

A resource for those who are new to Health Insurance...

If you are new to how health insurance works, below are some common terms and definitions. Understanding these terms will help you when choosing a medical plan, and when you need to use the plan for treatment.

Understanding Health Insurance Terms

Coinsurance

The amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. The coinsurance rate is usually expressed as a percentage. For example, if the health insurance company pays 80 percent of the claim, you pay 20 percent.

Co-payment

Another way of sharing medical costs. You pay a flat fee every time you receive a medical service (for example, \$50 for an Urgent Care visit). The health insurance company pays the rest. Copayments may also apply to prescription drug benefits (for example, \$7.50 for a 30 day supply generic medication).

Covered Expenses

Most health insurance plans, do not pay for all services. Covered services are those medical procedures the plan agrees to pay for. They are listed in the health insurance policy or Summary Plan Description (SPD).

Customary Fee

Most health insurance plans will pay only what they call a reasonable and customary fee for a particular service. If your doctor charges \$1,000 for a hernia repair while most doctors in your area charge only \$600, you will be billed for the \$400 difference. This is in addition to the deductible and coinsurance you would be expected to pay. To avoid this additional cost, seek treatment from an **In-Network Provider** who will accept your health insurance company's payment as full payment, or shop around to find a doctor who will, otherwise you will have to pay the rest yourself.

Deductible

The amount of money you must pay each year to cover your medical care expenses before your health insurance policy starts paying.

Exclusions

Specific conditions or circumstances for which the policy will not provide benefits.

Explanation of Benefits (EOB) Statement

After a claim has been processed, the insurance company will produce a statement showing the date of service, charges submitted, network discounts, deductible or coinsurance applied, and the patient's final payment responsibility. This statement can be reviewed online (www.myuhc.com) and should be compared to the provider's billing statement before payment to the provider is made.

HSA (Health Savings Account)

A savings account set up to be used for medical expenses and nothing else. Funds directed to the HSA are pretax dollars, thus reducing taxable income, and HSA's offer interest on the balance. The medical expenses and HSA can be used for include optical, insurance deductions, dental and some over-the-counter medications. HSA's can be very efficiently used in conjunction with a high deductible health insurance policy. Unlike Flexible Spending Accounts (FSA's) any amount remaining in an HSA at the end of the year is [u]not[u] forfeited but remains in the account for later use.

In-Network Provider

Providers who are contracted to provide services at discounted rates. Utilizing these providers will save you money and protect you from charges that are over the **Customary Fee**.

www.healthcarelane.com/Creighton

Visit this interactive web tool where visitors can stroll down a virtual street and learn more about how health insurance works!

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Maximum Out-of-Pocket Expenses

The most money you will be required to pay per year for deductibles and coinsurance. It is a stated dollar amount set by the health insurance plan, in addition to regular premiums.

Out-of-Network Provider

A provider who is not contracted with the **TPA**, is considered an out-of-network provider. Though benefits may be available through the plan, higher deductibles, coinsurance, and out-of-pocket maximums may apply. Also, these providers are able to set their own fee schedules and are not bound by contracted rates, so you would be responsible for charges that are over the **Customary Fee**.

PPO (Preferred Provider Organization)

A PPO is a network/group of hospitals, doctors, labs and other medical providers who the insurer has contracted with to provide care and services at a discounted rate. When you use providers that are part of the PPO, you can have a larger part of your medical bills covered. You can use other providers outside the network, but you will be responsible for a higher percentage of cost, which could be significant.

Premium

The amount you or your employer pays in exchange for health insurance coverage.

Preventive Care Services

Also called "routine" or "wellness visits", these services include immunizations, well-baby or well-child care, routine physical examinations and screenings including cholesterol tests, mammograms, PSA, and colonoscopies. The plan pays for services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital.

Primary Care Doctor

Usually your first contact for health care. This is often a family physician, pediatrician, or internist, but some women use their gynecologist. A primary care doctor monitors your health and diagnoses and treats minor health problems, and refers you to specialists if another level of care is needed.

Provider

Any person (doctor, nurse, dentist) or institution (hospital or clinic) that provides medical care. A **Preferred Provider** is contracted with the insurance plan/TPA to offer services to members at a discounted price.

Third-Party Administrator (TPA)

Any payer for health care services other than you. This can be an insurance company, an HMO, a PPO, or the Federal Government.

United Healthcare – Medical Insurance

Creighton University is self-insured and works with United Healthcare to process medical insurance claims. For easy access to participating provider, benefits, and claims information, log on to www.myuhc.com. Contact Customer Service for detailed questions or assistance by calling the number located on the back of your United Healthcare card.

When to Pay Your Bill

If you need to see a doctor, soon after your visit you will receive a bill or statement from the provider. Because you have enrolled in health insurance, verify that your insurance has processed the claim and applied all discounts, deductibles, coinsurance, and payments before paying your provider. Use the online **EOB (Explanation of Benefits statement)** to verify your final patient responsibility.

WHI – Walgreens Health Initiatives – Prescription Drug Program

Creighton University is self-insured and works with WHI to process prescription drug claims. To locate a participating pharmacy, look up preferred drug costs and coverage, or to review benefits or claims information log on to <http://www.walgreenshealth.com/>. Contact Customer Service for detailed questions or assistance by calling the number located on the back of your Walgreens Prescription Drug Program card.