



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 -Trinity University \(studentinsurance.com\)](http://WellfleetStudent-TrinityUniversity(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 : \$350/ individual; Out-of-Network Provider : \$700/ 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 Expenses, Prescription Drugs , and 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? | Yes. Intercollegiate Sports Injury deductible (in lieu of medical deductible): In- Network Provider : \$100 per Injury Out-of-Network Provider : \$100 per Injury | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | In- Network Provider : \$8,000/ individual; \$16,000/ family Out-of-Network Provider : \$15,000/ individual; \$30,000/ family | 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 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 | \$40 copay /visit Deductible does not apply | 40% coinsurance | —————none————— |
| | Specialist visit | \$40 copay /visit Deductible does not apply | 40% coinsurance | —————none————— |
| | Preventive care/screening/immunization | No charge | 50% 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) | Diagnostic Imaging: 20% coinsurance Laboratory Procedures: 20% coinsurance | Diagnostic Imaging: 40% coinsurance Laboratory Procedures: 40% coinsurance | Pre-Authorization required but not for Laboratory Procedures. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Pre-Authorization 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 | \$15 copay /prescription Deductible does not apply | \$15 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 | \$45 copay /prescription Deductible does not apply | \$45 copay /prescription Deductible does not apply | |
| | Tier 3 | \$80 copay /prescription Deductible does not apply | \$80 copay /prescription Deductible does not apply | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at [Wellfleet Student -Trinity University \(studentinsurance.com\)](http://Wellfleet Student -Trinity University (studentinsurance.com)) **Page 2 of 8**

| 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) | |
| | Specialty drugs | \$80 copay /prescription Deductible does not apply | \$80 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. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | —————none————— |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Pre-Authorization Required. |
| If you need immediate medical attention | Emergency room care | \$75 copay /visit 20% coinsurance | \$75 copay /visit 20% coinsurance | Benefits will be payable for services received in a hospital emergency department or independent freestanding emergency department. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Including ground and/or air, water transportation. |
| | Urgent care | \$50 copay /visit | \$50 copay /visit | Treatment for non-life-threatening conditions |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Subject to Semi-Private room rate unless intensive care unit is required. Pre-Authorization required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Pre-Authorization required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office visits: \$40 copay /visit Deductible does not apply All Other Outpatient Services except emergency services and prescription drugs : 20% coinsurance | Office visits: 40% coinsurance All Other Outpatient Services except emergency services and prescription drugs : 40% coinsurance | Day or visit limits do not apply to mental health disorder and substance use disorder benefits. 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 |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
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| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | benefit information.) Pre-Authorization may be required for certain All Other Outpatient Services. *See the certificate for details regarding Pre-Certification. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Pre-Authorization required. |
| If you are pregnant | Office visits | \$40 copay /visit Deductible does not apply | 40% 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-Authorization required for all inpatient maternity care after the initial 48/96 hours. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | Pre-Authorization required. |
| | Rehabilitation services | Inpatient Facility: 20% coinsurance Outpatient: 20% coinsurance | Inpatient Facility: 40% coinsurance Outpatient: 40% 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. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | Includes Physical, Occupational and Speech Therapies. Limited to 35 visits for each therapy for Physical, Occupational, and Speech 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 | 20% coinsurance | 40% coinsurance | Pre-Authorization required. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Pre-Authorization is required for over \$500 per item. |
| | Hospice services | 20% coinsurance | 40% coinsurance | —————none————— |
| If your child needs dental or eye care | Children's eye exam | \$20 copay /visit Deductible does not apply | \$20 copay /visit Deductible does not apply | To the end of the month when the Insured Person turns age 19. Limited to 1 visit per Policy Year. |
| | Children's glasses | \$20 copay /visit Deductible does not apply | \$20 copay /visit Deductible does not apply | 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 | 50% coinsurance | 50% coinsurance | 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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- 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.)

- Bariatric surgery (Pre-Authorization required)
- Chiropractic care (Limited to 35 visits per Policy year)
- Hearing aids (limited to 1 hearing aid per ear per 3-year period)
- Non-emergency care when traveling outside the U. S. (\$10,000 maximum per Policy Year)
- Private-duty nursing (While confined)
- 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): 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 plan's overall deductible | \$350 |
| ■ Specialist copayment | \$40 |
| ■ 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$350 |
| Copayments | \$50 |
| Coinsurance | \$1,900 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,360 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$350 |
| ■ Specialist copayment | \$40 |
| ■ 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$350 |
| Copayments | \$1,100 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,470 |

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$350 |
| ■ Specialist copayment | \$40 |
| ■ 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$350 |
| Copayments | \$200 |
| Coinsurance | \$300 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$850 |

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