STUDENT HEALTH INSURANCE PLAN(SHIP) WAIVER REQUEST FORM WORK SHEET
2015 FALL QUARTER OR SEMESTER

IMPORTANT POP-UP Alert:
Disable your POP-UP Blocker when you enter the online Waiver Form to receive important pop-up options.

DEAR STUDENT: Complete the waiver form easily and quickly by preparing your answers ahead of time. This work sheet can help you gather needed insurance information BEFORE you start the online waiver form. You may not be required to answer all these questions, depending on your health plan type.

Have your health plan booklet, benefits summary, or contract/policy handy to answer questions listed below. Call the customer service number listed on your ID card; or check online health plan information to find the details of your plan if you have questions. NOTE: Insurance terminology in bold italics is defined in the GLOSSARY of Medical Insurance Terminology.

	THE SHIP WAIVER FORM WILL REQUEST THE FOLLOWING INFORMATION	ANSWERS FROM PLAN BOOKLET, SUMMARY OF BENEFITS, OR CONTRACT/POLICY	NOTES
	YOUR HEALTH INSURANCE PLAN		
1	Select one of the following to describe your health insurance plan: Covered California Plan; Medicare; Medi-Cal; Military/TRICARE; or ***Employer Group Health Insurance Plan***? (Select "Other" if your plan is not one of these.)		
	PERSONAL AND HEALTH PLAN INFORMATION		
2	Provide your name, student ID number issued by your campus, current address, email address and phone number.		
3	Provide the name, address and phone number of your health insurance plan. You will also be asked to provide your insurance plan member identification number, or your medical record number, if you have Kaiser. This information is printed on your insurance ID card. **The Waiver Form will have a drop-down menu with a list of insurance companies from which to select. If you select "Other," you will be asked to provide the name, address and phone number of your health insurance company.**		
4	What is the name of the Primary Enrollee or ***Subscriber*** on your health plan?		
5	Does your insurance plan have local in-network primary care providers and a network hospital within at least **50** miles of your campus or your student residence? Check your insurance company's list of in-network or preferred providers and facilities to see if you can locate network providers close to your campus or your residence while attending college.	(YES or NO)	

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	THE UC SHIP WAIVER FORM WILL REQUEST THE FOLLOWING INFORMATION	ANSWERS FROM PLAN BOOKLET, SUMMARY OF BENEFITS, OR CONTRACT/POLICY	NOTES
	QUESTIONS ABOUT YOUR HEALTH PLAN BENEFITS		
6	If you have a Covered California Plan, what is the "metal level" of your plan? Visit https://www.healthcare.gov/how-do-i-choose-marketplace-insurance/ to learn more about "metal levels" of health plans in the new Affordable Care Act Marketplace.	Bronze, Silver, Gold, Platinum?	
7	Is there an overall lifetime limit on what your health plan pays?	(YES or NO)	
8	Does your health plan cover preventative health care services, such as an annual physical exam, preventive immunizations and laboratory tests?	(YES or NO)	
9	Does your health plan cover chronic disease care management, such as ongoing care for asthma and other chronic conditions?	(YES or NO)	
10	Does your plan cover hospital stays for medical and surgical care, with mental health care and substance abuse services covered as any other medical condition?	(YES or NO)	
11	Does your plan cover office visits for medical, mental health and substance abuse care?	(YES or NO)	
12	Does your health plan provide coverage for emergency room services?	(YES or NO)	
	Does your health plan provide coverage for diagnostic services, including laboratory tests and X-rays?	(YES or NO)	
	Does your health plan cover medications prescribed by a doctor (including contraceptives)?	(YES or NO)	
13	Does your health plan cover maternity care, including pre-natal care and delivery, with no ***pre-existing condition limitation***? *This question applies regardless of whether the student is male or female. The Affordable Care Act requires plans to cover these services as Minimum Essential Benefits.*	(YES or NO)	
16	What is the ***Annual Out-of-Pocket Maximum limit*** on your health plan?		
17	If your **Annual Out-of-Pocket Maximum limit** is more than $6,600 (or more than $13,200 for a family), do you have a Health Savings Account (HSA) or Health Reimbusement Account (HRA) funded sufficiently to reduce total out-of-pocket expenses to $6,600 for an individual, or $13,200 for a family, or less?	(YES or NO)	
	IF YOU ARE AN INTERNATIONAL STUDENT, YOU WILL BE ASKED TO ANSWER THESE *ADDITIONAL* QUESTIONS		
18	Is your health plan based on ***reimbursement*** of your expenses paid at the time of service for medical care or prescription drugs? Under this type of plan, you pay for medical, behavioral health and pharmacy services out of your own pocket and obtain reimbursement afterwards from your home government or from another party.	(YES or NO)	

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19	Are you participating in a UC-sponsored Education Abroad Program (EAP)?	(YES or NO)	
21	Are your medical insurance policy, benefit summary, and other plan materials written in English with benefits expressed in U.S. dollars?	(YES or NO)	
22	Does your insurance company have a claims office located in the United States, with a U.S. address?	(YES or NO)	
23	Does your health plan have an annual per injury/per illness benefit maximum?	(YES or NO)	
	NOTE: The Exclusions and Limitations section(s) in your health plan booklet or contract/policy may contain information requested in questions 24 -27 below.		
24	Does your health insurance plan have a ***Pre-existing Condition Exclusion or waiting period (or limitation)*** ?	(YES or NO)	
26	If you answered YES to the preceding question, have you been on your health plan long enough so that you are no longer subject to your plan's pre-existing condition limitation or waiting period?	(YES or NO)	
27	Does your health plan cover medical services (***inpatient or outpatient***) for illness or injury resulting from participation in recreational activities or amateur sports?	(YES or NO)	
28	Does your plan cover at least $50,000 for a ***Medical Evacuation*** ?*	(YES or NO)	
29	Does your plan cover at least $25,000 for ***Repatriation of Remains*** ?*	(YES or NO)	

***Note: International Students must be covered at all times for Medical Evacuation and Repatriation of Remains benefits in amounts required by the U.S. State Department or Department of Homeland Security, depending on your visa status. Waiver criteria for these benefits will be adjusted if federal requirements change.**