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-new.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. See www.cigna.com/hcpdirectory / or call 1-800-997-1654	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	Coverage is provided for telemedicine services when provided in state jurisdictions where telemedicine is legally permissible.
	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 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 $30 copay – mail order	$15 copay – retail only	There is a separate deductible for prescription drugs: $50 per person per plan year. Retail – Up to a 30 day supply. Mail order – Up to a 90 day supply. 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. Out-of-Network mail order is not available. 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 $50 copay – mail order	$25 copay – retail only	
	Non-preferred brand drugs	$40 copay – retail $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. 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 Outpatient partial hospitalization: No charge	Office visits: 30% coinsurance 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----------
If you need help recovering or have	Home health care	20% coinsurance	30% coinsurance	Up to a combined maximum benefit of 60 days per plan year.

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)	
other special health needs	Rehabilitation services	Inside Princeton area: $35 copay per visit then 20% coinsurance / Outside Princeton area: $50 copay per visit then 20% coinsurance	30% coinsurance	Physical therapy is limited to 30 visits per plan year.
	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 except as specificaly provided in the Policy)
- 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.)

- Acupuncture
- Bariatric surgery (for morbid obesity only)
- Chiropractic care
- Hearing aids (1 per each impaired ear per 24 months)
- Infertility
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (inpatient only-60 visits per plan year)
- Routine Eye Care (Adult)-1 per plan year

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

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 for Individual plans.

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,200**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,000
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,070**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$150
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.