

Question no.1 - ANS: Other (e.g. "Individual" plan purchased directly from an insurance company)

1. What kind of Health Insurance Plan do you have?

Choose selection:*

2. If you have Medi-Cal (California Medicaid),

Choose selection:*

3. Does your plan provide unrestricted access to medical services at or near your home or student's place of residence?

Choose selection:*

An alternate health insurance plan must:

1. Has an annual out-of-pocket maximum. A higher out-of-pocket maximum is allowed if the subscriber has a Health Savings Account (HSA) or a Health Reimbursement Account (HRA).
2. Inpatient (hospital) and outpatient care for mental health and substance abuse disorder conditions the same as any other medical condition.
3. Doctor office visits for medical, including mental health, and alcohol/drug abuse conditions.
4. Provides coverage for all Minimum Essential Health Benefits. For the criteria, please see: <https://www.cms.gov/ccio/resources/data-resources/ehb.html>

✓ -- Select --

A federal or state exchange plan (e.g. Covered California Plan)

Employer Group Health Insurance

Medi-Cal (California Medicaid)/Medicaid

Medicare

Military/Tri-Care

Ministry Sharing Plan

UC Employee Health Plan

Your Country's Health Plan

Other (e.g. "Individual" plan purchased directly from an insurance company)

Question no.2 - ANS: I Do Not have Medi-Cal (California Medicaid) / Does not apply to me

2. If you have Medi-Cal (California Medicaid), which county is your Medi-Cal from?

Choose selection:*

✓ -- Select --

I Do Not have Medi-Cal (California Medicaid) / Does not apply to me

Alameda

3. Does your plan provide unres
or student's place of residence v

k hospital,
signed with

Question no.3 - ANS: Yes

3. Does your plan provide unrestricted access to an in-network primary care physician (PCP), in-network hospital, and full non-emergency medical and behavioral health care within 55 miles of campus or student's place of residence while attending school? (Plans with an assigned PCP must have one assigned within 55 miles of campus or place of residence while attending school.)

Choose selection:*

✓ -- Select --

YES

NO

An alternate health insurance plan is provided by the student's parent/guardian:

1. Has an annual out-of-pocket maximum of \$6,250 or less for an individual or \$18,400 or less for a family. Deductibles, copayments, and coinsurance paid by the member accrue toward meeting the out-of-

Question no.4 - ANS: Yes

4. Does your health insurance plan cover the above services?

Choose selection:

✓ -- Select --

YES

NO

5. Please let us know your main

SHIP.

Choose Selection:

Question no.5 - ANS: I found another plan that cost less

5. Please let us know your main reason for choosing to waive UC SHIP.

Choose Selection:*

6. Does your health insurance cover you for auditing purposes.

Choose Selection:*

7. Does your medical insurance cover you for auditing purposes.

Choose Selection:*

8. Does your health insurance plan have a maximum benefit limit per-medical or per-mental health/substance use disorder condition?

✓ -- Select --

I am on my parent's or spouse's/domestic partner's plan

Financial aid doesn't pay for UC SHIP

I don't know much about UC SHIP or how to use it

I found another plan that cost less

My plan has no co-pays (e.g. Medi-Cal)

My plan has richer benefits than UC SHIP

Other

Question no.6 - ANS: Yes

6. Does your health insurance company have a complete master policy written in standard English with benefits expressed in U.S. dollars? (Please attach below, as your master policy is required for auditing purposes.

Choose Selection:*

✓ -- Select --

YES

NO

7. Does your medical insurance with an address and phone number in the United States?

Choose Selection:*

Question no.7 - ANS: Yes

7. Does your medical insurance plan have a claims payment office with an address and phone number in the United States?

Choose Selection:

✓ -- Select --

YES

NO

8. Does your health insurance plan cover per-medical or per-mental health/substance use disorder condition per year?

Choose Selection:

Question no.8 - ANS: No

8. Does your health insurance plan have a maximum benefit limit per-medical or per-mental health/substance use disorder condition per year?

Choose Selection:*

✓ -- Select --

YES

NO

9. Does your health plan cover services, including attempted suicide or suicidal thoughts?

Choose Selection:*

9. Does your health plan cover services related to suicidal conditions, including attempted suicide or suicidal thoughts?

Choose Selection:*

Question no.9 - ANS: Yes

10. Does your health insurance plan have a pre-existing condition waiting period or exclusion?

Choose Selection:*

Question no.10 - ANS: No

11. Does your health plan have any lifetime benefit maximums?

Choose Selection:*

Question no.11 - ANS: No

12. Does your health insurance plan cover medical services related to injury from participation in all types of recreational activities or amateur sports?

Choose Selection:*

Question no.12 - ANS: Yes

Question no.13 - ANS: Yes

Requirements of their country must stated. These requirements are subject to change.

13. Does your plan cover at least \$50K for Medical Evacuation (medical evacuation provides transportation to your home country in the event of a medical emergency) and also \$25K for Repatriation of Remains (repatriation provides transportation to your home country in the event of death)?

Choose Selection:*

✓ -- Select --

YES

NO

Documentation of alternative health insurance

Attach proof of insurance coverage front and back of ID card. Please note that you will not be able to submit your waiver without uploading this requested documentation. If you are using Medi-Cal as your alternate insurance, please submit your **local Medi-Cal Managed Care Health Plan card**. Do NOT upload the Benefits Identification Card (BIC) issued by the State of California as the BIC is not the local Medi-Cal insurance.

Attachment 1: Please upload your ID card

Attachment 2: Please upload the fulfillment package (packet)

Attachment 3: Please update the master certificate :

<https://cdn.internationalstudentinsurance.com/pdfs/isi/brochures/pdf/student-defender-ca-v1.pdf>

The link is located on the bottom of page 4 of the fulfillment package

Documentation of alternative health insurance coverage

Attach proof of insurance coverage [front and back of ID card]. Please note that you will not be able to submit your waiver without uploading this requested documentation. If you are using Medi-Cal as your alternate insurance, please submit your **local Medi-Cal Managed Care Health Plan card**. Do NOT upload the Benefits Identification Card (BIC) issued by the State of California as the BIC is not the local Medi-Cal insurance card and is not sufficient to waive UC SHIP. FOR TIPS ON ATTACHING YOUR DOCUMENT [CLICK HERE](#). TO VIEW A SAMPLE SBC [CLICK HERE](#)

Attach Supporting Documentation *(DO NOT use special characters in attachment name. Give each attachment a unique name. Your attachment(s) size cannot exceed 25 Mb.)

Attachment 1*

Choose File

No file chosen

Attachment 2

Choose File

No file chosen

Attachment 3

Choose File

No file chosen

Attachment 4

Choose File

No file chosen

Policy Holder Information

First Name (Policy Holder)*

Your First Name

What type of health insurance plan do you have?

PPO

Member ID*

ID number start with 00

Address (Policy Holder)*

Your school or US living address

Zip (Policy Holder)*

Zipcode of your school or US living address

Insurance Company Name*

Aetna

Last Name (Policy Holder)*

Your Last Name

Relationship to Student*

Self

Member Service Phone #*

888-293-9229

Group Number (Required if listed on card)

0863989-011-00110

City (Policy Holder)*

City of your school or US living address

State (Policy Holder)*

State of your school or US living address




Please allow seven to ten business days for waivers to be processed.

View Submitted Waiver

Show **100** entries

Search:

Waiver Id	Name	Student ID	Date of Submission	Waiver Name	Waiver Type	Status	Action
2583546-10529-2			06/04/2025	WAIVE - International - Spring 2025-26	Spring	Approved	Prior Waiver
2583546-10527-1			06/04/2025	WAIVE - International - Fall 2025-26	Fall	Approved	No Action Required

Showing 1 to 2 of 2 entries

First Previous 1 Next Last

Once your status is Approved, it means you have successfully waived!