



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, visit [www.uhcsr.com/tufts](http://www.uhcsr.com/tufts) or call (888)224-4752. For general definitions of common terms, such as allowed amount, balance billing, coinsurance (coins), copayment (copay), deductible (ded), provider, or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or by call (888)224-4752 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>Preferred Providers</u> \$0 (Person) Out of Network \$250 (Person)	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> , Pediatric Dental, Pediatric Vision and categories with <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. Pediatric Dental \$500. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>Preferred Providers</u> \$3,000 (Person) <u>Preferred Providers</u> \$5,000 (Family) Out of Network \$10,000 (Person) Out of Network \$20,000 (Family)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.uhcsr.com/tufts">www.uhcsr.com/tufts</a> or call (888)224-4752 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . The <u>referral</u> requirement may not apply to dependents.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> per visit;	20% <u>Coins</u> \$40 <u>Copay</u> per visit; <u>ded</u> does not apply	May not apply when related to surgery or Physiotherapy.
	<u>Specialist visit</u>	\$20 <u>Copay</u> per visit;	20% <u>Coins</u> \$40 <u>Copay</u> per visit; <u>ded</u> does not apply	
	<u>Preventive care/screening/immunization</u>	No Charge	20% <u>Coins</u>	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>Coins</u>	30% <u>Coins</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	15% <u>Coins</u>	30% <u>Coins</u>	—————none—————
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.uhcsr.com/pdl">www.uhcsr.com/pdl</a>	Tier 1 - Your Lowest-Cost Option	\$15 <u>Copay</u> per prescription Tier 1;	20% <u>Coins</u> \$20 <u>Copay</u> per prescription generic drug; <u>ded</u> does not apply \$45 <u>Copay</u> per prescription brand-name drug; <u>ded</u> does not apply	<u>Preferred Providers</u> : up to a 31 day supply per prescription <u>Preferred Providers</u> : Mail order <u>Prescription Drugs</u> through UHCP at 2.5 times the retail Copay up to a 90 day supply
	Tier 2 - Your Midrange-Cost Option	\$35 <u>Copay</u> per prescription Tier 2;	20% <u>Coins</u> \$20 <u>Copay</u> per prescription generic drug; <u>ded</u> does not apply \$45 <u>Copay</u> per prescription brand-name drug; <u>ded</u> does not apply	Out of Network: up to a 31 day supply per prescription You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us. (and medicines lawfully obtainable only upon written prescription of a Physician.)

\*For more information about limitations and exceptions, see plan or policy document at [www.uhcsr.com/tufts](http://www.uhcsr.com/tufts)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 3 - Your Highest-Cost Option	\$55 <u>Copay</u> per prescription Tier 3;	20% <u>Coins</u> \$20 <u>Copay</u> per prescription generic drug; <u>ded</u> does not apply \$45 <u>Copay</u> per prescription brand-name drug; <u>ded</u> does not apply	
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>Coins</u>	30% <u>Coins</u>	_____none_____
	Physician/surgeon fees	15% <u>Coins</u>	30% <u>Coins</u>	_____none_____
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	15% <u>Coins</u> \$50 <u>Copay</u> per visit;	15% <u>Coins</u> \$50 <u>Copay</u> per visit; <u>ded</u> does not apply	May be limited to use of emergency room and supplies. The Copay will be waived if admitted to the Hospital. The Policy Ded does not apply.
	<u>Emergency medical transportation</u>	\$50 <u>Copay</u> per trip;	\$50 <u>Copay</u> per trip; <u>ded</u> does not apply	_____none_____
	<u>Urgent care</u>	\$25 <u>Copay</u> per visit;	20% <u>Coins</u> \$45 <u>Copay</u> per visit; <u>ded</u> does not apply	May be limited to facility fees.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	15% <u>Coins</u>	30% <u>Coins</u>	_____none_____
	Physician/surgeon fees	15% <u>Coins</u>	30% <u>Coins</u>	_____none_____
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Laboratory Procedures: 15% <u>Coins</u> Physician's Visits; \$20 <u>Copay</u> per visit	Physician's Visits 20% <u>Coins</u> Laboratory Procedures: 30% <u>Coins</u> Physician's Visits; \$40 <u>Copay</u> per visit	_____none_____
	Inpatient services	15% <u>Coins</u>	30% <u>Coins</u>	_____none_____
<b>If you are pregnant</b>	Office visits	\$5 <u>Copay</u> per visit;	20% <u>Coins</u> \$10 <u>Copay</u> per visit; <u>ded</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> when provided by a <u>preferred</u>

\*For more information about limitations and exceptions, see plan or policy document at [www.uhcsr.com/tufts](http://www.uhcsr.com/tufts)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			does not apply	provider. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% <u>Coins</u>	30% <u>Coins</u>	
	Childbirth/delivery facility services	15% <u>Coins</u>	30% <u>Coins</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	15% <u>Coins</u>	30% <u>Coins</u>	—————none—————
	<u>Rehabilitation services</u>	Physiotherapy: \$20 <u>Copay</u> per visit; Inpatient Rehabilitation Facility: 15% <u>Coins</u>	Physiotherapy: 20% <u>Coins</u> Inpatient Rehabilitation Facility: 30% <u>Coins</u> Physiotherapy: \$45 <u>Copay</u> per visit; <u>ded</u> does not apply	—————none—————
	<u>Habilitation services</u>	\$20 <u>Copay</u> per visit;	20% <u>Coins</u> \$45 <u>Copay</u> per visit; <u>ded</u> does not apply	—————none—————
	<u>Skilled nursing care</u>	15% <u>Coins</u>	30% <u>Coins</u>	—————none—————
	<u>Durable medical equipment</u>	15% <u>Coins</u>	30% <u>Coins</u>	—————none—————
	<u>Hospice services</u>	15% <u>Coins</u>	30% <u>Coins</u>	—————none—————
	<b>If your child needs dental or eye care</b>	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply
Children's glasses		Lens: \$40 <u>Copay</u> ; <u>ded</u> does not apply Frames: Tiered <u>Copays</u> from no charge to 40% based on retail cost. <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
Children's dental check-up		50% <u>Coins</u>	50% <u>Coins</u>	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

\*For more information about limitations and exceptions, see plan or policy document at [www.uhcsr.com/tufts](http://www.uhcsr.com/tufts)

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery except as noted in the policy
- Hearing aids except as noted in the policy
- Routine foot care except as noted in the policy
- Cosmetic surgery except as noted in the policy
- Long-term care
- Weight loss programs
- Dental care (Adult) except as noted in the policy
- Routine eye care (Adult)

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Non-emergency care when traveling outside the U.S.
- Chiropractic care
- Private-duty nursing
- Infertility treatment

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Massachusetts Division of Insurance at 1-617-521-7794 or visit <http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Massachusetts Division of Insurance at 1-617-521-7794 or visit <http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/>.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-260-2723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-260-2723.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-260-2723.

—————*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*—————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$0	■ The <u>plan's</u> overall <u>deductible</u>	\$0	■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$20	■ <u>Specialist copayment</u>	\$20	■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) coinsurance</u>	15%	■ <u>Hospital (facility) coinsurance</u>	15%	■ <u>Hospital (facility) coinsurance</u>	15%
■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$40	Copayments	\$900	Copayments	\$60
Coinsurance	\$1,600	Coinsurance	\$200	Coinsurance	\$20
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,700</b>	<b>The total Joe would pay is</b>	<b>\$1,160</b>	<b>The total Mia would pay is</b>	<b>\$80</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

## NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator  
United HealthCare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.



## LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-260-2723.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-260-2723。

XIN LŪU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-260-2723.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-260-2723.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-866-260-2723.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-260-2723.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-260-2723.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-260-2723.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-260-2723.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-260-2723.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-260-2723.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-260-2723 an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-260-2723 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-260-2723 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-260-2723

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-260-2723។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-260-2723.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániiti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjí' 1-866-260-2723 hodiilnih.

OGOW: Haddii aad ku hadasho **Soomali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-260-2723.