**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, please call 1-609-497-7781 or visit www.healthsmart.com/Princeton-Theological-Seminary.aspx. 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 https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf or call 1-609-497-7781 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network providers – $0 individual / $0 family Out-of-network providers – $250 individual / $750 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Out-of-network emergency room care is 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, prescription drug coverage: $50 per person per plan year. There are no other specific deductibles. | 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 providers – $3,500 individual / $7,000 family Out-of-network providers - $7,750 individual / $23,250 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, precertification penalties, balance billed 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, Cigna at www.cigna.com/hcpdirectory / University Medical Center of Princeton www.princetonhcs.org / Trinity Counseling Service / Specialty Counseling Network | 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 | $35 copay per visit | 30% coinsurance | ----------none---------- |
| | Specialist visit | $35 copay per visit | 30% coinsurance | ----------none---------- |
| | Preventive care/screening/ immunization | No charge | Not covered | PPACA Preventive Care Benefits. 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) | 20% coinsurance | 30% coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | $200 copay per visit then 20% coinsurance | 30% coinsurance | ----------none---------- |

| 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 drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at HealthSmart Rx 1-800-681-6912 or www.healthsmart.com/Princeton-Theological-Seminary.aspx | Generic drugs | $15 copay – retail<br>$30 copay – mail order | $15 copay – retail only | There is a separate deductible for prescription drugs: **$50** per person per plan year.<br><br>Retail – Up to a 30 day supply.<br>Mail order – Up to a 90 day supply.<br><br>If an Out-of-Network retail pharmacy is used, the participant will pay the full cost of the prescription up front and file a paper claim to HealthSmart Rx for reimbursement minus the applicable copay.<br><br>Out-of-Network mail order is not available.<br><br>If a Generic is available and allowed by the Physician, the individual will be required to pay the Brand copay plus the difference in cost between the Generic and Brand name if Brand is chosen (applies to both Retail and Mail Order prescriptions). |
| | Preferred brand drugs | $25 copay – retail<br>$50 copay – mail order | $25 copay – retail only | |
| | Non-preferred brand drugs | $40 copay – retail<br>$80 copay – mail order | $40 copay – retail only | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | ----------none---------- |
| | Physician/surgeon fees | $100 copay per visit then 20% coinsurance | 30% coinsurance | ----------none---------- |
| **If you need immediate medical attention** | Emergency room care | $100 copay per visit | $100 copay per visit (Deductible does not apply) | ----------none---------- |
| | Emergency medical transportation | $100 copay per trip then 20% coinsurance | 30% coinsurance | There are no in-network providers inside the Princeton area.<br>Air ambulance service is not covered. |
| | Urgent care | $35 copay per visit | 30% coinsurance | ----------none---------- |

| 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 a hospital stay** | Facility fee (e.g., hospital room) | $300 per admission copay then 20% coinsurance | 30% coinsurance | Precertification is required. Call HealthSmart 1-877-202-6379, Option 3. If precertification is not obtained, the plan will cover only 50% of eligible facility expenses. |
| | Physician/surgeon fees | Physician: 20% coinsurance Surgeon: $100 copay per visit then 20% coinsurance | 30% coinsurance | ----------none---------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office visits: $25 copay per visit / Trinity Counseling Services $15 copay per visit / Specialty Counseling Network $25 copay per visit<br><br>Outpatient partial hospitalization: No charge | Office visits: 30% coinsurance<br><br>Outpatient partial hospitalization: 30% coinsurance | ----------none---------- |
| | Inpatient services | $300 per admission copay then 20% coinsurance | 30% coinsurance | Precertification is required. Call HealthSmart 1-877-202-6379, Option 3. If precertification is not obtained, the plan will cover only 50% of eligible facility expenses. |
| **If you are pregnant** | Office visits | $35 copay per visit | 30% coinsurance | Cost-sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | $100 copay per visit then 20% coinsurance | 30% coinsurance | ----------none---------- |
| | Childbirth/delivery facility services | $300 per admission copay then 20% coinsurance | 30% coinsurance | ----------none---------- |

| 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 help recovering or have other special health needs** | Home health care | 20% coinsurance | 30% coinsurance | Up to a combined maximum benefit of 60 days per plan year. |
| | Rehabilitation services | Inside Princeton area: $35 copay per visit then 20% coinsurance / Outside Princeton area: 20% coinsurance | 30% coinsurance | Physical therapy is limited to 30 visits per plan year. Physical therapy services are not covered at in-network providers located outside the Princeton area. Physical Therapy is only covered at Penn Medicine in the Princeton area. |
| | Habilitation services | 20% coinsurance | 30% coinsurance | ----------none---------- |
| | Skilled nursing care | 20% coinsurance | 30% coinsurance | Precertification is required. Call HealthSmart 1-877-202-6379, Option 3. If precertification is not obtained, the plan will cover only 50% of eligible facility expenses. |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | ----------none---------- |
| | Hospice services | 20% coinsurance | 30% coinsurance | Precertification is required for inpatient services. Call HealthSmart 1-877-202-6379, Option 3. If precertification is not obtained, the plan will cover only 50% of eligible facility expenses. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | Limit 1 benefit per plan year. Routine vision screening for children as specified by PPACA Preventive Care Benefits. |
| | Children's glasses | No charge | No charge | Specified by PPACA/Pediatric Vision, limit 1 benefit per plan year. |
| | Children's dental check-up | No charge | No charge | Oral health risk assessment for children as specified by PPACA Preventive Care Benefits. |

## 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
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care

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

- Acupuncture
- Bariatric surgery (covered for morbid obesity only)
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (60 visits per plan year)
- Weight loss programs (only if prescribed by a medical provider)

## Your Rights to Continue Coverage:

There is no extension of benefits provision under this SHBP plan that would extend some or all of the plan benefits for expenses incurred after the termination date of a student's or dependent's coverage. This SHBP plan does not include any extension of eligibility provision as the SHBP is not an employer-sponsored plan and is not subject to regulation under the Consolidated Omnibus Budget Reconciliation Act of 1996.

**Extension of Eligibility or Conversion Privilege:** There is no Extension of Eligibility or Conversion Privilege under the Student Health Benefits Plan provided by Princeton Theological Seminary. For more information on your rights to continue coverage, contact the plan at 1-609-497-7781. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## 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 Princeton Theological Seminary at 1-609-497-7781.

## 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 1-844-221-0961.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-221-0961.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-844-221-0961.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-221-0961.

*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 | $0 |
| Specialist copayment | $35 |
| Hospital (facility) copay/coinsurance | $300+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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,300 |
| Coinsurance | $1,970 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,270** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $35 |
| Hospital (facility) copay/coinsurance | $300+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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $50 |
| Copayments | $1,000 |
| Coinsurance | $30 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,080** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $35 |
| Hospital (facility)copay/coinsurance | $300+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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $700 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$800** |

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