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 - Quincy College (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 deductible?	In-Network Provider: $250/ individual; Out-of-Network Provider: $500/ individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-Network Provider Preventive care, In-Network Provider Physician's Office Visits, Urgent Care, Prescription Drugs, and Pediatric Dental expenses are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Provider: $ 4,000/ individual; Out-of-Network Provider: $6,000/ individual	The out-of-pocket limit is the most you could pay in a year for covered services.
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 Health Care Provider Directory 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.

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	$20 copay/visit Deductible does not apply	20% coinsurance	——————none——————
	Specialist visit	$20 copay/visit Deductible does not apply	20% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge	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)	10% coinsurance	30% coinsurance	Pre-Certification required but not for Laboratory Procedures.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Pre-Certification required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellfleetrx.com/students	Tier 1	$20 copay/prescription Deductible does not apply	$20 copay/prescription Deductible does not apply	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. Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days. No cost sharing applies to Affordable Care Act (ACA) Preventive Care medications filled at a participating network pharmacy and Zero Cost Drugs.
	Tier 2	$40 copay/prescription Deductible does not apply	$40 copay/prescription Deductible does not apply	
	Tier 3	$60 copay/prescription Deductible does not apply	$60 copay/prescription Deductible does not apply	
	Specialty drugs	$60 copay/prescription Deductible does not apply	$60 copay/prescription Deductible does not apply	Your benefit is limited to a 30 day supply. Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days.

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)	10% coinsurance	30% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Pre-Certification Required.
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Benefits will be payable for services received in a hospital emergency department or independent freestanding emergency department.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Including ground and/or air, water transportation.
	Urgent care	$20 copay/visit Deductible does not apply	$20 copay/visit Deductible does not apply	Treatment for non-life-threatening conditions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Pre-Certification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $20 copay/visit Deductible does not apply All Other Outpatient Services: 10% coinsurance	Office visits: 20% coinsurance All Other Outpatient Services: 30% coinsurance	Day or visit limits do not apply to mental health disorder and substance use disorder benefits. Office Visits include but are not limited to: physician visits, individual and group therapy, medication management. All Other Outpatient Services (All Other Outpatient Services does not include emergency room care, urgent care, emergency medical transportation and prescription drugs. Refer to the emergency room care, emergency medical transportation, urgent care, and the prescription drugs sections for benefit

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)	
				information.) Pre-Certification may be required for certain All Other Outpatient Services. See the certificate for details regarding Pre-Certification.
	Inpatient services	10% coinsurance	30% coinsurance	Pre-Certification required.
If you are pregnant	Office visits	$20 copay/visit Deductible does not apply	20% coinsurance	Cost sharing does not apply for preventive services. 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. Pre-Certification required for all inpatient maternity care after the initial 48/96 hours.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Pre-Certification required.
	Rehabilitation services	Inpatient Facility: 10% coinsurance Outpatient: 10% coinsurance	Inpatient Facility: 30% coinsurance Outpatient: 30% coinsurance	Inpatient Rehabilitation Facility: Pre-Certification is required. Outpatient Includes Physical, Occupational, and Speech therapies. Limited to 60 visits for each therapy for Physical and Occupational therapy. Combined with Habilitation Services Therapy.
	Habilitation services	10% coinsurance	30% coinsurance	Includes Physical, Occupational and Speech Therapies. Limited to 60 visits for each therapy for Physical and Occupational therapy. Combined with Rehabilitation Services Therapy.

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)	
	Skilled nursing care	10% coinsurance	30% coinsurance	Pre-Certification required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Pre-Certification is required for over $500 per item.
	Hospice services	10% coinsurance	30% 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 Person 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 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.)

- Cosmetic surgery
- Long-term care
- Routine foot care

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

- Acupuncture (Limited to 30 visits per Policy Year)
- Bariatric surgery (Pre-Certification required)
- Chiropractic care (Limited to 30 visits per Policy Year)
- Dental care (Adult)
- Hearing aids (Limited to 1 hearing aid per ear up to a maximum of $2,000 for each hearing aid per 36 month period)
- Infertility treatment (Pre-Certification required)
- Non-emergency care when traveling outside the U. S. ($10,000 maximum per Policy Year)
- Private-duty nursing (While confined)
- Routine eye care (Adult)
- Weight loss programs

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: Division of Insurance | Mass.gov 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 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: Division of Insurance | Mass.gov .

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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (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	**$250**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**20%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$30
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,340**

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

The plan's overall deductible	**$250**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**20%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$900
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,240**

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

The plan's overall deductible	**$250**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**20%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$70
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

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