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 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 or by call (888)224-4752 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| What is the overall deductible? | Preferred Providers $0 (Person)  
Out of Network $250 (Person) | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Preventive care, Pediatric Dental, Pediatric Vision and categories with copay 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. Pediatric Dental $500. There are no other specific deductibles. | 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? | Preferred Providers $3,000 (Person)  
Preferred Providers $5,000 (Family)  
Out of Network $10,000 (Person)  
Out of Network $20,000 (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. |
<p>| What is not included in the out-of-pocket limit? | 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 <a href="http://www.uhcsr.com/tufts">www.uhcsr.com/tufts</a> or call (888)224-4752 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. The referral requirement may not apply to dependents. |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>$20 Copay per visit; 20% Coins $40 Copay per visit; ded does not apply</td>
<td>No Charge</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 Copay per visit; 20% Coins $40 Copay per visit; ded does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>20% Coins</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% Coins</td>
<td>30% Coins</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% Coins</td>
<td>30% Coins</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 - Your Lowest-Cost Option</td>
<td>$15 Copay per prescription Tier 1; 20% Coins $20 Copay per prescription generic drug; ded does not apply</td>
<td>Preferred Providers: up to a 31 day supply per prescription</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Your Midrange-Cost Option</td>
<td>$35 Copay per prescription Tier 2; 20% Coins $20 Copay per prescription generic drug; ded does not apply</td>
<td>Preferred Providers: Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/tufts*
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Tier 3 - Your Highest-Cost Option</td>
<td></td>
<td>$55 Copay per prescription Tier 3;</td>
<td>20% Coins $20 Copay per prescription generic drug; ded does not apply $45 Copay per prescription brand-name drug; ded does not apply</td>
</tr>
<tr>
<td>Tier 4 - Additional High-Cost Option</td>
<td></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>15% Coins</td>
<td>30% Coins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% Coins</td>
<td>30% Coins</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>15% Coins $50 Copay per visit;</td>
<td>15% Coins $50 Copay per visit; ded does not apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$50 Copay per trip;</td>
<td>$50 Copay per trip; ded does not apply</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 Copay per visit;</td>
<td>20% Coins $45 Copay per visit; ded does not apply</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>15% Coins</td>
<td>30% Coins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% Coins</td>
<td>30% Coins</td>
</tr>
<tr>
<td>If you need mental health, behavioral</td>
<td>Outpatient services</td>
<td>Laboratory Procedures: 15% Coinr</td>
<td>Physician’s Visits 20% Coins</td>
</tr>
<tr>
<td>health, or substance abuse services</td>
<td></td>
<td>Physician’s Visits; $20 Copay per visit</td>
<td>Laboratory Procedures: 30% Coins</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>15% Coins</td>
<td>Physician’s Visits; $40 Copay per visit</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$20 Copay per visit;</td>
<td>20% Coins $40 Copay per visit; ded</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/tufts
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>15% Coins</td>
<td>30% Coins</td>
<td>none</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>15% Coins</td>
<td>30% Coins</td>
<td>none</td>
</tr>
<tr>
<td>Home health care</td>
<td>15% Coins</td>
<td>30% Coins</td>
<td>none</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>Physiotherapy: No Charge Inpatient Rehabilitation Facility: 15% Coins Physiotherapy: $20 Copay per visit; ded does not apply</td>
<td>Physiotherapy: 20% Coins Inpatient Rehabilitation Facility: 30% Coins Physiotherapy: $45 Copay per visit; ded does not apply</td>
<td>none</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$20 Copay per visit; $45 Copay per visit; ded does not apply</td>
<td>20% Coins</td>
<td>none</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>15% Coins</td>
<td>30% Coins</td>
<td>none</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>15% Coins</td>
<td>30% Coins</td>
<td>none</td>
</tr>
<tr>
<td>Hospice services</td>
<td>15% Coins</td>
<td>30% Coins</td>
<td>none</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>$20 Copay per exam; ded does not apply</td>
<td>50% Coins; ded does not apply</td>
<td>See your plan’s Pediatric Vision Benefit Details. Age limits apply.*</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Lens: $40 Copay; ded does not apply Frames: Tiered Copays from no charge to 40% based on retail cost, ded does not apply</td>
<td>50% Coins; ded does not apply</td>
<td>See your plan’s Pediatric Vision Benefit Details. Age limits apply.*</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>50% Coins</td>
<td>50% Coins</td>
<td>See your plan’s Pediatric Dental Benefit Details. Age limits apply.*</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/tufts
## Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Excluded Generally</th>
<th>Services Generally Covered</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric surgery</td>
<td>Hearing aids</td>
<td>Acupuncture</td>
</tr>
<tr>
<td>except as noted in the policy</td>
<td>except as noted in the policy</td>
<td>Chiropractic care</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>long-term care</td>
<td>Infertility treatment</td>
</tr>
<tr>
<td>except as noted in the policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental care (Adult)</td>
<td>Weight loss programs</td>
<td></td>
</tr>
<tr>
<td>except as noted in the policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine foot care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>except as noted in the policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss programs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Limitations may apply to these services. This isn’t a complete list. Please see your plan document.*
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 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:


Navajo (Dine): Dinek’ehgo shika a’t’ohwol ninisingo, kwiijigo 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>$20</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:

- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

This EXAMPLE event includes services like:

- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
<th>$7,400</th>
<th>$1,900</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,600</td>
<td>$200</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $60 $60 $0

The total Peg would pay is $1,700 $1,160 $80

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

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


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


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.
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.


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

ATENTION : 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), udostępniamy 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 Hilfsmittel 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: آخر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می‌باشد. (866-260-2723-1 تمس بگیرید.

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 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 yánit'i'go, saad bee áka'anída'awo'ííjí, t'áá jíík'eh, bee ná'ahóó'tí'. T'áá shoodí kohdíj 1-866-260-2723 hodiínih.

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