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 www.wellfleetstudent.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?	Participating Provider: $150/individual Non-Participating Provider: $300/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. Except for Vasectomy, Preventive care, Medically Necessary Abortions, Prenatal Care in accordance to guidelines, Breastfeeding Support, Diabetic Equipment/Supplies, In-Network Prescription Drugs, and Pediatric Dental and Vision Care services 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?	Participating Provider: $7,350/individual Non-Participating Provider: $7,350/individual	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com 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.

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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
		Participating Provider (You will pay the least)	Non-Participating 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	$35 copay/visit, 0% coinsurance	$30 copay/visit, 30% coinsurance	Office or Home visits
	Specialist visit	$35 copay/visit, 0% coinsurance Chiropractor: $35 copay/visit, 0% coinsurance	$35 copay/visit, 30% coinsurance Chiropractor: $30 copay/visit, 30% coinsurance	Office or Home visits Preauthorization required.
	Preventive care/screening/ immunization	No Charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Except for Vasectomy, Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay/visit, 0% coinsurance	$30 copay/visit, 30% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellfleetstudent.com	Tier 1	$20 copay/prescription, 20% coinsurance Deductible does not apply	$20 copay/prescription, 20% coinsurance	Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating. If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of Covered Prescription Drug used to treat a substance disorder, including Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. For 30-day Supply.
	Tier 2	$40 copay/prescription, 40% coinsurance Deductible does not apply	$40 copay/prescription, 40% coinsurance	
	Tier 3	$60 copay/prescription, 40% coinsurance Deductible does not apply	$60 copay/prescription, 40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copay/visit 0% coinsurance	$30 copay/visit 30% coinsurance	——————none——————
	Physician/surgeon fees	$35 copay/visit 0% coinsurance	$30 copay/visit 0% coinsurance	Including Oral Surgery, Reconstructive Breast Surgery, Other Reconstructive and corrective surgery; and transplants. Preauthorization required.
If you need immediate medical attention	Emergency room care	$250 copay/visit 20% coinsurance	$250 copay/visit 20% coinsurance	Copay waived if hospital admission.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Includes Pre-Hospital Emergency Medical Ambulance and Non-Emergency Ambulance services.
	Urgent care	$75 copay/visit 20% coinsurance	$75 copay/visit 40% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Continuous confinement including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care. Preauthorization required. However, preauthorization is not required for emergency admissions or services in a neonatal intensive care unit.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Including Oral Surgery, Reconstructive Breast Surgery, Other Reconstructive and corrective surgery; and transplants. Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office and All Other Services: $35 copay/visit, 0% coinsurance	Office and All Other Services: $30 copay/visit, 30% coinsurance	Mental Health Care: Including Partial Hospitalization and Intensive Outpatient Program Services. Substance Use Services: Up to 20 visits/Plan Year may be used for family counseling.
	Inpatient services	20% coinsurance	40% coinsurance	Mental Health Care and Substance Use Services including Residential Treatment for a continuous confinement when in a Hospital. Preauthorization required. However, Preauthorization is not required for emergency admissions. Also for Substance Use, Preauthorization not required for participating OASAS-certified Facilities.
If you are pregnant	Office visits	$35 copay/visit, 0% coinsurance	$30 copay/visit, 30% coinsurance	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early. Includes inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	Specialist/Outpatient Hospital: $35 copay/visit, 0% coinsurance 20% coinsurance	Specialist/Outpatient Hospital: $30 copay/visit, 30% coinsurance 40% coinsurance	Outpatient: Cardiac and Pulmonary Rehabilitation, Physical Therapy, Occupational Therapy and Speech Therapy. Pre-authorization required. Inpatient: Physical, Speech and Occupational therapy. Pre-authorization required.
	Habilitation services	Outpatient: $35 copay/visit, 0% coinsurance Inpatient: 20% coinsurance	Outpatient: $30 copay/visit, 30% coinsurance Inpatient: 40% coinsurance	Outpatient: Physical Therapy, Occupational Therapy and Speech Therapy. Pre-authorization required. Inpatient: Physical, Speech and Occupation Therapy Pre-authorization required. 60 days per Plan Year for all therapies combined.
	Skilled nursing care	20% coinsurance	40% coinsurance	Including Cardiac and Pulmonary Rehabilitation. Pre-authorization required. Limit of 200 days per Policy Year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Includes braces. Preauthorization required.
	Hospice services	20% coinsurance	40% coinsurance	210 days per Policy Year. Five (5) visits for family bereavement counseling.
If your child needs dental or eye care	Children's eye exam	$20 copay/visit 0% coinsurance	30% coinsurance	Limit of 1 exam per Plan Year. Deductible does not apply.
	Children's glasses	Lenses/Frames: $40 copay/visit 0% coinsurance Contact Lenses: $40 copay/visit 0% coinsurance	Lenses/Frames: 30% coinsurance Contact Lenses: 30% coinsurance	Limit of 1 pair of prescribed lenses and frames or contact lenses per Plan Year. Deductible does not apply.
	Children's dental check-up	$35 copay/visit 0% coinsurance	$35 copay/visit	Limit of 1 dental exam and cleaning every 6 months. For Preventive. Orthodontics and Major Dental require Preauthorization. Deductible does not apply.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Chiropractic care (Preauthorization required)
- Hearing aids (a single purchase including repair and/or replacement of hearing aids for one (1) or both ears once every three (3) years)
- Infertility treatment (Preauthorization required)
- Non-emergency care when traveling outside the U.S. ($1,000 annual limit)

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://dfs.ny.gov/insurance/dfs_insurance.htm For more information on your rights to continue coverage, contact the plan at 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 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://dfs.ny.gov/consumer/fileacomplaint.htm

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-657-5030.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-657-5030.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-657-5030.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-657-5030.

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	$150
Specialist *Copay*	$35
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,960**

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

The plan's overall deductible	$150
Specialist *Copay*	$35
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,500
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,160**

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

The plan's overall deductible	$150
Specialist *Copay*	$35
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.wellfleetstudent.com or toll free 1-877-657-5030.

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

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact Betsy M. Stevens and John Kelley Civil Rights Coordinators.

If you believe that Wellfleet New York Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Betsy M. Stevens and John Kelley Civil Rights Coordinators,
PO Box 15369, Springfield, MA 01115-5369
(413)-733-4540; (413)-733-4612
Bstevens@wellfleetinsurance.com, or Jkelley@wellfleetinsurance.com.

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance Betsy M. Stevens and John Kelley of Civil Rights Coordinators are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-8681019; 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.