Princeton University
AETNA HMO
Summary Plan Description
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Introduction

Princeton University offers a Health Maintenance Organization (HMO) Plan administered by Aetna. Coverage under the HMO Plan is available to you and your dependents as long as you and they meet the eligibility requirements, defined in the About Your Benefits SPD.

If you are a non-U.S. citizen in this country on a J-1 Visa, you may enroll in the HMO Plan.

The Aetna HMO is comprised of a network of doctors, hospitals and other health care providers that provides medical care to participants. An HMO generally operates in a limited geographic area, and the emphasis is on preventive care. You must choose a primary care physician (PCP) who provides all of your general medical care and serves as a “gatekeeper” by providing a referral for all other necessary care such as specialist visits, lab work, and hospitalizations. You pay a copay for office visits, except for those related to preventive care. There is no deductible and most hospital benefits are paid at 100%. HMOs cover care received from network providers only. Care received from non-network providers is not covered.

Due to California state regulations, if you reside in California, you will not be able to elect coverage under the HMO plan. California residents may elect coverage under the CDHP or PHP. However, if you are on a J-1 Visa, and reside in California, your only option for coverage through Princeton will be the J-1 Visa plan.
How the Plan Works

Generally, here is how the HMO works:

- You and each covered family member select a primary care physician (PCP) to coordinate your care.
- If you need to see a specialist, you must obtain a referral from your PCP.
- Your PCP obtains all necessary pre-certification.
- When you visit your PCP or a network specialist, you pay a copay for your visit, unless the visit is for preventive care.
- Most other services are covered at 100%.
- You do not pay an annual deductible before the Plan pays benefits.

Choosing a Primary Care Physician (PCP)

When you enroll in the Aetna HMO, you select a primary care physician (PCP) for yourself and each dependent. Generally, you must choose a PCP from doctors in the specialties of family practice, general practice, internal medicine, or pediatrics. You may choose a different PCP for each eligible dependent. For example, you may choose a pediatrician for your child and a general practitioner for yourself.

Your PCP is your personal physician, the doctor you see for all of your routine medical care. He or she will provide preventive care and treatment when you are ill or injured, refer you to a network specialist when it is necessary, submit claims directly to Aetna, and fulfill any pre-certification requirements for you. If you need to visit a specialist, be admitted to a hospital, or have lab or x-ray work done, your PCP refers you to the appropriate provider or facility and is responsible for pre-certification if required.

The Aetna HMO Plan maintains a directory of providers that includes primary care physicians, specialists, hospitals and facilities. You can visit Aetna’s online directory at www.aetna.com/dse/princeton for a list of providers.

The doctor you choose may not be able to take on additional patients. Also, a doctor who is listed in the directory may decide to leave the HMO network. Therefore, when you enroll in an HMO, it is a good idea to check with a doctor before selecting that individual to determine his/her availability. It is also important to remember that you will be required to select a new primary care physician if your doctor decides to leave the HMO network. If your provider drops out of the network, this is not a qualifying event to change your medical plan mid-year. In most cases, services received from non-network physicians are not covered under the HMO.

You may change your PCP at any time by calling Aetna at 1-800-535-6689 or by logging onto the website at www.aetna.com and choosing a new PCP. The selection of
a new PCP, if made by the 14th of the month, is effective the 1st of the next month. However, when the change is caused by your PCP no longer participating in the network, the change to a new PCP is effective immediately.

Visiting a Specialist
Your PCP is responsible for making referrals for you to visit specialists. When you need to see a specialist, receive lab or x-ray services, have an outpatient procedure, or are admitted to the hospital, your PCP will provide you with a referral/or prescription, and may help arrange the visit. One exception is the annual visit to an OB/GYN; this visit is covered without a referral, as long as the OB/GYN participates in the Aetna HMO network.

When your PCP decides that you need to see a specialist, ask your PCP to verify that the specialist you are being sent to is a network specialist to avoid any confusion. Remember, you cannot request referrals after you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from Aetna before seeking specialty or hospital care.

Please Note: Primary care services received from physicians other than your PCP and specialist services obtained without a referral from your PCP are not covered by the HMO. However, under certain circumstances, your PCP may refer you to a non-participating provider for covered services that are not available within the network. Services from non-participating providers require prior approval by Aetna in addition to a special non-participating referral from your PCP. When properly authorized, these services are covered after the applicable copay.

Copays
Most services, like doctor’s office and Urgent Care Center visits, are covered at 100% after you pay the copay. If the office visit is for preventive care, no copay is required.

Office Visit Copay
If you visit your PCP or a specialist for preventive care, you will not be charged a copay. Otherwise, when you visit your PCP in his/her office, you will pay a $20 copay at the time of the visit. During after-hours or home visits, you will pay a $25 copay at the time of the visit. If you visit a specialist, you will pay a $25 copay at the time of the visit.

Keep in Mind: If you are pregnant, your initial office visit copay covers all subsequent pre-delivery maternity care office visits. If you are referred by your PCP to a facility for laboratory and diagnostic services or x-rays (other than dental x-rays), you will not be charged a copay. If you are undergoing chemotherapy at a facility, you will not be charged a copay.
What is Covered

Benefits Summary

This *Benefits Summary* summarizes the provisions of the Plan.

<table>
<thead>
<tr>
<th>Aetna HMO</th>
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</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>None</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$2,500 Individual/$5,000 Family</td>
</tr>
<tr>
<td>Lifetime Maximum Medical/Surgical/Mental Health and Substance Use Disorder</td>
<td>Unlimited</td>
</tr>
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</table>

**HOSPITAL BENEFITS**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Hospital Inpatient Medical/Surgical Care</td>
<td>You pay $175 copay per inpatient stay</td>
</tr>
<tr>
<td>Inpatient Care/Residential Treatment for Mental Health and Substance Use Disorder</td>
<td>You pay $175 copay per stay for inpatient care or Residential Treatment</td>
</tr>
<tr>
<td>Outpatient Medical/Surgical Care</td>
<td>You pay $0 for services received at an independent facility; you pay $75 copay for services received in a hospital setting</td>
</tr>
<tr>
<td>Emergency Room (Covers services administered for conditions meeting the definition of an emergency).</td>
<td>You pay $175 copay; ER copay waived if admitted. Non-emergency care not covered.</td>
</tr>
</tbody>
</table>

**OUTPATIENT BENEFITS**

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<tr>
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</thead>
<tbody>
<tr>
<td>Treatment by PCP</td>
<td>You pay $20 copay per office visit ($25 if after hours or home visit)</td>
</tr>
<tr>
<td>Treatment by Specialist Referral from PCP required.</td>
<td>You pay $25 copay per office visit</td>
</tr>
<tr>
<td>Teladoc (Network of board certified doctors that provide telephonic and video consults. Available 24/7/365 (855) 835-2362 <a href="http://www.teladoc.com/princeton">www.teladoc.com/princeton</a>)</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Service</td>
<td>Copay</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Annual Physical Adults (18+): One exam every calendar year.</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Well Baby Visits</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Seven exams in first 12 months of life, three exams the next 13 to 14 months, three exams the next 25 to 36 months, and one (1) exam every calendar year thereafter up to age 18.</td>
<td>You pay a $25 copay for the office visit to diagnose the pregnancy. All other prenatal visits will be covered at 100%. You pay a $25 copay for post-partum office visits.</td>
</tr>
<tr>
<td>Prenatal/Maternity Care</td>
<td>You pay $25</td>
</tr>
<tr>
<td>Lactation Support and Breastfeeding Equipment (Call Aetna at 800-535-6689 for additional information)</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Preventive Immunizations</td>
<td>You pay $0</td>
</tr>
<tr>
<td>High-Tech Radiology Services (MRI, CT, PET, and other scans) See page 21 for additional information regarding high-tech radiology services.</td>
<td>You pay $0 for services received at an independent facility; you pay $100 for services received in a hospital setting. Nuclear medicine scan covered at 100% any location.</td>
</tr>
<tr>
<td>Outpatient Lab and X-Ray Services for diagnosis or Treatment. See page 21 for additional information regarding x-ray services.</td>
<td>You pay $0 for services received at an independent facility; you pay $50 for services received in a hospital setting.</td>
</tr>
<tr>
<td>Laboratory and X-Ray Services for diagnosis or Treatment at Specialist.</td>
<td>Included in $25 specialist office visit copay</td>
</tr>
<tr>
<td>Outpatient Mental Health and Substance Use Disorder</td>
<td>You pay $25 copay per office visit</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA) Therapy Coverage for children whose diagnosis is on the autism spectrum</td>
<td>You pay $25 copay per office visit</td>
</tr>
<tr>
<td>Benefit Description</td>
<td>Cost</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Outpatient Diagnostic Cardiology, Sleep Studies, and Cardiac Rhythm Implant Devices. Requires enhanced clinical review through provider precertification process.</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Outpatient Physical Therapy Limited to 100 visits per calendar year.</td>
<td>You pay $15 copay per visit</td>
</tr>
<tr>
<td>Outpatient Rehabilitation Therapy Short-term occupational or speech therapies, and pulmonary and cardiac rehabilitation. Limited to 100 visits for each type of rehabilitation therapy per calendar year.</td>
<td>You pay $25 copay per visit</td>
</tr>
<tr>
<td>Outpatient Therapeutic Treatments Dialysis, intravenous, chemotherapy or other intravenous infusion therapy, and other treatments.</td>
<td>You pay $0</td>
</tr>
<tr>
<td><strong>OTHER BENEFITS</strong></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services Medically necessary transport covered</td>
<td>You pay $0 (subject to certification except in a medical emergency situation)</td>
</tr>
<tr>
<td>Chiropractic Services Limited to 20 visits per calendar year. Services related to physical therapy track towards a separate 100 visit limit for outpatient rehabilitation therapy.</td>
<td>You pay a $25 copay per visit</td>
</tr>
<tr>
<td>Allergy Testing and Treatment</td>
<td>You pay $20 copay per office visit for PCP You pay $25 copay per office visit for specialist No serum copay if office visit not charged.</td>
</tr>
<tr>
<td>Family Planning Services Contraceptive services, artificial insemination, assisted reproductive technology with certain limitations. Limited to $20,000 lifetime maximum.</td>
<td>You pay $20 copay per office visit to PCP; You pay $25 copay per office visit to a specialist; You pay $0 for inpatient, outpatient, and contraceptive services.</td>
</tr>
<tr>
<td>Urgent Care Center (for conditions that meet the definition of urgent care).</td>
<td>You pay $25 copay</td>
</tr>
<tr>
<td>Service</td>
<td>Details</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Services provided in the home by a licensed provider. Limited to 60 days per calendar year.</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Limited to 20 visits per calendar year.</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Limited to 12 visits per calendar year. Requires prescription from physician</td>
</tr>
<tr>
<td>Hearing Exams</td>
<td>Limited to one exam per calendar year. Requires prescription from physician</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Limited to maximum reimbursement of $1500 every three years.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Confinement and skilled nursing services in a hospital or specialized facility. Limited to 60 days per calendar year.</td>
</tr>
<tr>
<td>Hospice Care (Inpatient and Outpatient)</td>
<td>Limited to 180 days per lifetime.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Single purchase of a type of equipment is covered including repair. Replacements allowed once every three years. This covers prosthetic devices, including foot orthotics.</td>
</tr>
<tr>
<td>Wigs</td>
<td>Limited to maximum reimbursement of $2500 every three years for wigs or wig repair. Covered based on medical necessity e.g., chemotherapy, radiation (combined in-network/out-of-network.)</td>
</tr>
</tbody>
</table>
Prescriptions Administered by OptumRx

Retail copays: Generic $5, Preferred Brand $25, Non-Preferred Brand $40
Mail Order copays: Generic $10, Preferred Brand $50, Non-Preferred Brand $80

Member Pays the Difference Program for brand name medications that have a generic equivalent. See the Prescription Plan SPD for information.

Routine Annual Eye Exams
Limited to one exam per calendar year.
You pay $25 copay per office visit

Lens Reimbursement
You can receive a $70 reimbursement once every 24 months.
For children up to age 18, 100% reimbursement for frames and lenses once every calendar year. Limited to one pair of glasses per calendar year.

While the Benefits Summary provides an overview of your coverage under the HMO Plan, this section includes additional information about:

- Durable Medical Equipment
- Home Health Care
- Hospital and Other Facility Based Services
- Urgent Care
- Outpatient Surgery Center
- Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice
- Family Planning and Infertility Treatment
- Laboratory Procedures and X-Ray Examinations
- Maternity Care
- Mental Health and Substance Use Disorder Services
- Dental - Oral Surgery
- Primary and Preventive Care Benefits
- Private Duty Nursing Care
- Prosthetic Devices
- Reconstructive and Corrective Surgery
- Rehabilitation Services
- Specialty Care
- Transplants
- Gender Reassignment
- Travel
- Imaging Services

Durable Medical Equipment
Durable medical equipment (DME) is defined as equipment that Aetna HMO determines to be:

- designed and able to withstand repeated use,
• made for and used primarily in the treatment of a disease or injury,
• generally not useful in the absence of an illness or injury, and
• suitable for use while not confined in a hospital.

_Durable equipment used in altering air quality or temperature, and equipment for exercise or training is not covered._

The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:

• they are needed due to a change in your physical condition, or
• it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

The request for any type of DME must be made by your physician and coordinated through the Aetna Patient Management Department.

Home Health Care
The Plan covers home health services provided by a participating home health care agency, including:

• skilled nursing services provided or supervised by an RN,
• services of a home health aide for skilled care, and
• medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
• Limited to 60 days per calendar year.

Hospital and Other Facility Based Services
Coverage for any facility-based service requires pre-certification. You must receive a referral to a network facility from your PCP or network specialist in order to receive benefits.

Hospitalization
You are covered for inpatient hospital care, including room and board, routine nursing care, and ancillary services and supplies when provided to you by a hospital on an inpatient basis. If you or your dependent occupies a private room, you will be responsible for expenses incurred beyond those that are covered, except when Aetna HMO determines it to be medically necessary.

Hospital Emergency Room Visits
In the event of a life threatening medical emergency, you should seek immediate care at the nearest emergency room. Emergency medical care at the emergency room is subject to a $175 copay. The emergency room copay is waived if admitted.

For all other medical emergencies, those that are not life threatening, you must first call your PCP. If you cannot contact your PCP, call Aetna HMO at 1-800-535-6689. They are available 24 hours a day, seven days a week.

Medical Emergencies
You are covered for medical emergencies including diagnostic x-ray and lab, and urgent care for medical illness and mental illness on a 24-hour, seven days a week basis.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or part.

Urgent Care
Urgent care is defined as a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP. Urgent care is covered at a $25 copay.

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- the service is a covered benefit,
- you could not reasonably have anticipated the need for the care prior to leaving the network service area, and
- a delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Follow-up care provided by your PCP is covered, subject to the office visit copay. Other follow-up care by participating specialists is fully covered with a prior written or electronic referral from your PCP, subject to the specialist copay.
Outpatient Surgery Center
Surgical procedures, as well as the covered services and supplies performed at outpatient surgical centers and provided by the center on the day of your surgery, are covered. All outpatient surgery must be approved in advance by Aetna.

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice
If you are hospitalized by a participating PCP or specialist with prior referral except in emergencies, you receive the benefits listed below.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
  - cardiac rehabilitation, and
  - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Non-experimental, non-investigational transplants. All transplants must be ordered by your PCP and participating specialist and approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of
transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Family Planning Benefits and Infertility Treatment

The HMO 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 on non-surgical or drug induced pregnancy termination

The HMO Plan covers basic infertility services that are subject to a $25 copay for office visits. If your doctor or specialist determines that you are an appropriate candidate, comprehensive and advanced infertility services are covered. You may obtain the following basic infertility services from a participating gynecologist or infertility specialist without a referral from your PCP:

- initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
- evaluation of ovulatory function,
- ultrasound of ovaries at an appropriate participating radiology facility,
- postcoital test,
- hysterosalpingogram,
- endometrial biopsy, and
- hysteroscopy.

Semen analysis at an appropriate participating laboratory is covered for male Plan participants; a referral from your PCP is necessary.

The HMO 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.

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 lifetime maximum of six courses of treatment in a covered person’s lifetime.

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.)

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.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.
**Advanced Reproductive Technology (ART) Expenses**
The HMO 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.

**Laboratory Procedures and X-ray Examinations**
Coverage is provided for x-rays and laboratory tests. Certification for x-rays and laboratory tests coverage must be obtained from your PCP for any services beyond the routine exam and tests, except those that are provided or coordinated by a specialist under a separate referral. Pre-certification is needed for certain services and the provider is responsible for obtaining them.

**Maternity Care**
The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may, after consulting with you, discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or at www.aetna.com/dse/Princeton.
Please Note: Your participating obstetrician is responsible for obtaining pre-certification from Aetna for all obstetrical care after your first visit. They must request pre-certification or approval for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers on and after your effective date. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Mental Health and Substance Use Disorder Services
Your mental health/substance use disorder benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance use disorder providers. Instead, when you need mental health or substance use disorder treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Telemental Health services are available, and are a convenient option that allows you to video conference with a licensed health provider – including psychiatrists, psychologists and counselors – who can provide both therapy and medication management. Visits are covered the same cost as in-network in-person mental health visits. To schedule an appointment for this service, which is referred to as Televideo by Aetna, call the in-network provider, Inpathy at (800) 442-8938, if you reside in New Jersey, New York or Pennsylvania. If you reside outside of New Jersey, New York or Pennsylvania, call Aetna at (800) 535-6689 for information on the in-network provider.

Mental Health Treatment
The Plan covers the following services for mental health treatment:

- Inpatient medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential treatment facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an outpatient basis.

Treatment of Substance Use Disorder
The Plan covers the following services for treatment of substance use disorder:

- Inpatient care for detoxification, including medical treatment and referral services for substance use disorder.
- Inpatient medical, nursing, counseling and therapeutic rehabilitation services for
treatment of alcohol or substance use disorder or dependency in an appropriately licensed facility.

- Outpatient visits for substance use disorder detoxification. Benefits include diagnosis, medical treatment and medical referral services by your PCP.
- Outpatient visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance use disorder. Outpatient treatment for substance use disorder or dependency must be provided in accordance with an individualized treatment plan.

Dental - Oral Surgery Benefits
Dental services are not covered under the HMO Plan. However, there are certain limited dental and oral surgical procedures that are covered in either an inpatient or outpatient setting. These are limited to:

- extraction of bony, or partial bony, impacted teeth
- treatment of bone fractures,
- diagnosis and treatment of oral tumors and orthodontogenic cysts

Coverage is also provided for treatment of an injury to natural teeth or the jaw, but only if:

- the injury occurred when the member was enrolled in this plan,
- the injury was not caused, directly or indirectly, by biting or chewing, and
- all treatment is completed within six months of the date of the injury.

Treatment includes replacing natural teeth lost due to the injury, but excludes any orthodontic treatment.

Primary and Preventive Care Benefits
One of the Plan’s goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan at no charge to you if provided by your PCP or on referral from your PCP:

- Routine physical examinations, as recommended by your PCP.
- Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- Routine mammograms for female Plan participants age 35 or over.
• Annual mammography screening for asymptomatic women age 35 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP.
  Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
• Routine immunizations.

These items are covered by the Plan (after any applicable co-payment)
• Office visits with your PCP during office hours and during non-office hours.
• Home visits by your PCP.
• Treatment for illness and injury.
• Health education counseling and information.
• Periodic eye examinations. You may visit a participating provider.
• Prescription lenses and frames, including contact lenses, subject to any allowances.
• Routine hearing screenings performed by your PCP as part of a routine physical examination.
• Injections, including routine allergy desensitization injections.

Private Duty Nursing Care
Out-of-hospital private duty nursing care is not covered unless preAUTHORIZED by Aetna.

Prosthetic Devices
Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth) are covered under the Plan. Certain prosthetics require preauthorization by Aetna. Please refer to Page 8 for more information about Durable Medical Equipment.

Reconstructive and Corrective Surgery
The Women's Health and Cancer Rights Act of 1998 guarantees coverage to any plan member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with that mastectomy. It is required that you are provided coverage for:

• reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
• surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
• physical therapy to treat the complications of the mastectomy, including lymphedema.
Rehabilitation Services
Rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, and pulmonary and cardiac rehabilitation is covered on an outpatient basis. Coverage on an outpatient basis is limited to 100 visits per type of rehabilitation per calendar year.

Specialty Care
If your PCP cannot provide a specific medical service, he or she will give you a referral to a network specialist. As part of the referral process, your PCP will complete a referral form. You will be given the form to take with you to your appointment with the network specialist. Once you have obtained the referral, you may visit the network specialist and receive the covered services you need. You cannot obtain specialty care without a referral from your PCP.

Please Note: Referrals are valid for 90 days, as long as you remain an eligible participant in the Plan.

If further visits are necessary, or the referral expires, you must ask your PCP for another referral. Also, referrals become invalid when your coverage under the Plan terminates.

Transplants
Aetna’s National Medical Excellence Program® (NME) helps eligible Plan participants access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants.
- National Special Case Program developed to coordinate arrangements for treatment of Plan participants with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the Plan participant’s home.
- Out of Country Program, designed for Plan participants who need emergency inpatient medical care while temporarily traveling outside the United States.

If you need a transplant or other specialized care that cannot be provided within the service area, the NME Program will coordinate covered services and will provide the following lodging and travel expenses:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the Program facility. Travel expenses incurred by more than one companion are not covered.
- As the NME patient, your lodging expenses incurred while traveling between your
home and the National Medical Excellence facility to receive covered services.

- The lodging expenses you incur for lodging away from home to receive covered outpatient services from an NME Program provider.
- The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services.
- Your companion’s lodging expenses when their presence is required to enable you to receive services from an NME Program provider on either an inpatient or outpatient basis. Only the lodging expenses incurred by one companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of $10,000 per episode of care. Aetna has a $50 per night maximum for lodging expenses. Princeton will provide additional (taxable) reimbursement of up to a total of $250 per night. Contact the Benefits Department for additional information.

Travel and lodging expenses must be approved in advance by Aetna; if you do not receive approval, the expenses are not covered.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest to occur of:

- one year after the day a covered procedure was performed,
- the date you cease to receive any services from the Program provider in connection with the covered procedure, or
- the date your coverage terminates under the Plan.

Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.

The Plan covers only those services, supplies and treatments that are considered necessary for your medical condition. Treatment that is considered experimental, as determined by Aetna, is not covered by the Plan.

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 or electrolysis 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 Reassignment Surgery

Gender Reassignment Surgery
Gender Reassignment 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 cryopreservation embryos
- Rhinoplasty and Blepharoplasty
- Cosmetic procedures including, skin resurfacing, chin implants, nose implants and lip reduction
Travel
If you or a covered dependent temporarily relocate to another area and there are providers who are part of the same HMO network, you may choose a new PCP who is part of the network. You and your family will receive the maximum level of benefits as long as you use the HMO network for all non-emergency care.

Examples of relocations may include, but are not limited to, families separated by divorce or temporary job assignments and children attending school away from home. You must notify your HMO of your or your dependent’s temporary relocation.

Complex Imaging Services (High-Tech Radiology) and X-Ray Services
You pay $0 for x-ray and high-tech radiology services performed at an independent facility. You will pay $50 for x-ray services performed at an in-network hospital setting. You will pay $100 for high-tech radiology services performed at an in-network hospital setting. Pre-certification is required for hi-tech radiology. Nuclear medicine scan covered 100% after deductible any location.

High-Tech Radiology and X-ray services provided in an in-network hospital setting are considered medically necessary and covered at 100% for individuals who meet ANY of the following criteria:

- Less than 19 years of age
- Require obstetrical observation
- Require perinatology services
- Have a known contrast allergy
- Have a known chronic disease with prior radiology imaging procedures for the diagnosis, management or surveillance of the disease at the hospital outpatient department
- Have pre-procedure imaging where the surgery or procedure is being performed at the hospital

An advanced radiologic imaging procedure in the hospital outpatient department is considered medically necessary when there are no geographically accessible appropriate alternative sites for the individual to undergo the procedure, including but not limited to the following:

- Moderate or deep sedation or general anesthesia is required for the procedure; or
- The equipment for the size of the individual is not available; or
- Open magnetic resonance imaging is required because the member has a documented diagnosis of claustrophobia and/or severe anxiety

An advanced radiologic imaging procedure in the hospital outpatient department is considered medically necessary when imaging in a physician’s office or freestanding imaging center would reasonably be expected to delay care and adversely impact health outcome.
All other advanced radiologic imaging procedures in the hospital outpatient department are considered not medically necessary and will be covered at a copay.

Prescription Drug Benefits
The Prescription Drug Program is administered by OptumRx and is independent of Aetna HMO.

What’s Not Covered

The Plan does not cover the following services and supplies:

- Ambulance services, when used as routine transportation to receive inpatient or outpatient services. Medically necessary ambulance services are covered.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Blood, blood plasma, or other blood derivatives or substitutes. Actual blood transfusion is covered.
- Breast augmentation (except in the case of Gender Reassignment Surgery) and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
  - reconstructive surgery to correct the results of an injury.
  - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
  - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
- Expenses that are the legal responsibility of Medicare or a third party payer.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance. This exclusion will not apply to drugs:
– that have been granted treatment investigational new drug (IND) or Group
c/treatment IND status,
– that are being studied at the Phase III level in a national clinical trial sponsored
by the National Cancer Institute, or
– that Aetna has determined, based upon scientific evidence, demonstrate
effectiveness or show promise of being effective for the disease.

- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your
coverage is effective or after your coverage has been terminated.
- Household equipment, including (but not limited to) the purchase or rental of
exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-
allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your
home or place of work, including (but not limited to) ramps, elevators, handrails,
stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Infertility services, except as described on page 11. The Plan does not cover:
  – purchase of donor sperm and any charges for the storage of sperm.
  – purchase of donor eggs, and any charges associated with care of the donor
    required for donor egg retrievals or transfers or gestational carriers.
  – Storage of cryopreserved embryos.
  – all charges associated with a gestational carrier program (surrogate parenting)
    for the Plan participant or the gestational carrier.
  – drugs related to the treatment of non-covered benefits or related to the treatment
    of infertility that are not medically necessary.
  – injectable infertility drugs.
  – the costs for home ovulation prediction kits.
  – services for couples in which one of the partners has had a previous sterilization
    procedure, with or without reversal.
  – services for females with FSH levels greater than 19 mIU/ml on day 3 of the
    menstrual cycle.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or
disposable supplies such as syringes, incontinence pads, elastic stockings and reagent
strips.
- Personal comfort or convenience items, including services and supplies that are not
directly related to medical care, such as guest meals and accommodations, barber
services, telephone charges, radio and television rentals, homemaker services, travel
expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care.
- Radial keratotomy, including related procedures designed to surgically correct
refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand care services, or routine foot care services, including routine reduction
of nails, calluses and corns, except when needed for severe systemic disease or preventive foot care for covered persons with diabetes for which benefits are provided under the Plan.

- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy’s amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
  - obtaining or continuing employment,
  - obtaining or maintaining any license issued by a municipality, state or federal government,
  - securing insurance coverage, and
  - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific non-standard allergy services and supplies, including (but not limited to):
  - skin titration (wrinkle method),
  - cytotoxicity testing (Bryan’s Test),
  - treatment of non-specific candida sensitivity, and
  - urine autoinjections.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
  - primal therapy.
  - chelation therapy.
  - rolfing.
  - psychodrama.
  - megavitamin therapy.
  - purging.
  - bioenergetic therapy.
  - carbon dioxide therapy.
- Thermograms and thermography.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or
inadequacies that do not have a physiological or organic basis.

- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of sickness or injury covered by a worker’s compensation act or occupational disease law, or by United States Longshoreman’s and Harbor Worker’s Compensation Act.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - treatment performed by placing a prosthesis directly on the teeth, and
  - diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

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

Claims Information
If you participate in an HMO and visit an HMO provider, you do not have to submit a claim form. You simply pay your copay at the time of service. If you have a medical emergency and visit a non-HMO provider, you will have to pay for your care at the time of your visit, or the facility will bill you directly. You will then need to submit a copy of your receipt for services to the HMO for reimbursement. Send your receipt to the address on your HMO ID card.

Aetna HMO is responsible for evaluating all benefit claims under the Plan. Aetna will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. Aetna has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide that status of your claim.

Review Procedure for Denied Claims
When a claim for benefit payment is denied in whole or in part, you may appeal the denial. Please see the About Your Benefits section of this Summary Plan Description Handbook for an explanation of the claim review and appeal process.

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.

Other Important Information

Coordination of Benefits
The HMO 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 section.

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.

Reservation of Rights
The University reserves the rights to amend, suspend, or terminate its Aetna HMO 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.

Subrogation and Right of Recovery
The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan’s right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. “You” or “your” includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.
The plan’s right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan’s subrogation and reimbursement interest are fully satisfied.

Subrogation
The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement
If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan’s subrogation and reimbursement interest are fully satisfied.

Lien Rights
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.
Assignment
In order to secure the plan’s recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan’s subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim
By accepting benefits from the plan, you acknowledge that the plan’s recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan’s claim will not be reduced due to your own negligence.

Cooperation
You agree to cooperate fully with the plan’s efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.
You shall do nothing to prejudice the plan’s subrogation or recovery interest or prejudice the plan’s ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan’s subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act (“HIPAA”), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction
By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys’ fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.