



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 [Wellfleet Student-Roger Williams University\(studentinsurance.com\)](#) 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 <a href="#">deductible</a> ?                                | In- <a href="#">Network Provider</a> : \$150/ individual;<br><a href="#">Out-of-Network Provider</a> : \$300/ 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. In- <a href="#">Network Provider Preventive care</a> , In- <a href="#">Network Provider</a> Physician's Office Visits, <a href="#">Emergency Services</a> , <a href="#">Urgent Care</a> , <a href="#">Emergency Medical Transportation</a> , In- <a href="#">Network Provider Prescription Drugs</a> , Pediatric Vision and Pediatric Dental expenses 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 <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">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> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                                                                                                                                                                      | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | In- <a href="#">Network Provider</a> : \$7,500/ individual;<br><a href="#">Out-of-Network Provider</a> : No Maximum                                                                                                                                                                                                                                                                                                      | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="#">Cigna Health Care Provider Directory</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 <a href="#">plan's 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 <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> 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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | 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<br>(You will pay the least)                                       | Out-of-Network Provider<br>(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        | \$15 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply        | 40% <a href="#">coinsurance</a>                    | —————none—————                                                                                                                                                                                   |
|                                                                                                                                                                                                                          | <a href="#">Specialist</a> visit                        | \$15 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply        | 40% <a href="#">coinsurance</a>                    | —————none—————                                                                                                                                                                                   |
|                                                                                                                                                                                                                          | <a href="#">Preventive care/screening</a> /immunization | No charge                                                                             | 40% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed 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>                    | Pre-Certification required but not for Laboratory Procedures.                                                                                                                                    |
|                                                                                                                                                                                                                          | Imaging (CT/PET scans, MRIs)                            | 20% <a href="#">coinsurance</a>                                                       | 40% <a href="#">coinsurance</a>                    | Pre-Certification required.                                                                                                                                                                      |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.wellfleetrx.com/students">www.wellfleetrx.com/students</a> | Tier 1                                                  | \$15 <a href="#">copay</a> /prescription<br><a href="#">Deductible</a> does not apply | Not Covered                                        | Your benefit is limited to a 30 day supply. For package sizes that exceed a 30-day supply, see the "Retail Pharmacy Supply Limits" section in the Certificate.                                   |
|                                                                                                                                                                                                                          | Tier 2                                                  | 20% <a href="#">coinsurance</a><br><a href="#">Deductible</a> does not apply          | Not Covered                                        | No <a href="#">cost sharing</a> applies to Affordable Care Act (ACA) <a href="#">Preventive Care</a> medications filled at a participating <a href="#">network</a> pharmacy and Zero Cost Drugs. |
|                                                                                                                                                                                                                          | Tier 3                                                  | 30% <a href="#">coinsurance</a><br><a href="#">Deductible</a> does not apply          | Not Covered                                        |                                                                                                                                                                                                  |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                |                                                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | In-Network Provider<br>(You will pay the least)                                                  | Out-of-Network Provider<br>(You will pay the most)                              |                                                                                                                                                                                                                                                                                                                                  |
|                                                                           | <a href="#">Specialty drugs</a>                  | 20% <a href="#">coinsurance</a><br><a href="#">Deductible</a> does not apply                     | Not Covered                                                                     | Your benefit is limited to a 30 day supply.                                                                                                                                                                                                                                                                                      |
| 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>                                                 | Pre-Certification Required for Surgery only.                                                                                                                                                                                                                                                                                     |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$175 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply                  | \$175 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply | Benefits will be payable for services received in a hospital emergency department or independent freestanding emergency department.                                                                                                                                                                                              |
|                                                                           | <a href="#">Emergency medical transportation</a> | \$50 <a href="#">copay</a> /trip<br><a href="#">Deductible</a> does not apply                    | \$50 <a href="#">copay</a> /trip<br><a href="#">Deductible</a> does not apply   | Including ground and/or air, water transportation.                                                                                                                                                                                                                                                                               |
|                                                                           | <a href="#">Urgent care</a>                      | \$40 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply                   | \$40 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply  | Treatment for non-life-threatening conditions                                                                                                                                                                                                                                                                                    |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                                                                  | 40% <a href="#">coinsurance</a>                                                 | Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required.                                                                                                                                                                                                                            |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                  | 40% <a href="#">coinsurance</a>                                                 | Pre-Certification Required for Surgery only.                                                                                                                                                                                                                                                                                     |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office visits:<br>\$15 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply | Office visits:<br>40% <a href="#">coinsurance</a>                               | Office Visits include but are not limited to: physician visits, individual and group therapy, medication management.                                                                                                                                                                                                             |
|                                                                           |                                                  | All Other Outpatient Services:<br>20% <a href="#">coinsurance</a>                                | All Other Outpatient Services:<br>40% <a href="#">coinsurance</a>               | All Other Outpatient Services (All Other Outpatient Services does not include <a href="#">emergency room care</a> , <a href="#">urgent care</a> , <a href="#">emergency medical transportation</a> and <a href="#">prescription drugs</a> . Refer to the <a href="#">emergency room care</a> , <a href="#">emergency medical</a> |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                              |                                                        | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In-Network Provider<br>(You will pay the least)                                | Out-of-Network Provider<br>(You will pay the most)     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                |                                           |                                                                                |                                                        | <a href="#">transportation</a> , <a href="#">urgent care</a> , and the <a href="#">prescription drugs</a> sections for benefit information.)<br><br>Pre-Certification may be required for certain All Other Outpatient Services. See the certificate for details regarding Pre-Certification.                                                                                                                                                                                                                        |
|                                                                | Inpatient services                        | 20% <a href="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                        | Pre-Certification required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| If you are pregnant                                            | Office visits                             | \$15 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply | 40% <a href="#">coinsurance</a>                        | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).<br>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> . Pre-Certification required for all inpatient maternity care after the initial 48/96 hours. |
|                                                                | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                        | Pre-Certification required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                | <a href="#">Rehabilitation services</a>   | Inpatient Facility:<br>20% <a href="#">coinsurance</a>                         | Inpatient Facility:<br>40% <a href="#">coinsurance</a> | Inpatient Rehabilitation Facility: Pre-Certification is required.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                |                                           | Outpatient:<br>20% <a href="#">coinsurance</a>                                 | Outpatient:<br>40% <a href="#">coinsurance</a>         | Outpatient Includes Physical, Occupational, and Speech therapies. Pre-Certification required                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                        | Includes Physical, Occupational and Speech Therapies. Pre-Certification required                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                        | Pre-Certification required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                     |
|-----------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                               |                                           | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                            |
|                                               | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                 | 40% <a href="#">coinsurance</a>                    | Pre-Certification is required for over \$500 per item.                                                                                                                     |
|                                               | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>                 | 40% <a href="#">coinsurance</a>                    | —————none—————                                                                                                                                                             |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | No charge                                       | No charge                                          | To the end of the month when the Insured Person turns age 19. Limited to 1 visit per Policy Year.                                                                          |
|                                               | Children's glasses                        | No charge                                       | No charge                                          | To the end of the month when the Insured Person 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                | No charge                                       | No charge                                          | Limited to 2 exams every 12 months to the end of the month in which the Insured Person turns age 19. For Preventive Dental 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      | • Dental care (Adult) | • Routine foot care    |
| • Cosmetic surgery | • Long-term care      | • Weight loss programs |

##### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                                                            |                                                      |                                                                                          |
|------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------|
| • Bariatric surgery (Pre-Certification required)           | • Hearing aids                                       | • Non-emergency care when traveling outside the U. S. (\$10,000 maximum per Policy Year) |
| • Chiropractic care (Limited to 30 visits per Policy Year) | • Infertility treatment (Pre-Certification required) | • Private-duty nursing (While confined) (Outpatient, Pre-Certification is required)      |
|                                                            |                                                      | • Routine eye care (Adult)                                                               |

**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: Rhode Island Dept. Of Business Regulation at <https://dbr.ri.gov/insurance-banking-securities-and-charitable-organizations/insurance> or contact Wellfleet Insurance Company toll free 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 on how 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: Rhode Island Dept. Of Business Regulation at <https://dbr.ri.gov/insurance-banking-securities-and-charitable-organizations/insurance>.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Not Applicable.**

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 (877) 657-5030.

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

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

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

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$150 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 30%   |

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>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$150          |
| <a href="#">Copayments</a>        | \$30           |
| <a href="#">Coinsurance</a>       | \$2,000        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,240</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$150 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 30%   |

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>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$150          |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$800          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,270</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$150 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 30%   |

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>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$150        |
| <a href="#">Copayments</a>        | \$400        |
| <a href="#">Coinsurance</a>       | \$100        |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$650</b> |

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 the Civil Rights Coordinator.

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:

Civil Rights Coordinator  
PO Box 15369  
Springfield, MA 01115-5369  
(413) 733-4540  
[civilcoordinator@wellfleetinsurance.com](mailto:civilcoordinator@wellfleetinsurance.com)

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is 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  
800-868-1019; 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.

## LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：(877) 657-5030。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.  
(877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

مبينت: اذا كنت تحدثت **عربي (Arabic)**، نإفتامدخد عاسملا قيوغلا قينا جملأ تحتاملك. عاجرلا لاصتلاً ب (877) 657-5030.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語(**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030 にお電話ください。

ی سراف امشد نابز رگا: هجوتہ (**Farsi**) دشادی مامشد رایتخا رد ناگیار روط هبی نابز داما تامدخ،تسا.  
(877) 657-5030 تمسنا بیگرید.

कृपा ध्या दः याद आप (**Hindi**) भाषी ह तो आपके लिए भाषा सहायता सेवाएं: शुल् उपलब् ह। कृपा पर काल कर (877) 657-5030

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រជុំ: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ(**Khmer**) សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohji' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (**Gujarati**) યુ ના: જો તમે જરાતી બોલતા હો, તો િન:દુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો (877) 657-5030

λληνικά (**Greek**)ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

Українська (**Ukrainian**) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (**Amharic**) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደው(877) 657-5030

ਪੰਜਾਬੀ (**Punjabi**) ਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (**Lao**) ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (877) 657-5030