



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/williams or call 1-866-948-8472. 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.healthcare.gov/sbc-glossary/ or call 1-866-948-8472 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Preferred Providers</u> \$0 / (Person) <u>Out-of-Network Provider</u> \$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.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , Pediatric Dental, Pediatric Vision and categories that specify <u>ded</u> does not apply.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$4,000 / (Person) \$4,000 / (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.
What is not included in the out-of-pocket limit?	<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> .
Will you pay less if you use a network provider?	Yes. See www.uhcsr.com/williams or call 1-866-948-8472 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.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> /per visit	20% <u>Coins</u>	May not apply when related to surgery or Physiotherapy.
	<u>Specialist</u> visit	\$20 <u>Copay</u> /per visit	20% <u>Coins</u>	
	<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)	No Charge	20% <u>Coins</u>	_____none_____
	Imaging (CT/PET scans, MRIs)	\$25 <u>Copay</u> per service	20% <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 www.uhcsr.com/pdl	Tier 1 - Your Lowest-Cost Option	\$10 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	20% <u>Coins</u> \$20 <u>Copay</u> per prescription generic drug \$50 <u>Copay</u> per prescription brand-name drug	<u>Preferred Providers</u> : up to a 31 day supply per prescription <u>Preferred Providers</u> : Mail Order <u>Network</u> Pharmacy or Preferred 90 Day Retail <u>Network</u> Pharmacy at 2.5 times the retail <u>Copay</u> up to a 90-day supply <u>Out-of-Network Provider</u> : up to a 31 day supply per prescription You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us. You may need to obtain <u>prior authorization</u> for certain <u>prescription drugs</u> . You may pay more if <u>prior authorization</u> is not obtained. For opioid antagonists, the <u>Ded</u> , <u>Copay</u> , and <u>Coins</u> shall not apply. The <u>Copay</u> and <u>Coins</u> for insulin to treat diabetes will not exceed the amount allowed by applicable
	Tier 2 - Your Midrange-Cost Option	\$25 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply		
	Tier 3 - Your Highest-Cost Option	\$45 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply		
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/williams

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)	
				law. The <u>Copay</u> , <u>Coins</u> , and <u>Ded</u> for certain drugs to treat chronic, diabetes, asthma, or heart conditions will not exceed the amount allowed by applicable law. A new Insured taking one of these drugs may continue at the <u>Network</u> Benefit level upon receipt of documentation from the Insured's prescriber.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <u>Coins</u>	_____none_____
	Physician/surgeon fees	No Charge	20% <u>Coins</u>	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>Copay</u> /per visit	\$200 <u>Copay</u> /per visit <u>ded</u> does not apply	May be limited to use of emergency room and supplies. The <u>Copay</u> will be waived if admitted to the Hospital.
	<u>Emergency medical transportation</u>	No Charge	0% <u>Coins</u> <u>ded</u> does not apply	_____none_____
	<u>Urgent care</u>	\$20 <u>Copay</u> /per visit	20% <u>Coins</u>	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <u>Coins</u>	_____none_____
	Physician/surgeon fees	No Charge	20% <u>Coins</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$20 <u>Copay</u> /per visit Other: \$20 <u>Copay</u> /per visit	Office Visits: 20% <u>Coins</u> Other: 20% <u>Coins</u>	_____none_____
	Inpatient services	No Charge	20% <u>Coins</u>	_____none_____
If you are pregnant	Office visits	\$20 <u>Copay</u> /per visit	20% <u>Coins</u>	<u>Cost-sharing</u> does not apply for <u>preventive services</u> when provided by a <u>preferred provider</u> . 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	No Charge	20% <u>Coins</u>	

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)	
	Childbirth/delivery facility services	No Charge	20% <u>Coins</u>	_____none_____
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	0% <u>Coins</u> <u>ded</u> does not apply	_____none_____
	<u>Rehabilitation services</u>	Inpatient Rehabilitation Facility: No Charge Physiotherapy: \$20 <u>Copay</u> /per visit	20% <u>Coins</u>	Inpatient 60 days maximum (Per Policy Year) Outpatient 60 visits for any combination of physical therapy and occupational therapy
	<u>Habilitation services</u>	\$20 <u>Copay</u> /per visit	20% <u>Coins</u>	Outpatient 60 visits for any combination of physical therapy and occupational therapy
	<u>Skilled nursing care</u>	No Charge	20% <u>Coins</u>	100 days maximum (Per Policy Year)
	<u>Durable medical equipment</u>	No Charge	20% <u>Coins</u>	_____none_____
	<u>Hospice services</u>	No Charge	20% <u>Coins</u>	_____none_____
If your child needs dental or eye care	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	20% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits 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	20% <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	100% <u>Coins</u> ; <u>ded</u> does not apply	100% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

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.)

- Acupuncture except as specifically provided in the Policy
- Dental care (Adult) except as specifically provided in the Policy
- Long-term care
- Weight loss programs except as specifically provided in the Policy
- Bariatric surgery
- Hearing aids except as specifically provided in the Policy
- Routine eye care (Adult) except as specifically provided in the Policy
- Cosmetic surgery
- Infertility treatment except as specifically provided in the Policy
- Routine foot care

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

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

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: UnitedHealthcare Student Resources at 1-866-948-8472 and 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 on how 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.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

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)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$10
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$90

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$3,700
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,920

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$10
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$610

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

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below (“HPHC”) comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer (see below for contact information).

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity) you can file a grievance with:

Point32Health Civil Rights Legal Coordinator

1 Wellness Way

Canton, MA 02021-1166

866-750-2074, TTY service: 711

Fax: 617-668-2754

Email: OCRCoordinator@point32health.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at

www.hhs.gov/ocr/office/file/index.html

Language Assistance Services

Arabic (العربية) انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. يرجى الاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

French (Français) ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

Greek (Ελληνικά) ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

Gujarati (ગુજરાતી) ધ્યાન આપો: જો તમે અંગ્રેજી સિવાય બીજી ભાષા બોલો છો, તો ભાષા િહાય િવેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા િભ્ય આઈડી કાર્ડ પરના નંબર પર કૉલ કરો.

Haitian Creole (Kreyòl Ayisyen) ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

Hindi (हिंदी) ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके ललए ननिःशुल्क उपलब्ध हैं। कृपया अपने सदस्य आईडी कार्ड पर ददए गए नंबर पर कॉल करें।

Italian (Italiano) ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

Khmer (ភាសាខ្មែរ) ប្រសិនបើអ្នកនិយាយភាសាបសេដបប្បេរ្រពីភាសាអង់គ្លេស ស បសវាកម្មជំនួយ យភាសា ដែលឥតគិតថ្លៃ លីអាចរកបានសប្បាហ្ន ក។ សូម ម្យោទៅកាន់បលខប្រើប្រាស់ ID កាតសាជីករអង្គ ក។

Korean (한국어) 알림: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

Lao (ພາສາລາວ) ກະ ລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານ ວ່າ ພາສາ ອື່ ນ ທ່ານ ບໍ່ ມີ ພາສາ ອັງ ງ ກ, ທ່ານ ສາມາດ ໃ ຊ ບໍ ລິ ການ ດານພາສາ ດ ອື່ ນ ກະ ລຸນາ ທາງ ທາງ ບ ື ທ ອື່ ນ ອື່ ນ ບ ັ ດ ປ ະ ຈາ ຕ ື ວ ສະ ມາ ື ຊ ກຂອງ ທ່ານ.

Polish (polski) UWAGA: Jeśli posługujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

Portuguese (Português) ATENÇÃO: caso fale outro idioma que não o inglês, são-lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

Russian (Русский) ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки. Позвоните по номеру, указанному на вашей идентификационной карте участника.

Spanish (Español) ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

Traditional Chinese (繁體中文) 注意事項: 如果您講非英語的其他語言, 我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

Vietnamese (Tiếng Việt) LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.