**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 brochure, call 1-877-657-5041 or visit www.wellfleetstudent.com. 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: $0<br>Out-of-network provider: $250/ Individual; $1,000/Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and prescription drugs 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 deductible for specific services. |
| **What is the out-of-pocket limit for this plan?** | Medical: In-Network provider: $2,750/Individual; $7,500 family<br>Out-of-network provider: $8,150/Individual; $16,300/Family<br>Prescription Drugs: In-Network provider:. $1,000/Individual; $3,000 Family. Pediatric Dental: $1,000 | 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 Cigna OAP at www.cigna.com or call 1-877-657-5041 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. |

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 | $30 copayment 0% coinsurance | 20% coinsurance | None |
| | Specialist visit | $30 copayment 0% coinsurance | 20% coinsurance | None |
| | Preventive care/screening/ immunization | No charge: deductible does not apply<br>Only available at UNH Health & Wellness, except as specifically provided | Not covered | 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) | 15% coinsurance | 20% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $100 copayment 15% coinsurance | 20% coinsurance | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.wellfleetstudent.com **or call 1-877-657-5041.** | Generic drugs | Tier 1 $5 copayment/prescription<br>Tier 2 $15 copayment/prescription | Not covered | Tier One Prescription copayment: applies to prescriptions filled at UNH Health & Wellness Pharmacy. Tier Two Prescription copayment: applies to prescriptions filled through Benecard. copayment waived for generic contraception medications or medically necessary brand contraceptive medications at either Tier One or Tier Two pharmacy.<br>Up to 30-day supply. |
| | Preferred brand drugs | Tier 1 $25 copayment/prescription<br>Tier 2 $35 copayment /prescription | Not covered | |
| | Non-preferred brand drugs (Tier 3) | Tier One:$40copayment/prescription<br>Tier Two:<br>$50 copayment/prescription | Not covered | |
| | Specialty drugs | Tier One:<br>$40 copayment /prescription<br>Tier Two:<br>Generic $15 copayment/prescription<br>Preferred brand—<br>$35 copayment /prescription<br>Non-Preferred brand—<br>$50 copayment /prescription<br><br>In physician's office or hospital:<br>$50 copayment /prescription then 15% coinsurance | Not covered | |

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100 copayment per surgery<br>15% coinsurance | 20% coinsurance | Applies to inpatient surgery also. |
| | Physician/surgeon fees | 15% coinsurance | 20% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $100 copayment/visit<br>15% coinsurance | $100 copayment/visit<br>15% coinsurance | Copayment waived if admitted. |
| | Emergency medical transportation | $100 copayment/visit<br>15% coinsurance | $100 copayment/visit<br>15% coinsurance | None |
| | Urgent care | $40 copayment/visit<br>15% coinsurance | 20% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250 Copayment/admission<br>15% coinsurance | 20% coinsurance | Precertification required. |
| | Physician/surgeon fees | 15% coinsurance | 20% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copayment/visit<br>0% coinsurance | 20% coinsurance | Provider/Practitioner Home and Office Visits Charges, including diagnostic Lab, X-ray, and Clinic Tests that are billed by the Provider/Practitioner, and clinic services at a hospital<br><br>Partial Day/Intensive Outpatient Care |
| | Inpatient services | $250 copayment/admission<br>15% coinsurance | 20% coinsurance | None |
| **If you are pregnant** | Office visits | 0% coinsurance | 20% coinsurance | Cost sharing does not apply for 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 | $150 copayment/admission<br>15% coinsurance | 20% coinsurance | |
| | Childbirth/delivery facility services | 15% 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 | 15% coinsurance | 20% coinsurance | Precertification recommended. |
| | Rehabilitation services | Inpatient: 15% coinsurance<br>Outpatient: Physical, Occupational, and Speech therapies<br>$30 copayment/visit<br>15% coinsurance | 20% coinsurance | Inpatient: Precertification required.<br><br>Outpatient: Physical, Occupational, and Speech therapies (Precertification recommended).<br>Physical Therapy: Services limited to a maximum of 20 visits per Plan Year. |
| | Habilitation services | 15% coinsurance | 20% coinsurance | None |
| | Skilled nursing care | 15% coinsurance | 20% coinsurance | Precertification required. |
| | Durable medical equipment | 15% coinsurance | 20% coinsurance | Precertification recommended for equipment rental in excess of three (3) months, TENS units, and equipment in excess of $1,000. |
| | Hospice services | 15% coinsurance | 20% coinsurance | Precertification recommended |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | Limited to one visit/Plan Year for routine vision exam, including refraction and glaucoma testing. |
| | Children's glasses | No charge | No charge | Coverage limited to either prescription lenses and frames or contact lenses, but not both. Limited to one (1) benefit/Plan Year. |
| | Children's dental check-up | No charge | No charge | Limited to Covered Persons who are under age 19 (from birth through age 18). Oral Exams: One complete initial oral exam per provider per location. For Preventive. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan brochure for more information and a list of any other excluded services.)**

- Abortion
- Cosmetic surgery
- Dental Care (Adult)
- 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.)**

- Acupuncture (In-Network: up to a maximum of 10 visits per person per Plan Year.)
- Bariatric surgery
- Chiropractic care (charges made by a licensed chiropractor/subject to a maximum benefit of 12 visits per Plan Year.)
- Hearing aids (limited to 1 hearing aid each time prescription changes)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- 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: Your state insurance department at www.nh.gov/insurance/consumers/health.htm. For more information on your rights to continue coverage, contact the plan at 1-877-657-5041. 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: the New Hampshire Insurance Department at www.nh.gov/insurance/complaints/index.htm.

**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 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 1-877-657-5041.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-657-5041.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-657-5041.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-657-5041.

*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, copayment 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** **$30**
- **Hospital (facility) coinsurance** **15%**
- **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 | $80 |
| Coinsurance | $1,900 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,040** |

### 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** **$30**
- **Hospital (facility) coinsurance** **15%**
- **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 | $800 |
| Coinsurance | $300 |
| *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** **$30**
- **Hospital (facility) coinsurance** **15%**
- **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 | $400 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$500** |

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 Wellfleet 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.

TTY: 711

Language Assistance:

For language assistance in your language call 1-877-657-5041.

| | |
|---|---|
| Spanish | Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Wellfleet Insurance Company, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-657-5041. |
| French | Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Wellfleet Insurance Company, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-657-5041. |
| Chinese | 如果您，或您正在幫助的人，有關於 Wellfleet Insurance Company 方面的問 題，您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話，請致電1-877-657-5041。 |
| Nepali | यदि तपाई ंआफ्ना लादि आफैंआवेिनको काम ि◌ै, वा कसैलाई मद्दत ि◌ैहुनहु◌ुन्छ, Wellfleet Insurance Company बारेप्रश्नहरू छन्भनेआफ्नो मातभृ ाषामा दन[ सँि कुरा ि◌ुनुपरे )इन्टरप्रेटर( शल◌ुक सहायता वा जानकारी पाउनेअदिकार छ । ि◌ोभाष:े 1-877-657-5041 मा फोन ि◌ुनुहोस्। |
| Vietnamese | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Wellfleet Insurance Company, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-657-5041. |
| Portuguese | Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Wellfleet Insurance Company, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-657-5041. |
| Greek | Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Wellfleet Insurance Company, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-877-657-5041. |
| Arabic | إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Wellfleet Insurance Company فلديك الحق(، في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل بـ 1-877-657-5041 |

| | |
|---|---|
| Serbo-Croatian | Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Wellfleet Insurance Company, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-657-5041. |
| Indonesian | Jika Anda, atau seseorang yang Anda tolong, memiliki pertanyaan tentang Wellfleet Insurance Company, Anda berhak untuk mendapatkan pertolongan dan informasi dalam Bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan seorang penerjemah, hubungi 1-877-657-5041. |
| Korean | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Wellfleet Insurance Company에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘 기하기 위해서는 1-877-657-5041 로 전화하십시오. |
| Russian | Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Wellfleet Insurance Company, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-657-5041. |
| French Creole | Si oumenm oswa yon moun w ap ede gen kesyon konsènan Wellfleet Insurance Company, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-877-657-5041. |
| Bantu | Nimba wewe canke umuntu uriko urafasha afise ibibazo vyerekeye Wellfleet Insurance Company, utegerezwa kugira uburenganzira bwo kuronka ubufasha n'amakuru arambuye mu rurimi gwawe ataco utanze canke kurihira. Hamagara 1-877-657-5041 uhamagara umusobanuzi. |
| Polish | Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Wellfleet Insurance Company, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-877-657-5041. |