Comparison of benefits available through health care plans offered by Princeton University in 2007

Summary of Services

This is intended to provide an overview of plan benefits. Please refer to the various carrier packages or web-sites for the exact coverage level of specific services.

	UnitedHealthcare Options (PPO) www.myuhc.com/groups/princetonuniversity 877-609-2273 Group # 196484		UnitedHealthcare Select Plus POS www.myuhc.com/groups/princetonuniversity 877-609-2273 Group # 196484 * Additional UnitedHealthcare form required		Aetna Choice POS II www.aetna.com 800-535-6689 Group # 811281 * Additional Aetna form required		UnitedHealthcare Select EPO (HMO) www.myuhc.com/groups/princetonuniversity 877-609-2273 Group # 196484 * Additional UnitedHealthcare form required	Aetna HMO www.aetna.com 888-287-4296 Group # 3015	High Deductible Plan (UnitedHealthcare) www.myuhc.com/groups/princetonuniversity 877-609-2273 Group # 196484	J-1 Visa Health Care Plan (UnitedHealthcare) www.myuhc.com/groups/princetonuniversity 877-609-2273 Group # 196484
	Preferred Provider Organization Plan		**UnitedHealthcare Point-of-Service**		**Aetna Point-of-Service**		UnitedHealthcare Select EPO (HMO)	**Aetna HMO**	**High Deductible Plan**	**J-1 Visa Health Care Plan**
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**				
Annual Deductible	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	None	Individual: $5,000	Individual: $ 500 Family: $1,000
Annual Out-of-Pocket Maximum (Coinsurance Limit, including deductible)	Based on salary bands		**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	Not Applicable	Individual: $20,000	Individual: $2,500 Family: $5,000
Lifetime Maximum Medical/Surgical/Mental Health	Unlimited	$2,000,000	Unlimited	$2,000,000	Unlimited	$2,000,000	Unlimited	Unlimited	$500,000	$2,000,000
HOSPITAL BENEFITS										
Inpatient Medical/Surgical Care (including Maternity)	10% after deductible	20% after deductible	10% co-insurance	30% after deductible	10% co-insurance	30% after deductible	$0	$0	30% after deductible	20% after deductible
Inpatient Care for Mental Disorders	10% after deductible	20% after deductible	10% co-insurance	30% after deductible	10% co-insurance	30% after deductible	$0 covered up to 35 days per calendar year	$0 covered up to 35 days per calendar year	30% after deductible covered up to 30 days per calendar year	20% after deductible covered up to 30 days per calendar year
	30 days per calendar year (combined in-network/out-of-network)		30 days per calendar year (combined in-network/out-of-network)		30 days per calendar year (combined in-network/out-of-network)					
Emergency Room	$50 copay; waived if admitted	$50 copay; waived if admitted	$50 copay, waived if admitted	$50 copay; waived if admitted	$50 copay, waived if admitted	$50 copay; waived if admitted	$50 copay per visit, waived if admitted	$50 copay per visit, waived if admitted	30% after deductible	20% after deductible
OUTPATIENT BENEFITS										
Treatment by Physician	$15 copay per visit	20% after deductible	$15 copay per visit	30% after deductible	$15 copay per visit	30% after deductible	$15 copay per visit	$15 copay per visit	30% after deductible	20% after deductible
Annual Physical	$15 copay per visit	20% after deductible $200 max. per calendar year	$15 copay per visit	not covered	$15 copay per visit	not covered	$15 copay per visit	$15 copay per visit	not covered	20% after deductible $200 max per calendar year
Specialist	$15 copay per visit	20% after deductible	$20 copay per visit	30% after deductible	$20 copay per visit	30% after deductible	$20 copay per visit	$20 copay per visit	30% after deductible	20% after deductible
Well Baby Visits	$15 copay per visit	20% after deductible max. 6 visits first year only	$15 copay per visit	not covered	$15 copay per visit	not covered	$15 copay per visit	$15 copay per visit	not applicable	20% after deductible max. 6 visits first year only
Maternity	$15 copay 1st visit; pre & post partum care inclusive to surgical charge for delivery	20% after deductible	$20 copay 1st visit; pre & post partum care inclusive to surgical charge for delivery	30% after deductible	$20 copay 1st visit; pre & post partum care inclusive to surgical charge for delivery	30% after deductible	$20 copay 1st visit only	$20 copay 1st visit only	30% after deductible	20% after deductible
Preventive Immunizations	$15 copay per visit	not covered	$15 copay per visit	not covered	$15 copay per visit	not covered	$15 copay per visit	$15 copay per visit	not covered	not covered
Mental Health	50% coinsurance (no deductible required)	50% coinsurance after deductible	50% co-insurance	50% after deductible	50% co-insurance	50% after deductible	$25 copay per visit—covered up to 50 visits per calendar year	$25 copay per visit—covered up to 50 visits per calendar year	50% after deductible — covered up to 50 visits per calendar year	50% after deductible—covered up to 50 visits per calendar year
	50 visits per calendar year (combined in-network/out-of-network)		50 visits per calendar year (combined in-network/out-of-network)		50 visits per calendar year (combined in-network/out-of-network)					
All Prescription Drug Coverage is through Medco Health	Retail copays: Generic **$5,** Brand Name $20, Multi Source $30 Mail Order copays: Generic **$10,** Brand Name $40, Multi Source $60 Deductible: **None**		Retail copays: Generic **$5,** Brand Name $20, Multi Source $30 Mail Order copays: Generic **$10,** Brand Name $40, Multi Source $60 Deductible: **None**		Retail copays: Generic **$5,** Brand Name $20, Multi Source $30 Mail Order copays: Generic **$10,** Brand Name $40, Multi Source $60 Deductible: **None**		Retail copays: Generic **$5,** Brand Name $20, Multi Source $30 Mail Order copays: Generic **$10,** Brand Name $40, Multi Source $60 Deductible: **None**	Retail copays: Generic **$5,** Brand Name $20, Multi Source $30 Mail Order copays: Generic **$10,** Brand Name $40, Multi Source $60 Deductible: **None**	not covered	Retail copays: Generic **$5,** Brand Name $20, Multi Source $30 Mail Order copays: Generic **$10,** Brand Name $40, Multi Source $60 Deductible: **None**
Routine Annual Eye Exams	not covered	not covered	not covered	not covered	not covered	not covered	$20 copay per visit	$20 copay per visit	not covered	not covered
Prescription Eyeglasses or Contact Lenses	not covered	not covered	not covered	not covered	not covered	not covered	$70 reimbursement every 2 years	$70 reimbursement every 2 years, plus discounts at participating providers	not covered	not covered

*** UnitedHealthcare (POS and HMO) and Aetna (POS) forms are available online @ www.princeton.edu/hr/ben/forms**

2007 Plan Changes are Noted Above in Bold