

GLOSSARY of Medical Insurance Terminology

Annual Deductible is the amount you must pay each year for medical and mental health expenses before your medical plan begins to pay benefits. For example, if your health plan has a \$300 Annual Deductible, you will pay all your medical expenses up to \$300 after which your health insurance plan will begin paying a percentage of your expenses, according to your plan benefits. *The Annual Deductible does not include monthly insurance premium or set-dollar copayments for prescription drugs and doctor visits.*

Annual Maximum Per Injury or illness (or Annual Per Injury/illness Maximum). Some health plans limit the total benefit amount they will pay for each injury or illness during the plan year. For example, if you break an arm, your plan will pay only up to \$20,000 for all care related to that injury if the plan has a \$20,000 benefit limit for each injury. The plan will continue to pay benefits for other conditions but only up to the “per injury or illness maximum” for that plan year. If your plan has a “per injury or illness” annual limit or maximum, it should be stated on your benefit summary or in your benefit booklet.

Annual Out-of-Pocket Maximum is the most you will have to pay out of your own pocket for health care expenses during the year. UC SHIP adheres to the benefit standards of the Affordable Care Act, so the Out-of-Pocket Maximum includes health care expenses you have paid, including coinsurance, annual deductible and other deductibles (such as a deductible for hospital stays, for example), as well as copayments you are required to pay for medical, behavioral health and pharmacy services during the plan year, after which your medical, behavioral health and pharmacy care expenses are covered at 100% for the rest of that plan year.

This maximum does not include insurance premium, or the cost of health care your insurance plan doesn't cover. If you're not sure how to answer this question, ask your health plan customer service representative.

Coinsurance refers to the cost-sharing of medical expenses; the insurance company pays a portion of the expenses and you, the insured, pay the remaining expenses. “Coinsurance” usually refers to the **percentage** of medical expenses for which you are responsible after the insurance company pays according to your plan's benefits. For example, if a hospital charges \$1,000 for surgical services and your insurance plan pays 70%, the insurance company would pay \$700 and you would pay the remaining \$300 (30% coinsurance). (This example assumes a network hospital, so there are no charges above what your insurance company considers an “allowed amount.”)

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How do you know if your plan has “no coinsurance?” **HMO** plans, for example, usually have low set-dollar copayments members pay for medical services but no coinsurance. If your plan covers hospital stays, surgical services, laboratory tests, and other diagnostic services at 100% after a set-dollar copayment (such as \$15 for an ultra-sound test) or a deductible (such as \$500 per hospitalization; then 100% coverage), your plan does not have coinsurance.

Group Insurance Plan. If your health insurance is provided by your parents', your spouse/partner's, or your employer, you probably have group insurance. Companies with a certain number of employees (usually greater than 20) are able to obtain employee health insurance based on underwriting of the whole employee group together (rather than basing rates on each individual separately) which results in lower rates for the group.

Individual insurance is a plan you can purchase on your own directly from the insurance company or an insurance agent. Often you can apply for insurance through a health benefit exchange such as Covered California, with an online broker such as ehealthinsurance.com, or directly from an insurance company. For individual insurance your monthly premium rate is based upon the benefit plan you select, your age and residence zip code. State exchanges such as Covered California, may offer premium subsidies for low-income individuals.

Inpatient and Outpatient. You are “inpatient” if you are admitted to the hospital for medical, mental health, or surgical services and provided meals, lodging, and care overnight, or longer. “Outpatient” refers to obtaining services outside the hospital, such as in a doctor's office, an urgent care center, a free-standing surgical center (“outpatient surgery”) or some other setting outside a hospital facility; outpatient services can also be provided in a hospital facility, such as emergency services or a surgical procedure, if the patient is released within 24 hours of admission.

Lifetime Maximum Benefit. Some health plans limit the benefit amount they will pay for all your health care expenses together. Once this benefit limit is reached, whether you've been covered under the plan for one year or many years, your coverage under that insurance plan will end. Lifetime benefit maximum is not allowed under the Affordable Care Act standards for health plans, but some types of health plans may still have a Lifetime Maximum through 2015.

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Medical Evacuation coverage provides international students with transport back to their home country if they become seriously ill and cannot continue attending the University; or transport back to the U.S. for domestic students who if you become seriously ill while traveling abroad.

Plan Year (or Benefit Year). The insurance Plan Year is the 12-month period when your insurance company provides your health care benefits and also the year-long interval when your Annual Deductible and Out-of-Pocket Maximum accumulate according to the provisions of your plan. Some insurance plans renew each year in January, so their Plan Year coincides with the calendar year, while other plans (like student health insurance, for example) begin their Plan Year each fall and continue until the end of summer (for example, September 1 through August 31).

Pre-Existing Condition Exclusion or Limitation is a limit of health insurance benefits for a medical condition for which you received a diagnosis or treatment (including prescribed medication) prior to the start date of your insurance plan (usually up to 3 months prior). Plans that have a pre-existing condition *exclusion*, provide no benefits for that particular condition under the plan permanently.

Some plans only *limit* coverage for the pre-existing condition. The benefit limit for a pre-existing condition usually means that you will receive no benefits for that particular condition for a period of time, such as 6 or 12 months, depending on the terms of your health insurance plan.

For example, if you joined a plan with a pre-existing condition limitation of 12 months and

- You were one month pregnant on your health insurance start date, you would receive no insurance coverage for prenatal care or delivery.
- You had suffered with asthma since childhood, you would receive no benefits for treatment of your asthma for the first 12 months of coverage under your health insurance plan; after that, your asthma treatment would be covered.

Reimbursement Plan is a health care plan based on *reimbursement* of your expenses paid at the time of service. Under this type of plan, you (the plan member) pay for medical, behavioral health and pharmacy services out of your own pocket and obtain reimbursement for those expenses afterwards from your home government or from another party.

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Repatriation of Remains coverage provides transport of your remains back to your home country if you should die while traveling abroad and covered by the plan.

Subscriber (or primary enrollee). If you have insurance through your parent's, spouse's, or registered domestic partner's employer, the parent/spouse/ or domestic partner who is covering you as a dependent under his or her health insurance plan would be the primary subscriber, sometimes called primary enrollee. If, on the other hand, you have your own individual plan or a plan through your own employer, you would be the primary enrollee/subscriber.

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