

 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, [www.wellfleetstudent.com](http://www.wellfleetstudent.com) or calling toll free (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](http://www.healthcare.gov/sbc-glossary) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In- <a href="#">Network Provider</a> : \$400/individual Out-of- <a href="#">Network Provider</a> : \$400/individual	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In- <a href="#">Network Preventive care</a> , In- <a href="#">Network Prescription Drugs</a> , Medical Evacuation and Repatriation services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services without cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Combined In- <a href="#">Network Provider</a> and Out-of- <a href="#">Network Provider</a> : \$5,550/individual In- <a href="#">Network Provider</a> for <a href="#">Prescription Drugs</a> : \$1,350/Individual. Counts toward the overall <a href="#">out-of-pocket limit</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. Three family members must meet the individual deductible before the family will not be required to pay any further cost sharing under the deductible.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.cigna.com">www.cigna.com</a> or call 1-877-657-5030 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit 20% <a href="#">coinsurance</a>	\$25 <a href="#">copay</a> /visit 40% <a href="#">coinsurance</a>	1 visit per day
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit 20% <a href="#">coinsurance</a>  Chiropractor: \$25 <a href="#">copay</a> /visit 20% <a href="#">coinsurance</a>	\$25 <a href="#">copay</a> /visit 40% <a href="#">coinsurance</a>  Chiropractor: \$25 <a href="#">copay</a> /visit 40% <a href="#">coinsurance</a>	When requested and approved by the attending Physician. 1 visit per day  <a href="#">Pre-Certification</a> Required
	<a href="#">Preventive care/screening/immunization</a>	No Charge	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	When prescribed by a physician.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	When prescribed by a physician.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.wellfleetstudent.com">www.wellfleetstudent.com</a>	Tier 1	\$15 <a href="#">copay</a> /prescription 0% <a href="#">coinsurance</a>	Not Covered	No <a href="#">cost sharing</a> applies to ACA <a href="#">Preventive Care</a> medications and certain Generic Drugs. Per 30-day supply. In- <a href="#">Network</a> : <a href="#">Deductible</a> Waived.
	Tier 2	\$30 <a href="#">copay</a> /prescription 0% <a href="#">coinsurance</a>	Not Covered	
	Tier 3	\$50 <a href="#">copay</a> /prescription 0% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Specialty drugs</a>	\$50 <a href="#">copay</a> /prescription 0% <a href="#">coinsurance</a>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Physicians: limited to one visit per day. <a href="#">Pre-Certification</a> Required

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	<a href="#">Emergency room care</a>	\$100 <u>copay</u> /visit 20% <u>coinsurance</u>	\$100 <u>copay</u> /visit 20% <u>coinsurance</u>	Emergency treatment received at a hospital's emergency room or at an <u>Urgent Care Facility</u> .
	<a href="#">Emergency medical transportation</a>	\$100 <u>copay</u> /visit 20% <u>coinsurance</u>	\$100 <u>copay</u> /visit 20% <u>coinsurance</u>	Including ground and/or air, water transportation
	<a href="#">Urgent care</a>	\$25 <u>copay</u> /visit 20% <u>coinsurance</u>	\$25 <u>copay</u> /visit 40% <u>coinsurance</u>	Treatment for non-life-threatening conditions.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<a href="#">Pre-Certification</a> is required. Subject to Semi-Private room rate unless intensive care unit is required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<a href="#">Pre-Certification</a> is 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>  Other services: 20% <u>coinsurance</u>	\$25 <u>copay</u> /office visit 40% <u>coinsurance</u>  Other services: 40% <u>coinsurance</u>	<a href="#">Pre-Certification</a> required except for office visits
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<a href="#">Pre-Certification</a> 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>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> 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 <a href="#">Complications of Pregnancy</a> .
	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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Includes Inpatient Rehabilitation Facility: <a href="#">Pre-Certification</a> is required. Includes Cardiac, Pulmonary, Physical, Occupational, and Speech therapies. Outpatient: Limit of one visit per day. <a href="#">Pre-Certification</a> is required.
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	When prescribed by the attending Physician, limited to one visit per day. Covered to the extent that they are <u>Medically Necessary</u> . <u>Pre-certification</u> required.
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Covered to the extent of Medical Necessity. <a href="#">Pre-Certification</a> is required.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<a href="#">Pre-Certification</a> is required.
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
<b>If your child needs dental or eye care</b>	Children’s eye exam	0% <u>coinsurance</u>	0% <u>coinsurance</u>	To the end of the month when the insured turns age 21. Limited to 1 visit per Policy Year.
	Children’s glasses	0% <u>coinsurance</u>	0% <u>coinsurance</u>	To the end of the month when the insured turns age 21. Limited to 1 pair of prescribed 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>	Limited to 2 exams every 12 months to the end of the month in which the Insured Person turns age 21. For Preventive.

## 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
- Cosmetic surgery
- Infertility treatment
- 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.)

- Abortion
- Bariatric surgery ([Pre-Certification](#) required)
- Chiropractic care ([Pre-Certification](#) required)
- Dental care (Adult) (Sickness Dental and Accidental Injury)
- Hearing aids (for insured persons under age 17 and under when prescribed by a Physician)
- Non-emergency care when traveling outside the U.S. (\$10,000 maximum/Policy Year)
- 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: <http://www.dfr.vermont.gov/insurance/insurance-consumer/ask-question>. 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](http://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: <http://www.dfr.vermont.gov/insurance/insurance-consumer/file-insurance-complaint> or 1-800-964-1784 or 802-828-3302.

### 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](#) \$400
- [Specialist Copay](#) \$ 25
- 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$60
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,020</b>

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

- The [plan's](#) overall [deductible](#) \$400
- [Specialist Copay](#) \$ 25
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$900
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,960</b>

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

- The [plan's](#) overall [deductible](#) \$400
- [Specialist Copay](#) \$ 25
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$300
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>

## 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](mailto:Bstevens@wellfleetinsurance.com), or [Jkelley@wellfleetinsurance.com](mailto: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.