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, contact Benefits Team at 609-258-3302. 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.princeton.edu/hr/benefits/spd or call 609-258-3302 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each calendar Year In-Network Individual $0 / Family $0	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**All services.**	There is no deductible with this plan.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For this plan the out-of-pocket limit on medical services is Individual $2,500/Family $5,000. For the Prescription Plan the out-of-pocket limit is Individual $3,500/Family $7,000.	For Medical and Prescription, the out-of-pocket limit is the most you could pay for your share of the cost of covered prescriptions.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for prescriptions and health care this plan doesn't cover.	Services that are not covered under the HMO are not included. Under prescription, penalties for Member Pays the Difference and Home Delivery Incentive are not included.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.aetna.com/dse/princeton or call 1-800-535-6689.	If you use an in-network or other health care provider, this plan will pay some or all of the costs of covered services except in certain emergencies out of network providers are not covered. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kind of providers.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.

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 copay	Not covered	Applies to selected Primary Care Physician only.
	Specialist visit	$25 copay	Not covered	A referral is required to see a specialist.
	Preventive care/screening/ immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	X-ray covered at $0 at an independent facility; $50 copay at a hospital setting. No charge for diagnostic testing for COVID-19 at any lab.
	Imaging (CT/PET scans, MRIs) Independent Facility Hospital setting	No charge $100	Not covered	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.OptumRx.com/MyCatamaranRx	Generic drugs	Per Prescription $5 copay (retail) $10 copay (mail order)	Per Prescription $5 copay (retail) $10 copay (mail order)	Covers up to a 30-day supply (retail); 31-90 day supply (mail order). If a maintenance medication is purchased at a retail pharmacy for more than 3 months, subsequent refills will cost twice the retail copayment rate. Some prescriptions may require Prior Authorization, Step Therapy and Quantity Duration Programs. If there is a generic equivalent for a brand-name drug, Member pays the generic copay plus the difference between the Plan's cost of the brand drug and the Plan's cost of the generic drug.
	Preferred brand drugs	Per Prescription $25 copay (retail) $50 copay (mail order)	Per Prescription $25 copay (retail) $50 copay (mail order)	
	Non-preferred brand drugs	Per Prescription $40 copay (retail) $80 copay (mail order) If a generic equivalent exists, see "Limitations & Exceptions" for cost	Per Prescription $40 copay (retail) $80 copay (mail order) If a generic equivalent exists, see "Limitations & Exceptions" for cost	
	Specialty drugs	Costs are the same as the categories above	Costs are the same as the categories above	Most Specialty drugs must be purchased through Optum Rx Specialty Pharmacy, BriovaRx.
If you have outpatient surgery	Independent Facility Hospital	No charge $75 copay	Not covered Not covered	----------None----------
	Physician/surgeon fees	No charge	Not covered	----------None----------

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 need immediate medical attention	Emergency room care	$175 copay Waived if admitted	$175 copay Waived if admitted	Not covered for non-emergency use.
	Emergency medical transportation	No charge	No charge	Not covered for non-emergency use.
	Urgent care	$25 copay	Not covered	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$175 copay	Not covered	----------None----------
	Physician/surgeon fees	No charge	Not covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay	Not covered	----------None----------
	Inpatient services	$175 copay	Not covered	----------None----------
If you are pregnant	Office visits	Prenatal – No charge Postnatal - $25	Not covered	Prenatal copay of $25 for first visit
	Childbirth/delivery professional services	No charge	Not covered	----------None----------
	Childbirth/delivery facility services	$175 inpatient hospital copay	Not covered	----------None----------
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage limited to 60 visits per calendar year.
	Rehabilitation services	$25 copay	Not covered	Limited to 100 visits per calendar year each for Speech, Occupational and Physical Therapies and a separate 100 visits per calendar year for pulmonary and cardiac rehab. Physical Therapy subject to $15 copay.
	Habilitation services	$25 copay	Not covered	Age and visit limits may apply.
	Skilled nursing care	No charge	Not covered	60 days per calendar year maximum.
	Durable medical equipment	No charge	Not covered	Single purchase of a type of equipment is covered including repair. Replacements allowed once every three years.
	Hospice services	No charge	Not covered	Coverage limited to 180 days lifetime maximum.

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 your child needs dental or eye care	Children's eye exam	$25 copay	Not covered	1 eye exam per calendar year
	Children's glasses	Covered	Not covered	Pediatric Glasses Reimbursement - 100% once per 12 months Adult Reimbursement - Up to $70 per 24 months
	Children's dental check-up	Not covered	Not covered	Not covered under the HMO; covered under Aetna or MetLife Dental Plans if elected.

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.)

- Routine dental care
- Cosmetic surgery
- Long-term care
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing aids – limited to $1,500 every 36 months maximum
- Chiropractic care (limited to 20 visits per year)
- Acupuncture (20 visit limit per year)
- Infertility coverage – Diagnosis & treatment of underlying medical condition covered with no lifetime maximum. Other infertility treatment provided through Kindbody; four (4) Cycles per member per Lifetime. In-network only coverage. Proof of inability to conceive is not required
- Gender Reassignment services, including Psychotherapy, Hormone Replacement Therapy and Gender Reassignment Surgery

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: 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. 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 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? **Yes**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan does provide minimum essential coverage. 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**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (acturial value). This health coverage does meet the minimum value standard for the benefits it provides. 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 1-888-982-3862.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-888-982-3862.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

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 *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	$175
Other *[cost sharing]*	%

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	**$ 16,166**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$ 0
Copayments*	$ 200
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$ 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 *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	$175
Other *[cost sharing]*	%

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	**$ 5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$
Copayments**	$ 415
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$ 415**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	$175
Other *[cost sharing]*	%

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	**$ 2,430**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$ 0
Copayments	$ 290
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$ 290**

*Assumes a $30 copay for maternity care, 3 Mail Order copays for generic prescriptions and Tier 1 provider

**Assumes 4 Physician Specialist Tier 1 copays, 3 Nutritionist copays, and copays for 4 Mail Order generic prescriptions and 4 Mail Order Preferred Brand prescriptions

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