BERKELEY SHIP WAIVER REQUEST FORM WORKSHEET
2017-18 Academic Year

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

This is just a guide to help you get the answers for your waiver. Actual waivers must be submitted using the online form and submitted by January 1, 2018. The final deadline is January 15 with a $75 late fee. The questions may be worded slightly differently on the waiver application itself.

DEAR STUDENT: Complete the waiver form easily and quickly by preparing your answers ahead of time. This worksheet 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 the questions listed below. Call the customer service number listed on your insurance 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 BERKELEY 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; University of California employee plan or another ***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 subscriber 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 health insurance plan provide unrestricted access to an in-network primary care provider and hospital providing full non-emergency medical and behavioral health care within 50 miles of campus or the student's place of residence while attending school for the entire SHIP term? (Plans with an assigned PCP must have one assigned within 50 miles of campus or the student's place of residence while attending school prior to the start of the semester-January 9, 2018.)	(YES or NO)	

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	THE BERKELEY 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	Please indicate the type of health insurance plan you have: (select one)	**HMO (Health Maintenance Organization)** **EPO (Exclusive Provider Organization)** **PPO (preferred provider organization)** **POS (Point-of-Service)** **I don't know**	
7	Does your health insurance plan have unlimited annual and lifetime in-network benefits?	(YES or NO)	
8	Does your health insurance plan cover inpatient and outpatient hospital services for medical and surgical care?	(YES or NO)	
9	Does your health insurance plan cover hospital stays for mental health care and substance abuse disorder conditions the same as any other medical condition?	(YES or NO)	
10	Does your health insurance plan cover office visits for medical, including mental health and substance abuse conditions?	(YES or NO)	
11	Does your health plan provide coverage for emergency room services and emergency transport/ambulance services?	(YES or NO)	
12	Does your health plan cover medications prescribed by a doctor?	(YES or NO)	
	NOTE: The Exclusions and Limitations section(s) in your health plan booklet or contract/policy may contain information requested in the questions below.		
13	If your **Annual Out-of-Pocket Maximum limit** is more than $7,350 (or more than $14,700 for a family), do you have a Health Savings Account (HSA) or Health Reimbusement Account (HRA) funded sufficiently to reduce the total out-of-pocket expenses to $7,350 for an individual, or $14,700 for a family, or less?	(YES or NO)	
	IF YOU ARE AN INTERNATIONAL STUDENT, YOU WILL BE ASKED TO ANSWER THESE *ADDITIONAL* QUESTIONS		
14	Is your health plan based on ***reimbursement*** of your expenses paid at the time of service for medical care? Under this type of plan, you pay for medical and behavioral health services out of your own pocket and obtain reimbursement afterwards from your home government or from another party.	(YES or NO)	
15	Is your health plan based on ***reimbursement*** of your expenses paid at the time of service for prescription drugs? Under this type of plan, you pay for pharmacy services out of your own pocket and obtain reimbursement afterwards from your home government or from another party.	(YES or NO)	
16	Does your health insurance company have a complete master policy written in Standard English with benefits expressed in U.S. dollars?	(YES or NO)	
17	Does your medical insurance plan have a claims payment office with an address and phone number in the United States?	(YES or NO)	
18	Does your health insurance plan have a maximum benefit limit per-medical or per mental health/substance use disorder-condition per year?	(YES or NO)	
19	Does your health plan cover services related to suicidal conditions, including attempted suicide or suicidal thoughts?	(YES or NO)	
20	Does your health insurance plan have a ***Pre-existing Condition Exclusion or waiting period (or limitation)***?	(YES or NO)	

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21	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)	
22	Does your health plan have an annual or lifetime per injury/per illness benefit maximum?	(YES or NO)	
23	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)	
24	Does your plan cover at least $50,000 for a ***Medical Evacuation***?*	(YES or NO)	
25	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.**