

 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/> or call 1-609-258-3138 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$200 individual/\$400 family	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 <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes: Preventative Care Preferred Medical, Preferred Office Visits, Preferred Care Laboratory, Ambulance Expense	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. 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> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 individual/\$200 family for <a href="#">prescription drug coverage</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: \$5,000 individual/ \$10,000 family; Prescriptions: \$1,350 individual/\$2,700 family	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 on 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">Aetna's website</a> or call 1-877-480-4161 for a list of preferred care providers. Also, see the <a href="#">SHP Website</a> for a list of Exclusive Mental Health Network <a href="#">providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> 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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <b>copay</b> /office visit, <b>deductible</b> does not apply	30% <b>coinsurance</b>	None
	<u>Specialist</u> visit	\$10 <b>copay</b> per visit <b>Deductible</b> does not apply.	30% <b>coinsurance</b>	Coverage may require <b>referral</b> . \$20 <b>copay</b> /office visit for Exclusive Mental Health Network Providers/ <b>Specialists</b> .
	<u>Preventive care/screening/immunization</u>	No charge <b>Deductible</b> does not apply.	30% <b>coinsurance</b>	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge for blood work <b>Deductible</b> does not apply. 10% <b>coinsurance</b> for all other tests	30% <b>coinsurance</b>	None
	Imaging (CT/PET scans, MRIs)	10% <b>coinsurance</b>	30% <b>coinsurance</b>	None
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="https://uhs.princeton.edu/sites/uhs/files/OptumRx-Formulary-Reference-Guide.pdf">https://uhs.princeton.edu/sites/uhs/files/OptumRx-Formulary-Reference-Guide.pdf</a> .	Generic drugs (Includes Specialty)	\$5 <b>copay</b> /RX (retail) \$10 <b>copay</b> /RX (mail order)	\$5 <b>copay</b> /RX (retail) \$10 <b>copay</b> /RX (mail order)	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 <b>pre-authorization</b> , preferred brand copay will apply. Prescription drug <b>deductible</b> does not apply to <b>preventative</b> prescription drug expenses (including generic contraceptives).
	Preferred brand drugs (Includes Specialty)	\$20 <b>copay</b> /RX (retail) \$40 <b>copay</b> /RX (mail order)	\$20 <b>copay</b> /RX (retail) \$40 <b>copay</b> /RX (mail order)	
	Non-preferred brand drugs (Includes Specialty)	\$70 <b>copay</b> /RX (retail) \$140 <b>copay</b> /RX (mail order)	\$70 <b>copay</b> /RX (retail) \$140 <b>copay</b> /RX (mail order)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <b>coinsurance</b>	30% <b>coinsurance</b>	Coverage for Transgender Surgery requires <b>Pre-authorization</b> . If <b>Pre-authorization</b> is not obtained, service is not covered.
	Physician/surgeon fees	10% <b>coinsurance</b>	30% <b>coinsurance</b>	
<b>If you need immediate</b>	<u>Emergency room care</u>	10% <b>coinsurance</b>	10% <b>coinsurance</b>	None

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)	
medical attention	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	None
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Coverage for Transgender Surgery requires <a href="#">Pre-authorization</a> . If <a href="#">Pre-authorization</a> is not obtained, service is not covered.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /office visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> /office visit for Exclusive Mental Health Network Providers/Specialists and <a href="#">deductible</a> does not apply.
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$10 <a href="#">copay</a> /office visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	None
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to 60 visits per <a href="#">plan</a> year
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If your child needs dental or eye care	Children's eye exam	No charge	30% <a href="#">coinsurance</a>	Limited to one exam per <a href="#">plan</a> year.
	Children's glasses	No charge	30% <a href="#">coinsurance</a>	Glasses or contact lenses one time/ <a href="#">plan</a> year.
	Children's dental check-up	No charge <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	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                                    | • Long-Term care           | • Routine Foot Care    |
| • Dental Care (Adult except preventative up to \$125) | • Routine Eye Care (Adult) | • Weight Loss Programs |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |   |  |
|---|---|--|
| • Acupuncture (limited to 30 combined visits per year with Massage and Biofeedback) | • Hearing Aids (limited to one per ear/per <a href="#">plan</a> year) | • Non-Emergency Care when traveling outside the U.S. |
| • Bariatric Surgery   | • Infertility Treatment (except Advanced Reproduction Technology)     | • Private-Duty Nursing                               |
| • Chiropractic Care (limited to 30 visits per year with 2 modalities per visit)     |   |  |

**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:

- You may contact your state insurance department, the 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).
- 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](mailto: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](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 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](mailto:shpo@princeton.edu).

### 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? **Not Applicable.**

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, kwijjigo 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 copayment](#) \$10
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$280</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 copayment](#) \$10
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$300
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$200
<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 copayment](#) \$10
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$420</b>

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