**Important Questions** | **Answers** | **Why this Matters:**
---|---|---
What is the overall deductible? | For each Calendar Year In Network: Individual $1500/Family $3000. Out of Network: Individual $3000/Family $6000. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over every January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. The individual deductible applies if you elect Consumer Directed Health Plan coverage for *yourself* only, otherwise the family deductible applies. The deductible does not apply to preventive care.

Are there other deductibles for specific services? | No. | There are no additional deductibles for specific services.

Is there an out-of-pocket limit on my expenses? | For each Calendar Year In Network: Individual $3000/Family $6000 Out of Network: Individual $6000/Family $12000. | 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, penalties for prescriptions and 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**.

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. For a list of in-network providers, see www.aetna.com/dse/princeton. Certain specialties have Aexcel Tier 1 in-network providers, who are listed on the website. | 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 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? | No | You can see the specialist you choose without permission from this plan.

Are there services this plan doesn’t cover? | Yes. | Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

This is only a summary. If you want more detail about your coverage and costs, you can call 609-258-3302.
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, $20) 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 10% would be $100. 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 in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-Of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Applies to Internal Medicine, Pediatrics, Family Practice, and General Medicine.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance after deductible if non-tiered specialty or Tier 1 specialist, 20% coinsurance after deductible if Tier 2 specialist</td>
<td>50% coinsurance, after deductible.</td>
<td>If In-Network Tiered Specialty: Tier 1 Preferred 10% coinsurance after deductible Tier 2 Non-Preferred 20% coinsurance after deductible If In-Network non-tiered specialty 10% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Chiropractic visits limited to 20 per year, Nutrition visits limited to 12 per year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% coinsurance, after deductible.</td>
<td>Age and frequency schedules may apply.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge for Tier 1 Lab or 20% after deductible for Tier 2 Lab</td>
<td>50% coinsurance, after deductible.</td>
<td>X-rays covered no charged in-network and at 50% after deductible out-of-network</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance, after deductible.</td>
<td>Not covered.</td>
<td>Precertification is required or the test may not be covered.</td>
</tr>
</tbody>
</table>

Questions: Call 1-888-982-3862 (Aetna) or 609-258-3302 (Benefits Team). 
If you aren’t clear about any of the terms used in this form, see the Glossary at www.princeton.edu/hr/benefits/sbc.
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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<tr>
<td>If you need drugs to treat your illness or condition (Prescription coverage is provided by Optum Rx.)</td>
<td>Generic drugs</td>
<td>Per Prescription $5 copay (retail) $10 copay (mail order)</td>
<td>Per Prescription $5 copay (retail) $10 copay (mail order)</td>
<td>Federal guideline preventive drugs covered at $0 copay. For some maintenance drugs, costs apply with no deductible; all other drugs, costs apply after deductible. Retail is up to a 30-day supply; mail order, 31-90 day supply. If a maintenance drug is purchased at retail for more than 3 months, subsequent refills will cost twice the retail copay. Some prescriptions may require Prior Auth, 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 for the brand and generic drugs.</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand drugs</td>
<td>Per Prescription $25 copay (retail) $50 copay (mail order)</td>
<td>Per Prescription $25 copay (retail) $50 copay (mail order)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred Brand drugs</td>
<td>Per Prescription $40 copay (retail) $80 copay (mail order) If a generic equivalent exists, see &quot;Limitations &amp; Exceptions&quot; for cost</td>
<td>Per Prescription $40 copay (retail) $80 copay (mail order) If a generic equivalent exists, see &quot;Limitations &amp; Exceptions&quot; for cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Costs are the same as the categories above</td>
<td>Costs are the same as the categories above</td>
<td>Most Specialty drugs must be purchased through Optum Rx Specialty Pharmacy, Briova Rx. Deductible rules as above apply.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Precertification required or it will not be covered. You are responsible for Out-of-Network precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Same cost as Specialist Visit on Page 2</td>
<td>50% coinsurance, after deductible.</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room</td>
<td>No charge, after deductible.</td>
<td>No charge, after deductible.</td>
<td>Non-emergency use not covered.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge, after deductible.</td>
<td>No charge, after deductible.</td>
<td>Non-emergency use not covered.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Precertification required or it will not be covered. You are responsible for Out-of-Network precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>Same cost as Specialist Visit on Page 2</td>
<td>50% coinsurance, after deductible.</td>
<td></td>
</tr>
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<th>Your Cost If You Use an Out-Of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>None</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Precertification required or it will not be covered.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Substance use disorder outpatient services</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>None</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Substance use disorder inpatient services</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Precertification required or it will not be covered.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>Same cost as Specialist Visit on Page 2</td>
<td>50% coinsurance, after deductible.</td>
<td>In-network pre-natal care coinsurance for 1st visit, and postnatal visit, other visits covered 100%. For High Risk Specialist visits, and certain tests for mother or baby, deductible and coinsurance apply.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Delivery and all inpatient services</td>
<td>Same cost as Specialist Visit on Page 2</td>
<td>50% coinsurance, after deductible.</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Coverage limited to 60 visits per calendar year.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Limited to 50 visits per calendar year each for Speech, Physical and Occupational Therapy, pulmonary and cardiac rehab.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Age and visit limits may apply.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Skilled nursing care</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Coverage limited to 60 days per calendar year.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Durable medical equipment</td>
<td>20% coinsurance, after deductible.</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Hospice service</td>
<td>20% coinsurance, after deductible.</td>
<td>50% coinsurance, after deductible.</td>
<td>Coverage is limited to 180 days maximum per calendar year inpatient.</td>
</tr>
</tbody>
</table>
## Aetna

### Consumer Directed Health Plan

**Coverage Period:** 01/01/2016 - 12/31/2016  
**Coverage for:** Individual + Family  
**Plan Type:** POS  
**PRINCETON UNIVERSITY**

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

<table>
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<tr>
<th>Common Medical Event</th>
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<th>Your Cost If You Use an Out-Of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need dental or eye care</td>
<td>Eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered under the CDHP; covered under VSP if elected.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered under the CDHP; covered under VSP if elected.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered under the CDHP; covered under Aetna or MetLife Dental Plans if elected.</td>
</tr>
</tbody>
</table>

### 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.)

- Acupuncture (except in lieu of anesthesia)
- Cosmetic surgery
- Weight Loss Programs
- Glasses
- Long-term care
- Routine eye care
- Routine foot care

#### 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.)

- Nutritionist (12 visit limit per year)
- Chiropractic 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 infertility treatment limited to $20,000 lifetime maximum. Specific treatments may have lifetime attempt limits. Proof of inability to conceive is not required to receive treatment.
- Non-emergency care when traveling outside of the US (covered at out-of-network level)
- Gender Reassignment services, including Psychotherapy, Hormone Replacement Therapy and Gender Reassignment Surgery

Questions: Call 1-888-982-3862 (Aetna) or 609-258-3302 (Benefits Team).  
If you aren’t clear about any of the terms used in this form, see the Glossary at www.princeton.edu/hr/benefits/sbc.
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ouchiio.cms.gov.

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: Aetna at 1-888-982-3862, the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

• Additionally, a consumer assistance program can help you file an appeal. Contact information for Aetna is http://www.aetna.com/individuals-families-health-insurance/member-guidelines/complaints-grievances-appeals.html.

Language Access Services:
Para obtener asistencia en Español, llame al 1-888-982-3862.

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 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.

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

#### 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.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $3,500</td>
<td><strong>Plan pays:</strong> $1,700</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $4,040</td>
<td><strong>Patient pays:</strong> $3,700</td>
</tr>
</tbody>
</table>

**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:** $3,000
- **Copays:** $0
- **Coinsurance:** $1,040
- **Limits or exclusions:** $ -

| Total | $4,040 |

**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:** $3,000
- **Copays:** $240
- **Coinsurance:** $460
- **Limits or exclusions:** $ -

| Total | $3,700 |

*Deductible does not apply to routine obstetric care. Example assumes Tier 1 provider

**Assumes Employee and Children, Employee and Spouse/Partner or Employee and Family Coverage

***Assumes 4 Tier 1 Specialist visits, 3 Nutritionist visits, and copays for 4 Mail Order generic prescriptions and 4 Mail Order Preferred Brand prescriptions

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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.
- 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.