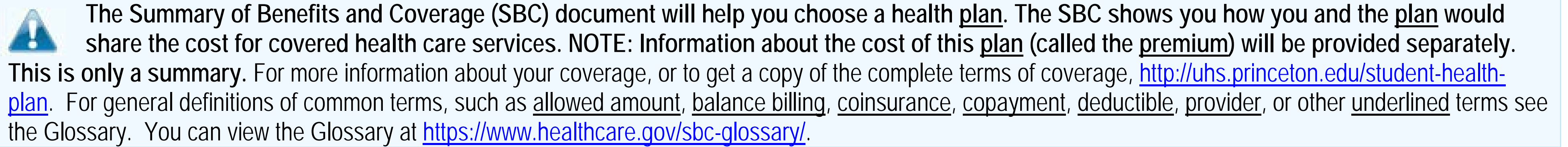
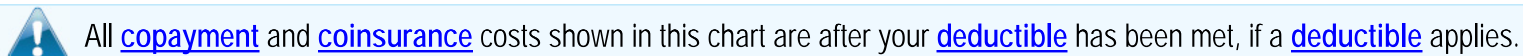


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, http://uhs.princeton.edu/student-health-plan. 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/.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual/$400 family Deductibles are waived for certain services	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 than individual coverage, at least one family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?	Yes. $100 individual or $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.
What is the out-of-pocket limit for this plan?	Medical: $5,000 individual or $10,000 family; Prescriptions: $1,350 individual/$2,700 family	The out-of-pocket limit is the most you as an individual could pay in a plan year for covered services. If you have other family members on this plan, the family out-of-pocket limit is the most you could pay for covered services for all family members.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See Aetna's website or call 1-877-480-4161 for a list of preferred care providers. Also, see the SHP Website for a list of Exclusive Mental Health Network providers.	This plan uses provider networks. You will pay less if you use a provider in the plan's networks. You will pay the most if you use a non-preferred care 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 a non-preferred care 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?	Yes. Certain specialists require a referral.	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
		Preferred Care (You will pay the least)	Non-Preferred Care (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	$10 copay/office visit, Deductible does not apply	20% coinsurance	None
	Specialist visit	$10 copay per visit	20% coinsurance	Coverage may require referral. $20 copay/office visit for Exclusive Mental Health Network Providers/Specialists. Deductibles do not apply.
	Preventive care/screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for blood work 20% coinsurance for all other tests	20% coinsurance	Deductible waived for preferred network Laboratory
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	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 (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 pre-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-authorization. If Pre-authorization is not obtained, service is not covered.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at http://uhs.princeton.edu/student-health-plan/.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Care (You will pay the least)	Non-Preferred Care (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible does not apply
	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-authorization. If Pre-authorization is not obtained, service is not covered.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit Deductible does not apply	20% coinsurance	$20 copay/office visit for Exclusive Mental Health Network Providers/Specialists and deductible does not apply.
	Inpatient services	20% coinsurance	20% coinsurance	None
If you are pregnant	Office visits	$10 copay/office visit	20% coinsurance	
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Limited to 60 visits per plan 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	20% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Limited to one exam per plan year
	Children's glasses	No charge	No charge	Glasses or contact lenses one time/plan year.
	Children's dental check-up	No charge	20% coinsurance	None

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)
- 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
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

[* For more information about limitations and exceptions, see the plan or policy document at http://uhs.princeton.edu/student-health-plan/.]

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the **Plan** at the Student Health Plan Office at 609-258-3138 or at shpo@princeton.edu. 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 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 Princeton University Student Health Plan Office at 609-258-3138 or at shpo@princeton.edu.

Does this plan provide Minimum Essential Coverage? [Yes/No]

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [Yes/No]

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 1-800-859-8475.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-859-8475.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 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 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]* $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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$20
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,580**

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]* $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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

- The plan's overall deductible $200
- 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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$20
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

*Note: This plan has other **deductibles** for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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