

Student Insurance

Cabrillo College does not provide nor require comprehensive health insurance for its students. The health fee that you pay entitles you to professional services provided in the Health Center, [Health Center Services](#), with reduced charges for medicines and lab work. This is not coverage for ongoing health issues, injuries or accidents off campus, or major medical coverage for emergencies, surgeries or chronic illnesses. If possible, you should always maintain health insurance.

Here are some things to keep in mind when considering health insurance issues:

- If you are able to obtain coverage through by your parents health insurance while you are in school, be sure you maintain the necessary units to be considered a full time student (usually 12 units.) Insurance companies will often ask for a registration confirmation from the Registrar's office to continue coverage after the age of 18. Know what the upper age limit is for your coverage; some companies will end coverage at a predetermined age, even if you are a full time student. You may also lose coverage if you are not a tax dependent of your parents.
- If you are losing coverage for one of the above reasons (less than full time status, etc.) be sure and obtain a 'Certificate of Creditable Coverage' from your insurance company. When you obtain new insurance, this proof of continuous coverage allows you to avoid the waiting period for pre-existing conditions (see glossary).
- You may qualify for coverage through the MediCal program if you are under 21 or over 64 years of age, or have a disabling condition. We can help you with the application requirements for this in the Health Center, please come in and talk to our office staff about this option. Your children under age 19 may qualify for the Healthy Family or Healthy Kids program even if you are not eligible for MediCal; again, come and ask us about this.
- Group coverage eligibility (through your employer, your parents' or spouse's employment, the Community College League, etc) allows you to apply for and receive coverage based on your membership in a group, not on the insurance company's willingness to insure you. You do not have to prove you are healthy ('underwriting') but will be accepted for insurance without this process. If you have chronic conditions such as depression, asthma, or other issues, this may be the only way you can obtain coverage.
- Shop carefully for coverage, and be sure you understand what you are buying. The attached glossary explains some of the terminology used in the insurance business; make sure you understand the difference between such things as deductible, co-pay and out-of-pocket expenses. Do not be afraid to ask questions, and make sure you understand how to access the services you are paying for. Going to a medical provider that is not covered by your insurance company can be costly! It is always a good idea to know where the local providers in your plan are, and how to access after-hours care before you need it.
- Independent insurance agents represent many different companies and insurance products. They are the experts in their field, and can be a great resource in finding the insurance plan that fits your budget and your needs. Check your local telephone directory for agents or try one of these local insurance brokers

[Betty Lindstrom Insurance](#)
[Seuss Insurance](#)
[KBK Insurance](#)

[ANB Insurance](#)
[Cecy Insurance](#)
[Monterey Bay Insurance](#)

- There are several group policies for California Community College students. Check out these links for possible coverage in a group plan.

[Wells Fargo Insurance Services](#)
[STUDENT INSURANCE AGENCY](#)

Health Insurance Terminology

Policy: A contract between a person and an insurance company to cover a person or persons for designated health related expenses.

Broker: Person or agency that sells insurance policies from various insurance companies.

MediCal: State sponsored insurance for low income children and disabled adults

MediCruz: County sponsored program for adults who have medical needs they cannot afford to get care for.

Group plan: Insurance plan that provides coverage for an identified group of persons; i.e. everyone who works at the Boardwalk.

Individual Plan: Insurance available to individuals, who buy it for themselves or their families and is not connected to their job or school.

Preferred Provider Organization, PPO: You pay a monthly premium and can choose a physician from primary to specialist without getting a referral first. When you use the doctors and hospitals that are part of the PPO, you can have a larger part of your medical bills covered.

Health Maintenance Organization, HMO: You pay a monthly premium and the specific plan HMO covers your physician visit(s), hospital stay(s), emergency and other medical treatments. You must use the physicians and hospitals designated by the HMO. The insurance provider will give you a list of physicians to choose from. For further visits with specialists or test you will need to go to a primary care physician and get a referral.

Underwriting: The process by which an insurance plan reviews your health history to decide if they want to sell you an insurance policy. You may have to go through underwriting if you are buying an individual policy, but it usually is not necessary for group coverage. The insurance company will ask you for records from all the doctors you have visited in the last few years.

Co-payment: Another way of sharing medical costs. You pay a flat fee every time you receive a medical service (an example of this is \$5 for every visit to the doctor). The insurance company pays the rest.

Covered Expenses: Most insurance plans, whether they are fee-for-service, HMOs, or PPOs, do not pay for all services. Some may not pay for prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the policy.

Claim form: Document used for billing the insurance company for covered services.

Deductible: The amount of money you must pay each year to cover your medical care expenses before your insurance policy starts paying.

Exclusions: Specific conditions or circumstances for which the policy will not provide payment.

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.

Out-of-Pocket Expenses: The money you will be required pay a year for deductibles and coinsurance. It is a stated dollar amount set by the insurance company, in addition to regular premiums.

Pre-existing Condition: A health problem that existed before you purchased your insurance policy.

Premium: The amount you or your employer pays in exchange for insurance coverage.

Primary Care Doctor: This is often a family physician. A primary care doctor diagnoses and treats minor health problems, and refers you to specialists if another level of treatment is needed.

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

Fee-for-Service. A method of charging whereby a physician or other practitioner bills for each visit or service.

Maximum Out-of-Pocket: The amount of money an insured will pay in a benefit period in addition to regular premium payments. Non-covered expenses are the insured's responsibility in addition to out-of-pocket amounts.

Premium: A periodic payment made by a policyholder (employer, individual) for the cost of insurance.

Cafeteria Plan Benefits: An employer decides a maximum amount they will pay each month per employee for benefits such as health insurance, dental insurance, etc. The employee then decides where they want these dollars spent.

Cafeteria Benefit \$500 per month	Employee A	Employee B
	Health insurance \$300 Dental Insurance \$100 Childcare allowance \$100	(Health ins. through spouse) Dental Insurance \$100 Child care allowance \$400
Total	\$500	\$500