

A Student Life Guide to Understanding US Medical Insurance



What is Medical Insurance?

An insurance contract paid yearly, quarterly, or monthly which helps pay for your medical expenses.



Questions?

Health Services



Health Services is available to support students who are on the RISD student health plan or have a private insurance policy.

University Health Plans



Contact UHP with questions about any of the student insurance plans, including medical, optional dental, and/or optional vision coverage.

Learn More About Health Insurance



Find more frequently asked questions, enrollment waivers and forms, brochures, coverage lists, and much more!

You can always contact your insurance provider with any coverage, billing or plan questions.



STUDENT LIFE

Common Medical Insurance Plans

HEALTH MAINTENANCE ORGANIZATION (HMO)

A low cost, small network plan. With this plan you must stay in network, and specialist visits require a referral or you would be fully responsible for payment.

PREFERRED PROVIDER ORGANIZATION (PPO)

Higher cost and larger network. This plan has more options for providers and services, and does not require a referral to visit a specialist.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

This type of plan offers a lower premium in exchange for a higher annual out-of-pocket deductible.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

Smaller network of providers, no need for referrals.

POINT OF SERVICE (POS)

Must receive referrals from a primary care provider for out-of-network providers.

CATASTROPHIC HEALTH PLAN (CHP)

A plan available to people under 30 (or over 30 with qualifying waiver) that covers only worst-case scenarios, such as a severe car accident or sudden unexpected disability.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

A legal protection that allows you to keep the insurance offered by your employer, up to a year and a half after your employment ends. However COBRA coverage often comes at a significantly higher cost.

There are other types of health insurance plans. Check your insurance card to determine which plan you have!

Insurance Policy Terminology

PREMIUM

The fee you pay for insurance coverage. Premiums may be charged annually, quarterly, or monthly. Missing payments can result in immediate termination of coverage leaving you uninsured and responsible for the payment of your healthcare.

DEDUCTIBLE

The amount you pay out-of-pocket towards services each year before your insurance provider starts covering these costs. This is often confused with out-of-pocket maximum.

COPAY

A fixed amount you pay for specific services or prescriptions. This fee is paid even if you meet your deductible.

COINSURANCE

A percentage of costs you pay after meeting your deductible. While some insurance plans cover all costs after the deductible has been met, some require that you continue to pay a percentage of the total costs, like 10% or 20%.

OUT-OF-POCKET

This describes the amount you are responsible for paying, after all insurance payments have been deducted. If you do not have insurance, all medical costs are out-of-pocket expenses.

OUT-OF-POCKET MAXIMUM

The most you will pay in a year for covered medical services. After you reach this, the insurance provider will pay all remaining costs, including copays.

EXPLANATION OF BENEFITS (EOB)

An Explanation of Benefits shows you the total charges from your visit. It is NOT a bill. It simply breaks down how much your insurance covers, and what you are likely to owe your provider (your out-of-pocket costs) after insurance has paid their portion.

Review your policy to find your premium, deductible, copay, coinsurance and out-of-pocket maximum.

APPEAL

A request made to dispute any decision regarding billing for your medical care that your health insurer or plan reviews. Appeals can be submitted to request that your insurance pays for all or part of services which are yet to happen or have already happened. Insurance companies usually have a time limit for submitting an appeal.

REFERRAL

A medical referral is a formal request or written order from your primary care doctor (or RISD Health Services) sending you to see a specialist or get specific medical services. On some plans a referral may be required to use your insurance for those services.

MODIFIED ADJUSTED GROSS INCOME (MAGI)

A term used to determine eligibility for certain coverages based on income, decided at state level.



You visit an in-network provider for covered services.

Depending on what you have already paid this year, you may owe the entire cost of the visit, a co-pay, a co-insurance percent, or nothing at all.

DEDUCTIBLE IS NOT YET MET, YOU PAY ALL COSTS FOR THIS VISIT



DEDUCTIBLE IS MET, YOU PAY EITHER YOUR CO-PAY (SET DOLLAR AMOUNT) OR CO-INSURANCE (SET PERCENTAGE OF BILL), DEPENDING ON YOUR PLAN, YOUR INSURANCE COVERS THE REMAINING BALANCE



OUT-OF-POCKET MAXIMUM IS MET, YOUR INSURANCE PAYS ALL COSTS FOR THIS VISIT



PROVIDER

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. Insurance requires providers be licensed, certified, or accredited as required by state law.

IN-NETWORK

A medical provider that has an agreement with your insurance provider to offer coverage at lower or no additional cost.

OUT-OF-NETWORK

A medical provider who is not partnered with your insurance. Out-of-Network providers are often more expensive, and may not have any portion of the bill covered by your insurance provider, leaving you responsible for paying for services and appointments entirely out-of-pocket.

MULTI-TIER NETWORK

A medical provider that may be partially covered, but is not preferred. A multi-tier network may have partial coverage for a procedure. For instance if a doctor is in-network, but moves to an out-of-network hospital, your procedure may be considered multi-tier network coverage.

Not sure if your provider(s) are in-network?

Most insurance carriers have a provider search function on their website so you can find providers and check their network status.



Enrollment Terminology

OPEN ENROLLMENT

This is the period of time when you are permitted change your current medical, dental and/or vision plan(s) or sign up for coverage. For employer-supported insurance, this period typically takes place between November 1 and January 15, but dates will vary.

For RISD student health insurance, open enrollment is based on the semester you start classes at RISD. You are automatically enrolled in coverage unless you have an approved waiver. You can sign up and pay for additional coverage (dental, vision and more) before the posted deadline, which is also based on the semester you start classes.

QUALIFYING LIFE EVENT (QLE)

A major change in your life that has greatly impacted your financial and medical circumstances. Valid QLE's include but are not limited to marriage, loss of employment, aging out of parents coverage, or leaving an abusive domestic living situation. Experiencing a QLE may allow you to update your plan, see Special Enrollment Period.

SPECIAL ENROLLMENT PERIOD (SEP)

A 30 or 60 day window that comes before or after a QLE. Examples may include 60 days after the loss of employment, or up to 60 days before the birth of your child.



IN THE US HEALTHCARE SYSTEM, DENTAL, VISION, AND MEDICAL INSURANCE ARE ALL CONSIDERED SEPARATE FIELDS OF PRACTICE AND COVERAGE.

This means your medical health insurance will not cover glasses, or a tooth cavity, but it may cover things like glaucoma testing, or an office visit for a mouth injury.

However, you may be able to use your medical savings or spending account to pay for those services that are not covered by your medical insurance.

Financial Acronyms

HEALTH SAVINGS ACCOUNT (HSA)

Only open to users with plans that are High Deductible Health Plans (HDHP) (typically the lowest upfront cost plan from a provider). HSAs are saving accounts that are tax-deductible, and money rolls over each year, sometimes with small fees. You own the money in the account, even if employment ends, or you later change insurance plans.

MEDICAL SAVINGS ACCOUNT (MSA)

This plan functions similarly to an HSA, but is available to self-employed individuals and Medicare. Additionally, contributions into an MSA are not tax deductible.

FLEXIBLE SPENDING ACCOUNT (FSA)

Available through your employer. Contributions are tax free, but do not roll over and must be used by the end of the calendar year. FSAs can cover doctors appointments, prescription medication and over the counter (OTC) medications *if* a valid receipt is shown as proof for reimbursement.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

An agreement offered by an employer to reimburse you for certain pre-approved medical expenses.

Drug Tiers and Terminology

GENERIC

The cheapest, off brand option. Typically has the same formulation as non-generic, though sometimes subtle differences in manufacturing may cause medical providers to strictly prescribe the brand name for those with more sensitive medical needs.

BRAND NAME (OR NAME BRAND)

The brand name medication is typically the original formulator of the medication. For example Zoloft is the brand name for sertraline hydrochloride, and Cymbalta is the brand name for Duloxetine.

NON-PREFERRED BRAND NAME

A brand name medication that is not covered by an insurance plan. Many insurance providers will prefer customers to use generic medications over brand names due to cost saving measures.

SPECIALTY

A medication that treats complex chronic conditions. Some common medical treatments in this category would be medications to treat cancer, multiple sclerosis, rheumatoid arthritis, and so on.

COMPOUNDED

A compounded drug is a prescription whose ingredients are mixed individually to create personalized doses for a patient who cannot be treated with an FDA-approved medication, such as a patient who has an allergy to a certain dye and needs a medication to be made without it, or a patient who cannot swallow a tablet or capsule and needs a medicine in a liquid dosage form.



Not sure if your prescription is covered?

Ask your pharmacist, and discuss any brand preferences with your prescriber.

Government Insurance

MEDICAID

A federal insurance program intended for low income individuals and families. Plans are offered and administered at a state level. Eligibility is determined by the state based on a number of factors including MAGI, location, and need.

MEDICARE

A federal coverage program offered to people 65 and older, people with ALS, lifelong dialysis patients, and those who have been on Social Security Disability Insurance (SSDI)/disability benefits for over 24 months. Medicare covers Hospital/Inpatient care with no premium, outpatient care/doctor visits with a monthly premium, and prescription drugs.

MEDICARE ADVANTAGE

A private insurance provider that is approved and subsidized by Medicare.

ACA MARKETPLACE

Healthcare.gov is where you can check eligibility and sign up for government health insurance. Some states have their own websites, like Rhode Island has "HealthSource RI".



Medicaid.gov



Medicare.gov



Healthcare.gov

Frequently Asked Questions

WHY SHOULD I HAVE MEDICAL INSURANCE?

Medical care and services can be very expensive, and health insurance can significantly reduce your out-of-pocket costs. For example, according to Aflac, the cost of treating a broken bone without insurance may range from \$310 to \$150,000, depending on the medical services needed. According to Good RX, an office visit at urgent care typically runs from \$125 to \$300 without insurance, not including imaging, tests or lab costs.

WHAT DOES RISD INSURANCE (OR ANY INSURANCE) COVER?

This is a complicated question and includes hundreds of thousands of unique circumstances, which is why no insurance provider will ever give a 100% comprehensive list upfront. Regardless of your insurance provider, your policy will explain what is covered. For specific questions about coverage, students should call their insurance provider or discuss exception to coverage with their insurance provider. To learn more about what may be covered with your student health insurance visit www.universityhealthplans.com.

IF I HAVE RISD INSURANCE, WHY ARE VISITS TO HEALTH SERVICES FREE, BUT OUTSIDE PROVIDERS CHARGE FOR THE SAME SERVICE?

RISD's Health Services is entirely funded by student tuition and since you attend the college, this is one of your on-campus resources. We do our best to control costs related to staffing, supplies and space to fit our student needs, which helps us provide free services to all students, regardless of insurance provider.

Health Services does utilize your insurance for any care outside the health center, like lab processing, medication prescribing, imaging orders, and/or specialist referrals.

HOW MUCH SHOULD I BUDGET FOR MEDICAL EXPENSES EACH YEAR?

This depends on your medical needs and finances. At minimum, you will want to budget for the cost of your insurance premium, expected co-pays and prescription costs (including types not covered by your insurance). You will want a financial plan in place to pay your full deductible and your out-of-pocket maximum should the need arise.

Remember, out-of-network services may not be covered by your insurance plan at all, so if you choose to visit out-of-network providers, expect to cover those costs yourself and include those expected costs in your budget.

Off-campus medical providers utilize your health insurance. RISD has no control over what outside providers charge.

HOW DOES PAYMENT FOR INSURANCE WORK?

If you are on a RISD provided insurance plan as a student, payment is collected automatically with your tuition, since you are automatically enrolled in coverage each year.

NOTE- You may waive this insurance by completing a waiver and providing proof of outside equivalent coverage by the posted deadline. Waivers must be completed each year.

If you are on a private plan outside of RISD, payment may be collected upfront, quarterly, or monthly depending on your plan. Missing payment may result in a lapse of coverage, so make sure to double check when you sign up!



HOW DO EMPLOYER-SPONSORED HEALTH PLANS WORK?

If your employer offers insurance, they will have a contract with one or more insurance providers to offer a discounted rate for employees. Employees can choose to either opt into the discounted plan (which will typically offer higher coverage) offered during open enrollment and/or find a private plan if they have needs that are not met by employers.

Each year during open enrollment you will be asked to update or confirm your choices. Typically employers will then take the employee's installment payments out of their paycheck automatically. Experiencing a QLE may allow you to update your plan outside of open enrollment.

NOTE- Student workers and students on Work-Study are not RISD employees, and are not eligible for RISD employer-sponsored insurance.