

Choosing a Medical Plan

Issues to Consider:	Details
Types of Medical Insurance	
Group Insurance	Typically provided by an employer, educational institution or association. Premiums are often lower in group plans than in individual plans. Some group plans exclude pre-existing conditions if there has been more than a
Individual Insurance	Can be obtained from a variety of individual health insurers. Individuals are medically underwritten based on their health status. Policies exclude pre-existing conditions temporarily or permanently.
Government Programs	Medicare is provided by the Federal Government and is offered to those over 65 or those under 65 who are disabled or suffer from ESRD. Medicaid is run state by state and is offered based on financial need or physical disability. CoverFlorida is a newly launched public/private partnership
Managed Care in Group Health Plans	
Health Maintenance Organizations	Coverage is typically restricted to the insurer's network of providers with the exception of Emergency Room care. Often requires that members select a Primary Care Physician (PCP) and obtain referrals to see Specialists. Some HMOs are local, while others are national. If you are residing outside of the network area for your HMO, you may only have coverage at the
Preferred Provider Organizations	Includes the insurer's network of providers but allows for treatment from any provider outside of the network. PCP selection and referrals are not
Point of Service Plans	A hybrid of HMO and PPO plans. Allow for coverage within and outside of the insurer's network. May or may not require selection of a PCP and
Paying for Medical Care	
Premiums	The amount you pay for the insurance coverage itself.
Billed Charges	The full amount billed by the healthcare provider. Comparable to a "retail price" as though no insurance discount was available. When services are received from an out of network provider, a member's expense is based on the billed charges. However, the insurer will consider charges based on
Negotiated rate/Contracted Rate	The discounted price negotiated between an insurer and a healthcare provider for a service. Comparable to the "wholesale price." When services are received from an in-network provider, a member's expense is based on
Reasonable and Customary	When services are received from an out of network provider, the member's expense is based on the negotiated rate. However, the insurer's payment for the services is based on what the insurer considers to be reasonable and customary for that service in the area in which it was provided. There is typically a significant difference between the billed charge and the insurer's R&C, leaving the member with a potential for considerable expense.
Copays	A flat, fixed dollar amount you pay for services such as office visits.
Coinsurance	A percentage of the negotiated rate that you are responsible for.
Deductibles	The amount you pay before your insurance coverage/benefit begins. The higher the deductible, the lower the premium.
Out of Pocket Expenses	The amounts you pay for covered services such as copays, coinsurance and

Out of Pocket Maximum	The maximum amount of out of pocket expenses you are responsible for in a policy year before the insurance begins to pay at 100%. Not all expenses count towards an out of pocket maximum. Its important to understand which expenses count towards an out of pocket maximum (deductible,
Access to Care	
In Network	The roster of physicians and facilities which have an agreement with an
Out of Network	Any physician or facility which does not have an agreement with an insurer.
Open Access	Referrals from PCPs to Specialists are not required.
Other Issues to Consider	
Pre-Existing Conditions	May or may not be covered by a plan either temporarily or permanently. Group plans will likely cover these if there has not been a 63-day break in coverage between plans. Individual plans will exclude pre-existing
Covered Benefits/Exclusions	Does the policy include prescription drug benefits? Are there any conditions/services which are excluded from coverage (like maternity)?
Coordination of Benefits	If a person is covered under more than one plan, or another type of insurance is responsible (auto, workers comp, etc), the insurers will coordinate the benefits so that each is responsible for their respective
Dependent Coverage	The option to cover a spouse, domestic partner (same sex or opposite sex), children or step children. This option will differ amongst plans as will the
Changing Coverage (Qualifying Status Changes)	Group plans allow changes once per year during Open Enrollment, unless qualifying status change occurs mid-year. Examples of qualifying status
COBRA	The Federally mandated option to continue coverage through a group plan with the individual bearing the full cost of the premiums.

Questions:

- 1) What is the premium? When/how will it change?
- 2) What are the benefits (deductibles, copays, coinsurance, Rx)?
- 3) Where can I receive care and from whom?
- 4) Where can I receive emergency care and at what expense?
- 5) What services/conditions are excluded from the policy?
- 6) What is my maximum expense per year under the plan? What is not counted towards that maximum?