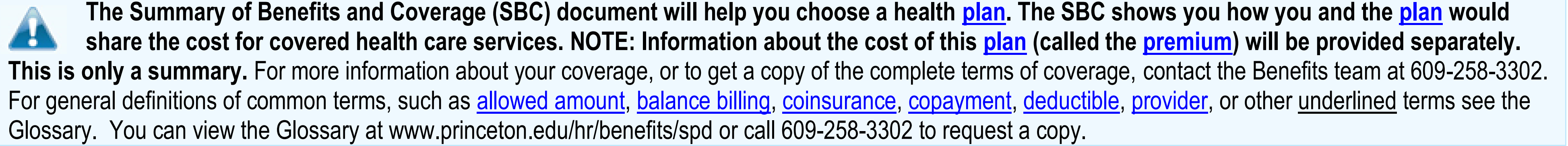
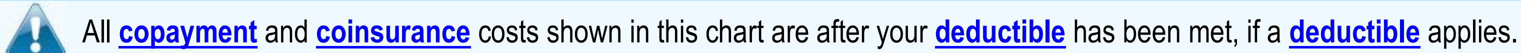


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the 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 the Individual deductible is $500 and the Family deductible is $1,000	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts over every January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	**No.**	All services require that the deductible be satisfied met before the plan begins to pay.
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?	The out-of-pocket limit is $2,500 ind./$5,000 family. For the Prescription Plan the In-Network limit is $3,500 ind./$7,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for prescriptions and failure to obtain pre-authorization for services 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. For a list of in-network providers, see www.aetna.com/dse/princeton or call 1-800-535-6689. You may also utilize out-of-network providers.	While you may utilize any hospital, facility or physician of your choice, if you utilize a provider in Aetna's Open Choice PPO network, you may be able to take advantage of Aetna's negotiated rates which may lower your out-of-pocket expenses.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.


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% coinsurance, after deductible.	20% coinsurance, after deductible	———— None ————
	Specialist visit	20% coinsurance, after deductible	20% coinsurance, after deductible	———— None ————
	Preventive care/screening/ immunization	20% coinsurance, after deductible	20% coinsurance, after deductible	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance, after deductible	20% coinsurance, after deductible	No charge for diagnostic testing for COVID-19 at any lab.
	Imaging (CT/PET scans, MRIs)	20% coinsurance, after deductible	20% coinsurance, after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com/My CatamaranRx	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); 90 day supply (mail order). If maintenance medication is purchased at a retail for more than 3 months, subsequent refills will cost twice the retail copayment rate. Some scripts 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	Facility fee (e.g., ambulatory surgery center)	20% coinsurance, after deductible	20% coinsurance, after deductible	———— None ————
	Physician/surgeon fees	20% coinsurance, after deductible	20% coinsurance, after deductible	

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	20% coinsurance, after deductible	20% coinsurance, after deductible	Not covered for non-emergency use.
	Emergency medical transportation	20% coinsurance, after deductible	20% coinsurance, after deductible	——————— None ———————
	Urgent care	20% coinsurance, after deductible	20% coinsurance, after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance, after deductible	20% coinsurance, after deductible	Precertification required or benefits may be reduced by $200.
	Physician/surgeon fees	20% coinsurance, after deductible	20% coinsurance, after deductible	——————— None ———————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance, after deductible	20% coinsurance, after deductible	——————— None ———————
	Inpatient services	20% coinsurance, after deductible	20% coinsurance, after deductible	Precertification required or benefits may be reduced by $200.
If you are pregnant	Office visits	20% coinsurance, after deductible	20% coinsurance, after deductible	——————— None ———————
	Childbirth/delivery professional services	20% coinsurance, after deductible	20% coinsurance, after deductible	——————— None ———————
	Childbirth/delivery facility services	20% coinsurance, after deductible	20% coinsurance, after deductible	——————— None ———————
If you need help recovering or have other special health needs	Home health care	20% coinsurance, after deductible	20% coinsurance, after deductible	Coverage limited to 60 visits per calendar year. Precertification required or benefits may be reduced by $200.
	Rehabilitation services	20% coinsurance, after deductible	20% coinsurance, after deductible	Limited to 30 visits per calendar year each for Speech, Occupational and Physical Therapies and a separate 50 visits per calendar year for pulmonary and cardiac rehab.
	Habilitation services	20% coinsurance, after deductible	20% coinsurance, after deductible	Age and visit limits may apply.
	Skilled nursing care	20% coinsurance, after deductible	20% coinsurance, after deductible	60 days per calendar year maximum. Precertification required or benefits may be reduced by $200.
	Durable medical equipment	20% coinsurance, after	20% coinsurance, after	---------------------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)	
		deductible	deductible	
	Hospice services	20% coinsurance, after deductible	20% coinsurance, after deductible	Inpatient -180 days per lifetime maximum. Precertification required or benefits may be reduced by $200.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered under J-1 Visa Plan; covered under the MetLife Vision Plan, or Aetna or MetLife Dental Plan, if elected.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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
- Routine foot care
- Glasses
- Long-term care
- Routine eye care
- Weight Loss Programs

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

- Nutritionist (12 visit limit per year)
- Chiropractic care (20 visit limit per year)
- Hearing aids – up to $1,500 every 3 years
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.

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** **$500**
- **Specialist *[cost sharing]*** **20%**
- **Hospital (facility) *[cost sharing]*** **20%**
- **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 Mother and Baby	$ 1,000
Copayments*	$ 30
Coinsurance*	$ 2,864
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$ 3,894**

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

- **The plan's overall deductible** **$500**
- **Specialist *[cost sharing]*** **20%**
- **Hospital (facility) *[cost sharing]*** **20%**
- **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	$ 500
Copayments**	$ 240
Coinsurance	$ 460
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$ 1,200**

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

- **The plan's overall deductible** **$500**
- **Specialist *[cost sharing]*** **20%**
- **Hospital (facility) *[cost sharing]*** **20%**
- **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	**$2430**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$
Coinsurance	$404
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$904**

*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.