A Student Health Insurance Guide for International Students at Oklahoma Christian University

Health insurance in the United States

What is health insurance?

Health insurance provides protection against the risk of financial loss resulting from an insured person's sickness, accidental injury, or disability. The term "insurance" refers to many different types of insurance plans, ranging from those that cover the costs of doctors and hospitals to those that meet a specific need—like long-term care or dental coverage. When you hear people talk about health insurance, however, they're usually referring to the kind of plan that covers doctor bills, surgery, and hospital costs.

Are you required to have it?

US federal regulations require Exchange Visitors, Scholars, and their dependents (J-1 and J-2) to buy adequate health insurance. Students coming to the US to study on a J-1 Student Visa, and their family members joining them, must carry medical insurance for the full duration of their stay in the United States.

F-1 international students and their dependents are not eligible for federal aid, and they must attest to their financial ability to support themselves while pursuing their full course of study. Therefore, it is strongly recommended, and often required by the college or university, that F-1 students and their dependents also have health insurance.

Why is health insurance important?

The United States offers superior health care, but it can be expensive. Should an accident or illness occur and you're not covered by your home-based health insurance, you may find yourself facing a financial burden. You may find yourself in a position where you can no longer afford to continue your education. Lack of adequate coverage may also prevent you from getting the care you need. Some providers may refuse to provide services to international students without an up-front payment.

Health insurance may help reduce these costs by providing coverage for specific health care services.

Account Information

Log into your **www.uhcsr.com/oc**
From there you can find your plan materials and other helpful information regarding the available services, as well as general health information.

UnitedHealthcare®

Understanding managed care plans

Managed care plans have agreements with certain health care providers to provide a range of quality health services at a negotiated rate. These negotiated rates are generally lower than if you received the care outside of the network. As a patient, you have to stay within the plan's network of providers and health facilities to get the best benefits.

Preferred Provider Organization (PPO) A PPO has arrangements with a network of health care providers, collectively referred to as Preferred Providers, who have agreed to accept lower fees from the insurer for their services. As a result, your costs are generally lower than if you go outside the network.

PPO plans encourage you to seek treatment in-network. Usually, you will pay a copay for a doctor visit or a prescription, and will have to pay a deductible before the plan begins to pay. After you've paid your deductible, the plan will begin to pay for a certain percentage of covered expenses.

Your coinsurance will be based on lower charges for PPO members. It's less expensive to visit one of the providers in-network.

In addition to the PPO doctors making referrals, you can choose other doctors, including ones outside the plan, who are considered out-of-network. If you go outside the plan's list, your share of the bill will be higher. You will have to meet the deductible and pay coinsurance based on higher charges and may have to pay the difference between what the provider charges and what the plan will pay.

A PPO plan includes an out-of-pocket maximum, which is the maximum amount of money you pay for your percentage of eligible healthcare services before the insurance company pays 100% of eligible services up to the policy's maximum lifetime benefit. A PPO makes it a best-of-both-worlds option for many patients: lower costs in the network, but flexibility to leave the network if necessary.

Plans vary by college. Be sure to review your plan materials carefully to understand the benefits available under your school's plan.

Using your school-sponsored health plan

There are a variety of situations in which you might need to receive medical care. Depending on your circumstances, here's how to get the care you need and maximize your benefits under your student health insurance plan.

Tips for choosing a doctor

Being far from home, you're likely not able to see your regular doctor. You'll need to select a doctor in the United States, and here are some tips on how to choose a new physician:

- Ask your Student Health Center for a referral in the area. Talk with friends and associates about their physician recommendations.
- Search the provider database at **www.uhcsr.com**. UnitedHealthcare has strict standards for its network physicians.
- Once you've found a doctor who fits your criteria, call to confirm office hours and admitting privileges at in-network hospitals.
- Remember, if you're not comfortable with your chosen physician, you're free to search the provider database and select a different physician at any time.

UHC Global
Global Emergency Services

UnitedHealthcare **Student**Resources policies automatically come with a powerful global assistance plan called UHC Global. International students studying at a US institution who are covered under the insurance plan are eligible for UHC Global services—both on campus and while traveling in a country that's not their country of origin—for the duration of their studies.

Accessing UHC Global services is as easy as making a single phone call to the Operations Center for help. The call will be answered by one of their experienced crisis management professionals, who can put in motion a vast number of emergency resources to solve any problem, 24/7. The UHC Global number is on the back of your UnitedHealthcare insurance ID card. Services include:

- Medical and dental referrals
- Facilitation of hospital admittance payments
- Dispatch of doctors/specialists
- Transfer of medical records
- Updates to family and home physician
- Hotel arrangements for convalescence
- Emergency medical evacuation
- Transportation to join a hospitalized participant
- Return of dependent children
- Repatriation of mortal remains
- Replacement of lost/stolen travel documents
- Security and policitical evacuation
- Natural disaster evacuation
- Transfer of funds
- Legal referrals
- Message transmittals

Glossary

- Deductible: the amount you owe for services your health insurance plan covers before the plan begins to pay. For example, if your deductible is $100, your plan won't pay anything until you've met your $100 deductible for covered health care services subject to that deductible. The deductible may not apply to all services.
- Copayment: a specific out-of-pocket dollar amount you pay to a provider at the time of service.
- Coinsurance: a percentage of covered expenses you pay. For instance, a plan could be set up so the insurer pays 80% of a bill, and you pay the other 20%.
- Usual and customary charges: (also sometimes called "usual, customary and reasonable") refer to the charges and costs typical or standard for your region. Let's say the usual, customary, and reasonable fee (based on an accurate study of doctors' charges) for an anesthesiologist is $500. If he charges you $600, your insurance will pay its percentage of the $500. You'll pay anything above that percentage of the $500, plus your deductible.
- Preferred allowance: the amount a Preferred Provider will accept as payment in full for covered medical expenses.
- Preferred Provider: a health care provider who has contracted with UHCSR to provide services to insureds for specific negotiated rates.
- Out-of-Network Provider: a Provider not contracted with UHCSR. Typically, the deductible and coinsurance are both higher if you go to an out-of-network provider. You'll save money by opting to be seen by a preferred provider.
- Exclusions and Limitations: various conditions, situations, and services not covered by the health insurance plan.