

Health care coverage is something all of us need at some point. No one likes getting sick or hurt. Having health insurance will pay for preventive care and pay a part of the cost when you're sick or hurt — sometimes a big part.

THE BASICS

Insurance Coverage



When you buy, or enroll in, a health plan, the insurance company agrees to pay for preventive services to help you stay well, plus part of your medical bills when you need a checkup, get sick or have an accident. These include things like doctor or hospital visits, prescription drugs, tests, maternity care and other medical services you may need. That's called "**coverage**."

Premium Payments



Premiums are payments you make each month to your insurance company for your health insurance coverage. Keeping these payments up-to-date ensures that you will have coverage when you need it, whether it's an unexpected illness or a chronic condition.

SO HOW EXACTLY DOES IT WORK?

We can
Help!

When you apply for coverage and make your first month's premium payment, you are issued a health plan policy with a date that your coverage will start. Each month, you pay a monthly bill for your health plan. This is called a **premium**. You may qualify for help from the government to pay part of your premium. This financial assistance is called a premium tax credit or **subsidy**. The government will send the subsidy directly to the health insurance company. This lowers the cost of your monthly payment.

You may have to pay part of the cost when you get health care services. This is called your **cost share**.

Most health insurance plans will have a network, or a list of doctors, hospitals and other health care providers that you can choose from. These are called **in-network health care providers**. Going to these health care providers when you need care will generally save you the most money. If you go to a provider that is not in your plan's network, you may have to pay more.

Some plans, such as HMO coverage, only cover services by in-network providers. Other plans require that you use exclusive providers (EPO) for certain services, such as prescription drugs or medical equipment. These are things you may want to ask before you choose a health plan.

YOUR COST SHARE

In-network Advantage



Certain covered health care services may have a lower cost share or a \$0 cost share when you go to in-network health care providers.

Upfront Cost



Other covered services may have a **deductible** that you pay first. After you have paid the deductible, you may pay a smaller amount for those same covered services, as either **coinsurance** (a percentage of the allowed amount) or a **copay** (a flat fee). Check your plan to see which services require the deductible to be paid first.

Flat Fees



Some covered health care services may have a **copay**, which means you'll pay a flat fee each time.

Annual Out-of-Pocket Maximum



Your plan will have an annual **out-of-pocket maximum**. This is the most you pay each year for services covered by your health plan. After you have paid this amount, your insurance pays 100% of covered medical services for the rest of the year.

How a Copay Works

A **copay** is a flat fee that you may pay for covered health care services when you go to an in-network health care provider. For example, if your plan has a \$25 copay for visits to a primary care doctor, that's the flat fee you'll pay for each primary care visit. Some plans may require that a deductible is paid first. There may be different copays depending on where you go or the type of care you need, but you'll know the cost right away.

How a Deductible Works

A deductible is the dollar amount you must pay for certain health care services each year before your health plan starts to pay. After you have paid the deductible, you usually pay only a copayment (a flat fee) or coinsurance (a percentage of the bill) for covered services.

The maximum amount that your plan will pay for a covered service is based on an **Allowed Amount** that has been negotiated with in-network providers. This amount is usually less than the normal rate.

This is an example of how cost-share works **before** you reach the deductible when you go to an **in-network** health care provider.

Doctor's full charge:	\$155
Allowed Amount:	\$95
YOU WOULD PAY:	\$95

Goes toward your deductible and out-of-pocket maximum

How Coinsurance Works

When your **deductible has been met**, you may pay a coinsurance percentage (%) for certain services. The percentage you pay is based on the Allowed Amount that has been negotiated with in-network providers. See the 20% example below:

Goes toward your out-of-pocket maximum

Doctor's full charge:	\$155
Allowed Amount:	\$95
YOU WOULD PAY 20% of the Allowed Amount:	\$19

* **Important:** The examples above assume that you go to an in-network health care provider. If your plan has out-of-network benefits, out-of-network providers can charge more than the **Allowed Amount** and bill you for the difference.

How Florida Blue Can Help

If you have any questions, we encourage you to click **Chat Now**, find a [local agent](#) or visit a nearby [Florida Blue Center](#).