Comparison of Benefits

available through health care plans offered by Princeton University in 2009

2009 Plan changes are noted below in bold

** UnitedHealthcare (POS) and Aetna (POS and HMO) forms are available online at www.princeton.edu/hr/ben/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 Options (PPO) www.myuhc.com/groups/princetonuniversity 877-609-2273 Group # 196484		**Aetna Preferred Provider (PPO)*** www.aetna.com 800-535-6689 Group # 863750		**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		**Aetna HMO** www.aetna.com 888-287-4296 Group # 3015 ** Additional Aetna form required	**High Deductible Plan (Aetna)** www.aetna.com 800-535-6689 Group # 811281	**J-1 Visa Health Care Plan (Aetna)** www.aetna.com 800-535-6689 Group # 811281
	Preferred Provider Organization Plan		**Aetna Preferred Provider Organization Plan**		**UnitedHealthcare Point-of-Service Plan**		**Aetna Point-of-Service Plan**		**Aetna HMO Plan**	**High Deductible Plan**	**J-1 Visa Health Care Plan**
	In-network	Out-of-network	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: $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	Individual: $5,000	Individual: $ 500 Family: $1,000
Annual out-of-pocket maximum (coinsurance limit, including deductible)	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	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	$2,000,000	Unlimited	$500,000	$2,000,000
HOSPITAL BENEFITS											
Inpatient medical/surgical care (including maternity)	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	30% after deductible	20% after deductible
Inpatient care for mental health	10% after deductible 30 days per calendar year (combined in-network/out-of-network)	20% after deductible	**10% after deductible 30 days per calendar year (combined in-network/out-of-network)**	**20% after deductible**	10% (no deductible) 30 days per calendar year (combined in-network/out-of-network)	30% after deductible	10% (no deductible) 30 days per calendar year (combined in-network/out-of-network)	30% after deductible	$0 covered up to 35 days per calendar year	30% after deductible covered up to 30 days per calendar year	30% after deductible covered up to 30 days per calendar year
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; waived if admitted	$50 copay; 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**	**20% after deductible**	$15 copay per visit	30% after deductible	$15 copay per visit	30% after deductible	$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**	**20% after deductible $200 max. per calendar year**	$15 copay per visit	Not covered	$15 copay per visit	Not covered	$15 copay per visit	Not covered	20% after deductible $200 max. per calendar year
Specialist	$15 copay per visit	20% after deductible	**$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	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**	**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	Not applicable	20% after deductible max. 6 visits 1st year only
Maternity	$15 copay 1st visit; pre- & post-partum care inclusive to surgical charge for delivery	20% after deductible	**$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	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	Not covered	$15 copay per visit	Not covered	Not covered
Mental health	20% coinsurance (no deductible required) 50 visits per calendar year (combined in-network/out-of-network)	30% coinsurance (no deductible required)	**20% coinsurance (no deductible required) 50 visits per calendar year (combined in-network/out-of-network)**	**30% coinsurance (no deductible required)**	20% coinsurance 50 visits per calendar year (combined in-network/out-of-network)	30% coinsurance (no deductible required)	20% coinsurance 50 visits per calendar year (combined in-network/out-of-network)	30% coinsurance (no deductible required)	$20 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
All prescription drug coverage is through Medco Health	Retail copays: Generic $5, brand name $20, **multi-source $35** Mail order copays: Generic $10, brand name $40, **multi-source $70** Deductible: None		Retail copays: Generic $5, brand name $20, **multi-source $35** Mail order copays: Generic $10, brand name $40, **multi-source $70** Deductible: None		Retail copays: Generic $5, brand name $20, **multi-source $35** Mail order copays: Generic $10, brand name $40, **multi-source $70** Deductible: None		Retail copays: Generic $5, brand name $20, **multi-source $35** Mail order copays: Generic $10, brand name $40, **multi-source $70** Deductible: None		Retail copays: Generic $5, brand name $20, **multi-source $35** Mail order copays: Generic $10, brand name $40, **multi-source $70** Deductible: None	Not covered	Retail copays: Generic $5, brand name $20, **multi-source $35** Mail order copays: Generic $10, brand name $40, **multi-source $70** Deductible: None
Routine annual eye exams	Not covered	Not covered	**Not covered**	**Not covered**	Not covered	Not covered	Not covered	Not covered	$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	Not covered	Not covered	$70 reimbursement every 2 years, plus discounts at participating providers	Not covered	Not covered

* For the new Aetna PPO Plan, when searching for providers on the Aetna website, please select the Aetna choice POS II (open access) network.