

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.

Aetna has been designated as claims administrator for benefits under the Plan with full discretion and authority to make claim and appeal determinations. The claims administrator is the appropriate named fiduciary of the plan for purposes of reviewing denied claims for benefits. In exercising this fiduciary responsibility, Aetna has full discretionary authority to make factual determinations, to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe terms of the Plan with respect to benefits. Aetna’s decisions are final and binding upon you and any person making a claim on your behalf. Your employer retains sole and complete authority to determine eligibility of persons to participate in the 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.

Aetna HMO	
Annual Deductible	None
Annual Out-of-Pocket Maximum	\$2,500 Individual/\$5,000 Family
Lifetime Maximum Medical/Surgical/Mental Health and Substance Use Disorder	Unlimited
HOSPITAL BENEFITS	
Hospital Inpatient Medical/Surgical Care	You pay \$175 copay per inpatient stay
Inpatient Care/Residential Treatment for Mental Health and Substance Use Disorder	You pay \$175 copay per stay for inpatient care or Residential Treatment
Outpatient Medical/Surgical Care	You pay \$0 for services received at an independent facility; you pay \$75 copay for services received in a hospital setting
Emergency Room (Covers services administered for conditions meeting the definition of an emergency).	You pay \$175 copay; ER copay waived if admitted. Non-emergency care not covered.
OUTPATIENT BENEFITS	
Treatment by PCP	You pay \$20 copay per office visit (\$25 if after hours or home visit)
Treatment by Specialist Referral from PCP required.	You pay \$25 copay per office visit
Teladoc Network of board certified doctors that provide telephonic and video consults. Available 24/7/365 (855) 835-2362 www.teladoc.com/princeton	You pay \$0 for general medicine visits. You pay \$25 copay for Teladoc dermatology. You pay \$20 copay for Teladoc Behavioral Health.

Annual Physical Adults (18+): One exam every calendar year.	You pay \$0
Well Baby Visits 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.	You pay \$0
Prenatal/Maternity Care	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.
Lactation Support and Breastfeeding Equipment (<i>Call Aetna at 800-535-6689 for additional information</i>)	You pay \$0
Preventive Immunizations	You pay \$0
High-Tech Radiology Services (MRI, CT, PET, and other scans) See page 21 for additional information regarding high-tech radiology services.	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.
Outpatient Lab and X-Ray Services for diagnosis or Treatment. See page 21 for additional information regarding x-ray services.	You pay \$0 for services received at an independent facility; you pay \$50 for services received in a hospital setting. You pay \$0 for diagnostic testing for COVID-19 at any lab.
Laboratory and X-Ray Services for diagnosis or Treatment at Specialist.	Included in \$25 specialist office visit copay
Outpatient Mental Health and Substance Use Disorder	You pay \$20 copay per office visit
Applied Behavioral Analysis (ABA) Therapy Coverage for those whose diagnosis is on the autism spectrum	You pay \$20 copay per office visit

Outpatient Diagnostic Cardiology, Sleep Studies, and Cardiac Rhythm Implant Devices. Requires enhanced clinical review through provider precertification process.	You pay \$0
Outpatient Physical Therapy Limited to 100 visits per calendar year.	You pay \$15 copay per visit
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.	You pay \$25 copay per visit
Outpatient Therapeutic Treatments Dialysis, intravenous, chemotherapy or other intravenous infusion therapy, and other treatments.	You pay \$0
OTHER BENEFITS	
Ambulance Services Medically necessary transport covered	You pay \$0 (subject to certification except in a medical emergency situation)
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.	You pay a \$25 copay per visit
Allergy Testing and Treatment	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.
Family Planning Services Contraceptive services, artificial insemination, assisted reproductive technology with certain limitations. Limited to \$20,000 lifetime maximum.	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.
Urgent Care Center (for conditions that meet the definition of urgent care).	You pay \$25 copay

<p>Home Health Care Services provided in the home by a licensed provider. Limited to 60 days per calendar year.</p>	<p>You pay \$0</p>
<p>Acupuncture Limited to 20 visits per calendar year.</p>	<p>You pay \$25 copay per office visit</p>
<p>Nutritional Counseling Limited to 12 visits per calendar year. Requires prescription from physician</p>	<p>You pay \$20 copay per office visit for PCP You pay \$25 copay per specialist office visit</p>
<p>Hearing Exams Limited to one exam per calendar year. Requires prescription from physician</p>	<p>You pay \$20 copay per office visit for PCP You pay \$25 copay per specialist office visit</p>
<p>Hearing Aids Limited to maximum reimbursement of \$1500 every three years.</p>	<p>Plan pays 100% up to a maximum reimbursement of \$1500 every three years</p>
<p>Skilled Nursing Facility Confinement and skilled nursing services in a hospital or specialized facility. Limited to 60 days per calendar year.</p>	<p>You pay \$0</p>
<p>Hospice Care (Inpatient and Outpatient) Limited to 180 days per lifetime.</p>	<p>You pay \$0</p>
<p>Durable Medical Equipment Single purchase of a type of equipment is covered including repair. Replacements allowed once every three years. This covers prosthetic devices, including foot orthotics.</p>	<p>You pay \$0</p>
<p>Wigs 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.)</p>	<p>You pay \$0. If you visit an out-of-network provider, you will have to submit a claim to the plan for reimbursement.</p>

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
	<i>Member Pays the Difference Program for brand name medications that have a generic equivalent. See the Prescription Plan SPD for information.</i>
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
Tobacco Prevention Consultations	You pay \$0 up to 8 visits per year with your primary care physician Tobacco cessation medications covered through OptumRx

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. Certain outpatient surgeries must be approved in advance by Aetna. Contact Aetna for a list of the services that require precertification.

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 fertility services subject to a \$25 copay for office visits without a referral from your PCP. You pay \$0 for outpatient services at an independent facility; you pay \$75 for outpatient services at a hospital. Services provided inpatient at a hospital will be covered after a \$175 copay.

The HMO Plan covers Fertility and Family Planning services through Kindbody for you and your covered spouse. Fertility and Family Planning services are not provided for covered children.

Fertility and Family Planning coverage provided by Kindbody; services covered in-network at Kindbody's clinics or Kindbody's Centers of Excellence network. No out-of-network coverage. Fertility services not authorized through Kindbody will not be covered. Fertility benefit coverage of four (4) Cycles, including prescriptions, per member per Lifetime. Once a member exhausts their four cycles, no further fertility services or fertility related prescriptions will be covered under the plan.

Kindbody will provide each member with a dedicated Patient Care Navigator to provide support and guidance throughout treatment. Each member will also receive a Kindbody membership that provides access to all ancillary services, including but not limited to, fertility care, gynecology, wellness coaching, nutritionist, back to work coaching and more for all members.

Infertility services for fertility preservation treatments and procedures are covered for men and women in the case of members facing iatrogenic infertility caused by medical intervention, such as radiation, medication, surgery or underlying pre-existing condition.

The following infertility services expenses will be covered:

- Ovulation Induction/Stimulation
- Male Factor Testing
- Artificial Insemination
- Preimplantation Genetic Testing
- Assisted Reproductive Technology
 - In Vitro Fertilization (Fresh/Frozen)
 - Frozen Embryo Transfers
- Cryopreservation (Medically Necessary)

Not covered are charges for:

- Ovulation predictor kits and home pregnancy tests
- Donor services and medical and non-medical costs of oocyte or sperm donation (e.g., donor agency fees)
- Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes
- Artificial reproductive treatments done for eugenic (selective breeding) purposes
- Gestational carrier programs
- Drugs related to the treatment of non-covered benefits
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal
- Procedures, services and supplies to reverse voluntary sterilization
- Ancillary services

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. Birth center and nurse-midwife services are covered, including services provided for home-birth. 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.

Kindbody provides access to gynecological services, fertility and post-partum focused mental health services, fertility focused nutrition, maternity and delivery care navigation, return-to-work coaching, child care guides, and lactation consultants. These services are available to you and your covered spouse whether or not you seek fertility or family-building services through Kindbody.

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 (referred to as Televideo), call the in-network provider MDLive at (855) 824-2170 or go to www.mdlive.com/BHCOMM, call Inpathy at (800) 442-8938, or call Aetna at (800) 535-6689.

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.

AbleTo

AbleTo provides virtual therapy and emotional support to assist members with the stress and anxiety that comes with a medical condition or life change. This program is available to members with certain co-occurring behavioral and medical conditions. AbleTo participants will work with two AbleTo specialists for eight weeks – once a week with a therapist and once a week with a behavior coach. There are no fees or copays for this service under the PHP.

To access AbleTo, members can call (855) 773-2354 or visit www.member.ableto.com/princeton

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.

Coverage is provided for medically necessary temporomandibular joint syndrome (TMJ) surgery. Prior authorization is required. The plan does not cover orthodontics, devices, therapy or other services and supplies received for the evaluation and treatment of TMJ.

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.
Home blood pressure monitors are covered at 100%.

- Member must be 18 years of age or older
- Members are entitled to one of the following units:
 - Sphygmomanometer/blood pressure apparatus with cuff and stethoscope
 - Blood pressure cuff only
 - Automatic blood pressure monitor

Members can order from a participating provider or purchase over the counter and submit for reimbursement. For assistance with ordering, contact Aetna member services.

Private Duty Nursing Care

Out-of-hospital private duty nursing care is not covered unless pre-authorized 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 travel benefits outlined in this section apply to transplants.

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 for travel related to transplants. 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
- Blepharoplasty

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.

Travel and Lodging

If covered services are not available from a network provider within 100 miles of your home, the following travel and lodging expenses are covered under the plan:

- U.S. domestic travel and lodging expenses for you and one companion, to travel from your home to receive the covered services from a network provider (coach class air fare, train or bus travel are examples of covered services).
- The maximum lodging benefit is \$50 per person per night, up to a total maximum lodging benefit of \$100.
- Total maximum travel and lodging benefit is \$10,000 per year.

To be eligible for travel and lodging reimbursement, Aetna Member Services must first confirm a network provider is not available within 100 miles of your home and a travel and lodging claim form must be completed. To obtain this confirmation and the travel and lodging claim form, and for detailed information about these covered services, including specific eligibility requirements and any limitations, contact Member Services at the toll-free number on your ID card.

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% 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.

Enhanced Clinical Review

This radiology program is designed, through a clinical prior authorization process, to promote appropriate and effective use of outpatient diagnostic imaging services and procedures. Aetna will provide these services nationally and/or regionally, and interact with, free-standing radiology and/or outpatient network facilities that provide the following services: Computed Tomography/Coronary Computed Tomography Angiograph (CT/CTA), Magnetic Resonance Tomography, Magnetic Resonance Angiography (MRIs/MRAs), Nuclear Medicine and Positron Emission Tomography (PET) and/or PET/CT Fusion, Stress Echocardiography (Stress Echo), and Diagnostic Cardiac Catheterization, Sleep Studies and Cardiac Rhythm Implantable procedures (Pacemakers, Implantable Cardioverter-Defibrillators, and Cardiac Resynchronization Therapy). The Enhanced Clinical Review program will typically be administered through relationships with third parties.

Prescription Drug Benefits

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

Precertification

Your network physician is responsible for obtaining any necessary precertification before you the care. Network providers cannot bill you if they fail to ask Aetna for precertification.

For non-emergency inpatient admissions or surgeries as well as certain outpatient surgeries and supplies, these services must be precertified 14 days prior to the confinement or scheduled date of treatment. Notification of emergency stays should be made within 48

hours of admission. There is no penalty for failure to precertify for in-network services. When you go to an out-of-network provider, you are responsible to get any required precertification from Aetna. There is a non-notification penalty of no coverage for out-of-network services.

What to Precertify

- inpatient hospital stays
- inpatient mental health, substance related disorders and/or rehabilitation
- Partial hospitalization treatment – mental health disorders and substance related disorders treatment
- inpatient skilled nursing
- certain outpatient surgeries
- Gene-based, cellular and other innovative therapies – inpatient and outpatient
- Gender affirming treatment – inpatient and outpatient
- Outpatient injectables
- Outpatient kidney dialysis
- Bariatric surgery
- Stays in a hospice facility
- Private duty nursing services
- Sleep studies
- TMS
- Applied behavioral analysis
- ART services
- Complex imaging
- Emergency transportation by airplane.

Contact Aetna for a list of services that require precertification; this list may change from time to time.

When to Precertify

Inpatient Hospitalization – For inpatient hospitalization, you must notify Aetna of the scheduled admission date at least 14 days before the start of the confinement. If a confinement is planned but no admission date is set, you must make two phone calls to Care Coordination: one when the confinement is planned and a second as soon as the admission date is set.

Pregnancy is subject to the following precertification time periods:

- **Prenatal Programs:** Aetna should be notified during the first trimester (the first 12 weeks of pregnancy). This early precertification makes it possible for the mother to participate in the prenatal programs.
- **Inpatient Hospitalization for Delivery of Child:** Care Coordination must be notified only if the inpatient care for the mother or child is expected to continue beyond:
 - 48 hours following a normal vaginal delivery, or

– 96 hours following a cesarean section.

If the need for care is expected to continue, notification should take place prior to the end of the time periods above.

- **Non-Emergency Inpatient Hospitalization Without Delivery of Child:**
Hospitalization during pregnancy but before the admission for delivery, which is not emergency care, requires precertification as a scheduled confinement. Aetna must be notified prior to the scheduled admission.

Outpatient Surgery Services – For outpatient services which require precertification, you must notify Aetna at least 14 days before the service is given.

Organ/Tissue Transplants – Notification must occur at least 14 days before the scheduled date of the evaluation, the donor search, the organ procurement/tissue harvest, or the transplant procedure, or as soon as reasonably possible.

Gene-based, cellular and other innovative therapies (GCIT) – These services require precertification. You must get Gene-based, cellular and other innovative therapies (GCIT) covered services from the GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your network, it's important that you contact Aetna to help you determine if there are other facilities that may meet your needs. If you do not get your GCIT services at the facility/provider Aetna designates, they will not be covered services. Travel and lodging benefits are available if services are not available within 100 miles of your home; see Travel and Lodging section on page 20.

After receiving precertification information, Aetna will then complete the utilization review. You, the physician and the facility will be sent a letter confirming the results of the review.

Emergency Care – When emergency care is required and results in a hospital or similar facility stay, you, your representative, or physician must call Aetna within 48 hours of admission. If it is not reasonably possible to call Care Coordination within 48 hours, notification must be made as soon as possible. When emergency care has ended, Aetna must be called before any additional services are received.

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.
- 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 and supplies received for the evaluation and treatment of temporomandibular joint syndrome, TMJ, whether the services are considered to be medical or dental in nature.
- 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.
- Gene-based, cellular and other innovative therapies (GCIT) covered services must be performed by a GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your network, it’s important that you contact Aetna to help you determine if there are other facilities that may meet your needs. If you do not get your GCIT services at the facility/provider Aetna designates, they will not be covered.
- Abortion services will be covered in Texas only if, in accordance with the Texas

Heartbeat Act (Tex. Health & Safety Code § 171.201 et seq.), the physician who is performing/inducing the abortion provides documentation establishing either that (a) no detectable fetal heartbeat exists after the physician conducted appropriate medical testing, or (b) the abortion was necessary due to a medical emergency to preserve the health of the pregnant member. Aetna will otherwise follow the current plan benefits and process accordingly.

- 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.
- Services not permitted under applicable state law or local laws
 - Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the plan will not cover such health care services. Note that in some cases the plan may provide travel benefits for services affected by this exclusion. For detailed information about these excluded services, contact Member Services at number on your ID card.

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.

Emergency Services

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help. Your coverage for emergency services will continue until your condition is stabilized and:

- Your attending physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care
- You are in a condition to be able to receive from the out-of-network provider delivering services the notice and consent criteria with respect to the services
- Your out-of-network provider delivering the services meets the notice and consent criteria with respect to the services

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the *How the Plan Works, Precertification* section and the *What's Not Covered* section that fits your situation. You can also contact us or your network physician or primary care physician (PCP).

Non-emergency services

If you go to an emergency room for what is not an emergency medical condition, the plan may not cover your expenses. See the Benefits Summary for more information.

Surprise Billing

In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by certain out-of-network providers
- Not available from a network provider
- Emergency services

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a network provider. If you receive a surprise bill, your cost share will be calculated at the median contracted rate.

Important Note:

In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

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.

Medically Necessary or Medical Necessity

Health care services or supplies that prevent, evaluate, diagnose, or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion:

- In accordance with “generally accepted standards of medical practice”
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease
- Not primarily for your convenience, the convenience of your physician or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease.

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, and
- Following the standards set forth in our clinical policies and applying clinical judgment. physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Important note: We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is experimental or investigational. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us at the member services number on the back of your ID card with any questions.

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.