
 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, go to www.wellfleetstudent.com or call toll free 1-877-657-5030. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- Network Provider : \$500/Individual, \$1,000/family Out-of- Network Provider : \$1,000/Individual, \$2,000/family	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. In- Network Preventive care , In- Network Prescription Drugs , In- Network Tobacco Cessation prescription drugs , In- Network Diabetic Supplies , Medical Evacuation and Repatriation services 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In- Network Provider : \$5,000/Individual; \$10,000/Family. Out-of- Network Provider : \$8,000/Individual; \$16,000/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, 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.cigna.com or call 1-877-657-5030 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
		In-Network 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 /visit, 20% coinsurance	\$25 copay /visit, 40% coinsurance	Limit one visit per day.
	Specialist visit	\$35 copay /Office visit, 20% coinsurance Chiropractic: 20% coinsurance	40% coinsurance	Limit one visit per day. Chiropractic: Pre-Certification required. 12 visits per policy year.
	Preventive care/screening/immunization	No Charge	40% coinsurance	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)	\$25 copay /visit, 20% coinsurance	40% coinsurance	When prescribed by a physician.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	When prescribed by a physician.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.wellfleetstudent.com	Tier 1 (Generic drugs)	\$15 copay /prescription	\$15 copay /prescription 40% coinsurance	Out of Network Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days. No cost sharing applies to ACA Preventive Care Medications filled at a participating pharmacy. In-Network: Deductible Waived. For 30-day supply.
	Tier 2 (Preferred brand drugs)	\$30 copay /prescription	\$30 copay /prescription 40% coinsurance	
	Tier 3 (Non-preferred brand drugs)	\$45 copay /prescription	\$45 copay /prescription 40% coinsurance	
	Specialty drugs	\$45 copay /prescription	\$45 copay /prescription 40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	—————none—————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Physician: Limit of one visit per day.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$125 <u>copay</u> /visit, 20% <u>coinsurance</u> <u>Copay</u> waived if admitted.	\$125 <u>copay</u> /visit, 20% <u>coinsurance</u> <u>Copay</u> waived if admitted.	Out-of-Network: The cost-share is the same as in-network, however the benefit will be based on the greatest of the following three. <ul style="list-style-type: none"> • The median in-network rate; • The amount for the Emergency Service calculated using the same method We generally use to determine payments for Out-of-Network services but substituting the In-Network <u>cost-sharing</u> provisions for the Out-of-Network <u>cost-sharing</u> provisions; or • The amount that would be paid under Medicare for the Emergency Service.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Including ground, water, fixed wing and rotary wing air transportation.
	Urgent care	\$35 <u>copay</u> /visit, 20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to Semi-Private room rate unless intensive care unit is required. <u>Pre-Certification</u> required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-Certification</u> required. Physicians: Limited to one visit per day
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /Office visit, 20% <u>coinsurance</u> All other: 20% <u>coinsurance</u>	\$25 <u>copay</u> /Office visit, 40% <u>coinsurance</u> All other: 40% <u>coinsurance</u>	<u>Pre-Certification</u> required except for office visits.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-Certification</u> required.
If you are pregnant	Office visits	\$25 <u>copay</u> /visit, 20% <u>coinsurance</u>	\$25 <u>copay</u> /visit, 40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of <u>Complications of Pregnancy</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to maximum 100 visits per Policy Year.
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Inpatient: Includes 60 days/Policy Year of Physical Therapy. Also includes Inpatient Rehabilitation Facility with Physical Medicine and Day Rehabilitation therapy. <u>Pre-Certification</u> is required. Outpatient Visits per Policy Year: for Cardiac Rehabilitation (36); Pulmonary Rehabilitation (20); Physical, Occupational, Speech, and Inhalation Therapies (20) for each therapy. <u>Pre-Certification</u> required for Physical, Occupational, Speech, and Inhalation Therapies.
	Habilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Visits per Policy Year: for Physical, Occupational, and Speech (20) for each therapy. Covered to the extent that they are <u>Medically Necessary</u> .
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-Certification</u> required. Up to 90 visits per Policy Year. Covered to the extent of Medical Necessity.
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-Certification</u> required.
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	No charge	No charge	To the end of the month in which the person turns 19. Limit to 1 visit per Policy Year.
	Children's glasses	No charge	No charge	To the end of the month in which the person turns 19. One pair of prescription lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year.
	Children's dental check-up	0% <u>coinsurance</u>	0% <u>coinsurance</u>	To the end of the month in which the person turns 19. For Diagnostic and <u>Preventive care</u> .

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](#).)

<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery	<ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care• Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none">• Chiropractic care (12 maximum visits/Policy Year; Pre-Certification required)	<ul style="list-style-type: none">• Dental care (Adult) (Accidental Injury limited to \$3,000 per Injury/Policy Year)	<ul style="list-style-type: none">• Private-duty nursing (Inpatient; Outpatient with 90 visits/Policy Year and Pre-Certification required)
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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: <https://oci.wi.gov/Pages/Homepage.aspx> For more information on your rights to continue coverage, contact the plan at 1-877-657-5030. 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: <https://oci.wi.gov/Pages/Consumers/GrievancesComplaints.aspx>

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 1-877-657-5030.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-657-5030.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-657-5030.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-657-5030.

————— *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](#) \$500
- [Specialist Copayment](#) \$35
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$600
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,460

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist Copayment](#) \$35
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1,500
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,360

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist Copayment](#) \$35
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact Betsy M. Stevens and John Kelley Civil Rights Coordinators.

If you believe that Commercial Casualty Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Betsy M. Stevens and John Kelley Civil Rights Coordinators,
PO Box 15369, Springfield, MA 01115-5369
(413)-733-4540; (413)-733-4612
Bstevens@wellfleetinsurance.com, or Jkelley@wellfleetinsurance.com.

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance Betsy M. Stevens and John Kelley of Civil Rights Coordinators are 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, DC 20201
800-8681019; 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.