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 by calling 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 https://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 & Out-of-Network Provider: $0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. All 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?	For In-Network Provider: $3,000/individual, $6,000/family; for Out-of-Network Provider $10,000/individual	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, the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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 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.

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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, 0% coinsurance	$25 copay/visit, 20% coinsurance	1 visit per day.
	Specialist visit	25% coinsurance 0% coinsurance Chiropractor: $25 copay/visit, 0% coinsurance	$25 copay/visit, 20% coinsurance Chiropractor: $25 copay/visit, 20% coinsurance	When requested and approved by the attending Physician. Limited to 1 visit per day. Pre-Certification Required. Short-term therapy only.
	Preventive care/screening/ immunization	0% coinsurance	20% 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)	0% coinsurance	20% coinsurance	When prescribed by a physician.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% 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	$15 copay/prescription, 0% coinsurance	Not Covered	No cost sharing applies to ACA Preventive Care medications and certain Generic Drugs. Per 30-day supply.
	Tier 2	$30 copay/prescription, 0% coinsurance	Not Covered	
	Tier 3	$50 copay/prescription, 0% coinsurance	Not Covered	
	Specialty drugs	$50 copay/prescription, 0% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	----------none----------
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Physicians: limited to one visit per day. Pre-Certification 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	$100 copay/visit, 0% coinsurance	$100 copay/visit 0% coinsurance	Copay waived if admitted
	Emergency medical transportation	0% coinsurance	20% coinsurance	Including ground and/or air, water transportation.
	Urgent care	$50 copay/visit, 0% coinsurance	$50 copay/visit, 20% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification is required.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Pre-Certification is required. Physicians: limited to one visit per day.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit, 0% coinsurance	$25 copay/visit, 20% coinsurance	----------none----------
	Inpatient services	0% coinsurance	20% coinsurance	Pre-Certification is required.
If you are pregnant	Office visits	$25 copay/visit, 0% coinsurance	$25 copay/visit, 20% 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	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% 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	0% coinsurance	20% coinsurance	----------none----------
	Rehabilitation services	Inpatient: 0% coinsurance Outpatient: 0% coinsurance	Inpatient: 20% coinsurance Outpatient: 20% coinsurance	Pre-Certification is required. Cardiac Therapy limited to 36 visits/Policy Year. Includes Pulmonary therapy. Rehabilitation Therapy, including Physical therapy and Occupational Therapy limited to 40 visits for each therapy/Policy Year. Speech Therapy (short-term only). When prescribed by the attending physician. Limited to one visit per day. Pre-Certification is required.
	Habilitation services	0% coinsurance	20% coinsurance	Including Physical Therapy and Occupational therapy subject to 40 visits for each therapy/Policy Year. Also includes Speech Therapy. When prescribed by the attending physician. Limited to one visit per day.
	Skilled nursing care	0% coinsurance	20% coinsurance	Covered to the extent of Medical Necessity. Pre-Certification is required.
	Durable medical equipment	0% coinsurance	20% coinsurance	Pre-certification required.
	Hospice services	0% coinsurance	20% coinsurance	----------none----------
If your child needs dental or eye care	Children's eye exam	0% coinsurance	0% coinsurance	To the end of the month when the insured turns age 19. Limited to 1 visit per Policy Year.
	Children's glasses	0% coinsurance	0% coinsurance	To the end of the month when the insured turns age 19. 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% coinsurance	0% coinsurance	Limited to 2 exams every 12 months To the end of the month in which the Insured Person turns age 19. 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
- 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 (Pre-Certification required, short-term therapy only)
- Dental care (Adult) (Accidental Injury only)
- Hearing aids (for covered person under the age of eighteen (18) who is certified as deaf or hearing impaired. One (1) hearing aid per, ear, once every three (3) years.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (inpatient)
- 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: https://oci.wi.gov/Pages/ConsumersHome.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://ociaccess.oci.wi.gov/complaints/public/.

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	$0
Specialist *Copayment*	$25
Hospital (facility) *Coinsurance*	0%
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	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

The plan's overall deductible	$0
Specialist *Copayment*	$25
Hospital (facility) *Coinsurance*	0%
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	$0
Copayments	$1,100
Coinsurance	$0
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	$0
Specialist *Copayment*	$25
Hospital (facility) *Coinsurance*	0%
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	$0
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$80**

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,
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.