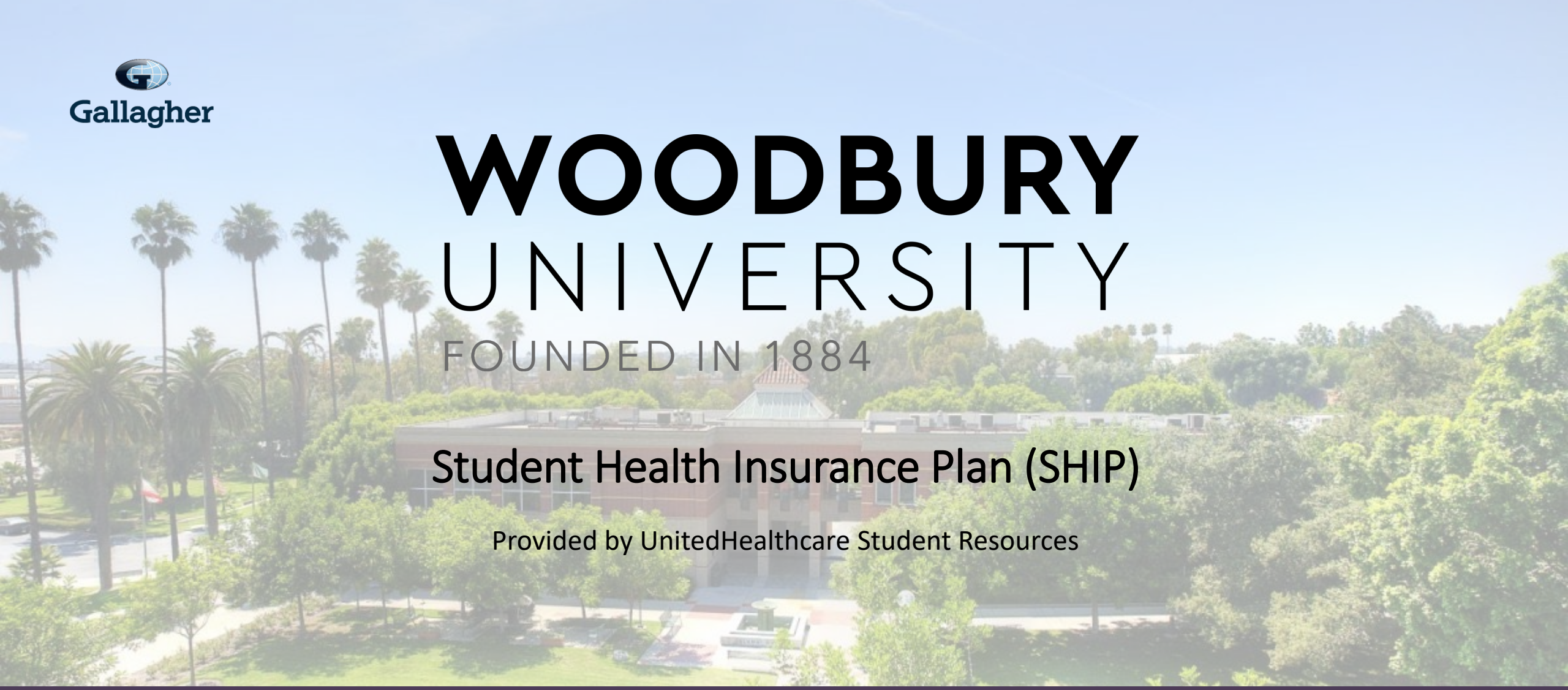


WOODBURY UNIVERSITY

FOUNDED IN 1884

Student Health Insurance Plan (SHIP)

Provided by UnitedHealthcare Student Resources

Gallagher Benefit Services

Eligibility

The following types of students will be automatically enrolled* in SHIP and billed for the applicable premium amount at the beginning of each semester.

- Traditional Undergraduate Students
- Students residing in University-operated housing (including graduate students)
- International students on an F-1 or J-1 visa, including those residing off-campus

*Students who have alternate, comparable insurance coverage may waive out of SHIP.

Plan Information

Core Benefits	In-Network Provider	Out-of-Network Provider
Deductible	$ 500 per individual , per policy year	$ 1,000 per individual , per policy year
Co-insurance	20% after deductible	50% of Usual & Reasonable, after deductible
Office Visit Copay	$ 10 per visit	$ 20 per visit
Urgent Care Copay	$ 10 per visit	$ 20 per visit
Emergency Room Copay	$ 50 (waived if admitted)	$ 50 (waived if admitted)
Prescription Drugs	$15 copay generic $ 40 copay/ preferred brand $ 100 copay/ non-preferred brand and non-formulary	50% Usual & Reasonable*
Out-of-Pocket Maximum	$ 7,900 per individual, per policy year $ 15,800 per family, per policy year	$ 15,000 per individual , per policy year $ 30,000 per family, per policy year

When and Where to Access Care

Type of Provider	Scenario	Type of Illness or Injury
Primary Care Physician (PCP) **(Common under HMO plan)**	Annual wellness exams, or moderate pain you need diagnosed	General checkup, moderate pain of unknown origin, etc.
Specialist **(Requires referral from PCP under HMO)**	Experiencing pain specific to a particular region of the body (i.e. muscular, gastrointestinal, ocular, bone/joint, skin, ears/nose/throat, etc.)	Ulcers, rash, digestive problems, vision problems, elevated levels, etc.
Hospital	Having an inpatient or outpatient procedure performed, in a critical state	Delivering a baby, major/minor surgery, recovery, monitoring, etc.
Walk-in Clinic	Treatment of unscheduled, non-emergency illnesses/injuries and certain immunizations	Vaccination, mild cold/flu, minor cuts/abrasions, etc.
Urgent Care **(Alternative to ER)**	Treatment of most non-life threatening emergencies	Broken bones (not multiple fractures), minor wounds (not bleeding profusely), mild fever, flu, acute sinusitis, etc.
Emergency Room (ER)	Treatment of all life/limb-threatening emergencies	Severe head trauma, multiple/compound fractures, heavy bleeding, elevated fever, severe burns, seizures, poison, etc.

Preventative Care

No Deductibles, Copays, or Coinsurance will be applied when services are received from an In-Network Provider for preventative care.

- Routine physical examinations
- Routine Adult immunizations
- Well-woman exams
- FDA approved general contraceptive drugs
- Other services include but are not limited to: Pre-natal maternity, screening for gestational diabetes, HPV DNA testing, screening and counseling for interpersonal and domestic violence, contraceptive methods and counseling, as well as breastfeeding support, supplies and counseling.

Waiver Process

If you already have alternate, comparable health insurance coverage, you can complete a waiver application that will exempt you from mandatory enrollment in SHIP.

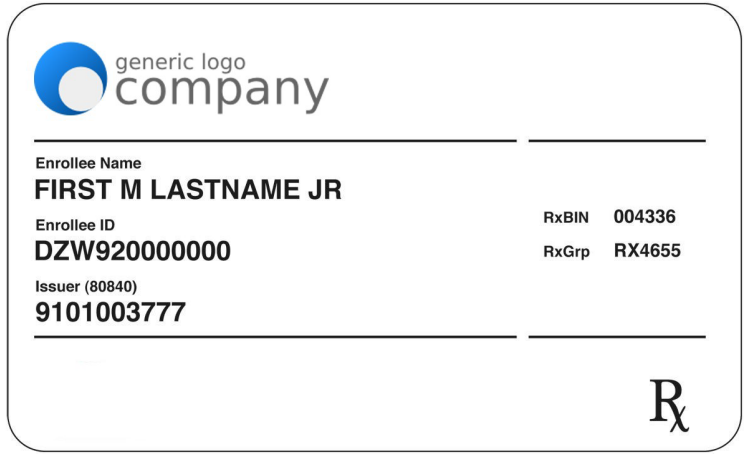
The waiver application can be submitted online through the dedicated SHIP website and must include a copy of your valid insurance card and additional supporting documentation if necessary.

Once Gallagher Benefit Services reviews your coverage and verifies that it qualifies as comparable, your waiver will be approved and your SHIP premium credited.

Waiver Process

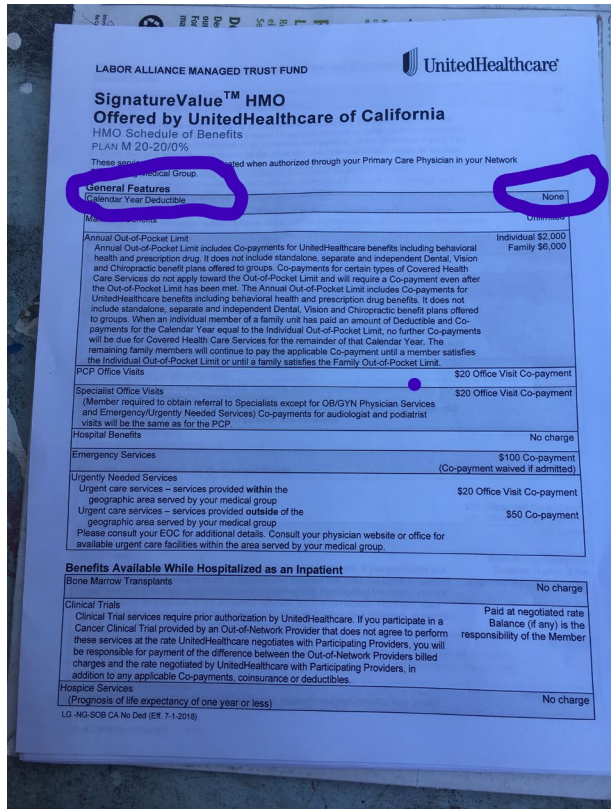
Your ID card will likely contain the following information:

1. Your Name
2. Your Subscriber (Enrollee) ID
3. Your Group (Issuer) ID
4. Your Rx (BIN) ID
5. Deductible amount (if this is not on your ID card additional documents will be reguired)



Waiver Process

Example of document that will list your deductible amount. You are required to submit documentation if your card does not contain this information.



LABOR ALLIANCE MANAGED TRUST FUND

UnitedHealthcare

SignatureValue™ HMO
Offered by UnitedHealthcare of California
HMO Schedule of Benefits
PLAN M 20-20/0%

These services are covered when authorized through your Primary Care Physician in your Network

General Features	
Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. Co-payments for certain types of Covered Health Care Services do not apply toward the Out-of-Pocket Limit and will require a Co-payment even after the Out-of-Pocket Limit has been met. The Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. When an individual member of a family unit has paid an amount of Deductible and Co-payments for the Calendar Year equal to the Individual Out-of-Pocket Limit, no further Co-payments will be due for Covered Health Care Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Co-payment until a member satisfies the Individual Out-of-Pocket Limit or until a family satisfies the Family Out-of-Pocket Limit.	Individual $2,000 Family $6,000
PCP Office Visits	$20 Office Visit Co-payment
Specialist Office Visits (Member required to obtain referral to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services) Co-payments for audiologist and podiatrist visits will be the same as for the PCP.	$20 Office Visit Co-payment
Hospital Benefits	No charge
Emergency Services	$100 Co-payment (Co-payment waived if admitted)
Urgently Needed Services Urgent care services – services provided **within** the geographic area served by your medical group	$20 Office Visit Co-payment
Urgent care services – services provided **outside** of the geographic area served by your medical group Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the area served by your medical group.	$50 Co-payment
Benefits Available While Hospitalized as an Inpatient	
Bone Marrow Transplants	No charge
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	No charge

LG -NG-SOB CA No Ded (Eff. 7-1-2018)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2018 – 12/31/2018
Coverage for: Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/Individual or $1,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Waiver Process

1. Coverage must be continuous (no break or termination) for the entire academic year
2. Coverage must be ACA compliant with an unlimited maximum benefit
3. Deductible must be no more than $1,000 per person, per policy year
4. Benefits must be paid at 80% or higher for in-network providers and 50% or higher for out-of-network providers
5. Claims must be paid by a company based in the U.S. with an underwriter owned, operated and headquartered in the U.S., and must be in full compliance with all applicable federal laws
6. Insurance must be accepted in Southern California for doctor visits and urgent care

Plan Rates

Coverage Type	Annual	Fall	Spring/Summer
Student	$2,304.00	$953.00	$1,351.00

Note: Rates include a fee that is charged by the University to cover your school's costs associated with offering this plan.