Princeton University
J-1 Visa Health Care Plan
Summary Plan Description
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Introduction

The J-1 Visa Health Care Plan is designed to meet the coverage limits mandated for health care insurance for certain foreign visitors. The J-1 Visa Plan is available only to those employees who are non-U.S. citizens visiting the United States on a J-1 Visa, and to their dependents on J-2 Visas. The Plan is not offered to employees who are United States citizens or foreign citizens with other types of Visas. Visitors on J-1 Visas may opt to waive the required medical coverage if they can prove that they have the equivalent of the federally mandated coverage. Visitors on J-1 Visas may also participate in the Health Maintenance Organization (HMO) offered by the University. However, J-1 Visa holders are not permitted to elect coverage under the Aetna or UnitedHealthcare Princeton Health Plan (PHP), or the Aetna Consumer Directed Health Plan (CDHP).

Period of Coverage
Princeton University covers employees on J-1 Visas and their dependents on J-2 Visas from the first date of appointment. If you do not have comparable coverage elsewhere, you must enroll in either the J-1 Visa Health Care Plan or the HMO Plan as soon as you arrive at Princeton University. If you do not enroll in any plan, you will be defaulted to the J-1 Visa Plan with employee only coverage.
How the Plan Works

The J-1 Visa Health Care Plan is a passive PPO Plan. This means that while you may utilize any hospital, facility or physician of your choice, if you utilize a provider in Aetna’s Open Choice PPO network, you may be able to take advantage of Aetna’s negotiated rates which may lower your out-of-pocket expenses. As an indemnity (fee-for-service) plan that allows you to select any provider, reimbursement through this plan will not begin until an annual deductible is reached. You are required to pay the doctor or health care provider at the time of your visit or service. Individual physician offices and health care facilities have different guidelines for payment. You should comply with the payment arrangements set by the health care provider. The health care provider will give you an itemized bill for the services rendered during the visit which will show the diagnosis and the provider’s tax number. In order to be reimbursed for your expenses, you must submit a claim form to Aetna. Again, you do not receive any payment from the Plan until you meet the deductible. The deductible is the amount you will pay before the plan begins to reimburse you for your expenses. This means that you must pay $500 ($1,000 for a family) of your own money (the deductible) before the Plan begins to reimburse you for your expenses.

Reasonable and Customary (R&C) Reimbursement

In-network services have negotiated prices whereas out-of-network services do not. Therefore, when you use out-of-network providers, the maximum amount a plan will allow to be charged for a service is called “reasonable and customary” (R&C). R&C charges are based on information provided by Fair Health, Inc., a not-for-profit company formed to compile claims information to show how much providers charge for services in any zip code. Our plans will reduce the out-of-network reimbursement to the 70th percentile of R&C charges. To search estimated R&C fees for services in your area, go to www.fairhealthconsumer.org or call Aetna for assistance.

For out-of-network services, the Plan pays 80% of the reasonable and customary (R&C) charge for most services. In addition to your 20% coinsurance, you may also be required to pay amounts above R&C, and these amounts do not count toward your annual out-of-pocket maximum.
What is Covered

Benefits Summary

This Benefits Summary summarizes the provisions of the Plan, including benefit amounts, maximum amounts, copays and deductibles.

<table>
<thead>
<tr>
<th>J-1 Visa Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
</tr>
<tr>
<td>The amount you pay each year before the Plan begins covering particular medical expenses.</td>
</tr>
<tr>
<td>Individual: $500</td>
</tr>
<tr>
<td>Family: $1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
</tr>
<tr>
<td>The percentage of medical expenses you pay out-of-pocket after you meet your deductible.</td>
</tr>
<tr>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Coinsurance Limit (Annual Maximum Out-of-Pocket) (including deductible)</td>
</tr>
<tr>
<td>Individual: $2,500</td>
</tr>
<tr>
<td>Family: $5,000</td>
</tr>
<tr>
<td>Lifetime Maximum Medical/Surgical/Mental Health</td>
</tr>
<tr>
<td>Unlimited</td>
</tr>
</tbody>
</table>

**HOSPITAL BENEFITS**

<table>
<thead>
<tr>
<th>J-1 Visa Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification/Compliance Requirement</td>
</tr>
<tr>
<td>Some services require pre-certification by calling Aetna at 1-800-535-6689.</td>
</tr>
<tr>
<td>Please see When to Pre-Certify section</td>
</tr>
<tr>
<td>Inpatient Medical/Surgical Care (including maternity)</td>
</tr>
<tr>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Inpatient Care/Residential Treatment for Mental Health and Substance Use Disorder</td>
</tr>
<tr>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Surgery (Inpatient/Outpatient)</td>
</tr>
<tr>
<td>Anesthesia and use of an operating room or related facility in a hospital or authorized institution.</td>
</tr>
<tr>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Emergency Room Services administered for conditions meeting the definition of an emergency.</td>
</tr>
<tr>
<td>You pay 20% after deductible. Non-emergency care not covered.</td>
</tr>
</tbody>
</table>
### J-1 Visa Plan

**Non-Notification/Non-Compliance Penalty**
The amount you must pay if you do not call Aetna at 1-800-535-6689 before hospitalization and certain types of surgery, or fail to follow concurrent review procedures.

You pay $200 per procedure and/or admission

### OUTPATIENT BENEFITS

**Notification/Compliance Requirement**
Some services require pre-certification by calling Aetna at 1-800-535-6689.

Please see *When to Pre-Certify* section

**Treatment by Physician**
You pay 20% after deductible

**Annual Physical**
Adults (18+): One exam every calendar year.

You pay 20% after deductible

**Well Baby Visits**
Children: Seven exams in first 12 months of life, three exams the next 13 to 24 months, three exams the next 25 to 36 months, and one (1) exam every calendar year thereafter up to age 18).

You pay 20% after deductible

**Preventive Immunizations**
You pay 20% after deductible

**Outpatient Lab and X-Ray Services for Diagnosis or Treatment**
You pay 20% after deductible

**Outpatient Mental Health and Substance Use Disorder Services**
You pay 20% after deductible

**Applied Behavioral Analysis (ABA) Therapy**
Coverage for children whose diagnosis is on the autism spectrum

You pay 20% after deductible

**Outpatient Physical Rehabilitation**
Short-term outpatient rehabilitation services for physical therapy, occupational therapy, speech therapies. Maximum of 30 visits each type per calendar year. Pulmonary and cardiac rehabilitation therapy covered at a maximum of 50 visits each type per calendar year.

You pay 20% after deductible

**Outpatient Therapeutic Treatments**
You pay 20% after deductible
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>J-1 Visa Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments.</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td><strong>OTHER BENEFITS</strong></td>
<td></td>
</tr>
<tr>
<td>Notification/Compliance Requirement</td>
<td>Please see When to Pre-certify section</td>
</tr>
<tr>
<td>Some services require pre-certification by calling Aetna at 1-800-535-6689.</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services - Emergency Only</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Chiropractic Services or Acupuncture Limited to 20 visits each per calendar year.</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Services related to physical therapy track towards a separate 30 visit limit for outpatient rehabilitation therapy.</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Single purchase of any one type of equipment is covered including repair. Replacements allowed once every three years. This covers Prosthetic Devices, including foot orthotics.</td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Limited to 12 visits per calendar year. Requires prescription from physician</td>
<td></td>
</tr>
<tr>
<td>Hearing Exams</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Limited to one exam per calendar year. Requires prescription from physician</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Plan pays 100% up to a maximum reimbursement of $1500 every three years</td>
</tr>
<tr>
<td>Limited to maximum reimbursement of $1500 every three years.</td>
<td></td>
</tr>
<tr>
<td>Prescriptions – Administered by OptumRx.</td>
<td>Retail copays: Generic $5, Preferred Brand $25, Non-preferred Brand $40 or member pays the difference</td>
</tr>
<tr>
<td>Mail-Order copays: Generic $10, Preferred Brand $50, Non-preferred Brand $80 or member pays the difference</td>
<td></td>
</tr>
<tr>
<td>Routine Annual Eye Exam</td>
<td>Not covered</td>
</tr>
<tr>
<td>Prescription Glasses or Contact Lenses</td>
<td>Not covered</td>
</tr>
<tr>
<td>Supplemental Benefits</td>
<td></td>
</tr>
<tr>
<td>Medical evacuation to your home country Transport of deceased to home country. This is covered through Princeton</td>
<td>Maximum of $10,000</td>
</tr>
<tr>
<td></td>
<td>Maximum of $7,500</td>
</tr>
</tbody>
</table>
While the Benefits Summary above provides an overview of your coverage under the J-1 Visa Health Plan, this section includes additional information about:

- Family Planning Benefits
- Mental Health Benefits
- Pregnancy Benefits
- Prescription Drug Benefits
- Preventive Health Care Benefits
- Gender Confirming Coverage

**Family Planning Benefits and Infertility**
The J-1 Visa Plan covers a range of family planning benefits including the following:
- Sterilization
- Health services and associated expenses for abortion
- Contraception supplies and services
- Fetal reduction surgery
- Health services associated with the use of non-surgical or drug induced pregnancy termination

The J-1 Visa Plan covers the first 2 visits per calendar year for Contraceptive Counseling at 100% in-network, and you pay 40% after the deductible for out-of-network services. The plan covers the office visit for injectable contraceptives, as well as for the fitting or insertion/removal of contraceptive devices at 100% in-network, and you pay 40% after the deductible for out-of-network services.

The J-1 Visa Plan covers infertility services for you and your covered spouse. Infertility services are not provided for covered children. Infertility services are covered if all of the following tests are met (proof of inability to conceive is not required):

- There exists a condition that:
  - is not caused by voluntary sterilization or a hysterectomy.
  Or
- For a female whose FSH levels are less than or equal to 19 miU on day three of the menstrual cycle.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

Note: Infertility services for fertility preservation treatments and procedures are covered for men and women in the case of chemotherapy, pelvic radiotherapy, or other gonadotoxic therapies, as well as in advance of hormone treatment or gender surgery for male to female as well as for female to male changes, when a medical treatment or procedure will compromise or end the patient’s ability to reproduce. (*Contact Aetna for more information.*)
The following infertility services expenses will be covered:

- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of six courses of treatment in a covered person’s lifetime.
- Artificial insemination, subject to a maximum of six courses of treatment in a covered person’s lifetime.

Advanced Reproductive Technology (ART), is subject to a maximum of three attempts in a covered person’s lifetime. These expenses will be covered on the same basis as for disease.

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

Not more than $20,000 will be paid for all infertility services expenses in a covered person's lifetime. In figuring the above ART Lifetime Maximum, Aetna will take into consideration all of the following, whether past or present:

- Services received while covered, under a plan of benefits offered by Aetna or one of its affiliated companies,
- Services received while covered under a plan of benefits, on an individual or group basis, whether insured or self-insured, offered by any other carrier, and
- Services received while no plan coverage was provided.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.

**Advanced Reproductive Technology (ART) Expenses**

The PHP will also cover expenses incurred by a covered female for advanced reproductive technology expenses up to a maximum of three attempts per lifetime; if all of the following tests are met (proof of inability to conceive is not required):

- There exists a condition that:
  - is not caused by voluntary sterilization or a hysterectomy.
  Or
- For a female whose FSH levels are less than or equal to 19 miU on day three of the menstrual cycle.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

Covered medical expenses will include the following services:

- In vitro fertilization (IVF),
- Zygote intra-fallopian transfer (ZIFT),
- Gamete intra-fallopian transfer (GIFT),
- Cryopreserved embryo transfers,
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and
- Care associated with a donor IVF program, including fertilization and culture.

Covered medical expenses for the covered female will also include obtaining the sperm of a covered partner.

These expenses will be covered on the same basis as for disease.

Mental Health and Substance Use Disorder Benefits
The J-1 Visa Health Plan covers inpatient and outpatient care for mental health and substance use disorder services, subject to certain limits noted below. A residential treatment facility would also be covered as an inpatient benefit. The deductible and coinsurance amounts apply as shown in the Benefits Summary. The most commonly used Mental Health Benefits are:

- Assessment
- Diagnosis
- Treatment planning
- Medication management
- Individual, family and group psychotherapy
- Psychological education
- Psychological testing

Mental health and substance use disorder benefits are administered by Aetna Behavioral Health, and they can be reached at 1-800-535-6689.

Pregnancy Benefits
Benefits for pregnancy will be paid at the same level as benefits for any other condition, sickness or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

We also have special prenatal programs to help during pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Aetna during the first trimester, but no later than one month prior to the anticipated childbirth.

Coverage includes:

- At least 48 hours for a normal vaginal delivery or 96 hours for a cesarean section of inpatient care for the mother and newborn child. Authorizations are required for longer lengths of stay. However, the mother and/or newborn can be discharged from the hospital prior to the 48/96 hour length of stay requirement upon consultation between the mother (or in the case of the newborn, the child’s mother or authorized representative) and the attending provider.
- Birth Center and Nurse-Midwife Services.
- Routine well-baby care given for the duration of the baby’s confinement.
• Pregnancy is subject to the precertification requirement only if the member exceeds days beyond the minimum. Please see When to Pre-Certify.

For a hospital delivery, the hospital length of stay begins at the time of delivery (or at the time of the last delivery in the case of multiple births). For a delivery outside the hospital, the hospital length of stay begins at the time the attending provider admits the mother and/or newborn as hospital patients in connection with childbirth.

Prescription Drug Benefits
The Prescription Drug Program is administered by Optum Rx and is independent of Aetna. See the Prescription Plan Summary Plan Description for more details.

Preventive Health Care Benefits
Preventative health services are covered at 80% after you have met your annual deductible. The following are covered services associated with Preventive Health Care Benefits:

• Routine physical exams (including any outpatient lab work/x-rays ordered at the time of the visit) for you and your spouse and dependents once each calendar year,
• Prostate specific antigen,
• Breast examination and/or mammogram, and
• Pelvic examination.

The following exclusions apply:

• Any services for well-child care visits over the limit of seven visits during the first year of life.

Gender Confirming Coverage

Gender Confirming Coverage includes the following:

• Psychotherapy for individuals experiencing gender dysphoria.
• Continuous Hormone Replacement Therapy with hormones of the desired gender (Hormone Replacement Therapy is covered under the Prescription Drug Program administered by OptumRx).
• Fertility preservation in advance of hormone treatment or gender confirming surgery
• Laser hair removal services for male to female participants experiencing gender dysphoria. Services must be provided by an in-network medical specialist, such as a Dermatologist or Plastic Surgeon. Coverage from a non-medical professional or out-of-network provider will not be covered.
• Speech/Voice therapy to help participants experiencing gender dysphoria communicate in a manner consistent with their gender identities. Services must be provided by a licensed speech therapist.

• Gender Confirming Surgery

**Gender Confirming Surgery**

Gender Confirming Surgery requires prior authorization in order to ensure the readiness of the patient for such surgery as well as to confirm medical necessity exists for the transgender patient. These protocols follow guidelines established by WPATH for such surgery. Covered expenses include:

• Charges made by a physician for:
  • Performing the surgical procedure; and
  • Pre-operative and post-operative hospital and office visits.

• Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). Room and board charges in excess of the hospital’s semi-private rate will not be covered unless a private room is ordered by your physician and precertification has been obtained.

Prior Authorization Requirements for all surgeries:

1) Age 18 or older;
2) Capacity to make fully informed decisions
3) Diagnosis of severe gender dysphoria
4) If medical/mental health conditions exist they must be well controlled

Additional prior authorization requirements and referrals may be needed for specific surgeries. Please contact Aetna for additional information.

**Exclusions:**

• Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
• Storage of cryopreserved embryos
• Rhinoplasty and Blepharoplasty
• Cosmetic procedures including, skin resurfacing, chin implants, nose implants and lip reduction

**Utilization Review**

You and your physician make decisions about medical services and supplies that you should receive; however, all covered services and supplies are subject to a Utilization Review. Utilization Review is the process that Aetna follows when determining whether services and supplies received by an individual are medically necessary according to Plan benefits and provisions. This review is mandatory in certain situations, taking place upon notification by you either before (pre-certification) or after (notification for emergency care) you receive certain services and supplies.
Pre-Certification
You are required to notify Aetna prior to receiving certain services by calling the toll-free number shown on your ID card. In some cases, a provider may handle the pre-certification; however it is important to remember that it is ultimately your responsibility to ensure that authorization has been received for all procedures and confinements for which it is required.

What and When to Pre-certify:

- Admissions to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility. Notification must be received at least five days prior to admission. This requirement does not apply to an admission for inpatient maternity services related to delivery.
- Admissions to a Hospital for maternity services, which extend beyond the minimum stay requirements of 48 hours for a mother and newborn for any delivery other than cesarean section, and 96 hours for a cesarean section delivery.
- The following outpatient services:
  - Home Health Care
  - Organ/Tissue Transplants – Aetna must be notified within seven (7) working days before the scheduled date of any of the following or as soon as reasonably possible: the evaluation, the donor search, the organ procurement/tissue harvest and the transplant. You must notify Aetna within two business days or as soon as reasonably possible if you are confined due to an emergency. If you do not notify Aetna, as required, the non-notification penalty will apply.

Non-Notification/Non-Compliance Penalty
There is a $200 non-notification/non-compliance penalty per procedure and/or admission for failing to call at the required time, or for failing to comply with recommendations concerning continued need for treatment. The amount of the penalty will never be more than the amount of the covered expenses. The penalty amount may not be applied toward your annual coinsurance limit.

Appeals
As a member of the J-1 Visa Plan, you have the right to file an appeal about coverage for service(s) you have received from your health care provider or Aetna if you are not satisfied with the outcome of the initial determination regarding the following:

- certification of health care services,
- claim payment,
- plan interpretation,
- benefit determination, and
- eligibility.

You may file an appeal in writing to Aetna. Your request that Aetna reconsider the decision must be made in writing or by phone within 60 days of the decision.
The denial notice will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna’s Member Services Unit at the toll-free phone number on the front of your ID card. Your request should include the group name, your name, Social Security Number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

Your appeal will be acknowledged within five working days of receipt. An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

Please refer to the About your Benefits Section for further information regarding appeals.

What’s Not Covered

The Plan does not cover the following services and supplies:

- Services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician or dentist.
- Care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending physician or dentist.
- Services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
  - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - if required by the FDA, approval has not been granted for marketing,
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes,
  - the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:
- the disease can be expected to cause death within one year, in the absence of
effective treatment, and
- the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:
- have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
- are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
- if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Services and supplies related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; or carbon dioxide therapy.
- Treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Services of a resident physician or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for custodial care.
- Services and supplies:
  - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
  - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it is required by law or is provided on other than a group basis. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
- Lasik surgery to correct refractive errors, unless there is a pre-surgical refractive error greater than eight (8) diopters.
- Education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Weight control services including: weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or
food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

- Plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
  Improve the function of a part of the body that:
  - is not a tooth or structure that supports the teeth; and
  - is malformed as a result of a severe birth defect; including cleft lip, webbed fingers, or toes, or
  - as a direct result of disease or surgery performed to treat a disease or injury.
  Surgery must be performed in the calendar year of the accident which causes the injury or in the next calendar year.

- Those to the extent they are not reasonable charges, as determined by Aetna.

- Reversal of a sterilization procedure.

- Service or supply furnished by a Preferred Care Provider in excess of such provider's Negotiated Charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.

- Dental care and X-rays.
- Donor egg retrieval.
- Over-the-counter medications and supplies.
- Special duty nursing.

If you have a question about whether a service or supply will be covered, contact Aetna directly at 1-800-535-6689.
Claims Information

Identification Cards

*Aetna ID Card*

You should receive your Aetna ID card within one month of your enrolling in the Plan. You will receive one ID card for yourself, and one additional card showing your name and all enrolled dependents. The Aetna ID card may be used to access medical care.

If you need to seek medical treatment before you receive your ID card, please refer the provider to the following information:

<table>
<thead>
<tr>
<th>Plan:</th>
<th>J-1 Visa Health Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group number:</td>
<td>811281</td>
</tr>
<tr>
<td>Member number:</td>
<td>Provided by Aetna</td>
</tr>
<tr>
<td>Phone number:</td>
<td>1-800-535-6689</td>
</tr>
<tr>
<td>Address:</td>
<td>Aetna Life Insurance Company</td>
</tr>
<tr>
<td></td>
<td>PO Box 981106</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79998-1106</td>
</tr>
</tbody>
</table>

During this transition period, if a doctor's office or hospital needs to verify coverage, please give them the telephone number for your Office of Human Resources.

When you receive a service from a provider, you should pay for the visit and take the following steps to file a claim for reimbursement:

- Secure an Aetna claim form by visiting the Web site for the Office of Human Resources, ([www.princeton.edu/hr/forms](http://www.princeton.edu/hr/forms)) or by visiting your Office of Human Resources in person,
- Complete and sign the Employee portion of the form,
- Have the provider complete the Provider portion of the form or enclose a provider bill which includes the information listed under claim submission below, and
- Send the form and a copy of the provider’s bill to the address shown on the form.

When you submit a claim, you should make sure the bills and the form include the following information:

- Your name and your Princeton University ID number,
- Princeton University’s name and contract number (811281),
- The patient’s name,
• The diagnosis,
• The date the services or supplies were incurred, and
• The specific services or supplies provided.

Claims must be submitted within a period of 24 months following the date the expense was incurred. No benefits are payable for claims submitted after the 24-month period unless it can be shown that it was not reasonably possible to submit them in a timely manner.

Prescription Drug Plan
You will receive a separate ID card for the Prescription Drug Plan, administered through OptumRx. The Prescription Drug Program is independent of Aetna. Please see the Prescription Drug Plan Summary Plan Description for additional information.

How and When Claims are Paid
Aetna processes claims within 10 business days of the date of receipt. Reimbursement is made directly to you, except in the following cases:

• You request in writing that payments be made directly to a provider. You do this by signing the appropriate authorization when completing the claim form.

Aetna will send an Explanation of Benefits (EOB) to you along with your reimbursement. The EOB will explain how Aetna considered each of the charges submitted for payment. If any claims are denied in whole or in part, you will receive an explanation.

Recovery of Overpayments
If a benefit payment is made by the plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the plan has the right to require the return of the overpayment. The plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a participant in the plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this plan or other health plans that are administered by the plan’s third-party administrator — Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the plan may have with respect to overpayments.
Review Procedure for Denied Claims
When a claim for benefit payment is denied in whole or in part, you may appeal the denial. A request for review must be directed to Aetna within 60 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, you should state the reason you believe the claim was improperly paid or denied and submit any data or comments to support the claim.

A review of the denial will be made and Aetna will provide the claimant with a written response within 60 days of the date Aetna receives your request for review. If the denial is upheld, Aetna’s written response will cite the specific Plan provision(s) upon which the denial is based.

Other Important Information

Coordination of Benefits
The J-1 Visa Plan utilizes a coordination of benefits feature that applies when an individual is covered under more than one health care plan. This feature determines which plan has primary responsibility for paying benefits and which plan has secondary responsibility. The secondary plan will only make a payment after the primary plan and only if it provides benefits in excess of the primary plan. For details about how the coordination of benefits works, please see the About Your Benefits Summary Plan Description.

Your Rights Under ERISA
For information about your rights under the Employee Retirement Income Security Act (ERISA) and other important information, see the About Your Benefits section of this Summary Plan Description Handbook.

Reservation of Rights
The University reserves the rights to amend, suspend, or terminate its J-1 Visa Health Care Plan in whole or in part, at any time and for any reason. The University has full authority and discretion to construe, interpret and administer its plan. The plan is unfunded, and no employee or dependent shall have any right to, or interest in, any assets of the University which may be applied by the University to the payment of benefits. Neither the establishment of the plan, nor the provision of benefits to any person, shall be construed as giving an employee the right to be retained in the service of the University. The plan will be construed and enforced according to New Jersey State law.
Grandfathered Health Plan Notice
Princeton University believes your plan is a “grandfathered health plan” under the Patience Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health and what might cause a plan to change from grandfathered health plan status can be directed to your employer or Aetna member services using the phone number on your member id card.

If your plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. If your plan is a nonfederal governmental plan, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.