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/haverford or call 1-800-505-4160. 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 call 1-800-505-4160 to request a copy.

### Important Questions

| What is the overall deductible? | Preferred Providers $250 / (Person)  
Out-of-Network Provider $600 / (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 $7,500 / (Person)  
Preferred Providers $13,700 / (Family)  
Out-of-Network Provider $15,000 / (Person) | 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 healthcare 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/haverford or call 1-800-505-4160 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.

<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>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% Coins [ded does not apply $25 Copay per visit]</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% Coins [ded does not apply $25 Copay per visit]</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Your Lowest-Cost Option</td>
<td>$25 Copay per prescription Tier 1 [ded does not apply]</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Your Midrange-Cost Option</td>
<td>$60 Copay per prescription Tier 2 [ded does not apply]</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Your Highest-Cost Option</td>
<td>$75 Copay per prescription Tier 3 [ded does not apply]</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Additional High-Cost Option</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/haverford*
<table>
<thead>
<tr>
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<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 have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Preferred Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coins</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% Coins</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% Coins</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% Coins</td>
<td>20% Coins</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office Visits: 20% Coins</td>
<td>Office Visits: 20% Coins Other: 40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25 Copay per visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ded does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>20% Coins</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ded does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25 Copay per visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/haverford
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment</td>
<td>20% Coins</td>
<td>20% Coins</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% Coins</td>
<td>40% Coins</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td></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>
<td></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>
<td></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>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture except as specifically provided in the Policy.</td>
</tr>
<tr>
<td>• Dental care (Adult) except as specifically provided in the Policy.</td>
</tr>
<tr>
<td>• Long-term care except as specifically provided in the Policy.</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Infertility treatment except as specifically provided in the Policy.</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
</tbody>
</table>
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 1-800-505-4160 and Pennsylvania Insurance Department at 1-877-881-6388 or visit http://www.insurance.pa.gov. 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: Pennsylvania Insurance Department at 1-877-881-6388 or visit http://www.insurance.pa.gov.

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:
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijjigo 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</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>■ The plan’s overall deductible</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>■ Specialist copayment</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>■ Hospital (facility) coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>■ Other coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
<td>Primary care physician office visits (including disease education)</td>
<td>Emergency room care (including medical supplies)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests (blood work)</td>
<td>Diagnostic test (x-ray)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td>Durable medical equipment (glucose meter)</td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
</tbody>
</table>

| Total Example Cost | Peg is Having a Baby | $12,700 |
| Total Example Cost | Managing Joe’s Type 2 Diabetes | $5,600 |
| Total Example Cost | Mia’s Simple Fracture | $2,800 |

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost-Sharing</th>
<th>Peg is Having a Baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,500</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is $2,840

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost-Sharing</th>
<th>Managing Joe’s Type 2 Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$20</td>
</tr>
</tbody>
</table>

The total Joe would pay is $1,570

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost-Sharing</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$400</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is $1,050

The plan would be responsible for the other costs of these EXAMPLE covered services.
NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources 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.
We 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 toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
Քննարկության ծրագիրը զբաղվում է զարգացման ծրագրերով. կարող եք հայտնել 1-866-260-2723 համարակալով.

Bantu- Kirundi
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bengali- Bangala
ঘরোয়া : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দিন করে 1-866-260-2723-তে কল করুন।

Burmese
သင်တန်းမှာ ဗိုလ်သမားများ၏ ပြည်သူများသို့ ဆိုပြောပြပါ 1-866-260-2723

Cambodian- Mon-Khmer
អត្ថបទយើងមានឈ្មោះក្នុងសំណភាពជាច្រើនប្រភេទ 1-866-260-2723

Catalan
Servicis d'assessorament lingüístic disponibles gratuïts a totes les consultes telefòniques. Com aquest servei, cerqueu 1-866-260-2723.

Chinese
您可以免费获得语言援助服务，请致电 1-866-260-2723。

Cherokee
سوencesWahiyo SwiChopi OcholSwiChopi Gwet h,y RgOoTahatiT h,y IEGGGoT DcoT. HcoDh b,boWboS 1-866-260-2723.

Dutch
Taalbijstandsdienssten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole
Gen sévis e'd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German

Greek
Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Haitian Creole

Hindi
आप के लिए भाषा सहायता सेवाएं निश्चित उपलब्ध हैं। कॉल 1-866-260-2723 पर कॉल करें।

Hmong
Muaj cov pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo
Enyemaka na olumo na n’efu, diri g. Kpo 1-866-260-2723.

Ilocano
Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

Italian
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese
無料の言語支援サービスをご利用いただけます。

Karen
usdmw>„urRpXRr”D>erRM>tDRoh0J vXwvd[h.tyORb. (cDvD) M,vDRI 0Ho;plRqJ;usd;b. 1-866-260-2723 wuh>l

Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다。

Kru- Bassa
Bot b a o l ni kobol mahop ngui nsaa wogui wo ba ye ha i nyuu yo. Sebel i nsinga ini 1-866-260-2723.

Kurdish
خزماتكانتي كراميزي زمانی مخونزی بو تو داین د默کی. تکیه تلغاخون يبک بو زماری 1-866-260-2723.

Laotian
1-866-260-2723 op te bellen.
1-866-260-2723.

Marathi
भाषेच्या मदतीची सुविधा आपत्ताला विनामूल्य उपलब्ध आहे.
36-3671 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

Micronesian-Pohnpeian
Mie sawas en mahnesh ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo

Nepali
भाषा सहायता सेवाहरू निशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा करि गुन्हियाँ।

Nilotic-Dinka
Kák ì kuny ajucer ì thok atì tìnë yìn abac tì cìn wìë yëke thiëëc. Yìn col 1-866-260-2723.

Norwegian
Du kan fà gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.

Polish
Móżesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi
ਭਾਸਾ ਸਹਾਇਤਾ ਤੂਹਾਡੇ ਲਈ ਸਹਾਯਤਾ ਵਿਰਾਸ਼ ਦਿੱਤਾ ਜਾਂਦਾ ਹੈ। ਸਹਾਯਤਾ ਲਿਖਵੇ 1-866-260-2723 ਤੇ ਕਰੀ ਲੜਨੀ।

Romanian
Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

Russian
Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoa- Fa’amatai
O loo maua fesoasoani mo gagana mo oe ma e lē tohia. Faamolemololo le 1-866-260-2723.

Serbo-Croatian

Somali
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

Spanish
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.