generally applicable requirements of the plan and a loss of coverage occurs.

What is HIPAA?

HIPAA stands for the Health Insurance Portability and Accountability Act, which is a law mandating that anyone belonging to a group health insurance plan must be allowed to purchase health insurance within an interval of time beginning when the previous coverage is lost. The law protects employees, especially those with long term health conditions who may be reluctant to leave jobs because they are afraid pre-existing condition clauses will limit coverage of any such conditions under a new insurance plan, from losing health insurance due a change in employment status.

Health Insurance Glossary

Affiliation Period

The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that require an affiliation period cannot exclude

coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. See also HMO.

Alternative Trade Adjustment Assistance (ATAA)

ATAA is a benefit for workers at least 50 years old who have obtained different, full-time employment within 26 weeks of the termination of adversely-affected employment. These worker may receive 50% of the wage differential (up to $10,000) during their 2 year eligibility period. To be eligible for the ATAA program, workers may not earn more than $50,000 per year in their new employment. Also, the firm where the workers worked must meet certain eligibility criteria.

Certificate of Creditable Coverage

A document provided by your health plan that lets you prove you had coverage under that plan. Certificates of creditable coverage will usually be provided automatically when you leave a health plan. You can obtain certificates at other times as well. See also Creditable Coverage.

COBRA

Stands for the Consolidated Omnibus Budget Reconciliation Act, a federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent_s plan rules. You may choose to continue in the group health plan for a limited time and pay the full premium (including the share your employer used to pay on your behalf). COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances.

Continuous Coverage

Generally, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Affiliation Period, Creditable Coverage, Fully Insured Group Health Plan, HMO, Small Group Health Plan,

Waiting Period.

Conversion

Your right, when leaving a fully insured group health plan, to convert your policy to individual health insurance. There are rules about what conversion policies must cover and what premiums can be charged. See also COBRA, Fully Insured Group Health Plan, and HMO.

Creditable Coverage

Health insurance coverage under any of the following: a group health plan; individual health insurance; Medicare; Medicaid; CHAMPUS (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; state health insurance high risk pool, as well as certain coverage under state programs; policy or contract including short-term health insurance issued to an eligible individual; or policy issued to bona fide association members. See also Continuous Coverage, Group Health Plan, Individual Health Insurance.

Enrollment Period

The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health benefits when first hired, many employers and group health insurers hold an annual enrollment period, during which all employees can enroll in or change their health coverage. See also Group Health Plan, Special Enrollment Period.

Family and Medical Leave Act (FMLA)

A federal law that guarantees up to 12 weeks of job-protected leave for certain employees when they need to take time off due to serious illness, to have or adopt a child, or to care for another family member. When you qualify for leave under FMLA, you can continue coverage under your group health plan.

Fully Insured Group Health Plan

Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by state governments. See also Self-Insured Group Health Plans.

Genetic Information

Includes information about family history or genetic test results indicating your risk of developing a health condition. A health plan cannot consider pre-existing (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

Group Health Plan

Health insurance (usually sponsored by an employer, union or professional association) that covers at least two employees, or the self-employed. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue

A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. Most health plans sold to small employers are guaranteed issue. If you are HIPAA eligible, insurance companies must offer you a choice of basic and standard individual health plans that are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

Guaranteed Renewability

A feature in most health plans that means your coverage cannot be canceled because you get sick. HIPAA requires all health plans to be guaranteed renewable. Your coverage can be canceled for other reasons unrelated to your health status.

Health Coverage Tax Credit (HCTC)

The Health Coverage Tax Credit (HCTC) is a program that can help pay for nearly two-thirds of eligible individuals' health plan premiums. In general, in order to be eligible for the health coverage tax credit, you must be 1) receiving Trade Readjustment Allowance benefits (TRA), or 2) will receive TRA benefits once your unemployment benefits are exhausted, or 3) receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program, or 4) aged 55 or older and receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

Health Insurance (or health plan)

In this guide, the term means benefits consisting of medical care (provided

directly or through insurance or reimbursement) under any hospital or medical service policy, plan contract, or HMO contract offered by a health insurance company or a group health plan. It does not mean coverage that is limited to accident or disability insurance, workers compensation insurance, liability insurance (including automobile insurance) for medical expenses, or coverage for on-site medical clinics. Health insurance also does not mean coverage for limited dental or vision benefits to the extent these are provided under a separate policy.

Health Plan Year

That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

Health Status

When used in this guide, refers to your medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. See also Genetic Information.

HIPAA

The Health Insurance Portability and Accountability Act, better known as Kassebaum-Kennedy, after the two senators who spearheaded the bill. Passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets a national floor for health insurance reforms. Since states can and have modified and expanded upon these provisions, consumers protections vary from state to state.

HIPAA eligible

Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. You are also HIPAA eligible if your health plan was not renewed by an insurer who discontinued offering and renewing individual health benefit plans in your state. When you are buying individual health coverage, federal eligibility confers greater protections on you than you would otherwise have.

See also COBRA, Continuous Coverage, Creditable Coverage.

High Risk Pool

Subsidized health insurance pools that are organized by some states. High risk pools offer health insurance to individuals who have been denied health insurance because of a medical condition or to individuals whose premiums are rated significantly higher than average due to health status or claims experience. High risk pools can be a form of qualified health coverage if they are deemed state-qualified. To be considered qualified, the high risk pool must provide coverage to all individuals guaranteed coverage through HIPAA, not impose any preexisting condition exclusions, meet certain requirements for premium rates and covered benefits, and be officially qualified by the state.

HMO, or Health Maintenance Organization

Health maintenance organization. A kind of health insurance plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. If you are covered under an HMO, the HMO might require an affiliation period before coverage begins. See also Affiliation Period.

Individual Health Insurance

Policies for people not connected to an employer group. Individual health insurance plans are regulated by state governments.

Kassebaum-Kennedy

See HIPAA.

Large Group Health Plan

One with more than 50 eligible employees.

Late Enrollment

Enrollment in a health plan at a time other than the regular or a special enrollment period. If you are a late enrollee, you may be subject to a longer pre-existing condition exclusion period. See also Special Enrollment Period.

Look Back

The maximum length of time, immediately prior to enrolling in a health plan, that can be examined for evidence of pre-existing conditions. See also Pre-existing Condition.

Managed Care Plans

A kind of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by doctors or hospitals who work for or contract with them - also called "network" providers - and therefore may limit enrollment to those people who live within a particular coverage area. Managed care plan may require you to get permission (a "referral") from your family doctor before you get care from a specialist in their network. Some managed care plans will cover your care at a lower rate if you go to a non-network provider or if you get specialty care without a referral. See also HMO.

Medicaid

A program providing comprehensive health insurance coverage and other assistance to certain low-income residents. All states have Medicaid programs, though eligibility levels and covered benefits will vary.

Modified Community Rating

A requirement applicable to some group plans that requires that the rate for each policy not vary due to the health status of those who buy that health insurance. Premiums can vary based on age, gender, income, and by county, as well as by health plan option and family status.

Nondiscrimination

A requirement that group health plans not discriminate against you based on your health status. Your coverage under a group health plan cannot be denied or restricted, nor can you be charged a higher premium, based on your health status. Group health plans can restrict your coverage based on other factors (such as part time employment) that are unrelated to health status. See also Group Health Plan, Health Status.

Pension Benefit Guaranty Corporation (PBGC)

PBGC is a federal government corporation established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) to encourage the

continuation and maintenance of defined benefit pension plans, provide timely and uninterrupted payment of pension benefits to participants and beneficiaries in plans covered by PBGC. It currently guarantees payment of basic pension benefits earned by American workers and retirees participating in private-sector defined benefit pension plans. The agency receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.

Pre-existing Condition (Group Health Plans)

Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within a defined period (usually six months) immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Individual Health Plans)

Any condition for which you received a diagnosis, medical advice, or treatment prior to obtaining the individual policy. In some states, individual health insurers have broad discretion to define what constitutes a pre-existing condition, even including an undiagnosed condition you may unknowingly have had when you applied for the policy. Pregnancy can be subject to a pre-existing condition exclusion in most states. However, complications of pregnancy arising after coverage begins cannot be considered a pre-existing condition. Genetic information cannot trigger a pre-existing condition exclusion period in individual health insurance in most states.

Pre-existing Condition Exclusion Period

The time during which a health plan will not pay for covered care relating to a pre-existing condition. See also Pre-existing Condition.

Premium

The amount an individual pays in exchange for health coverage. An individual's employer sometimes pays a portion of this amount.

Self-Insured Group Health Plans

Plans set up by employers who set aside funds to pay their employees health claims. Because employers often hire insurance companies to run these plans, they may look to you just like fully insured plans. Employers must disclose in your benefits information whether an insurer is responsible for funding, or for only administering the plan. If the insurer is only administering the plan, it is self-insured. Self-insured plans are regulated by the U.S. Department of Labor.

Small Group Health Plans

Plans with at least 2 but not more than 50 eligible employees, or plans with at least one (self-employed) individual but not more than 50 employees.

Special Enrollment Period

A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 days. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

Supplemental Security Income (SSI)

A program providing cash benefits to certain very low income disabled and elderly individuals. When you qualify for SSI, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time if your income increases so that you no longer qualify for SSI. See also Medicaid.

Temporary Assistance for Needy Families (TANF)

A program that provides cash benefits to low income families with children. When you qualify for TANF, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time or longer if you no longer qualify for TANF. See also Medicaid.

Trade Adjustment Assistance (TAA)

A program authorized by the Trade Adjustment Assistance Reform Act of 2002. This program provides aid to workers who lose their job or whose hours of work and wages are reduced as a result of increased imports. The TAA Program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 65% of health insurance premiums for certain plans.

US Department of Labor

A department of the federal government that regulates employer provided health benefit plans. You may need to contact the Department of Labor if you are in a self-insured group health plan, or if you have questions about COBRA or the Family and Medical Leave Act. See also COBRA, Family and Medical Leave Act.

Waiting Period

The time you may be required to work for an employer before you are eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous. If your employer requires a waiting period, your pre-existing condition exclusion period begins on the first day of the waiting period. See also Pre-existing Condition Exclusion Period.