

## Health Insurance Overview

Health insurance is an important coverage that helps protect you and your family from the devastating financial effects of unexpected health problems or catastrophic illness.

Health coverage can be issued to individuals, to employees of an employer offering health coverage, or to individuals that are members of association groups. Some health coverage is provided by self insured funds, not regulated by the State of Florida. Although there are other forms of health insurance, the three main categories of health insurance are:

- Policies that provide managed care services, including major medical PPO coverage;
- Policies that offer traditional major medical coverage, and
- Policies that provide limited benefits.

### Policies that provide Managed Care Services

The managed care system combines the delivery and financing of health care services. This limits your choice of doctors and hospitals. In return for this limited choice, you usually pay less for medical care (i.e., doctor visits, prescriptions, surgery and other covered benefits) than you would with traditional health insurance as long as you obtain services from an in-network provider or facility. The managed care network controls health care services.

The types of Managed Care are:

- **Preferred Provider Organizations (PPOs)** - PPOs offer a provider network to meet the health care needs of its insureds. An insurer contracts with a group of health care providers to control the cost of providing benefits to its insureds. These providers charge lower-than-usual fees because they require prompt payment and serve a greater number of patients. Insureds usually choose who will provide their health care, but typically pay a lower deductible and less in coinsurance with a preferred provider than with a non-preferred provider. Most group health policies fall under this category of major medical coverage.
- **Health Maintenance Organization (HMO)** - HMO members pay a monthly fixed dollar amount (similar to an insurance premium), which gives them access to a wide range of health care services. In many cases, members also pay a predetermined amount, or copayment, for each doctor or emergency room visit and for prescription drugs, rather than paying the provider in full and obtaining a portion of the reimbursement later. Members must use the HMO's network of providers, which may include the doctors, pharmacies and hospitals under contract with that particular HMO. Emergency services are covered regardless of the network status of the medical provider or facility.
- **Point of Service plans (POS)** – A Point of Service plan is a HMO plan with an out of network option. In a POS plan, insured members may choose, at the point of service, whether to receive care from a physician within the plan's network or to go out of the network for services. The POS plan provides less coverage for health care expenses provided outside the network than for expenses incurred within the network. Also, the POS plan will usually require you to pay higher deductibles and coinsurance costs for medical care received out of network.
- **Exclusive Provider Organizations (EPOs)** - In an EPO arrangement, an insurance company contracts with hospitals or specific providers. Insured members must use the contracted hospitals or providers to receive benefits from these plans. Emergency services are covered regardless of the network status of the medical provider or facility.

### Policies that provide Traditional Major Medical coverage

Traditional health coverage is provided by major medical policies and is more expensive because it provides more benefits than basic policies. A major medical policy normally pays a percentage of covered expenses (normally 80%), after you pay the deductible. Insurance companies use fee schedules to determine the reasonable and customary cost of a procedure; however, this cost may differ from the actual charge you receive. Maximum out-of-pocket limits restrict the amount of coinsurance you pay. Not all policies include such limits, but those that do pay 100 percent of remaining covered expenses after you pay a stated amount of coinsurance. You are not restricted to a particular network of medical providers under a traditional major medical policy.

## Policies that provide limited benefits

Although there are others, the most popular policies that provide limited benefits are:

- **Basic Hospital Expense** - [Click here](#) for more information.
- **Basic Surgical Expense** - [Click here](#) for more information.
- **Specified diseases such as cancer** - [Click here](#) for more information.
- **Hospital Indemnity plans** - [Click here](#) for more information.

## There are other types of health-related services that are NOT health insurance plans

They are:

- **Discount Plans\*** - Medical Discount Plans, Prescription Discount Plans, Dental Discount Plans, and Vision Discount Plans are programs where a consumer pays a fee to join a plan in return for discounts on products and services from participating vendors and providers. Often, members who join these plans are issued a card similar to an insurance card identifying them as a member. However, these plans are NOT insurance. You are responsible for the provider's discounted charges at the time of service.

*\*Buyer Beware: [Click here](#) for a list of things to consider prior to purchasing a Medical Discount Plan.*

## Health Insurance Tips

- [Verify before you buy!!!!](#) Contact us to verify the license of the agent and the insurance company before you sign the application for a policy.
- [Health Insurance Guide](#) The guide is an excellent tool if you are shopping for a specific type of insurance and would like to gain a better understanding of all the aspects of the product prior to making your purchase.
- [Small Group Carrier List](#) A list of companies that are offering health insurance to Small Business Owners in Florida.
- [Individual Carrier List](#) A list of companies that are marketing guaranteed issue health insurance policies for eligible individuals as defined by Section 627.6487(3), Florida Statutes.
- [Review your policy carefully!!!!](#) Understand your deductible and coinsurance provisions. Understand your responsibility if you need a referral to see a specialist. Also, understand your rights to file an appeal or grievance if a claim is denied that you feel should be paid.
- [Regulated individual plans have a 10-day free-look provision.](#) This allows you to return the policy and receive a full refund if you are not happy with the policy.
- [An individual policy must include a grace period provision.](#) The grace period is from 7 to 31 days, depending on how the premium is paid. Individual HMO's must provide a 10 day grace period.

## Want more information?

Visit the [Health Insurance portion of the Insurance Library](#) or [Health Maintenance Organization portion of the Insurance Library](#) or call **1-877-MY-FL-CFO (1-877-693-5236)**.