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?	In-network deductible Individual $200 / Family $400; Out-of-network: Individual $750 / Family $1,500.	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 plan, each family member must meet their own individual deductible until the total amount of the deductible expenses paid by all family members meet the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	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?	The out-of-pocket limit for the medical plan is salary based. For the Prescription Plan the 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. 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 and $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 and $12,400 family.
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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 877-609-2273 for a list of network providers.	You pay the least if you use a provider in the preferred (Premium Tier 1) 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.
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 copay	40% coinsurance, after deductible	Applies to Internal Medicine, Pediatrics, Family Practice, and General Medicine.
	Specialist visit	$30 copay if preferred provider; $60 copay if non-preferred provider.	40% coinsurance after deductible.	In-Network Tiered Specialty categories: Preferred (Tier 1) $30 copay; Non-Preferred (Tier 2) $60 copay In-Network non-tiered specialty category $30 copay
	Preventive care/screening/ immunization	No charge	40% 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 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. In-Network provider will obtain necessary precertification. No coverage out-of-network.

[* 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://hr.princeton.edu/thrive/health/2020-prescription-drug-plan	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.
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 category, 10% after deductible.
	Physician/surgeon fees	10% coinsurance after deductible Preferred Provider; 20% coinsurance after deductible if Non-Preferred provider	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	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 after deductible Preferred Provider; 20% coinsurance after	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)	
		deductible if Non-Preferred provider		
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 $30 copay for preferred provider (Tier 1) or $60 copay 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	In-network inpatient facility charges covered at 10% after deductible.
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

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)	
	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 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 at https://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 1-877-609-2273

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-609-2273

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-609-2273

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-609-2273

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	**$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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$40
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,100**

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	**$5,600**
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	**$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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$470**

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.