BERKELEY SHIP WAIVER REQUEST FORM WORKSHEET

Summer 2020

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 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 insurance card (you are required to upload it), 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, ministry sharing 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?	(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)	PPO (Preferred Provider Organization) HMO (Health Maintenance Organization) POS (Point-of-Service) High Deductible Plan 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 mental health and substance abuse disorder conditions the same as any other medical condition?	(YES or NO)	
9	Does your health insurance plan cover office visits for medical, including mental health and alcohol/drug abuse conditions?	(YES or NO)	
10	Does your health insurance plan provide coverage for all Minimum Essential Health benefits? For the criteria, please see: https://www.cms.gov/cciio/resources/data-resources/ehb.html	(YES or NO)	
11	Is your health plan based on reimbursement of your expenses paid at the time of service for **medical** and/or behavioral health care? (A reimbursement plan means the student must pay for services, then file a claim with the insurance provider or home government for reimbursement).	(YES or NO)	
12	Is your health plan based on reimbursement of your expenses paid at the time of service for **pharmacy prescriptions**? (A reimbursement plan means the student must pay for the prescription, then file a claim with the insurance provider or home government for reimbursement).	(YES or NO)	
13	Does your health insurance plan have any per medical or mental health/substance abuse dollar maximum limits?	(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.		
14	If your **Annual Out-of-Pocket Maximum limit** is more than $7,900 (or more than $15,800 for a family), do you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) funded sufficiently to reduce the total out-of-pocket expenses to $7,900 for an individual, or $15,800 for a family, or less?	(YES or NO)	
	IF YOU ARE AN INTERNATIONAL STUDENT, YOU WILL BE ASKED TO ANSWER THESE *ADDITIONAL* QUESTIONS		
15	Does your health insurance company have a complete master policy written in standard English with benefits expressed in U.S. dollars? *(You will need to submit this when your plan is audited).*	(YES or NO)	
16	Does your medical insurance plan have a claims payment office with an address and phone number in the United States?	(YES or NO)	
17	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)	
18	Does your health plan cover services related to suicidal conditions, including attempted suicide or suicidal thoughts?	(YES or NO)	

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19	Does your health insurance plan have a ***pre-existing condition waiting period or exclusion?*** If your health insurance plan has a pre-existing period, has it been met?	(YES or NO)	
20	Does your health insurance plan cover medical services related to injury from participation in all types of recreational activities or amateur sports?	(YES or NO)	
21	Does your plan cover at least $50,000 for ***Medical Evacuation*** ?*	(YES or NO)	
22	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.**