



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-Austin College Master's PA\(studentinsurance.com\)](#) 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?	Combined In- Network and 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 Physicians Office Visits, Urgent Care Centers, Prescription Drugs , Pediatric Vision, 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?	Combined In- Network Provider and Out-of-Network Provider : \$8,150 /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 Open Access Plus (OAP) at 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	\$25 <u>copay</u> /visit <u>Deductible does not apply</u>	50% <u>coinsurance</u>	none
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit <u>Deductible does not apply</u>	50% <u>coinsurance</u>	none
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Diagnostic Imaging: 20% <u>coinsurance</u> Laboratory Procedures: 20% <u>coinsurance</u>	Diagnostic Imaging: 50% <u>coinsurance</u> Laboratory Procedures: 50% <u>coinsurance</u>	Pre-Authorization required but not for Laboratory Procedures.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-Authorization required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.wellfleetrx.com/students	Tier 1	\$20 <u>copay</u> /prescription <u>Deductible does not apply</u>	\$20 <u>copay</u> /prescription 50% <u>coinsurance</u> <u>Deductible does not apply</u>	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	\$45 <u>copay</u> /prescription <u>Deductible does not apply</u>	\$45 <u>copay</u> /prescription 50% <u>coinsurance</u> <u>Deductible does not apply</u>	<u>Out-of-Network Provider</u> benefits are provided on a reimbursement basis. <u>Claim</u> forms must be received within 90 days.
	Tier 3	\$60 <u>copay</u> /prescription <u>Deductible does not apply</u>	\$60 <u>copay</u> /prescription 50% <u>coinsurance</u> <u>Deductible does not apply</u>	No <u>cost sharing</u> applies to Affordable Care Act (ACA) <u>Preventive Care</u> medications [filled at a participating <u>network</u> pharmacy and Zero Cost Drugs.

*For more information about limitations and exceptions, see the plan or policy document at [Wellfleet Student - Austin College Master's PA\(studentinsurance.com\)](http://Wellfleet Student - Austin College Master's PA(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)	
	<u>Specialty drugs</u>	\$60 <u>copay</u> /prescription <u>Deductible</u> does not apply	\$60 <u>copay</u> /prescription 50% <u>coinsurance</u> <u>Deductible</u> does not apply	Your benefit is limited to a 30 day supply. <u>Out-of-Network Provider</u> benefits are provided on a reimbursement basis. <u>Claim</u> forms must be received within 90 days.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-Authorization Required.
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit 20% <u>coinsurance</u>	\$150 <u>copay</u> /visit 20% <u>coinsurance</u>	Benefits will be payable for services received in a hospital emergency department or independent freestanding emergency department.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Including ground and/or air, water transportation.
	<u>Urgent care</u>	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply	Treatment for non-life-threatening conditions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Subject to Semi-Private room rate unless intensive care unit is required.] Pre-Authorization required.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-Authorization required.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$25 copay /visit Deductible does not apply All Other Outpatient Services except emergency services and prescription drugs : 20% coinsurance Deductible does not apply	Office visits: 50% coinsurance All Other Outpatient Services except emergency services and prescription drugs : 50% coinsurance Deductible does not apply	All Other Outpatient Services (All Other Outpatient Services does not include emergency room care , urgent care , emergency medical transportation and prescription drug coverage . Refer to the emergency room care , urgent care , emergency medical transportation and the prescription drug coverage sections for benefit information.)
	Inpatient services	20% coinsurance	50% coinsurance	Pre-Authorization required.
If you are pregnant	Office visits	\$25 copay /visit Deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	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-Authorization required for all inpatient maternity care after the initial 48/96 hours.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Pre-Authorization required. Limited to 60 visits per Policy Year.
	Rehabilitation services	Inpatient Facility: 20% coinsurance Outpatient: 20% coinsurance	Inpatient Facility: 50% coinsurance Outpatient: 50% coinsurance	Inpatient Rehabilitation Facility: Pre-Authorization is required. Outpatient Includes Physical, Occupational, and Speech therapies. Limited to 35-visits for each therapy for Physical, Occupational, and Speech 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)	
	Habilitation services	20% coinsurance	50% coinsurance	Includes Physical, Occupational and Speech Therapies. Limited to 35 visits for each therapy for Physical, Occupational, and Speech therapy.
	Skilled nursing care	20% coinsurance	50% coinsurance	Pre-Authorization required.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-Authorization is required for over \$500 per item.
	Hospice services	20% coinsurance	50% coinsurance	none
If your child needs dental or eye care	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
• Bariatric surgery	• Infertility treatment	• Weight loss programs
• Cosmetic surgery	• Long-term care	

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

• Chiropractic care (limited to 35 visits per Policy Year)	• Non-emergency care when traveling outside the U. S. (\$10,000 maximum per Policy Year)	• Private-duty nursing (While confined)
• Hearing aids (limited to 1 hearing aid per ear per 3-year period)		• 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: <http://www.tdi.texas.gov/consumer/index.html> 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: <http://www.tdi.texas.gov/consumer/index.html>.

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, kwijjigo 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 plan's overall deductible	\$500
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ 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	\$500
Copayments	\$10
Coinsurance	\$2,400

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$2,970

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ 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	\$500
Copayments	\$900
Coinsurance	\$100

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,520

Mia's Simple Fracture

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ 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	\$500
Copayments	\$200
Coinsurance	\$300

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$1,000

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.