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 1-609-497-7781 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 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, including radiology, laboratory, and procedures performed by the provider during an office visit and billed by the provider.	$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	Includes coverage for procedures, same as provided for primary care visits, when the service is performed by the Specialist during an office visit and billed by the Specialist.
	Preventive care/screening/ immunization	No charge	Not covered	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----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available	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.
	Preferred brand drugs	$25 copay – retail $50 copay – mail order	$25 copay – retail only	

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
at www.wellfleetstudent.com	Non-preferred brand drugs	$40 copay – retail $80 copay – mail order	$40 copay – retail only	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 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). No cost sharing applies to Affordable Care Act (ACA) Preventive Care medications filled at a participating network pharmacy and Zero Cost Drugs.
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	Urgent care benefits are provided on the same basis as office visits.
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 Wellfleet 1-877-640-7940. If precertification is not obtained, the plan will cover only 50% of eligible facility expenses.

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)	
	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 / Center at 353 (formerly 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 Wellfleet at 1-877-640-7940. 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	
	Childbirth/delivery facility services	$300 per admission copay then 20% coinsurance	30% coinsurance	
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 In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
other special health needs	Rehabilitation services	Princeton Penn Medicine: $35 copay per visit then 20% coinsurance Cigna PPO Provider: $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 Wellfleet 1-877-657-5030. 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 Wellfleet 1-877-657-5030. 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 specifically 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 treatment
- 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 are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 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: 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.
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, kwiijigo holne' (877) 657-5030.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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) coinsurance	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) coinsurance	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) coinsurance	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**

*This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services? row above.

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 the Civil Rights Coordinator.

If you believe that Wellfleet 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:

Civil Rights Coordinator
PO Box 15369
Springfield, MA 01115-5369
(413) 733-4540
civilcoordinator@wellfleetinsurance.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is 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
800-868-1019; 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.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：(877) 657-5030.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

ملاحظة: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. اتصل بـ 657-5030 (877).

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語**(Japanese)** を話される場合、無料の言語支援サービスをご利用いただけ ます。(877) 657-5030 にお電話ください。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات ترجمه رایگان در دسترس شما می‌باشد. تماس بگیرید (877) 657-5030.

कृपा ध्या द: यद आप हंद (Hindi) भाषी ह तो आपके लए भाषा सहायता सेवाएं न:शुल् उपलब् ह। कृपा पर काल कर (877) 657-5030

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ**(Khmer)** សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) ચુ ના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો (877) 657-5030

Ελληνικά (Greek)ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਆਨ ਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (877) 657-5030