Princeton University

J-1 Visa Health Care Plan

Summary Plan Description

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

April 1, 2022

Contents

Introduction

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

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

How the Plan Works

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

Out-of-Network 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 you services was 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

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.

Note: Princeton University cannot guarantee that a specific provider, even though listedin 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/ordrops out of Aetna's network, this is not a qualifying event to change your medical plan coverage mid-year

What is Covered

Benefits Summary

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

	J-1 Visa Plan
Annual Deductible The amount you pay each year before the Plan begins covering particular medical expenses.	Individual: $500 Family: $1,000
Coinsurance The percentage of medical expenses you pay out-of-pocket after you meet your deductible.	You pay 20% after deductible
Coinsurance Limit (Annual Maximum Out-of-Pocket) (including deductible)	Individual: $2,500 Family: $5,000
Lifetime Maximum Medical/Surgical/Mental Health	Unlimited
HOSPITAL BENEFITS	
Notification/Compliance Requirement Some services require pre-certification by calling Aetna at 1-800-535-6689.	Please see *When to Pre-Certify* section
Inpatient Medical/Surgical Care (including maternity)	You pay 20% after deductible
Inpatient Care/Residential Treatment for Mental Health and Substance Use Disorder	You pay 20% after deductible
Surgery (Inpatient/Outpatient) Anesthesia and use of an operating room or related facility in a hospital or authorized institution.	You pay 20% after deductible
Emergency Room Services administered for conditions meeting the definition of an emergency.	You pay 20% after deductible. Non-emergency care not covered.

	J-1 Visa Plan
Non-Notification/Non-Compliance Penalty The amount you must pay if you do not call Aetna at 1-800-535-6689 before hospitalization and certain types of surgery, or fail to follow concurrent review procedures.	You pay $200 per procedure and/or admission
OUTPATIENT BENEFITS	
Notification/Compliance Requirement Some services require pre-certification by calling Aetna at 1-800-535-6689.	Please see *When to Pre-Certify* section
Treatment by Physician	You pay 20% after deductible
Annual Physical Adults (18+): One exam every calendar year.	You pay 20% after deductible
Well Baby Visits Children: Seven exams in first 12 months of life, three exams the next 13 to 24 months, three exams the next 25 to 36 months, and one (1) exam every calendar year thereafter up to age 18).	You pay 20% after deductible
Preventive Immunizations	You pay 20% after deductible
Outpatient Lab and X-Ray Services for Diagnosis or Treatment	You pay 20% after deductible You pay $0 for diagnostic testing for COVID-19 at any lab in and out-of-network.
Outpatient Mental Health and Substance Use Disorder Services	You pay 20% after deductible
Applied Behavioral Analysis (ABA) Therapy Coverage for those whose diagnosis is on the autism spectrum	You pay 20% after deductible

Outpatient Physical Rehabilitation Short-term outpatient rehabilitation services for physical therapy, occupational therapy, speech therapies. Maximum of 30 visits each type per calendar year. Pulmonary and cardiac rehabilitation therapy covered at a maximum of 50 visits each type per calendar year.	You pay 20% after deductible
Outpatient Therapeutic Treatments	You pay 20% after deductible

	J-1 Visa Plan
Dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments.	You pay 20% after deductible
OTHER BENEFITS	
Notification/Compliance Requirement Some services require pre-certification by calling Aetna at 1-800-535-6689.	Please see *When to Pre-certify* section
Ambulance Services - Emergency Only	You pay 20% after deductible
Chiropractic Services or Acupuncture Limited to 20 visits each per calendar year. Services related to physical therapy track towards a separate 30 visit limit for outpatient rehabilitation therapy.	You pay 20% after deductible
Durable Medical Equipment Single purchase of any one type of equipment is covered including repair. Replacements allowed once every three years. This covers Prosthetic Devices, including foot orthotics.	You pay 20% after deductible
Nutritional Counseling Limited to 12 visits per calendar year. Requires prescription from physician	You pay 20% after deductible
Hearing Exams Limited to one exam per calendar year. Requires prescription from physician	You pay 20% after deductible
Hearing Aids Limited to maximum reimbursement of $1500 every three years.	Plan pays 100% up to a maximum reimbursement of $1500 every three years

Prescriptions – Administered by OptumRx.	Retail copays: Generic $5, Preferred Brand $25, Non-preferred Brand $40 or member pays the difference Mail-Order copays: Generic $10, Preferred Brand $50, Non-preferred Brand $80 or member pays the difference
Routine Annual Eye Exam	Not covered
Prescription Glasses or Contact Lenses	Not covered
Supplemental Benefits Medical evacuation to your home country Transport of deceased to home country. This is covered through Princeton University, and not Aetna.	Maximum of $50,000 for medical evacuation Maximum of $25,000 for repatriation of remains

While the *Benefits Summary* above provides an overview of your coverage under the J-1 Visa Health Plan, this section includes additional information about:

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

Family Planning Benefits and Infertility

The J-1 Visa Plan covers a range of family planning benefits including the following:

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

Prior authorization is required.

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

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

Fertility and Family Planning coverage provided by Kindbody; services covered in-network at Kindbody's clinics or Kindbody's Centers of Excellence network. No out-of-network coverage. Fertility services not authorized through Kindbody will not be covered or reimbursed by the Plan. Fertility benefit coverage of four (4) Cycles per member per Lifetime.

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 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

Mental Health and Substance Use Disorder Benefits

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

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

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

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

Dental – Oral Surgery Benefits

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

Pregnancy Benefits

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

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

Coverage includes:

- At least 48 hours for a normal vaginal delivery or 96 hours for a cesarean section of inpatient care for the mother and newborn child. Authorizations are required for longer lengths of stay. However, the mother and/or newborn can be discharged from the hospital prior to the 48/96 hour length of stay requirement upon consultation between the mother (or in the case of the newborn, the child's mother or authorized representative) and the attending provider.
- Birth Center and nurse-midwife services, 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 only if the member exceeds days beyond the minimum. Please see *When to Pre-Certify*.

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

Prescription Drug Benefits

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

Preventive Health Care Benefits

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

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

The following exclusions apply:

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

Gender Confirming Coverage

Gender Confirming Coverage includes the following:

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

- Speech/Voice therapy to help participants experiencing gender dysphoria communicate in a manner consistent with their gender identities. Services must be provided by a licensed speech therapist.
- Gender Confirming Surgery

Gender Confirming Surgery

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

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

Prior Authorization Requirements for all surgeries:

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

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

Exclusions:

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

Teladoc

Teladoc general medicine visits are covered 100% per visit after Calendar Year Deductible (you will pay no more than $49 per visit until deductible is met) from January 1, 2022 to March 31, 2022. Visits incurred April 1, 2022 through December 31, 2022 will be covered at 100% not subject to the deductible.

Teladoc Behavioral Health and Teladoc Dermatology visits will be covered at 80% after deductible.

Utilization Review

You and your physician make decisions about medical services and supplies that you should receive; however, all covered services and supplies are subject to a Utilization Review. Utilization Review is the process that Aetna follows when determining whether services and supplies received by an individual are medically necessary according to Plan benefits and provisions. This review is mandatory in certain situations, taking place upon notification by you either before (pre-certification) or after (notification for emergency care) you receive certain services and supplies.

Pre-Certification

You are required to notify Aetna 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.

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.

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

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

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

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

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

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 Catherization, 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.

What's Not Covered

The Plan does not cover the following services and supplies:

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

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

panel will include professionals who treat the type of disease involved.

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

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

supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
Improve the function of a part of the body that:
  - is not a tooth or structure that supports the teeth; and
  - is malformed as a result of a severe birth defect; including cleft lip, webbed fingers, or toes, or
  - as a direct result of disease or surgery performed to treat a disease or injury.

Surgery must be performed in the calendar year of the accident which causes the injury or in the next calendar year.

- Those to the extent they are not reasonable charges, as determined by Aetna.
- Reversal of a sterilization procedure.
- Service or supply furnished by a Preferred Care Provider in excess of such provider's Negotiated Charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.
- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.
- Dental care and X-rays.
- 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.
- 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.

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

Claims Information

Identification Cards

Aetna ID Card

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

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

Plan:	J-1 Visa Health Care Plan
Group number:	811281
Member number:	Provided by Aetna
Phone number:	1-800-535-6689
Address:	Aetna Life Insurance Company PO Box 981106 El Paso, TX 79998-1106

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

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

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

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

- Your name and your Princeton University ID number,
- Princeton University's name and contract number (811281),
- The patient's name,

- The diagnosis,
- The date the services or supplies were incurred, and
- The specific services or supplies provided.

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

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

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

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

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

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

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

Review Procedure for Denied Claims

When a claim for benefit payment is denied in whole or in part, you may appeal the denial. A request for review must be directed to Aetna within 60 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, you should state the reason you believe the claim was improperly paid or denied and submit any data or comments to support the claim.

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

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.

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

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

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

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

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

Other Important Information

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

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

Reservation of Rights
The University reserves the rights to amend, suspend, or terminate its J-1 Visa Health Care Plan in whole or in part, at any time and for any reason. The University has full authority and discretion to construe, interpret and administer its plan. The plan is unfunded, and no employee or dependent shall have any right to, or interest in, any assets of the University which may be applied by the University to the payment of benefits. Neither the establishment of the plan, nor the provision of

benefits to any person, shall be construed as giving an employee the right to be retained in the service of the University. The plan will be construed and enforced according to New Jersey State law.

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.

Grandfathered Health Plan Notice

Princeton University believes your plan is a "grandfathered health plan" under the Patience Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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

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