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/maine or call 1-800-767-0700. 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 1-800-767-0700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers $250 / (Person) Out-of-Network Provider $1,000 / (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 that specify ded does not apply.	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 $5,000 / (Person) Preferred Providers $10,000 / (Family) Out-of-Network Provider $10,000 / (Person) Out-of-Network Provider $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.
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 www.uhcsr.com/maine or call 1-800-767-0700 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?	No.	You can see the specialist you choose without a referral.

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	$25 Copay/per visit ded does not apply	20% Coins	May not apply when related to surgery or Physiotherapy. **Student Health Center Benefits:** • The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Plan Copays will apply to all services rendered at the Student Health Center, including the $25 Physician Copay; except that the first visit each Plan Year will be paid without cost sharing. • The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at or referred by the SHC for the following services: Laboratory services at SHC and Laboratory, X-rays, and Test and Procedures services referred to Dahl Chase Diagnostics Services, Spectrum Health Partners and Quest Diagnostics.
	Specialist visit	$25 Copay/per visit ded does not apply	20% Coins	
	Preventive care/screening/immunization	No Charge	30% Coins	Includes preventive services 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 provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coins	30% Coins	——————none——————

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)	
	Imaging (CT/PET scans, MRIs)	10% Coins	30% Coins	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.uhcsr.com/pdl	Tier 1 - Your Lowest-Cost Option	$10 Copay per prescription Tier 1 ded does not apply	30% Coins $40 Copay per prescription generic drug $60 Copay per prescription brand-name drug ded does not apply	Preferred Providers: up to a 31 day supply per prescription or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply Out-of-Network Provider: up to a 31 day supply per prescription You may need to obtain certain specialty drugs from a pharmacy designated by us. You may need to obtain prior authorization for certain prescription drugs. You may pay more if prior authorization is not obtained. For insulin drugs the total amount of Ded, Copays or Coins shall not exceed $35 for an individual prescription of up to a 30-day supply.
	Tier 2 - Your Midrange-Cost Option	$40 Copay per prescription Tier 2 ded does not apply		
	Tier 3 - Your Highest-Cost Option	$60 Copay per prescription Tier 3 ded does not apply		
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coins	30% Coins	——————none——————
	Physician/surgeon fees	10% Coins	30% Coins	——————none——————
If you need immediate medical attention	Emergency room care	10% Coins $200 Copay/per visit ded does not apply	10% Coins $200 Copay/per visit ded does not apply	May be limited to use of emergency room and supplies. The Preferred Provider Copay will be waived if admitted to the hospital.
	Emergency medical transportation	10% Coins	20% Coins	——————none——————
	Urgent care	10% Coins	30% Coins	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coins	Hospital Miscellaneous Expenses: 30% Coins Room and Board Expense: 10% Coins	——————none——————
	Physician/surgeon fees	10% Coins	30% Coins	——————none——————

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 need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: $25 Copay/per visit ded does not apply Other: 10% Coins	Office Visits: 20% Coins Other: 20% Coins	————————none————————
	Inpatient services	10% Coins	10% Coins	————————none————————
If you are pregnant	Office visits	$25 Copay/per visit ded does not apply	20% Coins	Cost-sharing does not apply for preventive services when provided by a preferred provider. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% Coins	30% Coins	
	Childbirth/delivery facility services	10% Coins	Hospital Miscellaneous Expenses: 30% Coins Room and Board Expense: 10% Coins	————————none————————
If you need help recovering or have other special health needs	Home health care	10% Coins	30% Coins	————————none————————
	Rehabilitation services	Inpatient Rehabilitation Facility: 10% Coins Physiotherapy: 10% Coins $50 Copay/per visit ded does not apply	30% Coins	Inpatient 150 days maximum (Per Policy Year) Outpatient 40 visits of speech therapy Outpatient 40 visits of any combination of physical therapy and occupational therapy Outpatient Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services
	Habilitation services	10% Coins $50 Copay/per visit ded does not apply	30% Coins	Outpatient 40 visits of speech therapy Outpatient 40 visits of any combination of physical therapy and occupational therapy Outpatient Separate physical, occupational and speech therapy limits

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)	
				apply to rehabilitative and Habilitative Services
	Skilled nursing care	10% Coins	30% Coins	150 days maximum (Per Policy Year)
	Durable medical equipment	10% Coins	30% Coins	——————none——————
	Hospice services	Paid as any other Sickness	Paid as any other Sickness	——————none——————
If your child needs dental or eye care	Children's eye exam	$20 Copay per exam; ded does not apply	50% Coins; ded does not apply	See your plan's Pediatric Vision Benefit Details. Age limits apply.*
	Children's glasses	Lens: $40 Copay; ded does not apply Frames: Tiered Copays from no charge to 40% based on retail cost. ded does not apply	50% Coins; ded does not apply	See your plan's Pediatric Vision Benefit Details. Age limits apply.*
	Children's dental check-up	50% Coins	50% Coins	See your plan's 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.)

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

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

- Acupuncture
- 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 1-800-767-0700 and Maine Bureau of Insurance at 1-800-300-5000 or visit http://www.state.me.us/pfr/insurance/. 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: Maine Bureau of Insurance at 1-800-300-5000 or visit http://www.state.me.us/pfr/insurance/.

Additionally, a consumer assistance program can help you file your appeal, contact Consumer for Affordable Health Care at 1-800-965-7476 or visit http://www.mainecahc.org.

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, 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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$250**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$30
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,340**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$250**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$600
Coinsurance	$50
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$250**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**

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

Harvard Pilgrim Health Care

a Point32Health company

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

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Language Assistance Services

Arabic (العربية) انتباه: إذا كنتَ 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 િેવાઓ, તમારા માટે મફ્ત ઉપલબ્ધ છે. કૃપા કરીને તમારા િભ્ય આઈડી કાડડ 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। कृ पया अपने सदस्य आईडी काडड पर ददए गए नंबर पर कॉल करें।

Khmer (ភាសាខ្មែរ) ប្រសិនបរអ្ន កនិយាយភាសាបសេងបប្ៅពីភាសាអ្ង់បលេ ស បសវាកម្មជំនួ យភាសា ដែលឥតលិតថ្លៃ លឺអាចរកបានសប្ារអ្ន ក។ សូ ម្សៅបៅកាន់បលខបៅបលើ ID កាតសាជិករបស់អ្ន ក។

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

Lao (ພາສາລາວ) ກະ ຸລນາ ຮັບຊາບ: ຖ້າ ທ່ານເ ົວ້າພາສາ ືອ່ນ ີ່ທ່ ່ບແ ມ່ນພາສາ ອັງ ິກດ, ທ່ານສາມາດໃ້ຊ ່ບ ິລການ້ດານພາສາໄ ດ້ ໂດຍບໍ່ເສຍຄ່າ ກະ ຸລນາໂທຫາເ ີບ ີ່ທ ູ່ ຢໃນ ບັດປະ ຈໍາ ຕ ົວສະມາ ິຊກຂອງ 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.