

# Comparison of Benefits for Retirees Under Age 65

available through health care plans offered by Princeton University in 2012

\*\* Aetna (POS and HMO) forms are available online at [www.princeton.edu/hr/forms](http://www.princeton.edu/hr/forms)

Summary of Services This is intended to provide an overview of plan benefits. Please refer to the various carrier packages or websites for the exact coverage level of specific services.	UnitedHealthcare Choice Plus (PPO)* www.myuhc.com/groups/princetonuniversity 877-609-2273 Group # 196484		Aetna Preferred Provider (PPO)* www.aetna.com 800-535-6689 Group # 863750		UnitedHealthcare Choice Plus POS* www.myuhc.com/groups/princetonuniversity 877-609-2273 Group # 196484		Aetna Choice POS II* www.aetna.com 800-535-6689 Group # 811281 ** Additional Aetna form required		Aetna HMO www.aetna.com 888-287-4296 Group # 3015 ** Additional Aetna form required
	Preferred Provider Organization Plan		Aetna Preferred Provider Organization Plan		UnitedHealthcare Point-of-Service Plan		Aetna Point-of-Service Plan		Aetna HMO Plan
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	
<b>Annual deductible</b>	Individual: \$300 Family: \$600	Individual: \$ 600 Family: \$1,200	Individual: \$300 Family: \$600	Individual: \$ 600 Family: \$1,200	Individual: None Family: None	Individual: \$ 900 Family: \$1,800	Individual: None Family: None	Individual: \$ 900 Family: \$1,800	None
<b>Annual out-of-pocket maximum (coinsurance limit, including deductible)</b>	Based on salary band		Based on salary band		Individual: \$1,500 Family: \$3,000	Individual: \$4,500 Family: \$9,000	Individual: \$1,500 Family: \$3,000	Individual: \$4,500 Family: \$9,000	Not applicable
<b>Lifetime maximum medical/surgical/mental health</b>	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
<b>HOSPITAL BENEFITS</b>									
<b>Inpatient medical/surgical care (including maternity)</b>	10% after deductible	20% after deductible	10% after deductible	20% after deductible	10% (no deductible)	30% after deductible	10% (no deductible)	30% after deductible	\$0
<b>Inpatient care for mental health</b>	10% after deductible	20% after deductible	10% after deductible	20% after deductible	10% (no deductible)	30% after deductible	10% (no deductible)	30% after deductible	\$0
<b>Emergency room</b>	\$60 copay; waived if admitted	\$60 copay; waived if admitted	\$60 copay; waived if admitted	\$60 copay; waived if admitted	\$60 copay; waived if admitted	\$60 copay; waived if admitted	\$60 copay; waived if admitted	\$60 copay; waived if admitted	\$60 copay per visit, waived if admitted
<b>OUTPATIENT BENEFITS</b>									
<b>Treatment by physician</b>	\$25 copay per visit	20% after deductible	\$25 copay per visit	20% after deductible	\$20 copay per visit	30% after deductible	\$20 copay per visit	30% after deductible	\$20 copay per visit
<b>Annual physical</b>	\$25 copay per visit	20% after deductible \$200 max. per calendar year	\$25 copay per visit	20% after deductible \$200 max. per calendar year	\$20 copay per visit	Not covered	\$20 copay per visit	Not covered	\$20 copay per visit
<b>Specialist</b>	\$25 copay per visit	20% after deductible	\$25 copay per visit	20% after deductible	\$25 copay per visit	30% after deductible	\$25 copay per visit	30% after deductible	\$25 copay per visit
<b>Well baby visits</b>	\$25 copay per visit	20% after deductible max. 7 visits first year	\$25 copay per visit	20% after deductible max. 7 visits first year	\$20 copay per visit	Not covered	\$20 copay per visit	Not covered	\$20 copay per visit
<b>Maternity</b>	\$25 copay 1st visit; pre- & post-partum care inclusive to surgical charge for delivery	20% after deductible	\$25 copay 1st visit; pre- & post-partum care inclusive to surgical charge for delivery	20% after deductible	\$25 copay 1st visit; pre- & post-partum care inclusive to surgical charge for delivery	30% after deductible	\$25 copay 1st visit; pre- & post-partum care inclusive to surgical charge for delivery	30% after deductible	\$25 copay 1st visit only
<b>Preventive immunizations</b>	\$25 copay per visit	not covered	\$25 copay per visit	not covered	\$20 copay per visit	Not covered	\$20 copay per visit	Not covered	\$20 copay per visit
<b>Mental health</b>	\$25 copay per visit	20% coinsurance (no deductible required)	\$25 copay per visit	20% coinsurance (no deductible required)	\$25 copay per visit	30% coinsurance (no deductible required)	\$25 copay per visit	30% coinsurance (no deductible required)	\$25 copay per visit
<b>All prescription drug coverage is through Medco Health</b>	Retail copays: Generic \$5, brand name \$25, multi-source \$40 Mail order copays: Generic \$10, brand name \$50, multi-source \$80 Deductible: None		Retail copays: Generic \$5, brand name \$25, multi-source \$40 Mail order copays: Generic \$10, brand name \$50, multi-source \$80 Deductible: None		Retail copays: Generic \$5, brand name \$25, multi-source \$40 Mail order copays: Generic \$10, brand name \$50, multi-source \$80 Deductible: None		Retail copays: Generic \$5, brand name \$25, multi-source \$40 Mail order copays: Generic \$10, brand name \$50, multi-source \$80 Deductible: None		Retail copays: Generic \$5, brand name \$25, multi-source \$40 Mail order copays: Generic \$10, brand name \$50, multi-source \$80 Deductible: None
<b>Routine annual eye exams</b>	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	\$25 copay per visit
<b>Prescription eyeglasses or contact lenses</b>	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	\$70 reimbursement every 2 years, plus discounts at participating providers

\* For the Aetna PPO and POS Plans, when searching for providers on the Aetna website, please select the Aetna choice POS II (open access) network. For the UnitedHealthcare PPO and POS Plans, when searching for providers on the UnitedHealthcare website, please select the UnitedHealthcare Choice Plus network.

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