STUDENT HEALTH INSURANCE PLAN (SHIP) WAIVER WORK SHEET
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.

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 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; 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 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 a hospital providing full, non-emergency medical and behavioral health care within 30 miles of campus while attending school?	(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	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	Is there an overall annual limit on what your health plan pays?	(YES or NO)	
8	Does your health plan cover inpatient (hospital) and outpatient care for mental health and substance use disorder conditions the same as any other medical condition?	(YES or NO)	
9	Does your health plan cover preventive health care services, including an annual physical exam, preventative immunizations and laboratory/diagnostic tests to help determine your state of health?	(YES or NO)	
10	Does your health plan cover chronic disease care management, such as ongoing care for asthma, diabetes, HIV, and other chronic conditions?	(YES or NO)	
11	Does your plan cover inpatient and outpatient hospital services for medical and surgical care, including transplants and bariatric services?	(YES or NO)	
12	Does your health plan provide coverage for urgent care, emergency room services, and emergency transport/ambulance?	(YES or NO)	
13	Does your health plan provide coverage for diagnostic services, including laboratory tests and X-rays?	(YES or NO)	
14	Does your health plan cover medications prescribed by a doctor (including contraceptives)?	(YES or NO)	
15	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	Does your plan cover hospice and skilled nursing care?	(YES or NO)	
17	Does your plan cover acupuncture and obesity treatment?	(YES or NO)	
18	Does your plan cover durable medical equipment (i.e. crutches, wheelchairs, osteotomy supplies)?	(YES or NO)	
19	Does your plan cover rehabilitative and habilitative services?	(YES or NO)	
20	Does your plan cover allergy treatment and injections?	(YES or NO)	
21	Does your health plan cover Pediatric dental and vision coverage?	(YES or NO)	
22	If your **Annual Out-of-Pocket Maximum limit** is more than $7,150 (or more than $14,300 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 $7,150 for an individual, or $14,300 for a family, or less?	(YES or NO)	
	IF YOU ARE AN INTERNATIONAL STUDENT, YOU WILL BE ASKED TO ANSWER THESE *ADDITIONAL* QUESTIONS		

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23	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)	
24	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)	
25	Are you participating in a UC-sponsored Education Abroad Program (EAP)?	(YES or NO)	
26	Are your medical insurance policy, benefit summary, and other plan materials written in English with benefits expressed in U.S. dollars?	(YES or NO)	
27	Does your medical insurance plan have a claims payment office with an address and phone number in the United States?		
28	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)	
29	Does your health plan cover services related to suicidal conditions, including attempted suicide or suicidal thoughts?	(YES or NO)	
	NOTE: The Exclusions and Limitations section(s) in your health plan booklet or contract/policy may contain information requested in questions below.		
30	Does your health insurance plan have a ***Pre-existing Condition Exclusion or waiting period (or limitation)*** ?	(YES or NO)	
31	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)	
32	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)	
33	Does your plan cover at least $50,000 for a ***Medical Evacuation*** ?*	(YES or NO)	
34	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.**