

Princeton University
Aetna
Princeton Health Plan (PHP)
Summary Plan Description

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Introduction

Princeton University offers a Princeton Health Plan (PHP) administered by Aetna. Coverage under the PHP is available to you and your dependents as long as you and they meet the eligibility requirements defined in the *About Your Benefits* Summary Plan Description.

If you are currently a non-citizen on a J-1 Visa, you are not eligible to participate in this plan.

The PHP is a point-of-service plan, which provides two levels of coverage: in-network and out-of-network. With the PHP, you can choose any provider you wish, but you receive a higher level of benefits when you select an Aetna Choice POS II (open access) in-network provider.

You do not have to obtain a referral for in-network or out-of-network care. There are some services that are not covered out-of-network, such as Durable Medical Equipment, High-Tech Radiology and Sleep Studies. You should review the SPD or call Aetna at (800) 535-6689 to confirm coverage prior to seeking services.

How the Plan Works

The PHP features two levels of coverage: in-network and out-of-network coverage. You may choose an in-network provider and receive a higher level of benefits, or you can select an out-of-network provider and receive a reduced level of benefits. There are some services that are not covered out-of-network, such as Durable Medical Equipment, Hi-Tech Radiology and Sleep Studies. Prior to seeking services, review the SPD or contact Aetna at (800) 535-6689 to confirm coverage.

In-Network Preferred Lab: Quest Diagnostics and Lab Corp. are the preferred in-network labs for Aetna. If you use any other in-network lab, you will be charged more and will also have to meet your annual deductible prior to services being covered. Out-of-network labs are not covered.

In addition, precertification is required for all inpatient admissions and certain outpatient surgeries and services. If certain out-of-network services are not precertified, the penalty will be no coverage. For in-network services, it is the provider's responsibility to precertify services, and no penalty will apply to the member.

Aetna's authority as claim administrator

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. Princeton University retains sole and complete authority to determine eligibility of persons to participate in the Plan.

Plan Provision	In-Network Service	Out-of-Network Service
Referrals	You do not need a referral from a primary care physician to seek care from other physicians or specialists.	You do not need a referral from a primary care physician to seek care from other physicians or specialists.
Claim forms	No claim forms to file. Your provider will bill Aetna.	You must file a claim form to be reimbursed for your expenses.

Treatment by Physician For Illness or Injury	You pay a \$20 copay for office visits to a primary care physician and a \$35 copay for office visits to a specialist.	You pay 40% coinsurance, after you have met your annual deductible, for office visits preventive care and most office based services.
Preventive and Contraceptive Services	You pay \$0 for preventive services and certain contraceptive services.	You pay 40% coinsurance, after you have met your annual deductible.
Other Services (for example: Inpatient and outpatient medical/surgical facility charges; inpatient mental health and substance use disorder)	You pay a 10% coinsurance after you've met your annual deductible.	You pay 40% coinsurance, after you have met your annual deductible. If you do not receive precertification if required, you will beresponsible to pay 100%.
Annual Deductible The amount you pay each year before the plan begins covering particular medical expenses	Individual: \$200 Family:\$400	Individual: \$750 Family: \$1500
Coinsurance Limit (Out-of-pocket expense maximum) Total amount you pay out-of-pocket in a calendar year before plan pays 100% of your medical expenses	Is determined based on your annual base salary as of January 1 (or your date of hire, if later). See <i>Annual Out-of-Pocket Maximum</i> , Page 6.	Is determined based on your annual base salary as of January 1 (or your date of hire, if later). See <i>Annual Out-of-Pocket Maximum</i> , Page 6.

Out-of-Network Coverage and Reimbursement

You may seek care from a licensed or certified physician or facility outside of the Plan's network, however not all services are covered out-of-network. The amount of an out-of-network provider's charge that is eligible for coverage is called the recognized charge. You are responsible for all amount above what is eligible for coverage, in addition to any applicable out-of-network coinsurance.

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower

when you get care from a NAP provider. Through NAP, the recognized charge is determined as follows:

- If your service was received from a NAP provider, a pre-negotiated charge will be paid. NAP providers are out-of-network providers that have contracts with Aetna, directly or through third-party vendors, that include a pre-negotiated charge for services. NAP providers are not network providers.
- If your services were not from a NAP provider, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the recognized charge for specific services or supplies will be the out-of-network plan rate, calculated at 180% of the Medicare allowable rate.

If your provider bills less than the amount calculated using the out-of-network plan rate, the recognized charge is what the provider bills.

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 an out-of-network provider, unless that out-of-network provider is an assistant surgeon for your surgery
- Not available from a network provider.
- Emergency services – see page 37 for additional information.

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.

Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:

- The method CMS uses to set Medicare rates
- What other providers charge or accept as payment
- How much work it takes to perform a service
- Other things as needed to decide what rate is reasonable for a particular service or supply

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to hospitals or other providers. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.

- For medications payable/covered as medical benefits rather than prescription drug benefits, our rate is 100% of the rates CMS establishes for those medications.

For example: Your out-of-network doctor charges you \$120 for a covered service and the Plan determines that \$100 is the out-of-network plan rate. Assuming you have already met your deductible, the Plan reimburses 60% of \$100 or \$60. You are responsible for the \$40 coinsurance (40% of \$100). You are also responsible for the \$20 difference between the out-of-network plan rate and the doctor's charge. You pay a total of \$60 for the service.

Note: Princeton University cannot guarantee that a specific provider, even though listed in the Aetna directory will be available. Network providers may end their contract with Aetna, or decide not to accept new patients. If your provider does not participate and/or drops out of Aetna's network, this is not a qualifying event to change your medical plan coverage mid-year.

Copay

You pay a copay for office visits to an in-network provider (except for preventive care), for emergency room care, and for treatment at an in-network urgent care center.

In-Network Office Visit Copay

When you visit an in-network provider because you are ill, you will pay a \$20 copay for an office visit to a Primary Care Physician (PCP) or a \$35 copay for a visit to an in-network specialist at the time of the office visit, regardless of whether or not you have met your annual deductible. Copays do not count toward your deductible, but they do count towards your annual out-of-pocket maximum.

If your office visit is for a routine preventive examination, e.g., annual physical, well-child care, annual gynecological exam, or similar preventive care, no copay is required.

Note: If you are pregnant and seeking services in-network, your pre-delivery office visits are covered at 100%. However, the initial office visit to diagnose the pregnancy is covered at a copay.

Emergency Room Copay

The emergency room copay is \$175, regardless of whether the hospital is part of the network or not. It is important to remember the following about the emergency room copay:

- The copay applies only if it is determined that the services were delivered for a true emergency as defined by the Plan, and there is not a less intensive or more

appropriate place of service, or another diagnostic or treatment alternative that could have been used instead of emergency room services.

- If your emergency room visit is not considered a true emergency as defined by the Plan, the services will not be covered.
- The emergency room copay is waived if you are admitted to the hospital.

Urgent Care Center Copay

Urgent care is defined as care for a condition that needs immediate attention to minimize severity and prevent complications, but is *not* a medical emergency. If there is an urgent care center in your area, you have the option of visiting the center when an urgent care situation arises instead of going to your physician. You will pay a \$30 copay for services if the center is in-network. The visit is subject to the deductible and coinsurance if the center is out-of-network.

Annual Deductible

The annual deductible is the amount you must pay each year in covered expenses and coinsurance, before benefits are payable. Office visit copays do not apply to the annual deductible. There is an individual and family deductible for both in-network and out-of-network care. The deductibles for in-network and out-of-network services are tracked and accumulate separately. After you meet your annual deductible, benefits are payable at 90% (in-network) and 60% (out-of-network) for most services. There are some exceptions. Please see the *Benefits Summary*, Page 7. The annual deductible is applied toward your annual out-of-pocket maximum. Please see *Annual Out-of-Pocket Maximum*, Page 6.

The annual family deductible is cumulative among family members. This means that as an individual your services are only covered after you have met your individual deductible or the family as a unit has met the family cumulative deductible.

The in-network deductible can only be met by accumulating the necessary total of in-network services, and the out-of-network deductible can only be met by accumulating the necessary total of out-of-network services. Therefore, if you have met your in-network annual deductible, this amount will not apply towards meeting your out-of-network deductible.

For example: Suppose you are hospitalized at a network facility because you require surgery and you have family coverage and your family deductible is \$400. Let's assume that your husband has already paid \$200 and your daughter \$200 toward the deductible. Your family has met the family deductible so you need only pay the balance of 10% (the plan pays 90%). Your annual family deductible is now satisfied under the in-network portion of the plan, and any covered services that you receive from an in-

network provider for the remainder of the year will be covered at the coinsurance percentage. If you decide to use an out-of-network provider, you will be required to meet the out-of-network deductible, and the in-network family deductible of \$400 will not apply toward the individual out-of-network deductible of \$750, or the family out-of-network deductible of \$1,500.

Let's now assume that no member of your family has incurred expenses at the time of your hospitalization/surgery, then you will pay the first \$200 individual deductible of the hospital/surgical facility charges and the remainder of the facility charges will be covered at 90% coinsurance. You will never have to pay a deductible that is greater than the individual deductible for a single member of the family. As illustrated, if you decide to use an out-of-network provider, the in-network deductible you have already paid will not apply toward the out-of-network annual individual deductible of \$750 or family deductible of \$1,500.

Annual Out-of-Pocket Maximum

The maximum amount that you will pay out-of-pocket towards copays, deductibles and/or coinsurance each calendar year is called the annual out-of-pocket maximum (OPM). The in-network out-of-pocket maximum amount is based on your annual base salary as of January 1, or your date of hire, if later.

- If your annual base salary is \$75,000 or under, the in-network individual OPM is \$1,550 and the in-network family OPM is \$3,100. The out-of-network individual OPM is \$4,500 and the out-of-network family OPM is \$9,000.
- If your annual base salary is \$75,001 to \$150,000, the in-network individual OPM is \$2,350 and the in-network family OPM is \$4,700. The out-of-network individual OPM is \$4,700 and the out-of-network family OPM is \$9,400.
- If your annual base salary is \$150,001 or above, the in-network individual OPM is \$3,100 and the in-network family OPM is \$6,200. The out-of-network individual OPM is \$6,200 and the out-of-network family OPM is \$12,400.

If you meet the annual OPM, covered expenses are paid at 100% of the allowed amount.

Keep in mind that the following payments do not count toward the annual OPM for out-of-network services:

- Precertification non-notification penalty
- Charges above the out-of-network plan rate

You must continue to make these payments when applicable even if you have reached your annual out-of-pocket maximum.

There is both an individual and family annual OPM for both in-network and out-of-network care. When the in-network individual annual OPM is reached in a calendar year, all in-network covered expenses, except those shown above, are payable at 100% limit for that person for the rest of the year. (Precertification non-notification penalties and out-of-network plan rates do not apply to in-network services)

The same is true for the family annual OPM, and for both the individual and family annual OPM under the out-of-network portion of the Plan. However, the reimbursement is calculated based on the out-of-network plan rate, as described above. You are responsible for the applicable out-of-network coinsurance and charges above the out-of-network plan rate. Precertification non-notification penalties do apply to out-of-network services.

Expenses you incur that apply toward the annual OPM are tracked separately and do not accumulate for in-network and out-of-network services. In other words, in-network payments do not count toward your out-of-network limits and vice versa.

Benefits Summary

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

Annual Out-of-Pocket Maximum by Salary Band

Salary Band Find the range which includes your January 1 (or salary at date of hire, if later) base salary to determine your in-network and/or out-of-network maximum annual out-of-pocket expense.		In-Network Annual Out-of-Pocket Maximum		Out-of-Network Annual Out-of-Pocket Maximum	
From	To	Individual	Family	Individual	Family
\$0	\$75,000	\$1,550	\$3,100	\$4,500	\$9,000
\$75,001	\$150,000	\$2,350	\$4,700	\$4,700	\$9,400
\$150,001	and above	\$3,100	\$6,200	\$6,200	\$12,400

	In-Network	Out-of-Network
Annual Deductible The amount that you pay each year before the plan begins covering particular medical expenses. Annual deductible cross applies.	Individual: \$200 Family: \$400	Individual: \$750 Family: \$1,500
Coinsurance The percentage of medical expenses you pay out-of-pocket after you meet your deductible.	You pay 10% after deductible	You pay 40% after deductible
Annual Out-of-Pocket Maximum (including deductible, copays and coinsurance)	Based on salary bands	Based on salary bands
Lifetime Maximum Medical/Surgical/Mental Health	Unlimited	Unlimited

	HOSPITAL BENEFITS	
	In-Network	Out-of-Network
Inpatient Medical/Surgical Care from Specialist (including Maternity)	You pay 10% after deductible	You pay 40% after deductible. You pay 100% if services are not precertified.
Inpatient Care/Residential Treatment for Mental Health and Substance Use Disorder	You pay 10% after deductible	You pay 40% after deductible. You pay 100% if services are not precertified.
Surgical (Inpatient/Outpatient) Anesthesia and use of an operating room or related facility in a hospital or authorized institution.	You pay 10% after deductible	You pay 40% after deductible. You pay 100% if services are not Precertified when required.

	In-Network	Out-of-Network
Emergency Room Services administered for conditions meeting the definition of an emergency. Non-emergency care not covered.	You pay \$175 copay; waived if admitted.	You pay \$175 copay; waived if admitted.
Non-Notification Penalty for Failure to Pre-certify Applies to out-of-network inpatient and certain outpatient hospital or treatment facility.	No penalty for in network services	No Coverage. You pay the full cost for any procedure and/or admission that is not precertified.
	OUTPATIENT BENEFITS	
	In-Network	Out-of-Network
Preventive Care by Physician	You pay \$0	You pay 40% after deductible
Treatment by Physician for illness or injury	You pay \$20 copay per visit	You pay 40% after deductible
Treatment by Specialist	You pay \$35 copay per visit	You pay 40% after deductible
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 \$35 copay for Teladoc dermatology. You pay \$20 copay for Teladoc Behavioral Health.	Not applicable; all Teladoc doctors are in-network.
Physician Services Performed in a Hospital/Ambulatory Setting or in the Patient's Home	You pay 10% after deductible	You pay 40% after deductible.

<p>Annual Physical/Immunizations (Children: Seven exams in first 12 months of life, three exams the next 13 to 24 months, three exams the next 25 to 36 months, and one (1) exam every calendar year thereafter up to age 18. Adults 18+: One exam every calendar year. Includes coverage for immunizations.</p>	<p>You pay \$0</p>	<p>You pay 40% after deductible</p>
<p>Prenatal/Maternity Care</p>	<p>You pay a \$35 copay for the visit to diagnose the pregnancy. All other prenatal visits will be covered at 100%</p> <p>Delivery: You pay 10% after deductible(pre & post-partum care included in surgical charge for delivery)</p> <p>You pay a \$35 copay for post-partum office visits</p>	<p>You pay 40% after deductible</p>
<p>Lactation Support and Breastfeeding Equipment (<i>Call Aetna at 800-535-6689 for more information</i>)</p>	<p>You pay \$0</p>	<p>You pay 40% after deductible</p>
<p>Preventive Immunizations</p>	<p>You pay \$0</p>	<p>You pay 40% after deductible</p>
<p>Outpatient Hi-Tech Radiology (MRI, CT, PET, and other scans) Requires enhanced clinical review through provider precertification process.</p>	<p>You pay \$0 for services received at an independent facility; you pay 20% after deductible for services received in a hospital setting. Nuclear medicine scan covered 100% any location. See page 17 for additional information regarding hi-tech radiology services.</p>	<p>Not Covered</p>

Outpatient Diagnostic Cardiology, Sleep Studies, and Cardiac Rhythm Implant Devices. Requires enhanced clinical review through provider precertification process.	You pay \$0	Not Covered
Outpatient Lab Services for Diagnosis or Treatment (Quest and Lab Corp. are the preferred labs)	You pay \$0 if you utilize Quest or LabCorp. You pay 40% after deductible for all other in-network labs. You pay \$0 for diagnostic testing for COVID-19 at any lab in and out-of-network.	Not Covered
Outpatient X-Ray Services for Diagnosis or Treatment	You pay \$0 for services received at an independent facility; you pay 20% after deductible for services received in a hospital setting. See page 17 for additional information regarding x-ray services.	Not Covered
Outpatient Mental Health & Substance Use Disorder	You pay \$20 copay per visit	You pay 25% (no deductible required)
Teladoc Behavioral Health Network of licensed mental health providers who can provide both therapy & medication management. (855) 835-2362 www.teladoc.com/princeton	You pay \$20 copay per visit	Not applicable; all Teladoc doctors are in-network

Applied Behavioral Analysis (ABA) Therapy Coverage for those whose diagnosis is on the autism spectrum	You pay \$20 copay per visit	You pay 25% (no deductible required)
Outpatient Short-Term Rehabilitation Therapy Short-term physical therapy. Maximum of 100 visits per calendar year (combined in-network/out-of-network), if services will result in significant improvement in the member's condition within a 60 day period	You pay 10% after deductible	You pay 50% after deductible
Outpatient Short-Term Rehabilitation Therapy Short-term occupational or speech therapies, and pulmonary and cardiac rehabilitation. Maximum of 100 visits each type per calendar year (combined in-network/out-of-network), if services will result in significant improvement in member's condition within a 60 day period. For speech therapy both restorative and non-restorative services are covered.	You pay 10% after deductible	You pay 40% after deductible
Outpatient Therapeutic Treatments Dialysis, intravenous chemotherapy or other intravenous infusion therapy and other treatments.	You pay \$0 after deductible for outpatient treatments. You pay \$0 copay for treatments provided in an office setting.	You pay 40% after deductible
	OTHER BENEFITS	
	In-Network	Out-of-Network
Ambulance Services – Medically necessary transport is covered	You pay \$0	You pay \$0
Acupuncture Services Limited to	You pay \$35 copay per office visit	You pay 40% after

20 visits per calendar year (combined in-network/out-of-network).		deductible
Chiropractic Services Limited to 20 visits per calendar year (combined in-network/out-of-network). Services related to physical therapy are covered under & accumulate towards the 100 visit outpatient rehabilitation therapy maximum - See the Outpatient Short-Term Rehabilitation Therapy section for coverage information	You pay \$35 copay per office visit	You pay 40% after deductible
Family Planning Services Fertility treatment - Diagnosis & treatment of underlying medical condition covered with no lifetime max. Coverage provided for fertility services performed at a Kindbody Clinic or Kindbody Center of Excellence network only. Fertility benefit coverage of four (4) Cycles per memberper Lifetime. Proof of inability to conceive is not required.	You pay 10% after deductible if inpatient or outpatient service. If an office visit is charged, you pay \$35 copay	Not Covered
Preventive Care Preventive physicals, well-child care office visits (including scheduled immunizations), mammogram (one every year age 35 and over), PapSmear, Well-woman care, and Prostate Specific Antigen (PSA) tests (available at age 40)	You pay \$0	You pay 40% afterdeductible
Nutritional Counseling Limited to twelve visits percalendar year. Requires prescription from physician.	You pay \$35 copay per office visit	You pay 40% afterdeductible

<p>Home Health Care Includes visiting nursing care and private duty nursing care. Each visiting nurse care or private duty nursing care shift of four hours or less counts as one home health visit. Each such shift of over four hours and up to eight hours counts as two home healthcare visits. Limited to 60 visits per calendar year (combined in-network/out-of-network).</p>	You pay 10% after deductible	You pay 40% after deductible
<p>Hearing Exams Limited to one exam per calendar year. Requires prescription from physician.</p>	You pay \$35 copay	You pay 40% after deductible
<p>Hearing Aids Limited to maximum reimbursement of \$1,500 every three years (combined in-network/out-of-network).</p>	Plan pays 100% up to a maximum reimbursement of \$1,500 every three years.	Plan pays 100% up to a maximum reimbursement of \$1,500 every three years.
<p>Skilled Nursing Facility/Inpatient Physical Rehabilitation Confinement and skilled nursing services in a hospital or specialized facility; Limited to 60 days per calendar year (combined in-network/out-of-network).</p>	You pay 10% after deductible	You pay 40% after deductible
<p>Hospice Care Room and board in a licensed facility or in your home; services of medical personnel; other services and supplies; Limited to inpatient maximum of 180 days (combined in-network/out-of-network)</p>	You pay 10% after deductible	You pay 40% after deductible

Durable Medical Equipment Single purchase of any onetype of equipment is covered including repair. Replacements allowed once every three years. This covers prosthetic devices, including foot orthotics.	You pay 10% after deductible	Not Covered
Wigs - Limited to maximum reimbursement of \$2,500 every three years for wigs or wig repair. Covered based on medical necessity e.g., chemotherapy, radiation (combined in-network/out-of-network)	You pay 10% after deductible	You pay 10% after in-network deductible.
Prescriptions - Administered by OptumRx You will receive a separate ID card.	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	Not covered	Not covered
Prescription Eyeglasses or Contact Lenses	Not covered	Not covered
Tobacco Prevention Consultations	Plan pays 100% up to 8 visits per calendar year with your primary care physician Tobacco cessation medications covered through OptumRx	You pay 40% after deductible.

Additional Plan Benefits:

While the *Benefits Summary* provides an overview of your coverage under the PHP Plan, this section includes additional detail about:

- Allergy Testing and Treatment
- Imaging Services
- Family Planning Benefits and Infertility
- Pregnancy Benefits
- Mental Health and Substance Use Disorder Benefits
- AbleTo
- Dental - Oral Surgery
- Organ/Tissue Transplants
- Prescription Drug Benefits
- Preventive Care
- Gender Confirming Surgery
- Travel

Allergy Testing and Treatment

Testing and evaluations to determine the existence of an allergy are covered under the PHP. When a physician determines that an allergy exists, routine allergy injections, including serums, are also covered.

	In-Network	Out-of-Network
Allergy Testing and Treatment	<u>Allergy Testing office visit:</u> You pay a \$35 copay per visit <u>Allergy Serum and Injection:</u> You pay \$35 copay if office visit charged. You pay \$0 if no office visit charged <u>Office visit and serum or injection on same day:</u> You pay a \$35 copay per visit if office visit charged. You pay \$0 if no office visit charged.	You pay 40% after deductible

Imaging Services

Complex Imaging Services (High-Tech Radiology) and X-Ray Services

100% per procedure for utilizing an in-network independent facility. 80% per procedure after Calendar Year deductible for utilizing an in-network hospital setting. Pre-certification is required for high-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 80% after deductible.

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.

Family Planning Benefits and Infertility

The PHP covers a range of family planning benefits including the following:

- Sterilization
- Health services and associated expenses for abortion
- Contraception supplies and services
- Fetal reduction surgery
- Health services associated with the use of non-surgical or drug induced pregnancy termination

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

The Princeton Health 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 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 or 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

Pregnancy Benefits

An individual who becomes pregnant undergoes two types of care during the course of the pregnancy: prenatal office visits and hospitalization for the delivery of the child.

Office Visits

You will pay a \$35 copay for the initial office visit to diagnose the pregnancy. For all subsequent in-network prenatal office visits you will pay \$0, with the exception of pre- and post-partum hospital care and delivery. (Note: You will pay a copay for post-partum office visits.) You must meet your out-of-network deductible and coinsurance for out-of-network office visits.

Hospitalization

You will pay 10% coinsurance (in-network) and 40% coinsurance (out-of-network) after satisfying the applicable deductible for services and supplies associated with the birth of your baby. After satisfying the applicable deductible you will pay 10% coinsurance for the specialist fees or 40% for out-of-network specialist fees. Coverage includes:

- At least 48 hours (for a normal vaginal delivery) or 96 hours (for a cesarean section) of inpatient care for the mother and newborn child (authorizations are required for longer lengths of stay). These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The hospital or other provider is not required to get authorization for the time periods stated above. However, the mother and/or newborn can be discharged from the hospital prior to the 48/96 hour length of stay requirement upon consultation between the mother (or in the case of the newborn, the child's mother or authorized representative) and the attending provider.
- Birth center and nurse-midwife services, including services provided for home

births.

- Routine well-baby care given for the duration of the baby's confinement

Pregnancy is subject to the precertification requirement. Please see *When to Precertify*, Page 25.

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

Special prenatal programs are available. These programs are completely voluntary and there is no extra cost for your participation. To enroll, contact Aetna during your first trimester, but no later than one month prior to the anticipated childbirth.

Mental Health and Substance Use Disorder Benefits

The PHP covers inpatient and outpatient care for mental health and substance abuse treatment, subject to certain limits (noted below). A residential treatment facility would also be covered as an inpatient benefit. The copay and coinsurance amounts apply as shown in the *Benefits Summary*. Mental health benefits include, but are not limited to:

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

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

Telemental Health services are also available, and are a convenient option that allows patients 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.

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 PHP. However, there are certain limited dental and oral surgical procedures that are covered in either an inpatient or outpatient setting:

- diagnosis and treatment of oral tumors and cysts, and
- surgical removal of bony or partial bony impacted teeth.

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

- the injury occurs while you are covered
- the injury was not caused, directly or indirectly, by biting or chewing, and
- initial treatment must begin within three months of injury.

Under the PHP, coverage also includes dental work, surgery and orthodontic treatment needed to remove, repair, replace, restore or reposition natural teeth damaged, lost, or removed or other body tissues of the mouth fractured or cut. Oral surgery may be subject to the pre-certification requirement. Please see *When to Precertify*, Page 25.

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.

Durable Medical Equipment

Durable Medical Equipment is covered in-network when it meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.

The Plan provides benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every three calendar years. However, for children age 18 or younger, replacement is allowed once per year due to growth in stature.

Aetna will decide if the equipment should be purchased or rented.

Durable Medical Equipment is not covered out-of-network.

Prosthetic Devices

External prosthetic devices that replace a limb or an external body part are covered in-network, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
- Foot orthotics.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years. However, for children age 18 or younger, replacement is allowed once per year due to growth in stature.

Prosthetic devices is not covered out-of-network.

Reconstructive Procedures

(Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function)

Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Please note that benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Aetna at the Customer Service telephone number on your ID card for more information about benefits for mastectomy-related services.

Organ/Tissue 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. These facilities are known as Aetna Institute of Excellence (IOE) facilities. IOE's are the only facilities considered to be in-network for providing these services. If you receive these services at any other facility, you will pay 40% after the deductible because the facility will be considered out-of-network, even if it is in-network when providing non-transplant 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 near 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 and you are utilizing an IOE transplant

program facility, 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 a 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 a 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 with the earliest occurrence listed below:

- 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.

Prescription Drug Benefits

The Prescription Drug Program is administered by OptumRx and is independent of Aetna. For additional information please review the Prescription Plan SPD.

Preventive Care

In-Network

Preventive services are designed to help diagnose and prevent disease early. Preventive services, e.g., annual exams, colonoscopies, and mammograms, are covered at 100% in-network. A list of preventive services is available by contacting Aetna.

When you visit a network provider for a routine examination (e.g., annual physical, well-child care, annual gynecological exam, etc.), your copay is \$0 and applies to all covered services, supplies, and tests associated with the visit. For example, if the in-network provider orders routine blood work as a part of your physical, or if your child needs to receive a scheduled immunization, there will be no additional charge for these services.

The following are covered services associated with preventive health care benefits for you and your dependents (if enrolled):

- Routine immunizations
- Routine physical exams (including any outpatient lab work/x-rays ordered at the time of the visit) once each calendar year
- Contraceptive services
- Prostate specific antigen
- Breast examination and/or mammogram
- Pelvic examination
- Pap smear
- Child preventive care services given in connection with routine pediatric care, including PKU tests and immunizations

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.

Out-of-Network

- When you visit an out-of-network provider for a routine examination, you will pay 40% coinsurance after you have met your annual deductible. The following exclusions apply:
 - Any services for well-child care visits over the limit of seven visits during the first year, or more than 3 exams in the second year, or more than 3 exams in the third year or more than 1 exam yearly thereafter are not covered.
 - The annual visit is subject to the deductible and coinsurance payment.

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 Confirming Surgery

Gender Confirming Surgery

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

- Charges made by a physician for:
 - Performing the surgical procedure; and
 - Pre-operative and post-operative hospital and office visits.
- Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). Room and board charges in excess of the hospital's semi-private rate will not be covered unless a private room is ordered by your physician and precertification has been obtained.

Prior Authorization Requirements for all surgeries:

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

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

Exclusions:

- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Blepharoplasty

Travel

Aetna is a national vendor with a network of physicians, hospitals, and health-care providers throughout the United States. When traveling in the U.S., you access care as you normally would by either locating a participating provider to receive care under the in-network portion of the Plan, or by choosing an out-of-network provider to receive care on an out-of-network basis.

If you are traveling overseas on *University-sponsored* or *University-related business* and are enrolled in the PHP, you may be eligible to receive the in-network level of benefits coverage. Please contact the Office of Human Resources at 609-258-3302 *before* you leave to determine if you qualify for this benefit.

If you are traveling overseas on personal business that is not University-sponsored or University-related (including vacation), your coverage is provided under the out-of-network portion of the Plan. If, however, you or a family member experience an emergency situation while traveling on personal business, you should go directly to the nearest facility for treatment. In an emergency situation, benefits are payable under the in-network portion of the Plan.

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.

Care Coordination

You and your physician make decisions about medical services and supplies that you should receive; however, all covered services and supplies are subject to a utilization review. Utilization review refers to the process that Care Coordination goes through when determining whether or not services and supplies received by an individual are eligible for coverage according to Plan benefits and provisions. This review is mandatory in certain situations. It takes place upon notification by you either before (precertification) or after (notification for emergency care) you receive certain services and supplies.

Precertification

You are required to notify Aetna by calling the toll-free number shown on your ID card prior to receiving certain services. In some cases, a provider may handle the precertification; however, it is important to remember that it is ultimately your responsibility to ensure that authorization has been received for all procedures and confinements for which it is required. 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 28.

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.

Precertification Non-Notification Penalty

There is a penalty of no coverage for out of network services per procedure and/or admission for failing to call at the required time, or for failing to comply with recommendations concerning continued need for treatment. You will be responsible for 100% of the charges, if you do not precertify certain out-of-network services. The penalty amount may not be applied toward your annual out-of-pocket maximum.

Appeals

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

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

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

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

What's Not Covered

If you have a question about whether a service or supply will be covered, contact Aetna

directly at 1-800-535-6689. The Plan does not cover the following services and supplies:

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

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

- the disease can be expected to cause death within one year, in the absence of effective treatment, and
- the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

- have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
 - are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
 - if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.
- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
 - Services and supplies related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception

training; or carbon dioxide therapy.

- Treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Services of a resident physician or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for custodial care.
- Services and supplies:
 - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
 - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it is required by law or is provided on other than a group basis. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
- Lasik surgery to correct refractive errors, unless there is a pre-surgical refractive error greater than eight (8) diopters.
- Education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:
 - sildenafil citrate,
 - phentolamine,
 - apomorphine,
 - alprostadil, or
 - any other drug that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.

This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided under the prescription drug plan.

- Performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided, or in the case of chemotherapy or radiation (*Call Aetna at 800-535-6689 for more information*).
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Weight control services including: weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; exercise programs; exercise or other equipment; and other services and

supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions. Bariatric weight loss surgery may be covered.

- Plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
Improve the function of a part of the body that:
 - is not a tooth or structure that supports the teeth; and
 - is malformed as a result of a severe birth defect; including cleft lip, webbed fingers, or toes, or
 - as a direct result of disease or surgery performed to treat a disease or injury.Surgery must be performed in the calendar year of the accident which causes the injury or in the next calendar year.
- Those to the extent they are not reasonable charges, as determined by Aetna.
- Reversal of a sterilization procedure.
- Service or supply furnished by a Preferred Care Provider in excess of such provider's Negotiated Charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.
- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.
- Donor egg retrieval.
- Over-the-counter medications and supplies.
- Special duty nursing.
- 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.
- 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.
- 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 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

In-Network

When you receive services from a network provider, it is not necessary to file a claim. The provider is reimbursed directly from Aetna. You will receive an Explanation of Benefits (EOB) showing the details of the charges and benefits you received.

Out-of-Network

When you receive services from an out-of-network provider, you must pay for the visit and take the following steps to file a claim for reimbursement:

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

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

- Your name and social security number.
- Princeton University's name and policy/group number (486819).
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

An authorized representative means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit

claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 20 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 20 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 20 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 20 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan

representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within five (5) days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

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.

How and When Claims are Paid

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

- You have financial responsibility under a court order for a dependent's medical care, then Aetna will make payments directly to the provider of care.
- Aetna pays benefits directly to network providers.
- You request in writing that payments be made directly to a provider. You do this by signing the appropriate authorization when completing the claim form.

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

Recovery of Overpayments

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

This right does not affect any other right of recovery the plan may have with respect to overpayments.

Review Procedure for Denied Claims

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

Other Important Information

Coordination of Benefits

The PHP 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 of this Summary Plan Description Handbook.

Medically Necessary or Medical Necessity

Medically necessary, 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.

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.

Your Rights Under ERISA

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

Reservation of Rights

The University reserves the rights to amend, suspend, or terminate its Aetna Princeton Health Plan (PHP) 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.