As you begin your studies in the United States, you're likely faced with exciting challenges and preparing for new experiences. One important consideration in planning your stay here should be your health coverage. Many doctors and hospitals in the United States will not recognize out-of-country health insurance, and depending upon your visa requirements, U.S. Immigration or your College or University may require you to have U.S.-based health insurance.

Why should you care about health insurance when you have tuition, books and rent to worry about? You never know when you might get sick or injured. If you’re not covered by a comprehensive benefit plan, one accident or serious illness could jeopardize your academic plans. Enrolling in school-sponsored health insurance can protect those plans. This guide will help you navigate the world of U.S. health insurance, understand why it’s important to you and learn the ins and outs of using it to its greatest advantage.
What exactly 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?

U.S. federal regulations require Exchange Visitors, Scholars and their dependents (J-1 and J-2) to buy adequate health insurance. Students coming to the U.S. to study on a J-1 Student Visa, and their family members that are joining them, must carry medical insurance for the full duration of their stay in the United States. Colleges and universities are required to provide the government requirements for this insurance.

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 that F-1 students and dependents also buy health insurance.

Why is health insurance important?

The United States offers superior health care, but it's the most expensive in the world. Should an accident or illness occur and you’re not covered by your home-based health insurance, the financial burden can be overwhelming. 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 at the most appropriate facility. Some providers may refuse to provide services to international students without an up-front payment.

Health insurance protects you from these high costs and ensures the best care by providing coverage for specific health care services. The cost for insurance is far less than medical care would be, if you paid for these services on your own.

Voluntary vs. Mandatory health coverage at your school

If you are an international student with a J-1 Visa, you must enroll in your school's Student Health Care Plan or provide evidence that you have purchased U.S.-based health insurance. You will also be required to enroll any dependents accompanying you during your studies in the U.S. If you are a student studying under an F-1 Visa, you may voluntarily purchase coverage under the plan.

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**Average Annual U.S. Health Care Costs (Per Person Ages 18-44)**

- Total Health Services: $2880
- Emergency Room Services: $964
- Hospital Inpatient Services: $10,108
- Office-Based Physician Services: $829

Source: Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey, 2005
**Why StudentResources Health Insurance?**

UnitedHealthcare StudentResources’ student health plans are custom designed to meet the needs of schools and their students. With most plans tailored around a school’s Student Health Center and designed for a younger and typically healthier population, we are able to offer quality coverage at affordable rates. Traditional individual policies may not provide you with the coverage you need and tend to cost more.

Our student health insurance plans provide confidence with coverage that stays with you...year-round, round-the-clock, on or off campus.

We’re the leader in student health insurance for a reason. From insurance products backed by the financial strength of A-rated insurance carriers to our unparalleled service that includes:

- 24/7 online access to plan and account information and forms
- Toll-free Customer Service support
- Fast, efficient claims process
- UnitedHealthcare’s Preferred Provider networks
- Coverage is 24/7
- Access to more than 563,000 health care professionals and over 62,000 pharmacies nationwide, including hospitals and pharmacies near your school’s campus
- Use any provider you like, but pay less when you choose a network provider
- The Collegiate Assistance Program has Registered Nurses ready to answer your health questions and is available 24/7 year-round in 160 different languages
- Scholastic Emergency Services has you covered
Translating Insurance

You may have heard terms like “managed care,” “Fee-for-Service” and “indemnity.” These words define different types of coverage or health plans widely used by today’s health care consumers in the United States. You may have also heard terms like “PPO,” “SOB” and “exclusions.” Understanding these words will help you understand your student health plan. Confused? Don’t worry. We’ll help you make sense of the most common terms.

**What are the major types of health insurance policies?**

There are three overall types of health insurance—fee for service, managed care and consumer-driven. These types of plans cover medical, surgical and hospital expenses and depending on the plan, may cover prescription drugs, dental care, vision care and behavioral/mental health care.

**Managed Care**

*Preferred Provider Organization (PPO):* A PPO combines features of a fee-for-service plan and an HMO. 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 should be lower than if you go outside the network.

PPO plans encourage you to get treatment in-network. Usually, you will pay a small copay (i.e. $15 for a doctor visit or $10 for a prescription) and will have to pay a deductible before the plan begins to pay the provider. After you’ve paid your deductible, the plan will begin to pay for a certain percentage of eligible expenses. Your coinsurance will be based on lower charges for PPO members. It's less expensive to visit one of the providers in-network.

Managed care plans have agreements with certain health care providers to give a range of quality health services at a reduced cost. The key to these lower costs? As a patient, you have to stay within the plan's network of providers and health facilities to get the best benefits.

In addition to the PPO doctors making referrals, you can refer yourself to 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 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.

*Health Maintenance Organization (HMO):* With an HMO, you receive a range of health benefits for a set fee. Generally, there are no deductibles, but most plans require a small copay per office visit (around $10-$25). You must choose a primary care physician from the plan’s list of providers who will coordinate your care, see you when you are sick and make any decisions about whether you should see a specialist or other provider within the HMO network. With most HMOs, you will not receive benefits if you go out-of-network, except for emergency care.

Primary care doctors are predominantly family practice doctors, general practitioners, internists, pediatricians or OB/GYNs. Some plans may allow a specialist to be selected as a primary care physician, such as an endocrinologist for a person who is a diabetic.

If your current doctor does not belong to the HMO, you will have to switch to a doctor who is within the HMO network. Your choice is not set in stone. Most plans allow you to switch your primary care doctor several times a year. If you don’t like one, select another.

**Fee-for-Service**

Fee-for-Service (also known as indemnity or traditional) plans generally offer complete freedom to choose your own doctors and hospitals. Under a typical Fee-for-Service plan, the doctor or hospital is paid a fee for each service provided. In other words: You go to the doctor or hospital of your choice and you (or your doctor or
submit a claim to your insurance company for reimbursement. You will only receive reimbursement for the “covered” medical expenses listed in your policy. If you have met your deductible for the year, then the plan will pay a percentage of the bill (usually 80%). You pay for the other 20%, the portion of the bill that you pay is known as coinsurance.

Fee-for-Service policies usually have an out-of-pocket maximum. This means that once your covered expenses reach a certain amount in a given calendar year, the reasonable and customary fee for covered benefits will be paid in full by the insurer. If your provider bills you more than the reasonable and customary charge, however; you may still have to pay a portion of the bill. These plans may also have lifetime limits on the benefits paid and tend to be more expensive to the consumer.

Point of Service (POS) Plan: A Point of Service plan is a hybrid of the HMO and PPO. Like a standard HMO, your primary care doctor makes referrals to other providers within the plan. But if you want to go to a physician outside the network without consulting your primary care doctor, the POS plan will pay a predetermined amount of the bill and your share of the bill will be higher if you had stay in-network. These plans usually cost more in monthly premiums than straight HMOs, but they give you the flexibility to call any doctor - within the plan or not.

Consumer-Driven
A Consumer-Driven health plan gives you more choices and flexibility in making health benefits decisions, more control over your health benefit dollars and often includes a health fund or account for covered medical expenses. Depending on the type of fund or account, unused dollars may be rolled over annually to cover medical expenses in subsequent years for the duration of the members’ enrollment in the plan. Consumer-Driven plans include Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs) and Flexible Spending Accounts (FSAs).

Other Types of Coverage
The following types of coverage may also be available to you as supplemental or alternative plans.

Catastrophic Coverage: This plan pays hospital and medical expenses above a certain (usually high) deductible. The maximum lifetime limit may be high enough to cover the cost of a catastrophic illness.

Long-Term Care Policies: These policies cover medical care, nursing care and certain in-home care if you ever become unable to care for yourself due to an extended illness or disability.

Disability Income Insurance: This plan will provide you with an income if you become unable to work due to an injury or illness. Benefits are usually 60% of your income at the time of disability.

Dental Insurance: Some health insurance plans include dental coverage as part of your benefits package. If not, you have the option of purchasing separate dental insurance—offered as a Dental Fee-For-Service, a Dental Maintenance Organization (DMO) or a Dental PPO plan—and works in the same way as the medical plans described.

Vision Insurance: Vision coverage also might be included in a health insurance benefits package. If not, it may be purchased separately and is usually provided in the form of a Vision Maintenance Organization (VMO) or PPO network. Coverage generally includes yearly eye exams and a percentage of the cost of eyeglasses and contact lenses. Some plans cover all or a part of the cost of laser corrective surgery.
Whether you have a Fee-for-Service plan, a PPO or an HMO, you will find that all plans have certain rules you have to follow.

**Schedule of Benefits**

Often called an “SOB”, the schedule of benefits outlines what services are included in your plan and what services are excluded from your plan. No single plan will cover all costs associated with medical care, but some cover more than others.

If your plan is a PPO, your SOB will include both in and out-of-network coinsurance percentages. Becoming familiar with your SOB is a good first step in understanding your plan and its benefits. Before seeking treatment for a nonemergency condition, it is a good idea to review the SOB. If you have any questions about what your plan will pay for, you should call Customer Service. Understanding your benefits upfront will allow you to make informed choices about your care.

**Exclusions and Limitations**

The terms exclusions and limitations refers to conditions, situations and services not covered by the health plan. Here is a generic overview of items typically not covered. Keep in mind, each plan has its own list of exclusions and limitations.

- Very few plans will cover elective cosmetic surgery. Exceptions occur when the procedure is needed to correct damage caused by accidental injury, but check your plan to make sure!
- Some Fee-for-Service plans do not cover routine medical checkups. Women should take careful note if a plan covers annual gynecological exams -- pap smears and mammograms.
- Women should also note that some individual plans will cover complications of pregnancy but won’t cover normal pregnancy or childbirth.
- Procedures that are considered experimental or non-traditional, such as acupuncture, are usually not covered.
- Mental health coverage is not offered in many health plans. Others offer limited coverage for acute conditions only.
- Procedures the health plan determines are not medically necessary.
- Insurers will not pay duplicate benefits. You and your spouse may be covered under different health insurance plans, but under what is called a “coordination of benefits” provision, the total you can receive under both plans for a covered medical expense can never exceed 100% of the allowable cost. This provision benefits everyone in the long run by helping to keep overall insurance costs down.

**Getting the Most From Your Health Coverage**

How can you utilize your healthcare benefits most effectively? Be an active participant in your own health and health care.

*Remember the importance of preventive care.* Find out about health screenings and see that you get them.

*Eat well and exercise.* A healthy, balanced diet and moderate exercise three times a week can help you avoid many health problems (like obesity, heart disease and adult-onset diabetes), and may help with pre-existing conditions (like high blood pressure and depression).
Ask your doctor questions, and listen for clear answers. Know what prescriptions you are taking, when to take them and what not to mix with them. Ask about the risks and benefits of each test and treatment. Make certain that you understand your doctor’s responses. Take notes, if necessary.

When in doubt, write it down. Keep a log or diary of symptoms, concerns or unusual problems that occur. That way, you have a clear record when it comes time to meet with the doctor. Also, keep a record of treatments, vaccinations, lab tests, drug reactions and side effects.

Know your policy. Read your coverage policy and member handbook—particularly the information on benefits, coverage, exclusions and limitations. If your plan has a newsletter or magazine, make sure to read it. Stay informed with of policy changes and new services that may affect your care.

Know how to obtain care. Learn coverage specifics like urgent-care hours and how to schedule appointments now, before you need it. Don’t forget to find out how and where to get lab tests, as well as what number to call in an emergency.

When you’re sick about the treatment you received. If you have a bad experience with your managed health care provider, you have the right to complain. Contact the member services division of your plan immediately for more information on how to register a complaint. Health insurance plans have grievance or appeal processes. While in the complaint process, be sure to save records of all correspondence, claim forms and copies of bills. Also, keep a log of phone conversations and names of the people you speak with. If this process doesn’t solve your problem, you might consider bringing the matter to the state insurance commissioner or state department of health.
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 the Student Health Insurance Plan.

**The Student Health Center: Your first stop for health services**

Staying healthy is especially important during your college years, and getting routine physicals on a regular basis can help prevent problems from developing later on. Preventive care encompasses everything from annual checkups and immunizations to X-rays and lab work.

Some plans may not cover doctor visits for routine care. If your campus has a Student Health Center, a variety of preventive care services should be available to you there. Preventative care services, lab tests, immunizations, medications and other materials, are usually included in the student activity fee or available at an additional low fee. Consult your plan brochure and your school’s web site for more information about your Student Health Center.

**Tips for Choosing a Doctor**

Being far from home, you are likely not able to see your doctor for non-routine visits. You will need to select a doctor in the United States, and here some tips on how to select a new physician:

- Ask your Student Health Center for a referral in the area. Talk with friends and associates about their physician recommendations.
- If your school is offering a PPO plan, search the provider database at www.UHCSR.com. UnitedHealthcare has strict standards for its network physicians. You can choose to search for a UnitedHealth Premium Physician. The Premium designation program for physicians uses criteria and measures from nationally recognized organizations, such as the National Quality Forum, Ambulatory Care Quality Alliance and the National Committee for Quality Assurance, that identify evidence-based and/or consensus-based standards for treating medical conditions.
- Once you’ve found a doctor that fits your criteria, call to confirm their office hours and admitting privileges at in-network hospitals.
- Remember, if you are not comfortable with your chosen physician, you are free to search the provider database and select a different physician at any time.

**When You Are Sick or Injured**

It can be difficult to determine if a sudden illness or accident requires emergency care or can be treated by making an appointment to see a doctor. There are certain cases which usually require emergency care. They are provided in the “Is it An Emergency?” box.

If, after reviewing the guidelines at the right, you still have questions about whether you need emergency care, you can call the Collegiate Assistance Program 24/7, 365 days a year with any questions you may have.

Access to the College Assistance Program (CAP) is included in your student health plan. Through one toll free number, 877-257-7075, you can talk with a Registered Nurse who can help you decide whether you need to seek emergency care. Multi-lingual services support 160 languages to meet your individual needs.

If you need emergency care, go to the nearest emergency facility immediately or dial 911. You do not have to worry about ensuring that you are going to an in-network facility in an emergency. You will receive the same level of benefit either way.

If your illness or accident doesn’t require emergency care, you can select one of several options.

- **MyStudentHealthZone.com**: This online health resource, provided by UnitedHealthcare, contains 80 encyclopedias of health information, specifically targeted to college students.
- **Collegiate Assistance Program (CAP)**: Any time, day or night, 365 days a year, CAP's Registered Nurses are available to answer your health questions. Multi-lingual services are available to meet virtually all language needs. Just call toll free 877-257-7075.
- **Health Information Library**: Included with the Collegiate Assistance Program, this audio library contains information on 1,100 topics, provided in 170 languages.
If after researching your situation, you determine the need to see a physician, you should visit your school’s Student Health Center if available or go to a physician. If your school offers a Preferred Provider plan, be sure to see a physician who participates in the UnitedHealthcare PPO network to receive maximum benefits under the plan. Check your plan brochure to see whether a referral is required to see a provider outside of your Student Health Center.

Scholastic Emergency Services

UnitedHealthcare Student Resources policies automatically come with a powerful global assistance plan called Scholastic Emergency Services (SES), an Assist America partner. Foreign national students studying at a U.S. institution are eligible for SES services—both on campus and while traveling in a country that is not their country of origin—for the duration of their studies.

Accessing SES services is as easy as making a single phone call to the Operations Center for help. The call will be answered by one of SES’ medically-certified crisis managers, who can put in motion a vast number of emergency resources to solve any problem, 24/7. The SES number is on the back of your UnitedHealthcare Insurance I.D. card. Services include:

- Medical Consultation & Referral
- Medical Monitoring
- Emergency Medical Evacuation
- Medical Repatriation & Return of Mortal Remains (students DO have coverage from their campus location)
- Compassionate Visit
- Foreign Hospital Admission Guarantee
- Prescription Assistance
- Emergency Trauma Counseling
- Care of Minor Children
- Emergency Messaging
- Lost Luggage or Document Assistance
- Legal & Interpreter Referrals
- Pre-Trip Information

Maintaining Coverage Throughout Your stay in the United States.

It is important to remember that you must re-enroll each year to benefit from coverage while completing your studies. Your United HealthCare Insurance Company insurance policy only covers a period of one year and is non-renewable. Due to changing policies and benefits schedules, a new application must be completed each time insurance is purchased. You renew by simply enrolling for a new period of coverage.

Is it an Emergency?

No one wants to go to the emergency room if it can be avoided. Using the emergency room for non-emergencies costs you money because emergency room benefits are only paid for true emergencies.

Having said that, in a life-threatening emergency, seek immediate attention by calling 911 or going to the Emergency Room at your nearest hospital. Here is a list of situations that may be life threatening:

- Choking
- Not breathing
- Suspected poisoning or overdose
- Severe injuries, such as suspected broken bones, head injuries or heavy bleeding
- Seizures or convulsions
- Numbness or paralysis of an arm, leg or one side of the body
- A sudden, severe headache, especially if there is neck pain or a change in consciousness at the same time
- Domestic violence or rape
- A change in mental ability, such as not knowing where you are or being unable to recognize familiar people

Remember that emergency room visits are subject to a deductible and coinsurance.
FAQs

General

How do I pick a health insurance plan?

If you have a choice of plans through your school or you are purchasing your own coverage, it's important to understand your choices and pick the plan that is right for you and your family. There are several questions to ask yourself when reviewing health insurance plan options:

- How affordable is the cost of care?
- How much are monthly premiums?
- How much are the deductibles?
- Are the co-payments or co-insurance flat fees or percentages of service fees?
- What out-of-pocket expenses have to be paid before the plan begins reimbursement?
- How does the reimbursement process work?
- What is the cost of out-of-network care?

Does the plan cover the services that I may use?

- Network providers and out-of-network care
- Treatments for pre-existing medical conditions or chronic conditions
- Prescription drugs

What is the quality of the health insurance plan?

- Ratings of the plan by independent government and non-government organizations
- Accreditation from groups like the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Patient complaints and member drop-out rates for the plan
- Other patient and doctor experiences with the plan

I'm young and healthy. Why do I need health insurance?

Despite your age and health, you never know when a serious injury or illness will strike. You're not invincible. And if you don't have insurance, who'll pay your bills? Do you have the money to pay $1,500 to fix a broken leg or $3,000 to stay in the hospital? Insurance gives you the peace of mind that, yes, most of your medical bills will be covered in case something happens.

If I get sick but don't have the money to pay, won't doctors and hospitals treat me?

Yes, most doctors and hospitals will treat you, but they will aggressively pursue collection of your unpaid medical bills by turning your account over to a collection agency. Some hospitals write off a certain amount of care each year, called “indigent care,” but if you or your family fails to meet strict requirements, they'll expect you to pay.
UnitedHealthcare StudentResources’ Administered Health Plan

**How can I find a network provider?**

Go to www.UHCSR.com, “Find My School’s Plan” and search for your school. Click on the link provided under Search for a Provider. You will have access to locate a provider within the network appropriate for your policy.

**Where do I send claims?**

Mail your claims to:
UnitedHealthcare StudentResources
P.O. 809025 Dallas, Texas 75380-9025
Fax claims to: 469-229-5510

**Where can I review policy details before I enroll?**

Policy brochures for schools and associations that have online enrollment capabilities can be found by going to www.UHCSR.com and selecting the “Find My School’s Plan” link. You can search the school or association name. All policies that are valid for the information provided will be displayed. Simply choose the policy you are interested in (if more than one appears) and click the Policy Brochure link. The brochure is stored as an Adobe Acrobat PDF.

**What’s my coverage period or effective date?**

Login to MyAccount on www.UHCSR.com. Click on the link “Current Coverage Information” in the View My Information box and view the coverage period and effective date. Or, call Customer Service at 1-800-767-0700.
**annual out-of-pocket maximum**: A dollar amount set by the plan which puts a cap on the amount of money the insured must pay out of his or her own pocket for covered expenses over the course of a calendar year.

**brand-name (medications)**: Prescription medications that are manufactured by the developer of the medication in question.

**case management**: A utilization management technique that addresses the medical necessity of care as well as alternative treatments or solutions, especially when the patient is likely to require very expensive treatment.

**certificate of insurance**: A document that describes the type and length of coverage provided by a group insurance policy that is given to each insured by the group policyholder.

**claim**: A request for payment under the terms of an insurance policy.

**coinsurance**: A specified percentage of the cost of treatment the insured is required to pay for all covered medical expenses remaining after the deductible has been met.

**copay**: A fixed dollar amount required by many insurance plans that you pay at the time services are rendered. Typical copays are for office visits, prescriptions or hospitalizations.

**deductible**: A flat amount of covered medical expenses that an insured must incur before the insurer will make any benefit payments under a medical expense policy.

**dependent**: A person for whom the insured has some legal obligation to, such as the insured’s spouse and/or children. Some plans also allow non-traditional spousal relationships (significant other, life-partner, etc.) to be considered a dependent with some additional certifying paperwork.

**effective date**: The specified date of when the health insurance policy is to begin.

**enrollment or eligibility period**: The time during which a new group member may first enroll for group insurance coverage.

**generic (medications)**: When a new drug is put on the market, the pharmaceutical company patents it under a brand name. The company has the exclusive right to sell the drug under this name, but once its patent expires, other companies can sell the same drug under its chemical, or generic, name. Generic drugs are typically cheaper than brand-name drugs, but the Food and Drug Administration requires generic drug manufacturers to show that a generic drug “delivers the same amount of active ingredient in the same time frame as the original product.”

**health care provider**: A doctor, hospital, laboratory, nurse or anyone else who delivers medical or health-related care.

**inpatient surgery**: Medical procedures which require the patient to spend at least one night at the hospital. Most plans limit the amount of time an inpatient may stay at the hospital following surgery.

**insured**: The person whose life or health is insured under an insurance policy. Also referred to as a “member.”

**lifetime maximum**: The maximum amount of money a plan will pay towards healthcare services over the course of the insured’s lifetime.

**mental health**: Inpatient mental health care is generally reserved for severe mental health problems, such as schizophrenia and severe depression. Outpatient mental health benefits are generally divided into two categories, severe and non-severe health care. State laws vary widely on the degree to which insurance companies must cover mental illness. Most plans do provide some coverage, though there may be limitations such as the severity or nature of the illness and the duration of care.

**network**: A group of doctors, hospitals and other health-care providers contracting with a health plan, usually to provide care at special rates and to handle paperwork with the health plan.

**office visit**: Any time you visit a doctor at his or her office for medical care.

**out-of-network**: Health care services received outside the HMO, POS or PPO network.

**out-of-pocket expense**: Any medical care costs not covered by insurance, which must be paid by the insured. Out-of-pocket costs include premiums, co-payments, deductibles, co-insurance or other fees that you are required to pay outside of your health benefits plan.

**outpatient surgery**: Surgery that does not involve an overnight stay in a hospital.

**policy**: A written document that contains the terms of the contractual agreement between an insurance company and the owner of policy.

**policy year**: The period of time that the policy is to remain in force.

**pre-admission certification**: A component of utilization review under which the utilization review organization determines whether an insured’s proposed non-emergency hospital stay or some other type of care is most appropriate and what the length of an approved hospital stay may be.

**pre-existing condition**: A pre-existing condition is an illness, symptom or diagnosis you had before you enrolled in a health care plan. Some policies will never cover pre-existing conditions, while others will consider the condition after a waiting period.

**premium**: A premium is the fee you and/or your school pay to your insurance company to purchase a health insurance plan. This can be paid on a monthly, quarterly or annual basis.

**routine annual exam**: A yearly medical “checkup,” during which your doctor will perform simple medical care such as checking your height, weight, vision and blood pressure, as well as screening for problems like colon cancer, cervical cancer, prostate cancer and high cholesterol.

**rx drug: formulary/non-formulary**: Some plans divide all drugs into two categories: formulary or non-formulary. If you have drug coverage, your prescription (RX) copayment may be different for formulary and non-formulary drugs.

**usual, customary and reasonable fee**: The maximum dollar amount of a covered expense that is considered eligible for reimbursement under a major medical policy.