Got Insurance?

2015

F L O R I D A

Just the Facts: The 411 on Health Insurance for Young Adults Ages 18-30 in Florida

Including Those with Chronic Health Conditions or Disabilities

How to Get It, Keep It and Use It!

Version 1.4, July 2015 Edition
Just the Facts:
The 411 on Health Insurance
for Young Adults
Ages 18-30 in Florida

Visit www.FloridaHATS.org
to view in large print
This guide is a product of Florida Health and Transition Services (FloridaHATS), a program of the Florida Department of Health, Children’s Medical Services Network.

July 2015 edition updated and approved by authors Patti Hackett-Hunter, MEd, Janet Hess, DrPH, MPH, Meg Comeau, MHA, and Phyllis Sloyer, RN, PhD

Acknowledgements

Thank you to the following individuals and agencies for their contributions to this publication: Mallory Cyr (Healthy & Ready To Work National Resource Center), and Family Voices representatives Beth Dworetzky (Massachusetts) and Donene Feist (North Dakota) for their thoughtful review and comments. In addition, we thank Patience White, MD (George Washington University), Martha Crabb and Keith Young (Florida Agency for Health Care Administration), Ryan Sbrissa (Social Security Administration), Mary Beth Senkewicz and Gerry Smith (Office of Insurance Regulation), Fred Knapp (Florida Healthy Kids Corporation) and Virginia Hardcastle (Florida Department of Children and Families). A special thanks to the Florida Developmental Disabilities Council, Inc., for their sponsorship of the first edition.

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Recommended Citation


Graphic Design provided by Caryl Loper, Graphic Artist, Crystal Pathways, Inc.

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About......

Just the Facts:
The 411 on Health Insurance for Young Adults Ages 18-30 in Florida

Health insurance is a complicated subject. The Affordable Care Act of 2010 (also called ACA) has led to significant changes to health insurance practices nationwide, and expands health coverage to millions of previously uninsured Americans. We’ve written this guide to help you figure out what’s available to help you pay for health care services, and what might be the best choice for your particular needs.

Let’s be honest. When was the last time you read an insurance manual, or saw your parents or other adults reading one? We’ve learned that people who are looking for information about health insurance want answers that are to-the-point and easy to understand.

So here’s the scoop: This guide is designed to give you basic information, action steps and deadlines to help you stay focused and on track. Links to Web-based resources are included if you want to find out more about specific items. If you don’t know what some terms mean, there’s a glossary in the last section.

It’s always a good idea to ask for help from a trusted adult, so share this guide with your family, providers, and friends. And stay tuned: as updates become available, they will be posted to our website, www.FloridaHATS.org.

What’s our goal?
To make sure you and all young adults in Florida have the health insurance you need to be healthy, happy and productive!
Who should use the guide?

- Young adults between the ages of 18 and 30 living in Florida, including those with chronic health conditions or disabilities
- Parents, families, guardians, caregivers or other trusted adults who help them

Who else can use this information?

- Health Care Transition Coordinators
- Care Coordinators
- Benefit Navigators
- Community Providers
- Interfaith Community Leaders
- Post-Secondary and High School Teachers
- Vocational Rehabilitation Counselors
- Transition Planners
- Cultural Brokers
- Medical Providers (Physicians, Nurses, Specialists and Therapists)

**FACTOID #2**: While young adults are sometimes described as viewing themselves as ‘young invincibles,’ research indicates many worry about affording medical bills, particularly catastrophic ones.2
As a young adult who is making many important choices about your life, choosing a health care plan is probably not on the top of your “to do” list. Health insurance is a lot like car insurance: you don’t appreciate it until you need it. Then you really want to have it!

It might be tempting to think, “I’ll figure this out tomorrow.”

Getting and keeping health insurance is important for all of us no matter how old or young we are. Everyone, regardless of their age, needs to be able to go to the doctor or hospital if they get sick or hurt, as well as for annual check-ups. And that costs money. If you don’t have health care insurance, it can cost a LOT of money.

FACTOID #3: Contrary to the myth that young people don’t need health insurance, one in six young adults has a chronic illness like cancer, diabetes or asthma. Nearly half of uninsured young adults report problems paying medical bills.3

So, how do you get started? The following sections are designed to give you the information you need to make the best decision for you.
# Start Early!
Skills to Prepare for Adult Life

## Skills, Questions to Ask, Information to Learn in High School and After
Plan ahead while you are still in high school to make sure you have a plan for health care coverage when you graduate.

<table>
<thead>
<tr>
<th>Take it step-by-step!</th>
<th>Yes</th>
<th>Need Info</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grades 10 - 11 (ages 15-17)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>➡️ Start asking questions about options for health care coverage after age 18.</td>
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</tr>
</tbody>
</table>

**Student**
- Carry your current insurance card with you every day. It’s a form of identification and proves a payment source for medical services and medications, especially in an emergency.

  *Tip:* Keep a copy of your insurance card on your cell phone. You can scan it and email to yourself, then download as an attachment and store on your phone. OR take a clear photo and save it on your phone.

**Family**
- Explore options for coverage after your child turns 18, the age of majority.
- If on a family plan, find out when your son/daughter will no longer be covered on that plan. Are there forms you need to submit to keep them on your plan? Most likely, these forms will need to be submitted during annual enrollment.

<table>
<thead>
<tr>
<th><strong>Grade 12 (ages 17-18)</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>➡️ Notify your insurance company that your minor child is turning 18.</td>
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</tbody>
</table>

**Student**
- Planning to attend college out-of-state? Ask if your current health insurance will pay for your medical visits (routine, specialists or emergency) near your new school.
- Check out free/low cost care through the college Student Health Services. Check to see if it qualifies as coverage under the ACA.

**Family**
- Fill out any necessary forms for adult dependent child over age 18 if your son/daughter is staying on your health care insurance.

<table>
<thead>
<tr>
<th><strong>College/Employment/Community (18 and older)</strong></th>
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</thead>
<tbody>
<tr>
<td>➡️ Annually fill out forms to keep insurance. Be ready to submit this documentation every year.</td>
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</tbody>
</table>

**Student**
- Know how much your co-pays are before going to the doctor.
- Pay at the time of service and **keep receipts** (bill paid by cash, debit or credit card).
- If needed, get referrals to see a specialist or for medical tests.

**Family**
- With your son/daughter annually complete and submit paperwork on time.
5 Tips to Become Insurance Smart!

1. Ask Others

Talk to friends, family members and other adults who have health issues similar to yours. Ask them what they like about their health insurance.

Qs> Does the plan pay for the services they use? Are the out-of-pocket expenses or co-pays affordable?

You can also ask for help from doctors’ office managers or billing clerks. They deal with different health plans every day and know which plans pay for certain health services and which plans do not.

Remember, there is no perfect plan that pays for everything, but there are plans that may be better for you and your health care needs.

2. List Your Health Needs versus Wants

• Which health issues and services do you need?
• Do you want to stay with your current doctors?
• Do you want to save on out-of-pocket costs? This may require higher premiums.
• Do you want a particular medical treatment to be covered?

3. Do You Qualify? Know Your Eligibility

• All health insurance plans have their own rules about who is eligible.
• Some plans will ask about health issues, whether you are married or have children, etc.
• Depending on your income, you may qualify for government subsidies or tax credits to help pay for coverage.
4 **What Services are Paid for and Which Ones are Not?**

- Read your policy to understand the benefit packages that are available to you. Or you can call the health plan directly and ask them.
- Many employers and health insurance companies have information on their Websites about their health plans, including answers to frequently asked questions and phone numbers to call.

5 **Be Willing to Compromise**

- No health insurance plan is perfect, and no plan covers everything.
- Know your plan’s renewal schedule. If your plan isn’t paying for what you need, consider changing plans during the next open enrollment.
- Search for websites that let you compare plans, such as [www.healthcare.gov](http://www.healthcare.gov) or [www.healthpocket.com](http://www.healthpocket.com).

**Words To Know**

**In-Network Providers:**
Doctors who have a contract with the health plan, so you pay less out-of-pocket to see them.

**Out-of-Network Providers:**
Doctors who do not have a contract with the health plan, so you pay more out-of-pocket to see them.

**Open Enrollment:**
Time period when plan members can enroll or change their benefits program; generally held once a year.

**Essential Health Benefits:**
Ten health service categories that must be covered by most plans in order to meet ACA guidelines, including emergency care, hospitalization, maternity, mental health and substance abuse, prescriptions, preventive care, and chronic disease management services.
Health Insurance Options at a Glance

Before we give you “Just the Facts” about each option, look over the choices. There are more than most people realize. In the next sections, we’ll talk about how to qualify, out-of-pocket costs, monthly premiums, good points, potential downside to particular plans and resources to learn more. Remember, this guide offers just a few facts to give you an overall view and get you started. As you’ll see, there are a lot of issues to think about before choosing or changing a health insurance plan or benefit package.

### Health Insurance for Ages 18-30

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<tr>
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<td>• Any hospitalizations</td>
</tr>
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<td>• Waivers for special groups</td>
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<tr>
<td>College/University</td>
<td>Federal Public Insurance</td>
<td>Low Cost Options</td>
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<tr>
<td>• Student Health Plan</td>
<td>Medicare</td>
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<tr>
<td>Marketplace (ACA)</td>
<td>• Low income, with disability</td>
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<tr>
<td>• Individual</td>
<td>Indian Health Services</td>
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<td>• Family</td>
<td>TRICARE</td>
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<tr>
<td></td>
<td>Local Safety Net Plans</td>
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**FACTOID #4:** Nationally, over 2.3 million young people who would otherwise have been uninsured have gained coverage as a result of the ACA provision to allow children to remain on their parents’ policy until age 26.4
Private

Job-based group plans are provided through work. If you are employed, or if your parent is employed and you are under age 26, you may be offered health care coverage as an employment benefit. Employees generally work at least 30 hours per week to qualify for a job-based group plan. An employee can buy coverage for just him/herself, or buy a ‘family’ plan. Family members are called dependents, no matter how old the person is.

If you are a college student, you may have the option to purchase a student health plan through your college of university.

If you do not have affordable job-based insurance, you can purchase an individual plan or, if under age 26, be included in your family’s plan through the ACA Marketplace (sometimes called the “Exchange”). There are 4 categories of these plans plus a catastrophic plan that vary in cost and options.

- Employers typically pay for part of the plan’s premium.
- Young adults with or without disabilities can stay on their parents’ health care plan until age 26 and sometimes up to age 30.
- Young adults who are disabled, don’t work and are supported by their parent(s) can stay on their family plan indefinitely with annual review.

- If you are covered on a family plan but are studying or working in an area away from your parents’ home, there may be no local providers in the plan’s provider network, and going to out-of-network doctors or hospitals can be expensive.
- Some student health plans may not meet the ACA’s “essential health benefits” requirements, or, if you attend college out of state, may not cover medical services in your home state.

- Monthly premiums plus co-pays.
- By using in-network providers and services, the co-pays are cheaper than out-of-network providers.
- Depending on your income, you may qualify for subsidy or tax credit.

How to Apply

- Job-Based: Check with Human Resources (HR) Department.
- Student Health Plan: Check with Student Health Services at your college.
Government-Funded

Medicaid is the state and federal partnership for people with low incomes, with or without a disability.

Medicaid Waivers cover children, youth and adults who have special needs and meet certain rules.

Medicare is a federal health insurance program for persons with disabilities over age 19, people who are age 65 or older, or those with end-stage kidney disease at any age.

Indian Health Services provides coverage for members of federally recognized tribes.

TRICARE is a managed care program for active duty and retired military and their families.

Local Safety Net Plans are available to low-income residents in some Florida counties who meet eligibility criteria.

Florida Medicaid
- is a managed health care plan
- has several Waiver plans for special populations
• Who qualifies? Young adults who formerly were in foster care and people who have low income, including
  - Persons with disabilities
  - Those with high medical bills
  - Women who have children
  - Pregnant women

Trouble finding doctors and dentists, as some do not accept Medicaid.
• Co-pays can add up if you have a lot of medical visits.
• Some Florida Medicaid Waiver plans have long waiting lists.

Monthly premiums plus co-pays.
• Sliding scale fee for co-pays.

For Medicaid, visit www.myflorida.com/accessflorida. See Part 3 “Government-Funded Insurance” on page 34 for more information on each program.
## Private

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<th></th>
<th>Limits</th>
<th>Eligibility Based on Employment Status</th>
<th>Eligibility Based on Disability/Health Condition</th>
<th>Monthly Premiums</th>
<th>Requires Annual Certification</th>
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<td>19-26</td>
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<td><strong>Dependent Disabled Adult/Family Plan</strong></td>
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<td>19-up</td>
<td>Y</td>
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<td>Y</td>
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<tr>
<td><strong>College/University Student Health Plans</strong></td>
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<td><strong>Marketplace/Individual and Family Plans</strong></td>
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## Government-Funded

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<td><strong>Income</strong></td>
<td><strong>Age</strong></td>
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<td>Medicaid (Child EPSDT)</td>
<td>Y up to 21 *26 for former foster care</td>
<td>N</td>
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<td>Y</td>
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<tr>
<td>Florida KidCare (Title XXI)</td>
<td>Y up to 19</td>
<td>N</td>
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<tr>
<td>Full Pay Healthy Kids and MediKids</td>
<td>Y up to 19</td>
<td>N</td>
<td>N</td>
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<td>Medicaid (Adult)</td>
<td>18-up</td>
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<td>Medicare</td>
<td>16-up</td>
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<td>Medicaid &amp; Medicare Dual Eligibility</td>
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<td>N</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Qualified Medicare Beneficiaries</td>
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<td>Y</td>
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<tr>
<td>Specified Low-Income Medicare Beneficiaries</td>
<td>18-up</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Qualified Disabled Working Individuals</td>
<td>18-up</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
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<td>Medicaid Home &amp; Community-Based Service Waivers</td>
<td>3-up</td>
<td>N</td>
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</tr>
<tr>
<td>Adults with Cystic Fibrosis</td>
<td>18-up</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Long-Term Care Managed Care</td>
<td>18-up</td>
<td>N</td>
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<td>Y</td>
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<tr>
<td>Familial Dysautonomia</td>
<td>3-up</td>
<td>N</td>
<td>N</td>
<td>Y</td>
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<td>Model</td>
<td>0-20</td>
<td>N</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>TBI/Spinal Cord Injury</td>
<td>18-64</td>
<td>N</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Indian Health Service</td>
<td>0-death</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>TRICARE/ Dependents through ECHO and TYA</td>
<td>varies</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Local Safety Net Plans</td>
<td>19-up</td>
<td>varies</td>
<td>N</td>
<td>varies</td>
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</tbody>
</table>

*For each service unit*
Faces and Places of Young Adults in Florida

Here are some young adults who are in different situations. Are any of their situations similar to yours?

Heather, age 21, lives in Ocala

She lives with her divorced mom. She graduates from high school in June, and turns 22 in August. She’s been on KidCare for years.

Does Heather have any health issues that need extra support and services?

Max, age 18, lives in Gainesville

He lives in Gainesville and goes to college. His parents are divorced. He has complex medical needs that require a lot of appointments and medical equipment. His father is retired.

What state or federal insurance statute or law would protect his health insurance benefits?

Zach, age 25, lives in Cedar Key

He was recently laid off from his job and is looking for another one. His wife is 23 and pregnant, and they have a daughter who is 2 years old.

What options does he have for himself, his wife, and his child?
She plans on going to the local community college. She hasn’t qualified for government benefits before because of her parents’ income. Now, at age 19, she is considered “head of household” and her parent’s income does not count against her when she applies for different government programs.

What plans might work for her?

Juanita, age 19, lives in Gotha

Friends

These could be your high school buddies. Some are working, a few are going to college, some have insurance and some don’t.

Who can they turn to for the information they need about insurance?

Agwe, age 27, lives in Jacksonville

He’s thinking about going to college but is working full-time right now. His health has been good all his life. However, his father has health problems that keep him from working. This may be a genetic issue for Agwe sometime in the future.

* Individual names and descriptions are not real, and are for illustration purposes only.
# Private Health Insurance

## Health Insurance for Ages 18-30

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**TIP:** If you are a resident of Florida but spend more time in a different state, you should pick a plan that has a national provider network (in-network providers in more than one state).
Here are some of the major health insurance companies that offer job-based or Marketplace plans to Florida residents. Visit their Websites to learn more about each one.

Aetna [www.aetna.com](http://www.aetna.com)
Assurant Health [www.assuranthealth.com](http://www.assuranthealth.com)
Blue Cross and Blue Shield (Florida Blue) [www.bcbsfl.com](http://www.bcbsfl.com)
Cigna [www.cigna.com](http://www.cigna.com)
Coventry Health Care [http://chcflorida.coventryhealthcare.com](http://chcflorida.coventryhealthcare.com)
Florida Health Care Plans [www.fhcp.com](http://www.fhcp.com)
Health First [www.health-first.org](http://www.health-first.org)
Preferred Medical Plan [www.pmpmarketplace.com](http://www.pmpmarketplace.com)
Sunshine Health [www.sunshinehealth.com](http://www.sunshinehealth.com)
UnitedHealthcare of Florida [www.uhc.com/contact-us/florida](http://www.uhc.com/contact-us/florida)

**Words To Know**

**Subscriber/Policyholder** is the organization or individual who the health care coverage is issued to. In job-based group plans, the employer is the policyholder and the employee is the certificateholder.
- Generally, the subscriber/certificateholder pays the monthly premiums.
- He/she can have insurance through a plan that covers just the person or includes dependent family members.
- Can also purchase insurance through the Marketplace or directly from an insurance broker

**Dependent** is the person who is covered under the subscriber’s health care plan.
- Can be a spouse, a minor child, an adult child (under certain conditions).
- In Florida, some dependent children up to age 30 can remain on their parents’ plan; coverage for dependent disabled adults may be for their lifetime.
What to Know Before Choosing a Plan

There are several types of private insurance plans to choose from. Your first choice may be to decide between fee-for-service (or traditional) insurance and a managed care plan. Most individual and group policies sold today are managed care contracts, which typically include PPO, HMO, and POS options.

Fee-For-Service (also called Traditional or Indemnity Plan)

• You can see any doctor or go to any hospital you choose.
• You pay a percentage of the cost for the services you receive.
• Monthly premiums are usually higher than other types of plans.

PPO: Preferred Provider Organization

• Your portion of the cost is less expensive if you use the list of in-network providers.
• If you choose to see a doctor out-of-network, you’ll pay more.

HMO: Health Maintenance Organization

• Covers most of your health care needs - including checkups, immunizations and hospitalizations - for a small co-payment, typically between $5 and $40.
• No claim forms.
• Generally limited to in-network doctors and hospitals, though special circumstances may sometimes be treated as exceptions. In these cases you must obtain authorization to see Out-of-Network providers, and the copay is sometimes higher.
• Some services are not covered.

POS: Point of Service (typically 2 choices)

• A lower cost option is available for choosing in-network physicians and for obtaining service referrals from your primary care provider (PCP).
• A higher cost option allows your choice of doctors. You use your health plan just like a fee-for-service plan by choosing care from either a participating provider or a non-participating provider, without coordinating care through your PCP. You will pay a higher deductible and a percentage of your bill.
Second, consider what type of health care services you need and want:

- In the last year has your health status stayed the same, improved or gotten worse?
- Do you take prescription medications? Are they covered in your insurance plan?
- Do you get an annual physical? **If not, put it on your “To Do” list!**
- Do you want to select your own doctors, therapists, specialists and other providers?

So, before choosing a plan, ask about…

**Costs**

- How much are monthly premiums and co-pays? Do they fit in your budget?
- Is there a yearly maximum deductible? How much?
- If you have lots of medical services one year, will the plan pay for additional needed services or prescriptions?

**Doctors**

- Are your current doctors approved by the plan as in-network?
- Think about services you need now and may need in the future—will these be covered by the plan?

**Tests / Services**

- Do the benefits offered in the plan provide basic coverage for well visits?
- What kinds of preventative tests or other alternative services are covered by the plan?

**Prescriptions**

- Are your medications covered under the plan? If so, how much will co-pays cost?

**Paperwork / Paying for Services**

- Are health claims filed by the doctor’s office?
- If not, who can teach you how to fill in the insurance claim forms? Forms need to include the billing codes (CPT) and diagnosis codes (ICD-9). If the paperwork isn’t filled out right, the bill doesn’t get paid!

**TIP:** Remember, **there is no such thing as a perfect health insurance plan**, but some plans will meet your needs better than others. Only YOU can decide which!
Job-Based Group Plans

Group insurance through an employer is usually the most cost effective private insurance option, so try to take advantage of this benefit if it’s available to you. In addition to covering the employee, most job-based plans offer provisions to cover family members (spouse and dependent children) if needed. Always check with your insurance company to learn the specifics of your policy.

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**Job-Based/Employee and Family Plans**

|                  | N | N | Y | N | Y | N |

**Dependent Adult Child**

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**Dependent Adult Child/Family Plan**

|                  | N | 19-26 | N | N | Y | Y |

If possible, stay on your parent’s group family plan! Under the ACA, private insurance plans must allow adult children up to age 26 who do not have their own job-based insurance coverage to remain on their parents’ plan – even if the child is not a student, is married, lives in a different state, and/or files taxes as an independent. In Florida, some dependent children up to age 30 can remain on their parents’ plan (check with employer plan administrator).

- Young adults with or without disabilities can stay on their family’s employer-sponsored group health plan until age 26, and in some cases, to age 30.

- HMO plans limit routine well visits to in-network doctors that are in-state. This could be a problem for students who go to college out-of-state.
### Dependent Disabled Adult

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**An Adult Disabled Dependent is:**

- Incapable of self-sustaining employment due to intellectual,* mental or physical impairment;

- Chiefly dependent upon the policyholder or subscriber for financial support, care and maintenance.

- Provides parents with a way to pay for medical services for their disabled adult child over an extended period of time.

- Family may be “job locked,” that is, unable to change jobs or a work situation without losing coverage for an adult child who is dependent and disabled.

*The term “mental retardation” is being phased out of legislative language; “intellectual disability” or “cognitive impairment” are terms commonly used today.*
Courts have the power to order divorcing parents to maintain their child’s health insurance, including coverage for adult children with disabilities.

**Support for Adult Children with Disabilities**
- A divorce decree can mandate financial support to take care of the adult child who is disabled.

**Qualified Medical Child Support Order (QMCSO)**
- QMCSO orders the non-custodial parent to pay for their child’s health insurance regardless of the cost.
- No age limitation if dependency is due to a mental or physical disability which started before age 18.
- May not drop coverage for the child without proof that the QMCSO is no longer in effect.

Things to think about when purchasing a plan for someone who is medically complex:
- If the parent who is legally mandated to provide health insurance lives in one state and the adult dependent child lives in another state, he/she needs to make sure the plan will pay for all services. How will billing be coordinated? Who pays the premiums and co-pays?
- Can an adult disabled dependent also be covered by a step-parent’s employer-provided group plan, especially if it offers better coverage?
- Should a non-custodial parent buy a group health insurance policy as a back-up?
- Who is analyzing the plan to make sure needed services are covered and co-pays are affordable?
- Who is watching to see if a different plan should be selected during open enrollment?
- What happens if the subscriber retires and does not have an employer-provided group plan? Has the decree specified a plan to continue paying for coverage?
- Remember, some chronic health issues get worse over time.

**Make sure you have a copy of the court decree mandating who pays for health insurance and medical bills. Share this with your providers and file in the electronic health record.**

Ask if your group plan will pay for out-of-state health services that are non-emergency care. Some plans will not pay for well visits or preventative care that is not coordinated through their in-network provider without a preauthorized form. Some plans allow a sign-off from the in-state primary care provider. Find out more before leaving for school!
COBRA

What if you change jobs or lose job-based insurance? COBRA may provide a short-term coverage option for you.

The reality is that everyone will change jobs at one time or another, sometimes it is not our choice when it happens. The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provides some protections and coverage for a limited period of time.

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What is COBRA? Who is covered?

- COBRA may cover employees who have been laid off or terminated; dependents who lose coverage because of divorce, legal separation or death, or who lose dependent status due to age; retiring employees and those qualifying for Medicare.

- COBRA is mandated for companies that employ 20 or more people, including part-timers. Florida also has a “mini-COBRA” law for employees who work for companies with 2 to 19 employees.

- The employee pays for the entire premium; the employer does not pay for any portion of it.

- You have only 60 days to sign up for this coverage after the qualifying event (job loss, reduced hours, family change, etc.).
How long does coverage last?

- **18 months** coverage if you lost your job or have fewer hours (for reasons other than misconduct).

- **29 months** if you or another beneficiary of the plan are disabled at enrollment, using SSA (Social Security Administration) disability criteria. However, the plan can increase the cost of the premium for the last 11 months of this period.

- **36 months** if your parent who had the insurance plan dies or enrolls in Medicare; your parents divorce or are legally separated; or you lose “dependent child” status under the plan due to aging out.

What does it cost?

- COBRA participants must pay the full premiums out of their own pocket, plus up to a 2% administrative fee.

  - More than what you paid as an employee, but it’s better than not having insurance coverage and a pile of unpaid medical bills.

  - If premiums are paid on time, this plan can last 18 to 36 months.

  - Payment and paperwork must be received within 60 days; there is no grace period.

  - If payments are late, coverage ends.

  - Monthly premiums are high, and paid 100% by the participant.

When your group plan coverage ends, you will receive a written certificate of the time period that was covered, called a **Certificate of Prior Coverage**. This may be required when you enroll in a new plan.
College/University Student Health Plans

In addition to their parents’ group family plan, students in college or other types of post secondary schools may have the option to purchase insurance through their school.

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- Covers full-time or part-time students (undergraduate and graduate).
- Health coverage usually has a deductible, co-insurance provisions and co-payments for physician and hospital charges.
- Access to student health center (ask about after-hours care!)
- This kind of coverage is a good option if the student cannot stay on their family’s employer-provided group plan (due to loss of job, etc.).
- Provides limited coverage; may not meet the ACA’s “essential health benefits” requirements, or, if you attend college out of state, may not cover medical services in your home state.

FACTOID #5: Among young people aged 18- to 25, 77% said having health insurance was personally important to them and 76% said it was something they needed.²
Marketplace Plans

If you can’t get coverage through your parents, your job or your school, you may need to buy health insurance through the ACA Marketplace, also called the Exchange. The Marketplace was established to provide an easy means of shopping and purchasing individual and small group health coverage. It allows you to compare private health insurance options on the basis of price, benefits, quality and other factors. States choose whether to develop and manage their own exchange or have the federal government do it. In Florida, the federal government developed and runs the Marketplace.

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**Marketplace/Individual and Family Plans**

| N | N | N | N | N | Y | N |

Here are 3 important things to know about the Marketplace:

1. It’s an easy way to shop for health insurance - you can see all your options in one place, and with one application, you can explore every qualified option in your area.
2. Most people will be able to get a break on cost through tax credits that are based on income.
3. It offers clear options with apples-to-apples comparisons.

The ACA doesn’t require you to purchase private health insurance through the Marketplace, though tax credits are only available for plans sold through the Marketplace. You can purchase this coverage through the Marketplace web site or through an agent if he or she is approved to sell Marketplace plans. If you would rather buy coverage directly through an insurance company or broker off of the exchange, you are free to do so.

The Marketplace can be accessed at [www.healthcare.gov](http://www.healthcare.gov) or call (800) 318-2596, or TTYTDD at (855) 889-4325. The web site is updated regularly and includes FAQs about many topics, including coverage for young adults. You can also view a guide for Florida consumers at [www.myfloridacfo.com/division/Consumers/understandingCoverage/Guides/documents/healthguide.pdf](http://www.myfloridacfo.com/division/Consumers/understandingCoverage/Guides/documents/healthguide.pdf), or call the Florida Department of Financial Services Consumer Helpline toll-free at (877) 693-5236.
These are some key topic areas to consider as you explore your options.

Essential Health Benefits

All plans in the Marketplace are required to provide a package of essential health benefits so that comparisons are “apples-to-apples.” These benefits fall into 10 categories:

- Hospitalization
- Emergency services
- Ambulatory (outpatient) services
- Prescription drugs
- Rehabilitative (regaining skills that have been lost or preventing a further loss of skills) and habilitative (learning skills) services and devices
- Mental health and substance abuse services
- Preventive and wellness services, including chronic disease management
- Laboratory services
- Pediatric services, including oral and vision care
- Maternity and newborn care

The ACA also guarantees that you can’t be turned down for coverage due to your health history or a pre-existing condition, and cannot charge men and women different rates.

Coverage Levels

There are 4 categories of plans, or “metal tiers,” plus a separate catastrophic plan for certain qualifying individuals. The plans in these categories have different benefits, premium prices, doctors that can be used, and out-of-pocket expenses. However, all plans have the same quality of care and include the 10 essential health benefits. The levels of coverage are:

- **Bronze**: The plan must cover 60% of expected costs.
- **Silver**: The plan must cover 70% of expected costs.
- **Gold**: The plan must cover 80% of expected costs.
- **Platinum**: The plan must cover 90% of expected costs.
- **Catastrophic**: The plan is available to people under age 30, or those who can’t afford other health coverage and are approved for a hardship exemption. These plans carry very high deductibles; that is, you pay a large out-of-pocket cost before the plan begins to pay for covered services.

HealthPocket offers a useful tool to compare all of the plans available in a particular area, [www.healthpocket.com/individual-health-insurance](http://www.healthpocket.com/individual-health-insurance).
For an easy-to-understand, interactive subsidy tool, visit the Kaiser Family Foundation at http://kff.org/interative/subsidy-calculator. With this calculator, you can enter your income, age, and family size to estimate your eligibility for subsidies and how much you could spend on health insurance.
Enrollment Period

Just as with other types of insurance policies and subscriptions, there is a period of time during which you can sign up or change your health insurance plan more easily and with fewer restrictions. This is called the open enrollment period. Beginning in 2015, the annual open enrollment period will be October 15 through December 7 with a January 1 effective date.

You’ll be able to sign up or change your plan during this period each year (only) unless you have a qualifying life event such as birth, divorce, marriage, adoption, change in residence, income or other life circumstance. If you do, you can request a special enrollment period. Individuals have 60 days from the date of the change to request special enrollment.

Enrollment Assistance

If you choose to enroll for private coverage through the Marketplace, you can use Navigators or Certified Application Counselors (CAC) to assist you in the process. These individuals are trained and certified to help consumers prepare electronic or paper applications to establish eligibility and enroll in coverage. They can help you identify potential qualification for tax credits, reduced cost-sharing, or other coverage through a government-funded program. Visit https://localhelp.healthcare.gov to locate a Navigator or CAC near you.

TIP: If you are not getting a driver’s license, get a state-issued identification card (ID) before age 18 from the Florida Department of Highway Safety and Motor Vehicles. When you apply for health care insurance through the Marketplace, you will need to show official ID and proof of your income. Getting this information together ahead of time makes the process less stressful.
Government-Funded Health Insurance

Health Insurance for Ages 18-30

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<th>PRIVATE</th>
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| Job-Based Group Plans
  • Employee
  • Family
  • Dependent adult child
  • Dependent disabled adult
  • COBRA            | State Public Insurance
  Medicaid
  • Low income, with and without disability
  • Waivers for special groups
  • Aged out of foster care |
| College/University
  • Student Health Plan | Federal Public Insurance
  Medicare
  • Low income, with disability |
| Marketplace (ACA)
  • Individual
  • Family            | Indian Health Services           |
|                    | TRICARE                          |
|                    | Local Safety Net Plans           |

Medicaid and Medicare, the 2 major publicly-funded health insurance programs, can be confusing to many people. It takes patience to try to understand how these programs can be helpful to young adults. Let’s discuss where these programs can potentially benefit young adults who are low income, may have a disability and/or high medical expenses.

What is Medicaid?

Medicaid provides coverage for health care and health-related services to low income children and adults, in addition to some people with disabilities. Medicaid is a federal-state partnership; it is overseen by the federal government but is administered by the individual states. That is why different states have different eligibility rules and offer different kinds of benefits. The federal and state governments share the cost of covering people through Medicaid. To qualify, you must meet certain program criteria, including:

- Financially eligible (usually low income).
- “Categorically eligible,” which includes:
  - Low-income children and sometimes their parents
  - Pregnant women
  - People with disabilities, or
  - The elderly (age 65 and older ), or
- Enrolled in a Home and Community Based Services (HCBS) Waiver program.
You can apply for Medicaid through the Florida Department of Children and Families (DCF). Call (866) 762-2237, visit www.myflorida.com/accessflorida/ and apply through ACCESS Florida (Automated Community Connection to Economic Self-Sufficiency), or visit a Service Center near you. Find service center locations at www.dcf.state.fl.us/programs/access/map.shtml.

**What is Medicare?**

Medicare is a federal health insurance program for people who are age 65 or older, certain persons with disabilities, or those with end-stage kidney disease. Unlike Medicaid, Medicare is run by the federal government alone, so the eligibility rules and benefits are the same in every state.

Those who qualify include:

- Persons with disabilities who have received SSA disability benefits for a period of 2 years (SSA disability benefits, not SSI or early retirement).
- Persons who have end-stage renal disease, are receiving kidney dialysis or have had a kidney transplant.
- Persons age 65 and over and a resident of the U.S. for 5 years.
- Persons with Lou Gehrig’s disease.

For more information, visit www.medicare.gov.

**What Else Is Important To Know?**

There are several different types of programs in Medicaid and Medicare, and the financial criteria to qualify for them vary. Most public benefit programs are needs-based; that is, you have to make less than a specific income to qualify. Generally speaking, public programs use a percentage of the Federal Poverty Guidelines to determine income eligibility. The Federal Poverty Level or “FPL” is based not only on income but family size – families with more people in them can make more money.

---

**Do you qualify?** This is not as easy as it appears. Charts you may see are just guides, and sometimes agencies take other factors into consideration. So don’t just look at a chart and decide you shouldn’t apply because you make a little too much – there is no cost in applying and you might actually qualify! You can use the online pre-screening tool through ACCESS Florida to see if you might qualify for a variety of programs, including Medicaid, cash assistance and help buying food (www.myflorida.com/accessflorida).
Medicaid and other Public Options Up to Age 21

Publicly-funded programs for young people up to age 21 include Medicaid, KidCare (Title XXI), and Full Pay MediKids and Healthy Kids. The Florida KidCare programs provide coverage to children through age 18 and Medicaid is available up to age 26 for young adults formerly in foster care.

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**Medicaid (Child EPSDT)**

- Y up to 21
- N *26 for former foster care
- Y-CMSN
- N
- Y

* Children and youth with specific medical conditions or a disability may qualify for Children’s Medical Services Network (CMSN), MEDS-AD (for Aged and Disabled) and/or one of several Home and Community Based Services (HCBS) waiver programs.

The **Child Health Check-Up**, or **Early Periodic Screening, Diagnosis, and Treatment (EPSDT)**, is a benefit available to all Medicaid-eligible children up to age 21. Under Federal EPSDT rules, the Florida Child Health Check-Up program for young adults ages 18-21 consists of:

- Comprehensive health and developmental history
- Assessment of behavioral health status
- Thorough physical exam
- Vision, hearing and dental screenings
- Appropriate immunizations
- Laboratory tests
- Health education/anticipatory guidance
- Diagnosis and treatment; and referral and follow-up, as needed
- A referral to a dentist, examinations every 6 months, or more frequently as prescribed by a dentist or other authorized provider
- Health check-up once every year

See [http://mchb.hrsa.gov/epsdt/overview.html](http://mchb.hrsa.gov/epsdt/overview.html) for more information on EPSDT.

Income eligibility guidelines vary by age and circumstances of the family member, as outlined in the 2015 Family-Related Medicaid Programs Fact Sheet, [http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf](http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf).

If you’re not sure whether you qualify, it’s always better to apply at [www.myflorida.com/accessflorida](http://www.myflorida.com/accessflorida)!
For **young adults formerly in foster care**, there are special provisions. Medicaid is available until age 26 for those who:

- exit foster care at age 18
- were on Medicaid while in foster care
- are not eligible for other Medicaid coverage (e.g., pregnant, parent, disabled)

**No income is counted towards eligibility**, and the young adult is eligible even if they have another offer of coverage through an employer. Children who were adopted or placed in guardianship at age 18 are not eligible for Medicaid under the former foster care coverage group.

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* Children and youth with specific medical conditions may qualify for services up to age 21 through Children’s Medical Services Network (CMSN).

**Florida KidCare (Title XXI)**, Florida’s Children’s Health Insurance program, includes MediKids, Healthy Kids and Children’s Medical Services Network. Eligibility requirements are:

- Be under age 19
- Be uninsured
- Meet income eligibility requirements
- Be a U.S. citizen or qualified non-citizen
- Not be eligible for Medicaid
- Not be in a public institution
- Monthly premiums depend on your household’s size and income. Most families pay $15 or $20 per month.
- A child who is a member of a federally recognized American Indian or Alaskan Native tribe may qualify for no-cost KidCare coverage.
### Full Pay Healthy Kids and MediKids

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For more information about KidCare and all publicly-funded children’s health care plans, call (888) 540-5437 or visit [http://floridakidcare.org/](http://floridakidcare.org/).

- Mandated services include inpatient and outpatient hospital services; prenatal care; vaccines for children; physician services.

- Not all providers accept Medicaid and Florida KidCare. Make sure your doctor or dentist accepts Medicaid or a payment plan is agreed upon before treatment begins.

- Families pay monthly premium.

- Healthy Kids co-pays range from $1 - $3, per provider per visit. There are no co-pays for MediKids or Title XXI CMSN.

- For family-related Medicaid, apply at [www.myflorida.com/accessflorida](http://www.myflorida.com/accessflorida).

- If applying for children only, a single application will identify whether the child qualifies for any publicly funded program. Documentation required includes financial information and the child’s social security number. Apply at [http://floridakidcare.org/](http://floridakidcare.org/).
Medicaid for Adults Ages 18 and Over

There are several ways to qualify for Medicaid adult benefits starting at age 18. Outlined below are 3 programs that provide access to Medicaid: SSI, SSI-Related Medicaid, and the Medically Needy Program.

<table>
<thead>
<tr>
<th>Limits</th>
<th>Eligibility Based on Employment Status</th>
<th>Eligibility Based on Disability/Health Condition</th>
<th>Monthly Premiums</th>
<th>Requires Annual Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Age</td>
<td>18-up</td>
<td></td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

* Individuals under age 65 must be disabled to receive SSI or SSI Related Medicaid.

**SSI Recipients**

In Florida, *Supplemental Security Income (SSI)* recipients automatically qualify for Medicaid. Young adults who receive SSI benefits must be both significantly disabled and have low income and low assets. The SSI Program is administered by the Social Security Administration (SSA).

There are work incentives that allow SSI recipients to work, receive reduced SSI cash benefits and still maintain Medicaid. **The more you work, the lower your SSI cash benefits will be but you will still get Medicaid for your health care needs.** To view SSI’s Substantial Gainful Activity (SGA) monthly gross amounts for 2015, see [www.ssa.gov/OACT/COLA/sga.html](http://www.ssa.gov/OACT/COLA/sga.html).

To **apply** for SSI, schedule an appointment at your local SSA office. Find an office near you by entering your zip code at this site, [https://secure.ssa.gov/ICON/main.jsp](https://secure.ssa.gov/ICON/main.jsp). For more information about Medicaid and all SSI-related programs, see [www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf](http://www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf) and [www.ssa.gov/ssi/text-resources-ussi.htm](http://www.ssa.gov/ssi/text-resources-ussi.htm), or call toll free (800) 772-1213.

In addition, Work Incentives Planning and Assistance (WIPA) projects work with SSA beneficiaries with disabilities on job placement, benefits planning, and career development. If you want to locate the WIPA organization nearest you, call (866) 968-7842 (Voice) or (866) 833-2967 (TTY). You can also find contact information in the service provider directory at [www.socialsecurity.gov/work](http://www.socialsecurity.gov/work).

SGA for the blind does not apply to SSI benefits, while SGA for the non-blind disabled applies to both Social Security and SSI benefits.
SSRI-Related Medicaid

Medicaid for low income individuals who are either aged (65 or older) or disabled is called SSI-Related Medicaid. The MEDS for Aged and Disabled (MEDS-AD) Program provides Medicaid to individuals who are disabled or age 65 and older who meet technical requirements and have income and assets within program standards.

Medically Needy Program

The Medically Needy program helps families, pregnant women, individuals with disabilities or individuals aged 65 and over who would qualify for Medicaid except for having income and/or assets that are too high.

- Individuals enrolled in the Medically Needy program have a “share of cost” (which is like an insurance deductible) and the amount varies depending on the family’s size and income.
- There is no income limit to qualify for the Medically Needy program; however, gross income after medical expenses must be below Medicaid limits.
- There is an asset limit, which varies based upon the family’s size. Assets include income plus items that have value.

For more information and to apply online, visit ACCESS Florida, www.myflorida.com/accessflorida.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Asset Limit</th>
<th>Remember, if you’re not sure, it’s always better to apply! Apply online, visit a Service Center near you, or call DCF toll-free at (866) 762-2237 for more information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$5,000</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>$6,000</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$6,000</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>$6,500</td>
<td></td>
</tr>
</tbody>
</table>

- SSI, SSI-Related Medicaid, and the Medically Needy program all provide access to Medicaid health care coverage (vision, hearing, dental, mental health and family planning).
- Not all providers accept Medicaid. Make sure your doctor or dentist accepts Medicaid or a payment plan is agreed upon before treatment begins.
- Medicaid benefits for adults are more limited than they are for children.
**Medicare**

Medicare is the second major publicly funded health insurance program for adults. Most people think of Medicare as a health insurance plan for retirees, but there are some circumstances when young adults are eligible for Medicare.

<table>
<thead>
<tr>
<th>Limits</th>
<th>Eligibility Based on Employment Status</th>
<th>Eligibility Based on Disability/Health Condition</th>
<th>Monthly Premiums</th>
<th>Requires Annual Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

* No age limit if child has End Stage Renal Disease (ESRD)

Generally, Medicare has “richer” benefits than Medicaid; that is, more services are covered and more doctors serve Medicare patients. As with Medicaid, there are several ways to qualify for the program. One way is through the **Social Security Disability Insurance (SSDI)** Program. *Eligibility criteria for SSDI can be complex, so read the information below carefully!*

**SSDI Beneficiaries**

Young adults who are SSI beneficiaries become SSDI beneficiaries when:

1. The young adult has worked enough “qualifying quarters.”
   The amount of earnings required for a quarter of coverage in 2015 is $1,220.
   - If an individual became disabled before age 24, he/she needs 6 work credits within the past 3 years to be eligible for SSDI.
   - If an individual became disabled between the ages of 24 and 31, he/she needs 12 credits within the past 6 years to be eligible for SSDI.

2. The young adult is considered a Disabled Adult Child (DAC):
   - The young adult must
     - have become disabled before age 22 and the disability is continuing
     - be at least 19 years old
     - never have been married
   - There must be proof that the parent of the young adult on SSDI
     - worked enough quarters under the Social Security System, and
     - has retired OR has become disabled OR has died
To apply for SSDI, apply online at www.ssa.gov or schedule an appointment at your local SSA office. Find an office near you by entering your zip code at this site, https://secure.ssa.gov/ICON/main.jsp.

In addition, Work Incentives Planning and Assistance (WIPA) projects work with SSA beneficiaries with disabilities on job placement, benefits planning, and career development. If you want to locate the WIPA organization nearest you, call (866) 968-7842 (Voice) or (866) 833-2967 (TTY). You can also find contact information in the service provider directory at www.socialsecurity.gov/work.

- Young adults with a Medicare card have access to more physicians and medical services.

- Since Medicare is a federal program, eligibility and coverage criteria is the same no matter where you live in the U.S.

**FACTOID #6:** Young adults have the lowest rate of access to employer-based insurance. The uninsured rate among employed young adults is one-third higher than older employed adults.³
Medicaid & Medicare Dual Eligibility

In some cases, individuals may qualify for both Medicaid and Medicare benefits, which is called **Dual Eligibility**. This can be particularly tricky for young adults who are working, are staying under SGA income limits ($1,090 for non-blind individuals or $1,820 for blind individuals per month in 2015), or who are able to defer earned income through work incentive offsets. It can be an advantage for someone whose health issues are progressive and whose work income is not stable. Having both benefits will reduce out-of-pocket expenses. Listed below are 3 key levels (among multiple levels) for dual eligibility coverage.

<table>
<thead>
<tr>
<th>Limits</th>
<th>Eligibility Based on Employment Status</th>
<th>Eligibility Based on Disability/Health Condition</th>
<th>Monthly Premiums</th>
<th>Requires Annual Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y &lt; 100 FPL</td>
<td>18-up</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>QMB: Medicaid pays for Medicare Part A and Part B premiums, deductibles, coinsurance and co-payments. Resources/assets do not exceed $7,280 for individual or $10,980 for couple in 2015.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y 100%-120% FPL</td>
<td>18-up</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>SLMB: Medicaid pays for Medicare Part B premiums only. Resources/assets do not exceed $7,280 for individual or $19,930 for couple.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y 100%-120% FPL</td>
<td>18-up</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>QDWI: Medicaid pays for Medicare Part A premiums only. Resources/assets do not exceed $5,000 for individual or $6,000 for couple.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For more information on Medicaid & Medicare Dual Eligibility, visit:

- [www.cms.gov/Outreach-and-Education/Medicare-Learning-Net work-MLN/MLNProducts/downloads/Medicare_Beneficiaries_ Dual_Eligibles_At_a_Glance.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net work-MLN/MLNProducts/downloads/Medicare_Beneficiaries_ Dual_Eligibles_At_a_Glance.pdf)

Few out-of-pocket expenses for people who qualify for both Medicare and Medicaid.
Home and Community Based Waivers

Home and Community Based Services (HCBS) Waivers are Medicaid programs that provide services in the home for persons who would otherwise require institutional care in a hospital or nursing facility. Without waiver services being delivered in the community, some young adults might not be able to live at home or receive needed supports in the workplace. In addition to the HCBS waiver programs described on the next page, there are waivers for AIDS patients and other special populations.

Waivers provide specific services over and above those in the general Medicaid adult benefits package and are targeted to persons who demonstrate the need for a high level of care. Enrollment is typically capped; once enrollment reaches a specified number or dollar threshold, waiting lists are created.

The waiting lists for Florida Medicaid Waivers can be quite long, sometimes years. But don’t be discouraged from applying because of the waiting lists; remember, you can’t get on the waiver if you don’t apply! To apply for a waiver program, you must contact the operating agency. Each of those agencies is listed in the chart on the next page.

<table>
<thead>
<tr>
<th>Program</th>
<th>Eligibility Based on Employment Status</th>
<th>Eligibility Based on Disability/Health Condition</th>
<th>Monthly Premiums</th>
<th>Requires Annual Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits</td>
<td>Income Age</td>
<td></td>
<td></td>
<td>N Y N</td>
</tr>
<tr>
<td>iBudget</td>
<td>Y 3-up</td>
<td>Services for persons with developmental disabilities who meet level of care requirements to remain living at home and in the community. Services offered under this waiver include: support coordination, adult day training, consumable medical supplies, residential habilitation therapy, transportation, and personal care assistance. Apply online to the Agency for Persons with Disabilities (APD), <a href="http://apd.myflorida.com/customers/application/">http://apd.myflorida.com/customers/application/</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with Cystic Fibrosis</td>
<td>Y 18-up</td>
<td>This program provides services for individuals who are diagnosed with Cystic Fibrosis (CF) and are at risk of hospitalization but could remain at home if provided special services. Contact the Department of Health to apply, <a href="http://www.floridahealth.gov/diseases-and-conditions/adult-cystic-fibrosis/index.html">www.floridahealth.gov/diseases-and-conditions/adult-cystic-fibrosis/index.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care Managed Care</td>
<td>Y 18-up</td>
<td>Allows individuals ages 18 and over who meet nursing facility level of care to remain living at home and in the community. Services include nursing facility care, adult day health care, attendant care, case management, personal care services and home-delivered meals. Contact the Department of Elder Affairs to apply, or visit <a href="http://ahca.myflorida.com/medicaid/hcbs_waivers/ltc_trans_wav.shtml">http://ahca.myflorida.com/medicaid/hcbs_waivers/ltc_trans_wav.shtml</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Familial Dysautonomia</td>
<td>Y 3-up</td>
<td>Services for individuals with Familial Dysautonomia who are at risk of hospitalization but could remain at home if provided special services. Contact the Agency of Healthcare Administration (AHCA) to apply, <a href="http://ahca.myflorida.com/medicaid/hcbs_waivers/fd.shtml">http://ahca.myflorida.com/medicaid/hcbs_waivers/fd.shtml</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model Waiver</td>
<td>Y 0-20</td>
<td>Services for persons with degenerative spinocerebellar disease who require the level of care provided in an acute care hospital. Florida can serve up to 20 individuals at any one time. Contact AHCA to apply, <a href="http://ahca.myflorida.com/medicaid/hcbs_waivers/model.shtml">http://ahca.myflorida.com/medicaid/hcbs_waivers/model.shtml</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TBI/Spinal Cord Injury</td>
<td>Y 18-64</td>
<td>Services for individuals who have traumatic brain injury or spinal cord injury, meet nursing facility level of care but could remain at home if provided special services. Services offered under this waiver include case management, specialized medical equipment and supplies and personal care. Contact the Department of Health to apply, or visit <a href="http://ahca.myflorida.com/medicaid/hcbs_waivers/tbi.shtml">http://ahca.myflorida.com/medicaid/hcbs_waivers/tbi.shtml</a></td>
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</table>
## Indian Health Service (IHS)

The Indian Health Service (IHS) is a federal agency within the Department of Health and Human Services.

<table>
<thead>
<tr>
<th>Limits</th>
<th>Eligibility Based on Employment Status</th>
<th>Eligibility Based on Disability/Health Condition</th>
<th>Monthly Premiums</th>
<th>Requires Annual Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Age</td>
<td>0-death</td>
<td>For each service unit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IHS provides clinical and public health services such as doctor visits, check-ups, screenings, diabetes prevention and treatment, mental health and substance abuse services, and many more services - and often in remote locations. The individual must provide proof of enrollment as a member of a federally recognized tribe. Some tribes provide supplemental private insurance. Members can purchase plans on the Marketplace.

There are two federally recognized Indian tribes in Florida: the Miccosukee and Seminole Tribes. For more information about the Miccosukee Tribe, visit [www.miccosukeetribe.com](http://www.miccosukeetribe.com); for the Seminole Tribe, visit [www.seminoletribe.com](http://www.seminoletribe.com).

To find IHS services and facilities in your area, visit [www.ihs.gov/findhealthcare/](http://www.ihs.gov/findhealthcare/).

- Tribal contract health care facilities serve only their tribal members, with other qualified Indians/Alaska Natives being offered care on a space available basis.

- This policy makes it difficult or impossible for tribal members who leave the reservation for education or employment to receive the IHS services to which they are legally entitled.

**TIP:** You may qualify for more than one kind of health insurance coverage. It can be helpful to have 2 or more policies, private or government-funded. The policies may cover different services, or may each pay part of your medical bill so you have to pay even less. For example, a young adult SSI beneficiary who is enrolled in Medicaid may also want to take advantage of being on a job-based family plan that offers access to an additional network of providers.
TRICARE

TRICARE is a regionally managed health care program for Active Duty, Activated Guard and Reserves, retired members of the uniformed services, their families, and survivors.

<table>
<thead>
<tr>
<th></th>
<th>Limits</th>
<th>Eligibility Based on Employment Status</th>
<th>Eligibility Based on Disability/Health Condition</th>
<th>Monthly Premiums</th>
<th>Requires Annual Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Age</td>
<td>N</td>
<td>varies</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

TRICARE uses both military health care resources and networks of civilian health care professionals to provide services to their beneficiaries. If you are eligible for TRICARE, you will be automatically enrolled. For more information, visit [www.military.com/benefits/tricare](http://www.military.com/benefits/tricare) or [www.tricare.mil](http://www.tricare.mil). For young adult dependents, here are 2 options through TRICARE:

1. **TRICARE Young Adult (TYA)** is a plan that qualified adult children up to age 26 can purchase after eligibility for “regular” TRICARE coverage ends at age 21 (or 23 if enrolled in college). If purchased, TYA is minimum essential coverage under the ACA. See [www.tricare.mil/TYA/](http://www.tricare.mil/TYA/) for more information.

2. **TRICARE’s Extended Care Health Option (ECHO)** provides financial assistance to family members of active duty military who have moderate or severe cognitive impairment, or a serious physical disability. Children of sponsors who reach the usual TriCare eligibility age limit can retain their eligibility for ECHO services as long as the sponsor remains on active duty, the child is incapable of self-support because of a mental or physical incapacity that occurs prior to the loss of their eligibility, and the sponsor is responsible for more than one-half the child’s support. ECHO benefits may cover a wide range of services, including:

   - Medical and rehabilitative services
   - Training to use assistive technology devices
   - Special education
   - Institutional care when a residential environment is required
   - Transportation under certain circumstances
   - Assistive services (interpreter or translator)
   - Durable equipment
   - In-home medical services and respite

For more information about ECHO, see [www.tricare.mil/Plans/SpecialPrograms/ECHO.aspx](http://www.tricare.mil/Plans/SpecialPrograms/ECHO.aspx).
Local Safety Net Plans

Several counties in Florida provide cost-effective, accessible health care for low-income, uninsured residents in their respective areas. Among counties with local “safety net” health care plans are Hillsborough, Palm Beach, Pinellas and Polk counties.

<table>
<thead>
<tr>
<th>Limits</th>
<th>Eligibility Based on Employment Status</th>
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<th>Requires Annual Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Age</td>
<td>varies</td>
<td>N</td>
<td>varies</td>
</tr>
</tbody>
</table>

Local safety net programs vary in the way they’re organized and funded: some are entirely publicly funded by county governments and some are public-private partnerships with commercial insurance companies. Each plan has its own eligibility requirements and benefits package. While we have provided a few Web links below, you should contact the county government office where you live and ask whether a local health care program is available and how to apply.

- Pinellas County: [www.pinellascounty.org/humanservices/medical-home.htm](http://www.pinellascounty.org/humanservices/medical-home.htm)
- Polk County: [www.polk-county.net/boccsite/Our-Community/Health-Services/Polk-Healthcare-Plan/](http://www.polk-county.net/boccsite/Our-Community/Health-Services/Polk-Healthcare-Plan/)

- Provides important primary and preventive care services for those who don’t qualify for Medicaid or Medicare, and don’t have any other coverage options.
- Program limitations may not provide adequate, on-going coverage for people with chronic health conditions; not available in every county.
- Not available in every county.

Be sure to ask whether the local plan meets ACA minimum coverage requirements. If not, participants may be subject to a tax penalty.
# No Health Insurance

## Health Insurance for Ages 18-30

<table>
<thead>
<tr>
<th>PRIVATE</th>
<th>GOVERNMENT-FUNDED</th>
<th>NO INSURANCE</th>
</tr>
</thead>
</table>
| **Job-Based Group Plans**  
- Employee  
- Family  
- Dependent adult child  
- Dependent disabled adult  
- COBRA | **State Public Insurance**  
- Medicaid  
  - Low income, with and without disability  
  - Waivers for special groups  
  - Aged out of foster care | **You Pay All the Bills**  
- Every medical visit  
- All prescriptions  
- Any hospitalizations |
| **College/University**  
- Student Health Plan | **Federal Public Insurance**  
- Medicare  
  - Low income, with disability | **You Pay Penalty Tax**  
- Unless hardship exemption is approved |
| **Marketplace (ACA)**  
- Individual  
- Family | **Indian Health Services**  
| **TRICARE** | **Local Safety Net Plans** | **Low Cost Options** |

### None!

Not having health insurance means you “pay as you go” AND you may pay a tax penalty. Many young adults who don’t have a chronic health issue and currently feel healthy believe getting sick won’t happen to them. WRONG. People get sick, are in accidents, get hurt.

Urgent medical care costs money. Being sick costs time away from school or work. And people often don’t seek help until their medical symptoms get worse – which can be life threatening.

### FACTOID #7: As of 2015, 93% of Florida consumers who signed up for health insurance through the Marketplace qualified for an average tax credit of $294 per month.4
Individual Mandate

What happens if you don’t have health insurance, either private or government-funded? You may be responsible to pay the full price for every doctor’s appointment, every prescription, and every medical treatment you receive. If you can afford health insurance but choose not to buy it, you must also pay a fee known as the individual shared responsibility payment. It is a penalty.

One of the key parts of the ACA is the **individual mandate.** This requires that every eligible American have health care insurance that has “minimum essential coverage.” If you don’t have coverage or get approved for an exemption, you will get charged a penalty tax (a fee). This is reported on your annual tax form. If you expect a refund, the penalty is deducted from your check. For 2015, the penalty is $325 per adult plus $162.50 per child (with a family maximum of $975) or 2% of annual family income. And in 2016, the fee will be $695 per adult plus $347.50 per child (with a maximum of $2,085) or 2.5% of family income.

There are several exceptions to the individual mandate. Individuals who may not be required to have health insurance include:

- People experiencing financial hardship
- People who have religious objections
- American Indians
- Undocumented immigrants
- Certain individuals with very low incomes

If you have questions about your particular situation, call the Marketplace at (800) 318-2596 to find out if you are required to maintain coverage. Remember, you may qualify for reduced monthly premiums and reduced out-of-pocket cost through the ACA Marketplace.

What are My Options without Health Insurance?

Regardless of your circumstances, DO NOT ignore your health issues! There are a few options for people with no health care coverage.

Community Health Centers and Clinics

**Federally Qualified Health Centers (FQHC),** also known as community health centers, provide medical care to people without
health insurance. Generally, you are required to pay what you can afford based on your income, sometimes called a “sliding scale fee.” Community health centers provide:

- Checkups when you’re well
- Treatment when you’re sick
- Complete care when you’re pregnant
- Immunizations and checkups for your children
- Dental care and prescription drugs for your family
- Mental health and substance abuse care

To find a Florida community health center near you, visit [www.fachc.org/resources-find-health-center.php](http://www.fachc.org/resources-find-health-center.php)

In addition, many communities offer free clinics and mobile clinics. **We Care** programs (run by volunteer physicians) and county health departments can help with primary care and, in some cases, limited specialty care. For a comprehensive listing of free clinics and health centers in Florida, see [http://freeclinicdirectory.org/florida_care.html](http://freeclinicdirectory.org/florida_care.html)

**Florida Discount Prescription Cards**

Discount cards can help lower the cost of prescriptions for Florida residents. **Florida Rx Card**, endorsed by the Florida Medical Association, provides medication savings of up to 75% at 56,000 pharmacies nationwide, including CVS and Walgreens. Visit [www.floridaxrcard.com](http://www.floridaxrcard.com) to create a free card.

With both the Florida Rx Card and the **Florida Discount Drug Card**, there are no age limits, income, requirements, waiting periods, pre-existing condition restrictions, or membership fees. Request a Florida Discount Drug Card by visiting [www.FloridaDiscountDrugCard.com](http://www.FloridaDiscountDrugCard.com) or calling (866) 341-8894.

**Patient Assistance Programs**

Patient Assistance Programs (PAP) are run by pharmaceutical companies to provide free medications to people who can’t afford to buy their medicine. Search a comprehensive database of these programs by visiting [www.rxassist.org](http://www.rxassist.org).

**Partnership for Prescription Assistance**

Partnership for Prescription Assistance (PPA) helps qualifying people with prescription drug coverage access patient assistance programs where they may qualify for free or discounted drugs. You can find these programs as well as free and low-cost clinics by visiting [www.pparx.org](http://www.pparx.org).

**NeedyMeds**

NeedyMeds is an online information resource of programs that provide assistance to people who are unable to afford their medications and health care costs, [www.needymeds.org](http://www.needymeds.org).
# Need More Information?
## Glossary of Health Care Financing Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable Care Act (ACA)</td>
<td>The comprehensive health care reform law entitled The Patient Protection and Affordable Care Act was signed into law in 2010. The name “Affordable Care Act” (ACA) is sometimes referred as “Obama Care.”</td>
</tr>
<tr>
<td>Authorized Representative</td>
<td>Someone who you choose to act on your behalf with the Marketplace, like a family member or other trusted person. Some authorized representatives may have legal authority to act on your behalf.</td>
</tr>
<tr>
<td>Benefit</td>
<td>The amount payable by the insurance company to an individual (or a provider) for a health care service that is part of the insured’s coverage.</td>
</tr>
<tr>
<td>Catastrophic Health Plan</td>
<td>To qualify for a catastrophic plan, you must be under 30 years old OR get a “hardship exemption” because the Marketplace determined that you’re unable to afford health coverage. This type of plan mainly protects you from very high medical costs and generally requires you to pay all of your medical costs up to a certain amount, usually several thousand dollars. Preventative care services are paid for before the deductible has been met. The premium is generally lower than for other plans, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher.</td>
</tr>
<tr>
<td>Certification of Prior Coverage</td>
<td>A certificate of prior coverage is issued when a person who was insured under employer sponsored coverage leaves their job. It provides information on the amount of time a person held insurance coverage. This can be important as it can be used as a credit to reduce pre-existing condition limitations when you enroll in a new plan.</td>
</tr>
<tr>
<td>Certified Applicant Counselor</td>
<td>An individual (affiliated with a designated organization) who is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers. Also can be called: Certified Benefits Navigator.</td>
</tr>
<tr>
<td>Claim</td>
<td>A request to the insurance company by an individual (or his or her provider) to pay for services obtained from a provider.</td>
</tr>
</tbody>
</table>
Creditable Coverage  Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children’s Health Insurance Program (CHIP); or, a state health insurance high risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

COBRA  The Consolidated Omnibus Reconciliation Act of 1985 (or COBRA) is a federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of 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.

Co-Insurance  When you have co-insurance, instead of paying one set amount for a particular health care expense like you do with a co-pay, you pay a percentage of the total cost for your care, usually after paying a deductible. Co-insurance is common in indemnity and PPO plans.

Co-Pay  Most HMOs and some other plans provide full coverage for certain expenses with the insured paying only small, set co-pay to the provider at the time of service.

Deductible  The amount you must pay before your health insurance plan begins paying your health care expenses. HMO and POS plans may eliminate deductibles when you remain in-network for your care.

Dependents  Spouse and/or unmarried children (whether natural, adopted or step) relative, or other person who are claimed a personal exemption tax deduction. Under the ACA, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.

Dependent Coverage  Insurance coverage for family members (tax dependents) of the policyholder, such as spouses, children, or partners.

Essential Health Benefits  A set of health care service categories that must be covered by certain plans, starting in 2014. The ACA ensures health plans offered in the individual and small
group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits 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.

Depending on your policy, some services may not be included in your health plan benefits, like cosmetic dentistry or mental health care. And some items are limited, such as the length of time you can stay in the hospital. You are responsible for the cost of services excluded or limited by your plan.

A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan’s network (except in an emergency). An EPO is like an HMO, without the PCP gatekeeper. While there are exceptions for emergencies, be cautious about signing up if you travel frequently or have a chronic condition that requires timely treatment by certain specialists. EPOs are suitable for people looking for lower premiums but also the flexibility of being able to self-refer to specialists.

The insurance company’s written explanation for a claim, showing what they paid and what the subscriber must pay.

Federal Poverty Level (FPL) of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

Coverage that is offered to an employee (and often his or her family) by an employer. The premiums for group insurance are generally less expensive than for individual insurance. In Florida, both a single, self-employed individual and an employer with employees are eligible to buy group insurance. Proof of self-employment or business existence through income tax records is usually required. Also referred to as: Job-Based Group Plan, Work-Based Health Plan, Employer Health Based Health Plan and Group Health Plan.
Hardship Exemption

Under the Affordable Care Act, most people must pay a fee if they don’t have health coverage that qualifies as “minimum essential coverage.” One exception is based on showing that a “hardship” prevented them from becoming insured.

Health Insurance Marketplace

A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In Florida, the Marketplace is run by the federal government. In some states it is run by the state.

Health Plan Categories

Plans in the Marketplace are primarily separated into 4 health plan categories — Bronze, Silver, Gold, or Platinum — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The plan category you choose affects the total amount you’ll likely spend for essential health benefits during the year. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). This isn’t the same as coinsurance, in which you pay a specific percentage of the cost of a specific service.

Health Maintenance Organization (HMO)

Available to groups and individuals, HMO plans offer payment of benefits with co-pays required. These plans usually do well in providing coverage for preventative care and routine health care needs like those in an uncomplicated pregnancy. Members must use doctors and other providers who are contracted with the HMO or obtain a referral or authorization to see an out-of-network provider. The co-pay is sometimes higher for such providers.

Indemnity Plan

Insurance that allows the policyholder to use any doctor or other provider they want or need. Unlike PPO or HMO plans, there is no list of contracted providers or a network to be concerned about. Also referred to as fee-for-service or traditional health insurance.
<table>
<thead>
<tr>
<th><strong>Individual Health Insurance Policy</strong></th>
<th>Policies for people that aren’t connected to job-based coverage. Individual health insurance policies are regulated under state law.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Shared Responsibility Payment</strong></td>
<td>If you don’t have health coverage, you may have to pay a fee. The fee is paid on the federal income tax form. People with very low incomes and others may be eligible for waivers, exemptions from payment or hard exemptions. The fee is sometimes called the “penalty,” “fine,” “individual responsibility payment,” or “individual mandate.”</td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
<td>Providers or health care facilities which are part of a health plan’s network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.</td>
</tr>
<tr>
<td><strong>Managed Care</strong></td>
<td>A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems offer HMOs and PPOs that individuals are encouraged to use for their health care services. Some managed care plans attempt to improve health quality, by emphasizing preventative care and covering wellness activities (like smoking cessation, weight control, etc.)</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. 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 and may have a different name in your state.</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
<td>Medicare is a federal health insurance program for people who are age 65 or older, certain end-stage persons with disabilities, or those with kidney disease. Unlike Medicaid, Medicare is run by the federal government alone, so the eligibility rules and benefits are the same in every state.</td>
</tr>
<tr>
<td><strong>Minimum Essential Coverage</strong></td>
<td>The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.</td>
</tr>
<tr>
<td><strong>Modified Adjusted Gross Income (MAGI)</strong></td>
<td>The figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and CHIP. Generally, modified adjusted gross income is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.</td>
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</tr>
<tr>
<td><strong>Navigator</strong></td>
<td>An individual or organization that is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased and their services are free to consumers.</td>
</tr>
<tr>
<td><strong>Network</strong></td>
<td>The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.</td>
</tr>
<tr>
<td><strong>Non-Preferred Provider</strong></td>
<td>A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll 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.</td>
</tr>
<tr>
<td><strong>Open Enrollment</strong></td>
<td>Time period when members of group health insurance plans can enroll or change their benefits program; generally held once a year.</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>This phrase usually refers to physicians, hospitals or other health care providers who are considered non-participants in an insurance plan (usually an HMO or PPO). Depending on an individual’s health insurance plan, expenses incurred through out-of-network health professionals may not be covered, or covered only in part by an individual’s insurance company.</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit</strong></td>
<td>The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.</td>
</tr>
<tr>
<td><strong>Point of Service (POS)</strong></td>
<td>An insurance plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan’s network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.</td>
</tr>
<tr>
<td><strong>Preferred Provider Organization (PPO)</strong></td>
<td>An insurance plan, usually with a deductible and co-insurance, which offers full benefits when using in-network providers. Benefits are available out-of-network, but at a lower level and/or higher cost. Some PPO plans have Primary Care Provider referral requirements (see referral) and some PPO plans offer benefits with a co-pay and no deductible for certain services.</td>
</tr>
<tr>
<td><strong>Pre-Existing Condition</strong></td>
<td>A medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company. Beginning in September, 2010, the ACA ensured that insurance companies will no longer be able to deny coverage due to pre-existing conditions to children under age 19. Beginning January, 2014, insurers were no longer allowed to deny adults with pre-existing conditions.</td>
</tr>
<tr>
<td><strong>Premiums</strong></td>
<td>Total monthly or annual payment to the insurance company in return for providing coverage.</td>
</tr>
<tr>
<td><strong>Premium Tax Credit</strong></td>
<td>The ACA provides a tax credit to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you’re due, you’ll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.</td>
</tr>
<tr>
<td><strong>Primary Care Provider (PCP)</strong></td>
<td>A physician [either a Medical Doctor (M.D) or Doctor of Osteopathic Medicine (O.D.)], 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. Some plans require the insured obtain a referral from the PCP before seeing a specialist.</td>
</tr>
<tr>
<td><strong>Prior Authorization</strong></td>
<td>Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.</td>
</tr>
<tr>
<td><strong>Private Health Insurance</strong></td>
<td>Insurance plans marketed by the private health insurance industry. Coverage includes policies obtained through employer-sponsored insurance, with approximately 62% of non-elderly Americans receiving insurance provided as a benefit of employment.</td>
</tr>
<tr>
<td><strong>Provider Network</strong></td>
<td>A list of doctors, hospitals, and other providers that an HMO or PPO has a contract with to provide health care services to its members. Many provider networks have contracts with more than one insurance company and some are established and maintained by the insurance company or HMO themselves.</td>
</tr>
<tr>
<td><strong>Public Health Insurance</strong></td>
<td>Health insurance coverage that is funded by public (tax) dollars, usually through the state or federal government. Publicly funded programs include Medicare, Medicaid and the Children’s Health Insurance Program (CHIP). Also refer to as government-funded insurance.</td>
</tr>
<tr>
<td><strong>Qualified Health Plan (QHP)</strong></td>
<td>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. A QHP will have a certification by each Marketplace in which it is sold.</td>
</tr>
<tr>
<td><strong>Qualifying Life Event (QLE)</strong></td>
<td>A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby).</td>
</tr>
<tr>
<td><strong>Referral</strong></td>
<td>A written order from your primary care provider (PCP) for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don’t get a referral first, the plan may not pay for the services.</td>
</tr>
<tr>
<td><strong>Self Insured Plans</strong></td>
<td>Under the ACA, an insurance plan that is certified by the Coverage offered by a company, typically a large employer, that chooses to pay employees’ health care costs directly, instead of purchasing health insurance coverage through a private insurance company. Benefits are usually administered through a health plan.</td>
</tr>
<tr>
<td><strong>Special Enrollment Period (SEP)</strong></td>
<td>A time outside of the open enrollment period during which you and your family have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.</td>
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<tr>
<td><strong>State Mandated Benefits</strong></td>
<td>A specific benefit that must be covered by private insurers as a matter of state law. Companies that self-insure are exempt from such mandates. See Florida State Mandated Benefits at <a href="http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/fl-state-required-benefits.pdf">www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/fl-state-required-benefits.pdf</a></td>
</tr>
<tr>
<td><strong>Student Health Coverage</strong></td>
<td>Many colleges require proof of health insurance for students. Coverage options include insurance through family policies and coverage through school-sponsored student health plans. Generally, student health plans offer lower deductibles, access to your on-campus student health centers and flexible coverage that travels with you anywhere you go.</td>
</tr>
<tr>
<td><strong>Subscriber/Policyholder/Insured</strong></td>
<td>The subscriber/policyholder/insured is the individual or organization to whom the health care coverage is issued. In group plans the employee is the “certificate holder.”</td>
</tr>
<tr>
<td>• Generally, the subscriber/certificate holder pays the monthly premiums.</td>
<td></td>
</tr>
<tr>
<td>• The subscriber/policyholder can have insurance through a group plan that covers just that person or their dependent family members.</td>
<td></td>
</tr>
<tr>
<td>• A subscriber can also purchase a single or family plan directly from an insurance company.</td>
<td></td>
</tr>
<tr>
<td><strong>TRICARE</strong></td>
<td>A health care program for active-duty and retired uniformed services members and their families.</td>
</tr>
<tr>
<td><strong>Tax Household</strong></td>
<td>The taxpayer(s) and any individuals who are claimed as dependents on one federal income tax return. A tax household may include a spouse and/or dependents.</td>
</tr>
</tbody>
</table>

Resources: *A Consumer’s Glossary of Health Insurance Terms*, Glossary from the [healthcare.gov](http://healthcare.gov), and The Catalyst Center.
Additional Resources

National

HealthCare.gov
www.healthcare.gov
From U.S. Center for Medicaid & Medicaid Services, an interactive website to guide you through coverage options in your state,

healthfinder.gov
www.healthfinder.gov
An encyclopedia of over 1,600 health topics from trusted sources.

From Coverage to Care
A Roadmap to Better Care and a Healthier You! A step-by–step guide on what having health insurance means and how to navigate provider visits, from the U.S. Centers for Medicare & Medicaid Services.

Getting Covered
http://gettingcovered.org
From Young Invincibles, this site educates young adults and their families about health care coverage,

Questions are the Answer
www.ahrq.gov/questionsaretheanswer
You can improve your care and the care of your loved ones by taking an active role in your health care.: ask questions, understand your condition(s), and evaluate your options.

Health Insurance Resource Center
www.healthinsurance.org
A wealth of general and state-specific information, including a glossary of health care terms.

Social Security Online
www.ssa.gov/disability
Eligibility information and application for SSDI and SSDI disability benefits.

GovBenefits.gov
www.benefits.gov
Easy-to-use confidential online screening tool allows individuals and families to find out which federal and state government benefits they may be eligible to receive.

HealthPocket
www.healthpocket.com
Allows you to compare health insurance plans.
National Disability Navigator  
www.nationaldisabilitynavigator.org/state/fl/  
Provides national and state-level information and support to ensure people with disabilities receive accurate information when selecting and enrolling in insurance through the ACA Marketplace.

Kaiser Family Foundation  
www.kff.org  
Research and navigate health reform issues, including policy and costs for Medicaid, Medicare, and private insurance.

Alliance For Health Reform  
www.allhealth.org/  
Issue briefs, policy resources and web links.

Catalyst Center  
www.hdwg.org/catalyst  
National Center dedicated to improving health care coverage and financing for children and youth with special health care needs.

AARP  
www.aarp.org/health  
Information to better understand health care law, the Marketplace, Medicare, Medigap, and Medicaid.

State

Health Insurance and Health Maintenance Organizations: A Guide for Consumers  
A comprehensive guide to health insurance in Florida from the Florida Department of Financial Services. You may also call the Consumer Helpline toll-free at (877) 693-5236, M-F 8 AM – 5 PM ET.

Florida Health Finder  
www.floridahealthfinder.gov  
A collection of resources, health information, and provider locations in Florida.

Florida Consumer Assistance Program  
https://localhelp.healthcare.gov  
Helps people access health insurance, including Medicare, Medicaid, and private health plans, as well as assists individuals who encounter difficulties using the health benefits they have. On this site, you can enter your zip code to find a list of resources in your area.
Florida CHAIN
http://floridachain.org
A statewide consumer health advocacy organization that is dedicated to improving the health of all Floridians

Florida Medicaid Information
www.fdhc.state.fl.us/Medicaid/index.shtml
Florida’s Medicaid program covers prescription drugs and medical services for low-income individuals.

Florida Health and Transition Services (FloridaHATS)
www.floridahats.org
Clearinghouse of resources and information for adolescents and young adults transitioning from pediatric to adult care.

References

*In addition to sources listed throughout the guide


