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 https://www.healthcare.gov/sbc-glossary/ 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 $1,500/Family $3,000. Out of Network: Individual $3,000/Family $6,000	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 policy, the overall family deductible must be met before the plan begins to pay
Are there services covered before you meet your deductible?	Yes. In-network preventive services are covered before the deductible is met.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For each Calendar Year In-Network: Individual $3,000/Family $6,000; Out of Network: Individual $6,000/Family $12,000.	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, balance-billing charges, penalties for prescriptions, 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. See www.aetna.com/dse/princeton or call 800-535-6689 for a list of network providers.	You pay the least if you use a provider in the preferred (Aexcel) Network. You pay more if you use a provider in the non-preferred 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.

Important Questions	Answers	Why This Matters:
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
		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.	50% coinsurance after deductible.	Applies to Internal Medicine, Pediatrics, Family Practice, and General Medicine.
	Specialist visit	10% coinsurance after deductible Preferred Provider; 20% coinsurance after deductible if Non-Preferred provider.	50% coinsurance after deductible.	If In-Network Tiered Specialty: Preferred (Tier 1) 10% coinsurance after deductible; Non-Preferred (Tier 2) 20% coinsurance after deductible; If In-Network non-tiered specialty 20% coinsurance after deductible
	Preventive care/screening/ immunization	No charge	50% coinsurance after deductible.	Age and frequency schedules may apply. 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)	$0 after deductible at Quest or LabCorp; 40% after deductible for other in-network lab	Not covered	X-rays/Radiology covered $0 after deductible at in-network independent facility. 20% after deductible at in-network hospital. No coverage out-of-network. No charge for diagnostic testing for COVID19 at any lab.
	Imaging (CT/PET scans, MRIs)	$0 after deductible at in-network independent facility; 20% after deductible at in-network hospital.	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**	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
	Preferred brand drugs	Per Prescription $25 copay (retail)	Per Prescription $25 copay (retail)	

[* For more information about limitations and exceptions, see the plan or policy document athttps://hr.princeton.edu/summary-plan-descriptions-spds]

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)	
coverage is available at https://hr.princeton.edu/thrive/health/2020-prescription-drug-plan		$50 copay (mail order)	$50 copay (mail order)	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. Deductible must be met for most medications; exceptions for immediate coverage are preventive drugs for chronic conditions.
	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% 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 category, 20% after deductible.
	Physician/surgeon fees	10% coinsurance after deductible Preferred Provider; 20% coinsurance after deductible if Non-Preferred provider	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$0 after deductible		Not covered for non-emergency use.
	Emergency medical transportation	$0 after deductible	$0 after deductible	Non-emergency use requires precertification.
	Urgent care	$0 after deductible	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance, after deductible	50% 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, 20% after deductible.
	Physician/surgeon fees	10% coinsurance after deductible Preferred Provider; 20% coinsurance after deductible if Non-Preferred provider	50% coinsurance after deductible	

[* For more information about limitations and exceptions, see the plan or policy document athttps://hr.princeton.edu/summary-plan-descriptions-spds]

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 mental health, behavioral health, or substance abuse services	Outpatient services	20% after deductible	25% coinsurance after deductible	None
	Inpatient services	20% after deductible	50% coinsurance after deductible	Precertification required the same as described for outpatient surgery and hospital stays above.
If you are pregnant	Office visits	10% coinsurance after deductible Preferred Provider; 20% coinsurance after deductible if Non-Preferred provider	50% coinsurance after deductible	You pay 10% coinsurance after deductible for preferred provider (Tier 1) or 20% after deductible for a non-preferred provider (Tier 2) for 1st visit to diagnosis pregnancy as well as post-partum visits. All other visits covered at 100%.
	Childbirth/delivery professional services	10% coinsurance after deductible Preferred Provider; 20% coinsurance after deductible if Non-Preferred provider	50% coinsurance after deductible	Specialist fees are covered per tier (preferred or non-preferred). Precertification required, same as hospital stay.
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	In-network inpatient facility charges covered at 20% after deductible.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Coverage limited to 60 visits per calendar year. Precertification same as described for outpatient surgery on page 3.
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Chiropractic care 20 visits per calendar year limit. Limited to 100 visits per calendar year each for other rehab services.
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Age and visit limits may apply.
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Coverage limited to 60 visits per calendar year.
	Durable medical equipment	20% coinsurance after deductible	Not covered	None
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	Coverage limited to 180 days lifetime maximum.

[* For more information about limitations and exceptions, see the plan or policy document athttps://hr.princeton.edu/summary-plan-descriptions-spds]

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	Not covered	Not covered	Not covered under this 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.)

- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Long-term care
- Routine eye care (Adult)
- 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 (20 visit limit per year)
- Bariatric surgery (precertification required)
- Chiropractor care (20 visit limit per year)
- Hearing aids (up to $1,500 every 3 years)
- Infertility coverage – Diagnosis and treatment of underlying medical condition covered with no lifetime maximum. Other fertility treatment provided through Kindbody; four (4) cycles covered per member per lifetime. In-network only coverage through Kindbody. No out-of-network coverage.
- Non-emergency care when traveling outside of the US (covered at the out-of-network level)
- Private-duty nursing (precertification required; 60 visit limit per 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: 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 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: The Benefits Team at 609-258-3302 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

[* For more information about limitations and exceptions, see the plan or policy document athttps://hr.princeton.edu/summary-plan-descriptions-spds]

Does this plan meet the Minimum Value Standards? **Yes**

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 1-800-535-6689

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-535-6689

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-535-6689

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-535-6689

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	**$1,500**
Specialist *[cost sharing]*	**10%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	$1,500
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$1,710**

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

The plan's overall deductible	**$1,500**
Specialist *[cost sharing]*	**10%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	$1,770
Copayments	$200
Coinsurance	$50
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is*	**$1,770**

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

The plan's overall deductible	**$1,500**
Specialist *[cost sharing]*	**10%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	$1,500
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$1,710**

Note: *These numbers assume the patient is not participating in the condition management incentive program. If you participate in this program, you may reduce your costs. For more information, contact the Benefits Team at 609-258-3302.

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