




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 - Western New England Global \(studentinsurance.com\)](#) 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> : \$100/ individual; <a href="#">Out-of-Network Provider</a> : \$200/ 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</a> Preventive care, In- <a href="#">Network Provider</a> Physician's Office Visits, Urgent Care, <a href="#">Prescription Drugs</a> 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> : \$2,500/ individual; \$5,000/ family <a href="#">Out-of-Network Provider</a> : \$5,000/ individual; \$10,000/ family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
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 (You will pay the least)	Out-of-Network Provider (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	\$10 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <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)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-Certification required but not for Laboratory Procedures.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-Certification required.
If you need drugs to treat your illness or condition 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	\$10 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	\$10 <a href="#">copay</a> /prescription <a href="#">Deductible</a> 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.
	Tier 2	\$20 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	\$20 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	
	Tier 3	\$40 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	\$40 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	<a href="#">Out-of-Network Provider</a> benefits are provided on a reimbursement basis. <a href="#">Claim</a> forms must be received within 90 days.
	<a href="#">Specialty drugs</a>	\$40 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	\$40 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	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. Your benefit is limited to a 30 day supply. <a href="#">Out-of-Network Provider</a> benefits are provided on a reimbursement basis. <a href="#">Claim</a> forms must be received within 90 days.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Wellfleet Student - Western New England Global \(studentinsurance.com\)](http://Wellfleet Student - Western New England Global (studentinsurance.com))

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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	—————none—————
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-Certification Required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Benefits will be payable for services received in a hospital emergency department or independent freestanding emergency department.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Including ground and/or air, water transportation.
	<a href="#">Urgent care</a>	\$10 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$10 <a href="#">copay</a> /visit <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)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-Certification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$10 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply  All Other Outpatient Services: 10% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	Office visits: 20% <a href="#">coinsurance</a>  All Other Outpatient Services: 30% <a href="#">coinsurance</a>	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 <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 transportation</a> , <a href="#">urgent care</a> , and the

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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)	
				<a href="#">prescription drugs</a> sections for benefit information.)  Pre-Certification may be required for certain All Other Outpatient Services. See the certificate for details regarding Pre-Certification.
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-Certification required.
If you are pregnant	Office visits	\$10 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	20% <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). 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	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-Certification required.
	<a href="#">Rehabilitation services</a>	Inpatient Facility: 10% <a href="#">coinsurance</a>  Outpatient: 10% <a href="#">coinsurance</a>	Inpatient Facility: 30% <a href="#">coinsurance</a>  Outpatient: 30% <a href="#">coinsurance</a>	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 <a href="#">Habilitation Services</a> Therapy.

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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)	
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Includes Physical, Occupational and Speech Therapies. Limited to 60 visits for each therapy for Physical and Occupational therapy. Combined with <a href="#">Rehabilitation Services</a> Therapy.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-Certification required.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-Certification is required for over \$500 per item.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	To the end of the month when the Insured Person turns age 19. Limited to 1 visit per Policy Year.
	Children's glasses	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Wellfleet Student - Western New England Global \(studentinsurance.com\)](#)

### 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

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Wellfleet Student - Western New England Global \(studentinsurance.com\)](#)

**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](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: [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, 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>	\$100
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$1,000

What isn't covered	
Limits or exclusions	\$60

<b>The total Peg would pay is</b>	<b>\$1,180</b>
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### 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>	\$100
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$80

What isn't covered	
Limits or exclusions	\$0

<b>The total Joe would pay is</b>	<b>\$700</b>
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### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$200

What isn't covered	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$340</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.