Princeton University Student Health Plan (SHP)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 09/01/2016 – 08/31/2017

Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://uhs.princeton.edu/student-health-plan / or by calling 609-258-3138.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** individual/**$400** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** individual/**$200** family for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. Medical: **$5,000** individual /**$10,000** family, Prescriptions: **$1,350** individual/**$2,700** family	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, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See Aetna's website **or call 1-877-480-4161** for a list of preferred care providers.	If you use an in-network doctor or other health care **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, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Certain specialists require referral authorization from University Health Services.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 609-258-3138 or visit us at http://uhs.princeton.edu/student-health-plan

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at https://uhs.princeton.edu/sites/uhs/files/Uniform-Glossary.pdf or call 609-258-3138 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $10) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred care **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Care Provider	Your Cost If You Use a Non-Preferred Care Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	20% coinsurance	————————none————————
	Specialist visit	$10 copay per visit	20% coinsurance	Coverage requires referral from UHS
	Other practitioner office visit	20% coinsurance	20% coinsurance	————————none————————
	Preventive care/screening/immunization	No charge	20% coinsurance	ACA Preventive Care Benefits
If you have a test	Diagnostic test (x-ray, blood work)	No charge for laboratory 20% coinsurance for all other services	20% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Care Provider	Your Cost If You Use a Non-Preferred Care Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available on OptumRx's website or by calling 1-877-615-6319.	Generic drugs (Includes Specialty)	Retail $5 copay /Mail order $10 copay	Retail $5 copay /Mail order $10 copay	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription); Specialty limited to 30 day supply.
	Preferred brand drugs (Includes Specialty)	Retail $20 copay /Mail order $40 copay	Retail $20 copay / Mail order $40 copay	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription); Specialty limited to 30 day supply.
	Non-preferred brand drugs (Includes Specialty)	Retail $70 copay / Mail order $140 copay	Retail $70 copay / Mail order $140 copay	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription); Specialty limited to 30 day supply. If prescription undergoes prior authorization, preferred brand copay will apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Coverage for Transgender Surgery requires Pre-Certification. If Pre-Certification is not obtained, service is not covered.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Coverage for Transgender Surgery requires Pre-Certification. If Pre-Certification is not obtained, service is not covered.
	Physician/surgeon fee	20% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Care Provider	Your Cost If You Use a Non-Preferred Care Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay per visit	20% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	——————none——————
	Substance use disorder outpatient services	$10 copay per visit	20% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	20% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Limited to 60 visits per year
	Rehabilitation services	20% coinsurance	20% coinsurance	——————none——————
	Habilitation services	20% coinsurance	20% coinsurance	——————none——————
	Skilled nursing care	20% coinsurance	20% coinsurance	——————none——————
	Durable medical equipment	20% coinsurance	50% coinsurance	——————none——————
	Hospice service	20% coinsurance	20% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Limited to one exam per year
	Glasses	No charge	No charge	Glasses or contact lenses one time per year
	Dental check-up	No charge	30% coinsurance	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental Care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care (30 visits per year)
- Hearing aids (one per ear per year)
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

Coverage continues if a covered student is disabled or becomes confined to a hospital or is undergoing specialty treatment for an identified condition (and this condition has been documented in the student's medical records by the providers at University Health Services) within 30 days prior to the termination of the SHP. The condition must be due to an accidental bodily injury or illness incurred before the coverage would have terminated. Such coverage continues, subject to the provisions of the SHP for treatment of the disabling condition, until 90 days after the date of normal termination of coverage or 90 days after the student's scheduled graduation (whichever occurs first).

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Princeton University Student Health Plan Office at: Washington Road, McCosh Health Center – Room # 111, Princeton, NJ 08544-1004. Tel: 1-609-258-3138, Fax: 1-609-258-9191, shpo@princeton.edu.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-859-8475.**
Tagalog (Tagalog): Kung kailangan ninno ang tulong sa Tagalog tumawag sa **1-800-859-8475.**
Chinese (中文): 如果需要中文的帮助, □□打□个号□ **1-800-859-8475.**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-859-8475.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,390
- **Patient pays** $1,610

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$10
Coinsurance	$1,300
Limits or exclusions	$0
Total	**$1,610**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$300
Coinsurance	$300
Limits or exclusions	$0
Total	**$900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.