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 or calling 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: $100/individual Out-of-Network Provider: $200/individual	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 services, In-Network Prescription Drugs, and Student Health Center (SHC) expenses 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 Providers: $2,500/individual, $5,000 family; Out-of-Network Providers: $5,000/individual, No Maximum/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.cigna.com or call 1-877-657-5030 for a list of In-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 in-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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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	30% coinsurance	One visit per day.
	Specialist visit	$25 copay/visit Chiropractic Care 10% coinsurance	30% coinsurance Chiropractic Care 30% coinsurance	One visit per day. Preauthorization required. Maximum 35 visits/Policy Year and combined with Outpatient Rehabilitation.
	Preventive care/screening/ immunization	No Charge	30% 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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	When prescribed by a physician.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% 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	$10 copay/prescription	$10 copay/prescription, 30% 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 and certain Generic Drugs. In-Network: Deductible waived. Per 30-day supply.
	Tier 2	$25 copay/prescription	$25 copay/prescription, 30% coinsurance	
	Tier 3	$50 copay/prescription	$50 copay/prescription, 30% coinsurance	
	Specialty drugs	$50 copay/prescription	$50 copay/prescription, 30% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Physicians: limited to one visit per day. Preauthorization 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	Emergency room care	$500 copay/visit 10% coinsurance	$500 copay/visit 10% coinsurance	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	30% coinsurance	Including ground and/or air, water transportation.
	Urgent care	$100 copay/visit, 10% coinsurance	$100 copay/visit, 30% coinsurance	Copay waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization required. Subject to Semi-Private room rate unless intensive care unit is required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Physician: Limited to one visit per day. Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Preauthorization required except for office visits.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization required.
If you are pregnant	Office visits	$25 copay/visit	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance 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 Complications of Pregnancy.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

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	10% coinsurance	30% coinsurance	Up to 80 visits per Policy Year.
	Rehabilitation services	10% coinsurance	30% coinsurance	Includes Cardiac, Pulmonary, Physical, Occupational, and Speech therapies. When prescribed by the attending physician. Outpatient: Limit of one visit per day. Preauthorization required.
	Habilitation services	10% coinsurance	30% coinsurance	Covered to the extent that they are medically necessary. When prescribed by the attending physician. Limited to one visit per day.
	Skilled nursing care	10% coinsurance	30% coinsurance	Preauthorization required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization required.
	Hospice services	10% coinsurance	30% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	30% coinsurance	30% coinsurance	1 visit per Policy Year. To the end of the month in which the Insured Person turns age 19.
	Children's glasses	30% coinsurance	30% coinsurance	Limited to 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year. To the end of the month in which the Insured Person turns age 19.
	Children's dental check-up	0% coinsurance	0% coinsurance	To the end of the month in which the Insured Person turns age 19. For Preventive and Diagnostic care.

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
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- 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.)

- Chiropractic care (Preauthorization required. Maximum 35 visits/Policy Year and combined with Outpatient Rehabilitation)
- Dental care (Adult) (Accidental Injury, only)
- Hearing aids (and Cochlear Implants; limited to 1 hearing aid per ear per 3-year period, and 1 cochlear implant in each ear with internal replacement as medically or audiologically necessary)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (while confined)
- Routine eye care (Adult) (age 19 and older; routine eye exam once every 12 months)

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.tx.gov/cid/site/default.asp or call 1-800-203-3447. 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: http://www.tx.gov/cid/site/default.asp or call 1-800-203-3447.

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, kwiijigo 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	$100
Specialist *copay*	$25
Hospital (facility) *coinsurance*	10%
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$90
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,450**

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

The plan's overall deductible	$100
Specialist *copay*	$25
Hospital (facility) *coinsurance*	10%
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,160**

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

The plan's overall deductible	$100
Specialist *copay*	$25
Hospital (facility) *coinsurance*	10%
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY 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,
P.O. 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.