

INSURANCE 101

HEALTH INSURANCE BENEFITS ARE IMPORTANT.

Here's what you need to know.

To get the most out of your healthcare coverage, you need a solid understanding of how it works. This information sheet highlights key terms and what they mean to your healthcare coverage and out-of-pocket expenses.

How Does Health Insurance Work?

Health insurance – including medical, dental and vision insurance - helps protect you from the high costs of healthcare in the United States. It can help you pay for doctor visits, hospital stays, prescription drugs, preventive care and more. The basic concept of insurance is that one party, the insurer, guarantees payment for routine and unforeseen future events (such as a broken arm) and the other party, the insured or the policyholder (i.e., the student), pays a smaller fee or premium to the insurer in exchange for protection from making the entire payment for those services.

A great place to begin is with the different types of healthcare expenses: premium, copay, deductible, coinsurance, out-of-pocket maximum, network, balance billing and explanation of benefits. These are all important definitions to know.

- **Premium:** The amount you pay for having health insurance.
- **Copay:** A fixed charge you pay at the time you receive care. Copays vary by type of service or provider. For example, some services at the Purdue University Student Health Center, or PUSH, may require a copayment. You may have a different copay for emergency room services and another one when you get a prescription at the Purdue University Pharmacy. Copays do not count toward meeting your annual deductible.
- **Deductible:** The total amount you pay for services out of pocket in a plan year (can vary between calendar year and academic year) before the health insurance plan begins to pay. After you reach your annual deductible, the insurance company UnitedHealthcare StudentResources (UHCSR), in the case of medical) will share costs with you. That's called coinsurance.

Note: Some services such as preventive care (routine healthcare that includes screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems) are paid by the plan before the deductible is met. When the plan says "no deductible," it means that you don't have to meet your deductible, and that the amount you spend out of pocket will not apply toward the deductible.
- **Coinsurance:** The amount you pay for covered healthcare after you meet your deductible. Coinsurance is expressed in percentages. For example, if the plan plays 90 percent of a given charge, 10 percent is your coinsurance.
- **Out-of-pocket maximum:** The most you'll ever pay in a plan year for eligible expenses. Your deductible, coinsurance and copays all count toward your out-of-pocket maximum. If you reach your out-of-pocket maximum, the health plan will pay 100 percent of your covered expenses.

This does not include your monthly premiums or anything you spend for excluded services (ones your plan doesn't cover).

- **Balance Billing:** When you use an out-of-network provider – and there is a difference between the provider’s charge and the amount your health insurance allows – the provider may bill you for the balance. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. An in-network provider may not balance bill you for covered services.
- **Explanation of Benefits (EOB):** A notice sent from the health plan to the member describing the resolution of a claim. It includes services provided, amount billed, allowed amount (maximum amount a health plan will pay for a covered service), any discounts, payment made by the health plan and any costs that are the member’s responsibility. The EOB is not a bill and is for your information only; the provider will send you a bill separately if you owe an amount. Comparing the EOB to the bill is a good way to make sure you’re being billed correctly.
- **In-Network vs Out-of-Network:** A network is a large group of doctors, hospitals, pharmacies, labs and providers who have partnered with the insurer to provide services to the policyholders who will offer the best possible negotiated rates for the plan. These groups are called in-network, or participating providers.

Using in-network providers means your care will be more affordable (e.g., you’ll be protected from balance billing) and the providers will handle submitting your claims to the health plan.

Out-of-network providers do not have a contract with the health plan resulting in members paying more of the cost when receiving care (see Balance Billing above) and likely having to complete and submit their claims to the health plan for partial reimbursement.

Note: The network is the same for both the graduate staff and domestic and international student health insurance plans.

- **Sample Scenarios:** Here are a few scenarios for a student with self-only coverage using the 2022-2023 medical plan design for students and graduate staff.

- **In-Network Mental Health Visit***

Student has an office visit with an in-network therapist. Therapist charges \$100, but since they are in-network, they are contracted with the student’s insurance to accept \$80 instead.

Before deductible has been met

Student pays **100 percent of \$80** since they have not yet met their annual deductible (meaning they have not yet spent a total of \$200 out-of-pocket for the year on services and/or prescriptions).

After deductible has been met

Student pays **10 percent coinsurance** (the remaining 90 percent is paid by the insurer) of \$80 or \$8, since they have already met their deductible for the year (meaning they have spent a total of \$200 or more out-of-pocket for in-network services and/or prescriptions).

Out-of-Pocket Maximum has been met

Student pays **0 percent/\$0** since they have already met their out-of-pocket maximum for the year, (meaning they have spent a total of \$1,500 out-of-pocket for in-network services and/or prescriptions).

**Purdue University student health plan participants have 100 percent coverage for virtual Mental Health visits through [HealthiestYou](#).*

- **Out-of-Network Mental Health Visit**

Student has an office visit with an out-of-network therapist. Therapist charges \$100 and since they are not in-network, they are not contracted with the insurer to accept the discounted/allowed rate of \$80.

Before deductible has been met

Student pays **100 percent of \$100** since they have not yet met their annual deductible (meaning they have not yet spent a total of \$400 out-of-pocket for the year on out-of-network services and/or prescriptions). The entire \$100 they spend applies to their out-of-network out-of-pocket maximum for the year, but only the

allowed amount, \$80, applies to their deductible.

After deductible has been met

Student pays **30 percent coinsurance** (the remaining 70 percent is paid by the insurer) of the allowed \$80, or \$24, since they have already met their deductible for the year (meaning they have spent a total of \$400 or more out-of-pocket for out-of-network services and/or prescriptions). Since the provider is not contracted to accept the discounted rate of \$80, they can balance bill the student for the remaining \$20 from the original \$100 charge, **bringing the student's total payment to \$44**, which all applies to their out-of-network out-of-pocket maximum.

Out-of-Pocket Maximum has been met

Student pays **0%/ \$0 of the allowed \$80** since they have already met their out-of-pocket maximum for the year, (meaning they have spent a total of \$3,000 out-of-pocket for out-of-network services and/or prescriptions). Although the provider is not contracted to accept the discounted rate of \$80, should they choose to balance bill the student, the insurer will pick up the remaining \$20

- **Emergency Room (ER) Visit**

Student goes to an in-network hospital's ER with an emergency and has not yet spent anything toward their deductible or out-of-pocket maximum for the year. Hospital charges (facility fee, physician fee, treatment costs) total \$2,750. Since the hospital is in-network, they are contracted with the student's insurance to accept a negotiated rate of \$2,000.

Student is not admitted (observation /outpatient)

Student pays **\$50 copay** (does not apply toward the deductible), then **100 percent** of charges **up to the deductible, \$200**, then **10 percent coinsurance** of remaining hospital balance or **\$175**.

Total student responsibility: \$425

Plan pays: \$1,575

Deductible spent: \$200 of \$200

Out-of-pocket maximum spent: \$425 of \$1,500

Student is admitted (inpatient)

\$50 copay is waived (student does not have to pay it). Student pays 100 percent of charges **up to the deductible, \$200**, then **10 percent coinsurance** of remaining hospital balance or **\$180**.

Total student responsibility: \$380

Plan pays: \$1,620

Deductible spent: \$200 of \$200

Out-of-pocket maximum spent: \$380 of \$1,500

Did You Know? Urgent care facilities can handle a variety of non-life-threatening situations (e.g., broken bones, cuts requiring stitches, high fever, flu and more) and are more affordable and often take less time than a visit to the ER. If you do not have life-threatening symptoms or situations, consider using an urgent care facility.

- **Child Birth**

Student gives birth (non-cesarean) at an in-network hospital and has not yet spent anything toward their deductible or out-out-pocket maximum. Total hospital charges (room and board, facility fee, medicine, etc.) were \$12,000. Since the hospital is in-network, they are contracted with the student's insurance to accept a negotiated rate of \$10,000.

Student pays **100 percent** of charges up to the new **\$400 deductible** (with the newborn on the plan) or **\$400**.

Then the student pays **10 percent** coinsurance on the remaining amount of the hospital bill (\$9,600) up to the new \$3,000 out-of-pocket maximum or **\$960**.

Total student responsibility: \$1,360.

Plan pays: \$8,640

Deductible spent: \$400 of \$400

Out-of-pocket maximum spent: \$1,360 of \$3,000

What Do I Need to Do before Getting a Service?

When you're in need of healthcare services, it is best to search for an in-network provider to limit your out-of-pocket expenses. Make sure the service is covered and not limited by or excluded from your plan by reviewing your benefits. Have your insurance card readily available at the time of service. Review the Questions section below for useful resources.

When Do I Pay for Services?

Some services require up-front payment – such as an office visit with a copay or filling a prescription. Other services – such as X-rays and hospital stays – will first be processed by your insurance and then you will receive an invoice from your provider for the amount you owe.

Questions?

For more information and support specific to your health insurance, please refer to your benefits websites:

[Academic HealthPlans \(AHP\)](#)

Here you will find benefits information on the domestic and international student and graduate staff medical insurance plans, contact information for UnitedHealthcare StudentResources (UHCSR) – the insurance carrier – as well as information on portal registration, payment of premiums and enrollment in the medical insurance plans.

[Human Resources – Graduate Staff Benefits](#)

Here you will find information on graduate staff benefits – including medical, vision and dental plans along with other voluntary benefits, voluntary retirement savings plans and leaves. Additionally, information on eligibility, enrollment through Benefitfocus and benefits-related payroll deductions is included.

Your benefits. Your choices. Your well-being.