



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-Metropolitan Community 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:
<b>What is the overall deductible?</b>	In- <a href="#">Network Provider</a> : \$250 / individual Out-of- <a href="#">Network Provider</a> : \$500 / 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
<b>Are there services covered before you meet your deductible?</b>	Yes. In- <a href="#">Network Provider</a> <a href="#">Preventive care</a> , <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> .
<b>Are there other deductibles for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In- <a href="#">Network Provider</a> : \$6,600 / individual; \$13,200 Family <a href="#">Out-of-Network Provider</a> : \$25,000 / individual ; \$75,000 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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
		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% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	none
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	none
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge	40% <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)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-Certification required but not for Laboratory Procedures.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <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	\$15 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	Not Covered	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 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	Not Covered	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.
	Tier 3	\$75 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	Not Covered	
	<a href="#">Specialty drugs</a>	\$150 <a href="#">copay</a> /prescription 25% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	Not Covered	Your benefit is limited to a 30 day supply.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	none
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-Certification Required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> /visit 20% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> /visit 20% <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>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Including ground and/or air, water transportation.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Treatment for non-life-threatening conditions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-Certification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: 20% <a href="#">coinsurance</a>  Outpatient Services, other than office visits: 20% <a href="#">coinsurance</a>	Office visits: 40% <a href="#">coinsurance</a>  Outpatient Services, other than office visits: 40% <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

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				<a href="#">prescription drugs</a> . Refer to the 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	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-Certification required.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <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).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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 facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-Certification required. Limited to 60 visits per Policy Year.
	<a href="#">Rehabilitation services</a>	Inpatient Facility: 20% <a href="#">coinsurance</a>  Outpatient: 20% <a href="#">coinsurance</a>	Inpatient Facility: 40% <a href="#">coinsurance</a>  Outpatient: 40% <a href="#">coinsurance</a>	Inpatient Rehabilitation Facility: Pre-Certification is required.  Outpatient Includes Physical, Occupational, and Speech therapies. Limited to 45 visits for each therapy for Physical, Occupational, and Speech therapy. Combined with <a href="#">Habilitation Services</a> Therapy.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at: [Wellfleet Student-Metropolitan Community College](#)(studentinsurance.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If your child needs dental or eye care</b>	<u>Habilitation services</u>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Includes Physical, Occupational and Speech Therapies. Limited to 45 visits for each therapy for Physical, Occupational, and Speech therapy. Combined with <a href="#">Rehabilitation Services</a> Therapy.
	<u>Skilled nursing care</u>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-Certification required.
	<u>Durable medical equipment</u>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-Certification is required for over \$500 per item.
	<u>Hospice services</u>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 2 Bereavement visits per lifetime.
<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-Metropolitan Community College](#)(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.)

<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"><li>• Chiropractic care (Limited to 30 visits per Policy Year)</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U. S. (\$ 10,000 maximum per Policy Year)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (While confined) (Outpatient, Pre-Certification is required)</li></ul>
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**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: <https://doi.nebraska.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: <https://doi.nebraska.gov/consumer/appealing-denied-health-claim>.

**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ 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>
<b>In this example, Peg would pay:</b>	
Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,820</b>

### 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>	\$250
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ 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>
<b>In this example, Joe would pay:</b>	
Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,270</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ 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>
<b>In this example, Mia would pay:</b>	
Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,950</b>

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