Student Health Insurance

Questions about student health insurance may be directed to gshiplan@uga.edu or (706)542-2222 or hr.uga.edu/students/student-health-insurance

If you are required to be covered by the mandatory health insurance plan...

You are automatically enrolled in the plan. Visit the student insurance website regarding enrollment and your insurance ID card.

If you are required to be covered by the mandatory health insurance plan but already have health insurance...

You may request a wavier from the mandatory plan. To request a wavier, visit the student health insurance website for instructions and deadlines.

If you are not eligible for the mandatory health insurance plan...

You may be eligible to enroll in the University System Voluntary Plan. To enroll, visit the student health insurance website for instructions and deadlines.

If you wish to enroll dependents in the mandatory plan...

Visit the student health insurance website for instructions and deadlines.

Tips for Accessing and Using the UGA Mandatory Student Health Insurance Plan:

- Carry your insurance plan card(s) with you at all times
- Carry some form of photo identification with you at all times.
- Review your health insurance benefits before you need them. By doing so, you will know what to expect at the time of need.
- Know your deductible amount, coinsurance amount, co-pay amount, and out-of-pocket limits.
- Utilize contact numbers for questions about your coverage.

Common insurance terms:

- Allowable Charges: the maximum amount a provider participating in the network can charge for covered service. If a participating provider charges more than the allowable charge under the network contract, the participating provider must write off the difference. The difference cannot be charged to the insured.
- Balance Billing: if an insured uses an out-of-network provider, the provider can charge the patient the difference between the actual charge and the usual and customary rate that s reimbursable under the plan.
- Benefit: reimbursement for medical expenses covered under the plan.
- Claim: a formal request made by or on behalf of an insured person for the benefits provided by a policy.
- Co-Insurance: the percentage of covered expenses an insured individual shares with the insurance carrier. If applicable, co-insurance applies after the insured pays the deductible and is only required up to the plan's out-of-pocket maximum.
- Co-Payment: a specific amount an insured individual must pay toward the cost of various services.
- Deductible: the dollar amount an insured must pay for covered expenses during a policy year before the plan begins to pay for covered expenses.

- Exclusions: expenses which are not covered under an insurance plan.
- Explanation of Benefits (EOB): an insurance carrier's written response to a claim for benefits. The explanation states the amount paid to the provider by the plan and the total amount the patient is responsible for.
- ID Card/ Identification Card: card given to an insured individual which advises medical providers that a patient is covered by a particular health insurance plan.
- In-Network: describes a provider or health care facility which is part of a health plan's network. When applicable, insured individuals usually pay less when using an in-network provider.
- Insured: an individual who is covered by an insurance policy.
- Lifetime Maximum Benefit: the maximum amount a health plan will pay in benefits to an insured individual.
- Limitations: a restriction on the amount of benefits paid out for a particular covered expense.
- Network: a group of doctors, hospitals, and other providers contracted to provide services to insured individuals for less than their usual fees. Provider networks can cover large geographic markets and/or a wide range of health care services. If a health plan uses a preferred provider network, insured individuals typically pay less for a using a network provider.
- Out-of-Network: describes a provider or health care facility which is not part of a health plan's network. Insured individuals usually pay more when using an out-of-network provider, if the plan uses a network. Insured may be subject to balance billing if utilizing an out-of-network provider.
- Out-of-Pocket Maximum: the maximum coinsurance an individual will be required to pay, after which the insurer will pay 100% of covered expenses up to the policy limit.
- Pre-Certification: an insurance company requirement that an insured obtain per-approval before being admitted to a hospital or receiving certain kinds of treatment to ensure the medical necessity of the medical treatment.
- Premiums: payments to an insurance company to have benefit coverage under an insurance plan.
- Provider: any individual or group of individuals that provide health care services, such as physicians or hospitals.
- Referral: permission for an insured individual to consult with another physician or hospital.
- "Usual & Customary": the charge, fee, or expense which is the customary charge for a covered service rendered within a particular geographic area by those of similar professional standing.