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 609-258-302. 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 $200 / Family $400. Out-of-network: Individual $750 / Family $1,500. Does not apply to office visits, preventive care, and emergency care in-network.	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?	Primary care physician visits Specialist visits Urgent Care Center visits Chiropractic visits	No deductibles are required for these services.
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 for the medical coverage is salary based. Review the SPD for details. For the Prescription Plan the limit is Individual $3,500/Family $7,000.	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. Certain specialties have Aexcel Tier 1 in-network providers, who are listed on the website.	If you use an in-network provider, this plan will pay some or all of the costs of covered services. 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 kinds of providers.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

For more information about limitations and exceptions, see the plan or policy document at www.princeton.edu/hr/benefits

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	40% coinsurance, after deductible	Applies to Internal Medicine, Pediatrics, Family Practice, and General Medicine.
	Specialist visit	$30 copay if non-tiered specialty or Premium Tier 1 specialist, $60 copay if Tier 2 specialist	40% coinsurance, after deductible	If In-Network Tiered Specialty: Tier 1 Preferred $30 copay Tier 2 Non-Preferred $60 copay If In-Network non-tiered specialty $30 copay
	Preventive care/screening/ immunization	No charge	40% coinsurance, after deductible	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for Quest or LabCorp; 40% after deductible for other in-network labs.	Not covered.	X-rays/Radiology covered no charge at in-network independent facility. 20% after deductible at in-network hospital. No coverage out of network. $0 for diagnostic testing for COVID-19 at any lab.
	Imaging (CT/PET scans, MRIs) Independent Facility Hospital	 $0 20% after deductible	Not covered	Precertification required, or services will not be covered. In-Network provider will obtain necessary precertification. No coverage out of network.
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); 90 day supply (mail order). If maintenance medication is purchased at 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	

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)	
	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)	10% coinsurance, after deductible	40% coinsurance, after deductible	Precertification required or services will not be covered. In-Network provider will obtain precert. You are responsible for precert for Out-of-Network services. If in-network non tiered specialty, 10% after deductible.
	Physician/surgeon fees	10% coinsurance Tier 1 or 20% coinsurance Tier 2, both after deductible	40% coinsurance, after deductible	
If you need immediate medical attention	Emergency room care	$175 copay Waived if admitted		Not covered for non-emergency use.
	Emergency medical transportation (or treatment)	No charge	No charge	Non-emergency use requires precertification.
	Urgent care	$30 copay	40% coinsurance, after deductible	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance, after deductible	40% coinsurance, after deductible	Precertification required, or services will not be covered. In-Network provider will obtain precert. You are responsible for precert for Out-of-Network services. If in-network non tiered specialty, 10% after deductible.
	Physician/surgeon fees	10% coinsurance Tier 1 or 20% coinsurance Tier 2, both after deductible	40% coinsurance, after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay	25% coinsurance; no deductible	----------None----------
	Inpatient services	10% coinsurance, after deductible	40% coinsurance, after deductible	Precertification required the same as described for outpatient surgery and hospital stays on page 3.
If you are pregnant	Office visits	$30 copay Tier 1, $60 copay Tier 2	40% coinsurance, after deductible	In-network prenatal care you pay copay for 1st visit, and other visits covered 100%
	Childbirth/delivery professional services	10% Tier 1, 20% Tier 2 (both after deductible)	40% coinsurance after deductible	Precertification required, same as hospital stay.
	Childbirth/delivery facility services	10% coinsurance after deductible	40% coinsurance, after deductible	In-network inpatient facility charges covered at 10% 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 help recovering or have other special health needs	Home health care	10% coinsurance, after deductible	40% coinsurance, after deductible	Coverage limited to 60 visits per calendar year. Precertification same as described for outpatient surgery on page 3.
	Rehabilitation services	10% coinsurance, after deductible	40% coinsurance, after deductible	Chiropractic $30 copay and 20 visit per calendar year limit. Limited to 100 visits per calendar year each for other rehab services. PT covered at 50% after deductible out of network.
	Habilitation services	10% coinsurance, after deductible	40% coinsurance, after deductible	Age and visit limits may apply.
	Skilled nursing care	10% coinsurance, after deductible	40% coinsurance, after deductible	Coverage limited to 60 visits per calendar year.
	Durable medical equipment	10% coinsurance, after deductible	Not covered	----------None----------
	Hospice services	10% coinsurance, after deductible	40% coinsurance, after deductible	Coverage limited to 180 days lifetime maximum.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered under Princeton Health Plan; covered under Aetna or MetLife Dental Plans 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.)

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

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)
- Hearing aids – up to $1,500 every 3 years
- Chiropractic care (20 visit limit per year)
- Non-emergency care when traveling outside of the US (covered at out-of-network level)

- 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% (actuarial 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 family deductible	$400
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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)	$ 400
Copayments**	$ 30
Coinsurance*	$ 1,432
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$ 1,862**

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	$ 200
Copayments**	$ 450
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$ 650**

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	$ 200
Copayments ***	$ 385
Coinsurance ***	$ 10
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$ 595**

*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
***Assumes 1 Specialist follow up visit, 6 physical therapy visits, 10% coverage for crutches

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