Student Health Services

Insurance Waiver Appeal Form

Name: _____ Date: _____ / _____ / _____

Date of Birth: _____ / _____ / _____ Phone # _____ Email: _____

Health Insurance Plan: _____

Please review the minimum benefit requirements listed below necessary to waive the Student Insurance Plan. If after comparing to your employer-sponsored plan you feel the decision of not having a waiver granted is unfounded, please provide your argument to reverse your waiver denial.

Please provide details you feel are important to consider in reviewing your appeal.

Minimum Requirements for Comparable Insurance Coverage

- **Employer-sponsored plan**
- **Plan year minimum benefit:** $250,000 per condition per year or $500,000 per year; or aggregate lifetime maximum of $2 million or greater with a minimum of $500,000 per year
- **Annual Deductible:** $300 or less
- **Out-of-pocket expense cap per year:** $5,000 or less
- **Inpatient:** Network coverage at 80% or higher and/or out-of-network coverage at 60% or higher
- **Outpatient:** Network coverage at 80% or higher and/or out-of-network coverage at 60% or higher
- **Prescription coverage:** Not less than $4,000 per year, ability to fill a prescription written by a local physician, pharmacy access nationwide
- **Mental Health coverage:** Hospitalization **-** Network coverage at 80% or higher and/or out-of-network coverage at 60% or higher; Outpatient – at least 60% or higher for non-parity conditions, 80% or higher coverage for parity conditions
- **Geographic area covered:** All medically necessary care - State of CA (minimum area), Emergency care - world wide
- **Have a facility providing full services within 15 miles of program location**
- **Must stay in effect at all times while participating in program**
- **US owned company headquartered and operating in the US**

(Please add additional pages as necessary)

I certify that all of the statements made in this appeal are true, complete and accurate.

Signature: _____