

Health Care and Medical Insurance in the U.S. – An Overview

UCCS Policy:

International students in F-1 status attending University of Colorado Colorado Springs are highly encouraged to have a medical insurance policy that provides coverage for their study in the U.S. J-1 status students are required to have a health insurance policy that is compliant with U.S. Department of State requirements.

These insurance companies listed below are NOT endorsed by UCCS nor the International Affairs Office BUT are meant as a resource and starting point for our international students who wish to acquire adequate health insurance, including some plans with preventative care.

Insurance Company Name

[International Student Insurance](#)

[ISO Insurance](#)

[International Student Protection \(ISP\)](#)

[PGHGlobal](#)

[Compass Benefits Group](#)

US Health Care and Insurance Overview:

The quality of health care available in the United States is excellent, however it is extremely expensive and there is no national healthcare or insurance system. Therefore, it is very important that you have good medical insurance, and that you understand the U.S. system. Understand that YOU are responsible for your health care costs. Read this guide carefully and ask your IA advisor and the advisors in the UCCS Wellness Center with any questions. Items that are “quoted and underlined” appear in the glossary, below.

For most Americans, the cost of obtaining health care is the responsibility of the individual, not the government. For this reason, Americans purchase health insurance for themselves and their families. Most Americans obtain health insurance through their jobs. Most colleges and universities require that international students purchase medical insurance each year.

There are many different types of insurance policies available in this country, and U.S. policies for Americans are very expensive. However, some companies offer specific policies for international students, and these are cheaper. The benefits and conditions of coverage can greatly vary. In some cases, the type of insurance “policy” (also called an insurance “plan”) affects where you may obtain medical treatment. For this reason, it is important that you understand your insurance policy before you need to use it, especially the “Schedule of Benefits.” Read the policy or plan description. If you have questions, ask your international student advisor or contact the insurance company by phone or e-mail.

Where to Seek Medical Care

For most international students in the U.S., the best place to obtain treatment for a medical condition is the medical clinic facility (often called the ‘Student Health Center’) on your campus. At UCCS, that means the Gallogly Wellness and Recreation Center, which includes a medical and counseling care facility. The medical professionals there are specially trained to provide appropriate treatment and

assistance to all students, including international students, and medical care is provided on a “confidential” basis. In the event you need “specialized” medical care after your initial examination or treatment, the medical professionals at the on-campus clinic can provide a “referral” for you to an appropriate local specialized doctor or other medical provider.

In addition to the quality of care available from the on-campus medical clinic, there are also financial advantages for students who seek treatment there. First, the cost of medical care at on-campus medical facilities is lower than at a local doctor's office or hospital, and the level of care is comparably good. The fact is that the medical clinics on most campuses are financially supported by the university and also by student fees. So, since you are already paying a portion of your tuition and fees to support it, using your on-campus clinic makes sense. In addition, many insurance plans offer a reduced “deductible” and/or “Co-payment” to students who obtain their initial treatment at their campus medical clinic. At UCCS, the Wellness Center does not process any health insurance, but the cost for a visit is currently only \$15, which is extremely reasonable.

Again, check your health insurance policy to make sure there are no restrictions on which doctors from whom you can receive treatment. Some insurance plans allow you to seek treatment from any doctor. Other plans contract with “Preferred Provider Organizations” (PPO's) and have a “list” of participating doctors and hospitals. If your insurance is with a PPO plan, you will pay higher costs if you obtain medical treatment from a doctor or hospital that is not on their list.

Please note that you should only seek care from a hospital “emergency room” when you have a true medical emergency (examples – choking, not breathing, poisoning or overdose, severe injuries, seizures or convulsions, paralysis, sudden severe headache, domestic violence or rape, change in mental ability) or if there are no other medical facilities available. Usually, a hospital emergency room is the most expensive place to obtain medical care, and many insurance plans will limit or exclude emergency room care unless you have a true medical emergency. Oftentimes, international students make the mistake of going to the hospital emergency room for a minor injury or sickness only to discover later that their insurance plan will not pay for the treatment because it was not really a medical emergency. **Note that in emergencies the phone number to call is 911 (everywhere in the U.S.)**

[In-Patient vs. Out-Patient Care](#)

In the U.S., “outpatient care” for most conditions, illnesses, and injuries is the norm. Out-patient care means your treatment is done in a short time, and no overnight stay is needed. Out-patient care is usually done in public medical clinics, or in doctors’ private practice clinics, by appointment. To make an appointment with a doctor, you will typically need to call first and perhaps to get a referral from your clinic. “In-patient care,” on the other hand, is for more serious conditions. It means an overnight stay in a medical facility, most often a hospital. Of course, in-patient care is much more expensive. One night in a hospital can cost thousands of dollars.

[Medical Insurance Coverage](#)

Most colleges and universities require international students to purchase medical insurance coverage while studying in the U.S., for their own protection. In addition, the United States government requires students or scholars on a J-1 visa (and their dependents) to be insured. Most importantly, aside from government or institutional requirements, it simply makes sense to have comprehensive medical insurance while studying in the United States. A serious illness or injury can cost anywhere from \$10,000 to \$200,000 or more, and without insurance it will be up to the individual to pay these medical bills. This can easily put serious financial complications in your life.

Understand that insurance does not automatically cover all your medical expenses. Most plans have a deductible, or co-pay. These are costs that you are required to pay before your insurance plan begins to pay benefits. For example, if your plan covers 100% of expenses after a deductible of \$50 per injury or sickness and you incur medical expenses (doctors visit, X-ray, prescription medication) which total \$250, the insurance plan will pay \$200, which is the total amount of \$250 minus the deductible amount of \$50. Some plans have a deductible for each separate injury or sickness; other plans have a co-pay for each visit to the doctor or each prescription drug purchase. Again, read your plan description and make sure you understand how your plan works. If you have any questions, ask your international student advisor or contact your insurance company.

Most health insurance plans have a list of “exclusions” which tell you what types of medical expenses will not be covered. Typically, insurance plans for international students do not cover “pre-existing conditions,” medical treatment received in your home country, injury sustained as a result of war, suicide or self-inflicted injury, or treatment which is not medically necessary. The list of exclusions is different for each plan, so make sure you read your plan to understand what is covered.

Remember, health care in the United States is very good, but very expensive. The more you know about how to obtain health care and how your insurance policy will help you pay for the care you receive, the better off you will be. Do not hesitate to ask questions. If you do not understand the treatment your doctor is recommending, ask for an explanation. If you do not understand your insurance policy, ask your international student advisor or your insurance company to explain. Also remember, the best way to keep your health care costs under control is to practice good preventive measures – take good care of yourself with a healthy diet, exercise, and use preventive measures like screenings, seasonal flu shots, etc.

Glossary of Terms:

Coinsurance

The amount you are required to pay for medical care in a fee-for-service health 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 health claim, you pay 20 percent.

Confidential

Patients of health care in the U.S. (including mental health care) are protected by law from having information about their medical care/condition shared with any others in almost all cases, except if under the age of 18 in which case information can be shared with their parent/legal guardian. This protection is referred to as ‘confidentiality.’

Coordination of Benefits

A system to eliminate duplication of benefits when you are covered under more than one group health insurance plan / medical insurance plan. Benefits under the two health insurance plans usually are limited to no more than 100 percent of the health claim.

Co-payment

Another way of sharing medical costs. You pay a flat fee every time you receive a medical service (for example, \$5 for every visit to the doctor). The health insurance company pays the rest.

Covered Expenses

Most health insurance plans, whether they are fee-for-service, HMOs, or PPOs, do not pay for all health care services. Some may not pay for prescription drugs. Others may not pay for mental health

care. Covered health care services are those medical procedures the health insurer agrees to pay for. They are listed in the health insurance policy.

Customary Fee

Most health insurance plans will pay only what they call a reasonable and customary fee for a particular health care 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, ask your doctor to 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.

Emergency Services/Emergency Room

A medical emergency is an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergencies required immediate care, and the emergency room at the hospital is for those kinds of situations. Emergency room treatment is extremely expensive, and therefore should only be used for true emergencies.

Exclusions

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

HMO (Health Maintenance Organization)

Prepaid health insurance plans. You pay a monthly premium and the HMO covers your doctors' visits, hospital stays, emergency care, surgery, checkups, lab tests, x-rays, and therapy. You must use the doctors and hospitals designated by the HMO.

Inpatient Care

Health care that you get when you're admitted as an inpatient (requiring an overnight stay) to a health care facility, like a hospital or skilled nursing facility.

Managed Care

Ways to manage costs, use, and quality of the health care system. All HMOs and PPOs, and many fee-for-service plans, have managed care.

Maximum Out-of-Pocket Expenses

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

Non-cancellable Policy

A policy that guarantees you can receive health insurance / medical insurance, as long as you pay the premium. It is also called a guaranteed renewable policy.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. Using the providers in your network will make your costs lower. Insurers use approved providers who agree to cost controls, in their networks to keep costs down.

Outpatient care

In the U.S., outpatient care for most conditions, illnesses, and injuries is the norm. Out-patient care

means your treatment is done in a short time, and no overnight stay is needed. Out-patient care is usually done in public medical clinics, or in doctors' private practice clinics, by appointment.

'Out-of-Network'

This refers to care that you receive that is not provided by a doctor or health care facility in the network your insurance is part of. Out-of-network care will cost you more, as your co-insurance, deductible, and maximum out-of-pocket costs will all be higher.

'Out-of-Pocket'

A term used to refer to the amount that you may have to pay on your own for health care or prescription drug costs. Insurance plans have 'out-of-pocket' maximums, estimates, etc. Note that U.S. health care almost always has some out-of-pocket cost to the person seeking care.

Preferred Provider Organization - PPO

A combination of traditional fee-for-service and an HMO. When you use the doctors and hospitals that are part of the PPO, you can have a larger part of your medical bills covered. You can use other doctors, but at a higher cost.

Pre-existing Condition

A health problem that existed before the date your health insurance/medical insurance became effective.

Premium

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

Preauthorization (Prior Authorization)

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Services

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Doctor/Physician/Provider

Usually your first contact for health care. This is often a family physician 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 health care is needed. In many health insurance plans, health care by specialists is only paid for if you are referred by your primary care doctor. An HMO or a POS plan will provide you with a list of doctors from which you will choose your primary care doctor (usually a family physician, internists, obstetrician-gynecologist, or pediatrician). This could mean you might have to choose a new primary care doctor if your current one does not belong to the health insurance plan. PPOs allow members to use primary care doctors outside the PPO network (at a higher cost). Indemnity plans allow any doctor to be used.

Provider

Any person (doctor, nurse, dentist) or institution (hospital or clinic) that provides medical care.

Referral

A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you

can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Schedule of Benefits

The schedule of benefits section of your insurance plan outlines what services are included and excluded in your plan.

Specialist

A medical professional who specializes in a certain specialized area of care, such as a dermatologist (a skin doctor). To see a specialist, your insurance may require you to get a referral from your primary care doctor.

Third-Party Payer

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

Health Insurance Resource Links:

Video explaining US Healthcare for International students:

<http://www.internationalstudentinsurance.com/explained/us-healthcare-system-video.php>

Overview of Health Care (on and off-campus):

http://www.internationalstudent.com/study_usa/preparation/health-care/

'International Student Insurance Explained', with videos on Mental Health, Sexual Assault Awareness: <http://www.internationalstudentinsurance.com/explained/>

Article about US health care system with specific case examples of costs:

<http://www.isvmag.com/2016/07/understanding-united-states-healthcare-system/>

Basic Glossary of US Health care terms:

http://www.foreignborn.com/self-help/health_insurance/5-ins_terms.htm

Extensive Glossary of terms from U.S. government:

<https://www.healthcare.gov/glossary/>

'Roadmap' to understanding and Using US Healthcare system:

<https://marketplace.cms.gov/outreach-and-education/downloads/c2c-roadmap.pdf>