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University of Portland

Guide to My Health Insurance Coverage

Print out or save this guide to your insurance coverage and glossary of terms and fill it out as you speak with a representative for your health insurance company.

What does "covered" mean?

If a healthcare service or procedure is "covered" by your insurance, it means that your health insurance plan will pay for some, or all, of the costs. The amount they pay depends on what type of insurance plan you have, what type of care you received, and where you received that care.

How do I know what's covered?

To find out what is covered under your health insurance plan, you can:

1. **Call a Customer/ Member Service representative.** Most often, the phone number for the insurance company's Customer/ Member Services is listed on the back of your insurance card. If you have any questions about what your plan covers, call your insurance company. They are there to help you and can answer questions like whether a doctor, prescription, or service is covered and how much it might cost you. This is the best way to get specific information about your insurance coverage!
2. **View your Summary of Benefits and Coverage (SBC).** If you have an online account for your insurance company, you can sign in and look for a link to your health insurance plan's Summary of Benefits and Coverage. This is a document all plans are required to have that lists a general overview of services that your plan covers, and how much of the cost is covered. (You can view an Example SBC from Healthcare.gov here.)
3. **View your Member Handbook.** If you have an online account for your insurance company, you should be able to view your Member Handbook or Policy/ Plan Handbook. It is a document that outlines in detail what is or isn't covered, rules you must follow, your rights and responsibilities, and other important information about your health insurance plan.

What do I ask my insurance company when I call?

When you call your health insurance plan's Customer/ Member Services number, you should ask the representative the following questions, as they are applicable to you:

1. What type of health insurance plan do I have?

☐ HMO ☐ PPO ☐ Other: _____

2. Is the University of Portland Student Health Center an in-network provider with my plan?

You may be asked for the Student Health Center Tax ID or NPI.

Tax ID: 930401259

NPI: 1356545875

☐ yes ☐ no

<table>
<tr><td>If yes:
3. Does my health insurance plan have any deductibles?
☐ yes ☐ no</td><td>If no:
3. Does my plan have out-of-network benefits in Portland, OR?
☐ yes ☐ no</td></tr>
<tr><td>If yes:
• How much is the deductible?
• What services does the deductible apply to?
• When does my current benefit year end?
• How much of my deductible has been met so far this benefit year? (Today's date:_____)</td><td>If yes:
• If I choose to go out-of-network, what percentage of my bill will be paid by the insurance company?
• What will I have to pay?

If no:
If there are no local providers who are in-network, it will likely be more affordable to seek care within your network. The Health Center would be happy to assist you with finding this care, if needed! You can continue with questions 4-12 to get information about your in-network benefits only.</td></tr>
<tr><td colspan="2">4. Do I have to pay a co-insurance?
☐ yes ☐ no
If yes:
How much is the co-insurance for...
• Primary care office visits?
• Specialists?
• Urgent care visits?
• Hospital/ Emergency Room visits?</td></tr>
<tr><td colspan="2">5. Do I have to pay any co-payments?
☐ yes ☐ no
If yes:
How much is the co-pay for...
• Primary care office visits?
• Specialists?
• Urgent care visits?
• Hospital/ Emergency Room visits?</td></tr>
<tr><td colspan="2">6. How much do I have to pay for prescription medications?</td></tr>
<tr><td colspan="2">7. What is the maximum out-of-pocket cost I would pay each year?</td></tr>
</table>

8. Is there any cost for preventative services? For example: • Annual physicals? • Immunizations? • "Well Women's" visits/ Pelvic exams?
9. How much would I pay for… • Advanced diagnostic imaging (MRI, CT, PET, etc.)? • Diagnostic radiology (X-ray, Ultrasounds, etc.)? • Laboratory services?
10. Do I need prior authorizations or referrals for any services?
11. Are there limits on the number of visits to a provider, like a specialist?
12. Are there any other requirements or restrictions I should know about?

Glossary of Insurance Terminology

Benefit Year or Plan Year – The annual cycle that a health insurance plan follows. Sometimes this follows the same a calendar year and your health insurance plan renews in January. Sometimes this can follow a different annual cycle such as renewing in the summer or fall.

Claim – A bill submitted by a provider (or a member) to an insurance company that lists the services and procedures provided. The health care provider will usually file a claim for you.

Co-insurance – The amount (usually a percentage) of each bill you must pay out-of-pocket, after you have met your deductible.

Coordination of Benefits (COB) – When a person has two or more health insurance plans, a Coordination of Benefits is used to determine which plan pays first. The health insurance plan that pays first is your "Primary Coverage" and then the health insurance plan that pays based on any remaining balance is your "Secondary Coverage".

Co-payment – The fixed amount of each medical bill you must pay out-of-pocket. The co-pay is either due at the time of service, or gets billed to you after your visit.

Coverage or Covered Benefits – The services and procedures that a health insurance plan will pay for.

Date of Service – The date on which an insured person received healthcare services.

Deductible – The amount you pay out-of-pocket for covered healthcare services before your insurance plan will start to pay. For example: If you have a $400 deductible, you will pay the first $400, and then your health insurance plan will begin to pay a portion of your medical expenses. Sometimes the deductible may not apply to certain services, but will apply to others.

Dependent – Someone who relies on someone else for their primary source of income (this may or may not be you depending on your financial situation).

Effective Date – The date on which your health insurance becomes effective or 'active'.

Exclusions or Non-Covered Benefits – Conditions or services for which the insurance company will not pay. Common exclusions often include: travel vaccines and services, massage therapy, cosmetic procedures, non-medically necessary services or supplies, etc.

Explanation of Benefits (EOB) – A statement you receive from your insurance company that shows the services and procedures performed, the amount your health insurance plan paid for those services/procedures, and any remaining balance that you will be responsible for. An EOB is not a bill.

Health Maintenance Organization (HMO) – A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

In-Network – A health care provider or facility that has a contract with an insurance company. When you receive care from an in-network provider, generally you pay less. These providers may also be called "preferred providers" or "participating providers".

Insurance Company – An organization licensed to operate as an insurer. They can also be called a carrier or insurer.

Insurance Policy – The legal document issued by the insurance company to the policy holder that outlines the terms and conditions of the insurance; also called a contract.

Medicaid – Joint federal and state program that provides health insurance to some people with limited income or resources.

Medicare – Federal health insurance program for older US citizens and the disabled.

Member or Enrollee or The Insured – The person or who is getting coverage on a health insurance plan (this is you!).

Network – A group of health care providers that are contracted with a specific insurance company to provide healthcare services.

Open Enrollment – An annual period, usually shortly before the beginning of a new plan year, when eligible people can enroll in health insurance benefits and/or change their plan.

Out-of-Network – A health care provider or facility that does not have a contract with the insurance company. If you receive care or services from an out-of-network provider, typically you will end up paying more.

Out-of-Pocket Maximum – The maximum amount of money you will pay out-of-pocket for covered healthcare expenses during a plan year.

Policyholder or Subscriber or Guarantor – The person that the health insurance policy is under (i.e. the person who pays for the health insurance policy). In a family plan, this is typically a parent.

Preauthorization or Prior Authorization (PA) – For some services, your health insurance plan may require a Prior Authorization or Preauthorization before you receive those services, except in an emergency. A Prior Authorization is an approval given in advance by an insurance company to a provider for certain types of care. It is not a guarantee that your health insurance plan will pay for services. It is sometimes called a prior authorization, prior approval, precertification, or preauthorization.

Preferred Provider Organization (PPO) – A type of health plan that contracts with health care providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium – The amount that the Policyholder pays for your health insurance coverage each month.

Primary Care Provider (PCP) – A physician, nurse practitioner, clinical nurse specialist or physician assistant, who provides, coordinates, or helps a patient access a range of healthcare services.

Referral – An order written by your primary care provider for you to see a specialist or get certain healthcare services.

Request for Confidential Communication – A request that prevents your insurance provider from sending Explanations of Benefits (EOBs) and other communications to the insurance policyholder (probably Mom or Dad), and instead requests that EOBs be sent directly to the person who actually received the services (you).

Specialist – A physician specialist focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of conditions. (i.e. Dermatologist, Gastroenterologist, etc.)

Resources

- Coverage to Care: My Health Insurance At-a-Glance – A simple cheat sheet provided by CMS.gov
- From Coverage to Care: A Roadmap to Better Care and a Healthier You – Information provided by CMS.gov (Additionally available in 10 languages here.)
- Using Your Health Plan – Information provided by the National Association of Insurance Commissioners
- Glossary of Health Coverage and Medical Terms provided by CMS.gov
- Glossary of Terms provided by PacificSource