




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:
<b>What is the overall <a href="#">deductible</a>?</b>	In-network deductible Individual \$200 / Family \$400; Out-of-network: Individual \$750 / Family \$1,500.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meet the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In-network preventive services are covered before the deductible is met.	For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	The out-of-pocket limit for the medical coverage is salary based. For the Prescription Plan the limit is Individual \$3,500/Family \$7,000.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. Medical out-of-pocket limit for in-network: \$75,000 and under \$1,550 individual/\$3,100 family; \$75,001-\$150,000 \$2,350 individual/\$4,700 family; \$150,0001 and over \$3,100 individual/\$6,200 family. Out-of-network: \$75,000 and under \$4,500 individual/\$9,000 family; \$75,001-\$150,000 \$4,700 individual/\$9,400 family; \$150,0001 and over \$6,200 individual/\$12,400 family.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for prescriptions, failure to obtain pre-authorization for services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.aetna.com/dse/princeton">www.aetna.com/dse/princeton</a>	You pay the least if you use a <a href="#">provider</a> in the preferred (Aexcel) Network. You pay more if you use a <a href="#">provider</a> in the non-preferred Network. You will pay the most if you use an <a href="#">out-of-</a>

Important Questions	Answers	Why This Matters:
	or call 800-535-6689 for a list of <u>network providers</u> .	<u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your plan pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an out-of-network provider for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's office</u> or <u>clinic</u>	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.
	<u>Specialist</u> visit	\$30 copay if preferred provider; \$60 copay if non-preferred provider.	40% coinsurance after deductible.	In-Network Tiered Specialty: Preferred (Tier 1) \$30 copay; Non-Preferred (Tier 2) \$60 copay; If In-Network non-tiered specialty category \$30 copay
	<u>Preventive care/screening/immunization</u>	No charge	40% coinsurance after deductible.	Age and frequency schedules may apply. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$0 at 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 setting. No coverage out of network. \$0 for diagnostic testing for COVID-19 at any lab.
	Imaging (CT/PET scans, MRIs)	\$0 at in-network independent facility; 20% after deductible at in-network hospital.	Not covered	Precertification required, or services will not be covered. <u>In-Network provider</u> will obtain necessary precertification. No coverage <u>out-of-network</u> .
If you need drugs to treat your illness or condition	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

[\* For more information about limitations and exceptions, see the plan or policy document at <https://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)	
More information about <a href="https://hr.princeton.edu/thrive/health/2020-prescription-drug-plan">prescription drug coverage</a> is available at <a href="https://hr.princeton.edu/thrive/health/2020-prescription-drug-plan">https://hr.princeton.edu/thrive/health/2020-prescription-drug-plan</a>	Preferred brand drugs	Per Prescription \$25 copay (retail) \$50 copay (mail order)	Per Prescription \$25 copay (retail) \$50 copay (mail order)	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.  Most Specialty drugs must be purchased through Optum Rx Specialty Pharmacy.
	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	
	<a href="#">Specialty drugs</a>	Costs are the same as the categories above	Costs are the same as the categories above	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	40% coinsurance after deductible	Precertification required or services will not be covered. <u>In-Network provider</u> will obtain precert. You are responsible for precert for <u>Out-of-Network</u> services. If <u>in-network</u> non-tiered specialty category, 10% after <u>deductible</u> .
	Physician/surgeon fees	10% coinsurance after deductible Preferred Provider; 20% coinsurance after deductible if Non-Preferred provider	40% coinsurance after deductible	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$175 copay; waived if admitted.		Not covered for non-emergency use.
	<a href="#">Emergency medical transportation</a>	No charge.	No charge.	Non-emergency use requires precertification.
	<a href="#">Urgent care</a>	\$30 copay	40% coinsurance after deductible	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance, after deductible	40% coinsurance after deductible	Precertification required, or services will not be covered. <u>In-Network provider</u> will obtain precert. You are responsible for precert for <u>Out-of-Network</u> services. If <u>in-network</u> non-tiered specialty, 10% after <u>deductible</u> .
	Physician/surgeon fees	10% coinsurance after deductible Preferred Provider; 20% coinsurance after deductible if Non-Preferred provider	40% 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 mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay	25% coinsurance no deductible	None
	Inpatient services	10% after deductible	40% coinsurance after deductible	Precertification required the same as described for outpatient surgery and hospital stays above.
If you are pregnant	Office visits	\$30 copay in-network Preferred Provider; \$60 copay Non-Preferred provider	40% coinsurance after deductible	You pay 10% <u>coinsurance after deductible</u> 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	40% coinsurance after deductible	Specialist fees are covered per tier (preferred or non-preferred). Precertification required, same as hospital stay.
	Childbirth/delivery facility services	10% coinsurance after deductible	40% coinsurance after deductible	<u>In-network</u> inpatient facility charges covered at 10% after <u>deductible</u> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	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.
	<a href="#">Rehabilitation services</a>	10% coinsurance after deductible	40% coinsurance after deductible	Chiropractic \$30 <u>copay</u> and 20 visit per calendar year limit. Limited to 100 visits per calendar year each for other rehab services. PT covered at 50% after <u>deductible</u> out of network.
	<a href="#">Habilitation services</a>	10% coinsurance after deductible	40% coinsurance after deductible	Age and visit limits may apply.
	<a href="#">Skilled nursing care</a>	10% coinsurance after deductible	40% coinsurance after deductible	Coverage limited to 60 visits per calendar year.
	<a href="#">Durable medical equipment</a>	10% coinsurance after deductible	Not covered	None
	<a href="#">Hospice services</a>	10% coinsurance after deductible	40% coinsurance after deductible	Coverage limited to 180 days lifetime

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	maximum.
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Glasses</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (20 visit limit per year)</li> <li>• Bariatric surgery (precertification required)</li> <li>• Chiropractor care (20 visit limit per year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (up to \$1,500 every 3 years)</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside of the US (covered at the out-of-network level)</li> <li>• Private-duty nursing (precertification required; 60 visit limit per year)</li> </ul>

**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](http://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](http://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](http://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](http://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](#).

### 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, kwijigo holne' 1-800-535-6689

*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.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://hr.princeton.edu/summary-plan-descriptions-spds>



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](#) \$200
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,100</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is*</b>	<b>\$720</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$470</b>

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.