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?	$0	There is no deductible for this plan. See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	All services.	There is no deductible for this plan. This plan covers certain preventive services without cost sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-carebenefits/."
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 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.	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.	This plan uses a provider network. If you use an in-network 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 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral 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)	$0 at in-network independent facility; $100 copay at in-network hospital.	Not covered.	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	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,

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 at in-network independent facility; $75 copay at in-network hospital setting.	Not covered.	None.
	Physician/surgeon fees	No charge.	Not covered.	None.
If you need immediate medical attention	Emergency room care	$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	$20 copay	Not covered.	None.
	Inpatient services	$175 copay	Not covered.	None.
If you are pregnant	Office visits	No charge for prenatal visits; postnatal visits $25 copay.	Not covered.	$25 copay applies for 1st visit to diagnosis pregnancy.
	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.

[* 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)	
	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.
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.)

- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Long-term care
- 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)
- Route eye care (Adult)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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.

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.*

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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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$260**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is*	**$720**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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.