

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

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January 1, 2022

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Introduction

Princeton University offers the Princeton Health Plan (PHP) administered by UnitedHealthcare. 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* section of the Summary Plan Description Handbook.

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 three levels of coverage: in-network preferred, in-network non-preferred, 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 a UnitedHealthcare Choice Plus in-network provider. In addition, when utilizing certain specialists, you will receive a higher level of benefit if you use a preferred in-network provider (see page 2 for additional information).

You do not have to obtain a referral for in-network or out-of-network care. There are some services that are not covered at the out-of-network level, such as Durable Medical Equipment. You should review the SPD for details or call UnitedHealthcare at (877) 609-2273 to confirm coverage prior to seeking services.

How the Plan Works

The PHP features three levels of coverage: in-network preferred, in-network non-preferred and out-of-network coverage. You may choose a UnitedHealthcare Choice Plus 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. You should review the SPD for details or call UnitedHealthcare at (877) 609-2273 to confirm coverage prior to seeking services.

When utilizing specialists, first check to see if they are in a category that identifies in-network preferred specialist providers. On their website, www.myuhc.com, UnitedHealthcare's preferred providers are listed as Premium Tier 1. Below is a list of Premium Tier 1 categories and locations as of January 2022. For the most current list of categories and locations contact UnitedHealthcare.

UnitedHealthcare (Premium Tier 1) In-Network Preferred Specialists: Allergy; Cardiology; Ear, Nose and Throat (ENT); Endocrinology; Family Practice; Gastroenterology; General Surgery; Internal Medicine; Nephrology; Neurology; Neurosurgery-Spine; Obstetrics and Gynecology (OB/GYN); Ophthalmology; Orthopedics; Pediatrics; Pulmonology; Rheumatology; and Urology.

Locations with Limited or No Access to Preferred Specialists: AZ, CA, DE, GA, IN, KY, MA, MI, NC, NH, NV, OR, SC, TX, VT and WV. If you reside in one of these locations, and need to visit a UnitedHealthcare specialist in one of the Premium Tier 1 categories, contact the Human Resources Benefits Team at (609) 258-3302 for assistance.

In-Network Preferred: LabCorp. and Quest are the preferred in-network labs for UnitedHealthcare. 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. Participants can use the Quest lab on campus in McCosh Health Center and will have their services covered at 100%.

In addition, prior authorization to determine medical necessity is required for certain in-network and out-of-network inpatient and outpatient services as well as for Hi-Tech radiology (CT, PET, MRI, MRA, Nuclear Medicine), and sleep studies. For a complete list, please see Page 31. If the service is deemed not medically necessary, the service will not be covered. For in-network services, it is the provider's responsibility to contact UnitedHealthcare for the prior authorization review. For out-of-network services, it is the member's responsibility to seek prior authorization. If certain out-of-network services are not submitted for prior authorization, the penalty will be no coverage. You will be responsible for 100% of the cost.

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 UnitedHealthcare.	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, a \$30 copay to a preferred specialist, or a \$60 copay to a non-preferred 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 medical/surgical facility charges; inpatient mental health and substance use disorder care). Prior authorization required.	You pay 10% coinsurance after you have met your annual deductible.	You pay 40% coinsurance, after you have met your annual deductible. If you do not receive prior authorization, there will be no coverage; you will be responsible 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: \$1,500
Coinsurance (out-of-pocket expense)	You pay 10% coinsurance after you have met your annual in-network deductible for most services.	You pay 40% coinsurance after you have met your annual out-of-network deductible for most services.
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). <i>See Annual Out-of-Pocket Maximum on Page 6.</i>	Is determined based on your annual base salary as of January 1 (or your date of hire, if later). <i>See Annual Out-of-Pocket Maximum on Page 6.</i>

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 or eligible expense. You are responsible for all amount above what is eligible for coverage, in addition to any applicable out-of-network coinsurance.

When covered health services are received from an out-of-network provider, eligible expenses are determined based on the following:

Negotiated rates agreed to by the out-of-network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates, or subcontractors, at UnitedHealthcare's discretion.

If rates have not been negotiated, the recognized amount for specific services or supplies will be the out-of-network plan rate, calculated at 180% of the Medicare allowable rate. United makes the following exception:

- Eligible expenses are calculated at 70% of Medicare for the same or similar physical therapy services from a freestanding provider.
- When a rate is not published by Medicare for the services, UnitedHealthcare uses an available gap methodology to determine a rate for the service; contact United for additional information.

If your provider bills less than the amount calculated using the out-of-network plan rate, the recognized amount 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 - members may request a GAP exception if a service is not available from a network provider. Contact UHC for additional information .
- Emergency services - see emergency services section on page 46 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 typically update our systems with these revised rates within 90 days of receiving them from CMS.

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 place rates. 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 UnitedHealthcare directory will be available. Choice Plus network providers may end their contract with UnitedHealthcare, or decide not to accept new patients. If your health provider leaves the Choice Plus network, you may select another provider. If your network specialist leaves, you should work with your primary physician to choose another Choice Plus network specialist. If your provider does not participate and/or drops out of UnitedHealthcare's Choice Plus 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 and certain contraceptive services), 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, a \$30 copay for an office visit to a preferred specialist, or a \$60 copay for a visit to a non-preferred 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 toward 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 utilizing an in-network provider, your prenatal 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, but apply to the annual out-of-pocket maximum. There is an individual and family deductible for both in-network and out-of-network care. The in-network and out-of-network deductibles are tracked and accumulate separately. After an individual meets the annual deductible, benefits are payable for that person 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 for all covered individuals in a family will not exceed the family deductible. The individual and family deductible amounts are shown on 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 has also paid \$200 toward their individual deductibles. Since the in-network family deductible has been met, you need only pay the balance of 10% (the plan pays 90%). When your annual family deductible is satisfied under the in-network portion of the plan, 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. The \$400 in-network deductible will not apply towards meeting the \$750 individual out-of-network deductible or the \$1,500 family out-of-network deductible.

Let's now assume that no member of your family has incurred expenses at the time of your hospitalization/surgery. You will pay the first \$200 (individual in-network 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 paid will not apply towards the \$750 individual out-of-network deductible or the \$1,500 family out-of-network deductible.

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 and out-of-network OPM amounts are 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 recognized charge. The annual OPM for in-network and out-of-network services are tracked and accumulate separately.

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

- Prior authorization non-notification penalty (see Page 29)
- Charges above the out-of-network plan rate

You must continue to make these payments, when applicable, even if you have reached your annual OPM.

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 are payable at 100% for that person for the rest of the calendar year. (Prior authorization non-notification penalties and out-of-network plan rates do not apply to in-network services). The annual OPM for all covered persons in a family will not exceed the family amount shown in the salary band chart below.

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. In addition, the prior authorization penalties apply to out-of-network services.

Expenses you incur that apply toward the annual OPM accumulate and are tracked separately 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 Covered Health Services and outlines provisions of the Plan, including benefit amounts, maximum amounts, copays and deductibles.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

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 over	\$3,100	\$6,200	\$6,200	\$12,400

	Tier 1 In-Network Preferred	Tier 2 In-Network Non- Preferred	Tier 3 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: \$1500
Coinsurance The percentage of medical expenses you pay out-of-pocket after you meet your deductible.	You pay 10% after deductible	You pay 20% 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

	Tier 1 In-Network Preferred	Tier 2 In-Network Non-Preferred	Tier 3 Out-of-Network
Inpatient Medical/Surgical Care from Specialist (including Maternity) Prior Authorization Required	You pay 10% after deductible	You pay 20% after deductible	You pay 40% after deductible. You pay 100% if you do not receive prior authorization.
Inpatient Care/Residential Treatment for Mental Health and Substance Use Disorder Prior Authorization Required	You pay 10% after deductible		You pay 40% after deductible. You pay 100% if you do not receive prior authorization.
Surgical (Inpatient/Outpatient) Anesthesia and use of an operating room or related facility in a hospital or authorized institution. Prior Authorization may be required; see page 31 for additional details.	You pay 10% after deductible		You pay 40% after deductible. You pay 100% if you do not receive prior authorization.
Emergency Room Services administered for conditions meeting the	You pay \$175 copay; waived if admitted.		You pay \$175 copay; waived if admitted.

definition of an emergency. Non-emergency care not covered.			
Prior Authorization Non-Notification Penalty The amount you must pay if you do not call Care Coordination (1-877-609-2273) to precertify services that require prior authorization. See page 31 for details.	No penalty for in network services		No Coverage. You pay the full cost for any procedure and/or admission if you do not receive prior authorization.
OUTPATIENT BENEFITS			
Preventive Care by Physician	You pay \$0		You pay 40% after deductible
Treatment by Primary Care Physician for illness or injury	You pay \$20 copay per visit		You pay 40% after deductible
Treatment by Standard Specialist (refer to page 2 for the list of tiered specialists)	You pay \$30 copay per visit		You pay 40% after deductible
Treatment by Tiered Specialist (refer to page 2 for the list of tiered specialists)	You pay \$30 copay per visit	You pay \$60 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 \$30 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 (refer to page 2 for the list of tiered specialists)	You pay 10% after deductible	You pay 20% after deductible	You pay 40% after deductible.
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	You pay \$0		You pay 40% after deductible

<p>year thereafter up to age 18). (Adults (18+): One exam every calendar year. Includes coverage for immunizations).</p>			
<p>Prenatal/Maternity Care Prior Authorization may be required depending upon length of hospital stay. See Pregnancy on page 20.</p>	<p>You pay a \$30 copay for the visit to diagnose the pregnancy. All other prenatal visits will be covered at 100%. Delivery: You pay 10% after deductible (pre & post-partum care included in surgical charge for delivery). You pay \$30 copay for post-partum office visits.</p>	<p>You pay a \$60 copay for the visit to diagnose the pregnancy. All other prenatal visits will be covered at 100%. Delivery: You pay 10% after deductible (pre & post-partum care included in surgical charge for delivery). You pay 20% for physician services performed during delivery. You pay \$60 copay for post-partum office visits.</p>	<p>You pay 40% after deductible</p>
<p>Lactation Support and Breastfeeding Equipment <i>(Call UnitedHealthcare at 877-609-2273 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, MRA and nuclear medicine) Prior</p>	<p>You pay \$0 for services received at an independent facility; you pay 20% after deductible for services received in a hospital setting.</p>		<p>Not Covered</p>

authorization required.	Nuclear medicine scan covered at 100% any location. See page 16 for additional information regarding advanced radiologic imaging.		
Outpatient Diagnostic Cardiology, Sleep Studies, and Cardiac Rhythm Implant Devices. Prior authorization may be required.	You pay \$0		You pay 40% after deductible. You pay 100% if you do not receive prior authorization
Outpatient Lab Services for Diagnosis or Treatment (refer to page 2 for the preferred lab information)	<p>You pay \$0 for LabCorp or Quest</p> <p>You pay \$0 for diagnostic testing for COVID-19 at any lab.</p> <p>Outpatient lab services performed in an office setting covered at \$0 for Quest & LabCorp; all other in-network labs covered at 40% after deductible</p>	You pay 40% after deductible	Not Covered
Minor Diagnostics not otherwise described	You pay \$0 for services received in an office setting; you pay 20% after deductible for services received in a hospital setting.		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 16 for additional information regarding advanced radiologic imaging.		Not Covered
Outpatient Mental Health and Substance Use Disorder See Additional Plan Benefits for description and Prior Authorization for Mental	You pay \$20 copay per visit		You pay 25% (no deductible required)

Health and Substance Use Disorder Services		
Teladoc Behavioral Health Network of licensed mental health providers who can provide both therapy and 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. Prior authorization required.	You pay \$20 copay per visit	You pay 25% (no deductible required). You pay 100% if you do not receive prior authorization.
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 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. Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident is covered only when Medically	You pay 10% after deductible	You pay 40% after deductible

Necessary.		
Outpatient Therapeutic Treatments Dialysis, intravenous chemotherapy or other intravenous infusion therapy and other treatments. Prior authorization required.	You pay \$0 after deductible for outpatient treatments. You pay \$0 copay for treatments provided in an office setting.	You pay 40% after deductible. You pay 100% if you do not receive prior authorization.
OTHER BENEFITS		
Acupuncture Services Limited to 20 visits per calendar year (combined in-network/out-of-network).	You pay \$30 copay per office visit	You pay 40% after deductible
Ambulance Services – Covers Medically Necessary Transport or Treatment	You pay \$0	You pay \$0
Chiropractic Services Limited to 20 visits per calendar year (combined in-network/out-of-network). Services related to physical therapy are covered under and accumulate towards the 100 visit outpatient rehabilitation therapy maximum - See the Outpatient Short-Term Rehabilitation Therapy section for coverage information.	You pay \$30 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 member per Lifetime. Proof of inability to conceive is not required.	You pay 10% after deductible if inpatient or outpatient service. If office visit charged, you pay \$30 copay	Not covered.
Preventive Care	You pay \$0	You pay 40% after

Preventive physicals, well-child care office visits (including scheduled immunizations), mammogram (one every year age 35 and over), Pap Smear, Well-woman care, and Prostate Specific Antigen (PSA) tests (available at age 40)		deductible
Nutritional Counseling Limited to twelve visits per calendar year. Requires prescription from physician.	You pay \$30 copay per office visit	You pay 40% after deductible
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 health care visits. Limited to 60 visits per calendar year (combined in-network/out-of-network). Prior authorization required.	You pay 10% after deductible	You pay 40% after deductible. You will pay 100% if you do not receive prior authorization.
Hearing Exams Limited to one exam per calendar year. Requires prescription from physician.	You pay \$30 copay per office visit for a preferred provider or \$60 per office visit for a non-preferred provider.	You pay 40% after deductible
Hearing Aids Limited to maximum reimbursement of \$1500 every three years (combined in-network/out-of-network).	Plan pays 100% up to a maximum reimbursement of \$1500 every three years.	Plan pays 100% up to a maximum reimbursement of \$1500 every three years.
Skilled Nursing Facility/Inpatient Physical Rehabilitation Confinement and skilled nursing services in a	You pay 10% after deductible	You pay 40% after deductible. You will pay 100% if you do not receive prior authorization.

<p>hospital or specialized facility; Limited to 60 days per calendar year (combined in-network/out-of-network). Prior authorization required.</p>		
<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). Prior authorization required.</p>	<p>You pay 10% after deductible</p>	<p>You pay 40% after deductible. You will pay 100% if you do not receive prior authorization.</p>
<p>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. See Additional Benefits for description. The three year replacement limit does not apply to prosthetic devices.</p>	<p>You pay 10% after deductible</p>	<p>Not Covered</p>
<p>Wigs - Limited to maximum reimbursement of \$2500 every three years for wigs or wig repair. Covered based on medical necessity e.g., chemotherapy, radiation (combined in-network/out-of-network)</p>	<p>You pay 10% after deductible</p>	<p>You pay 10% after in-network deductible.</p>
<p>Prescriptions - Administered by OptumRx. You will receive a separate ID card.</p>	<p>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.</p>	
<p>Routine Annual Eye Exams</p>	<p>Not covered</p>	<p>Not covered</p>

Prescription Eyeglasses or Contact Lenses	Not covered	Not covered
Tobacco Prevention Consultations	Plans 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 Covered Health Services under the PHP, this section includes additional details for your Covered Health Services regarding:

- Advanced Radiologic Imaging
- Allergy Testing and Treatment
- Family Planning Benefits and Infertility
- Pregnancy Benefits
- Mental Health and Substance Use Disorder Benefits
- AbleTo
- Dental – Oral Surgery
- Durable Medical Equipment
- Prosthetic Devices
- Congenital Heart Disease Services
- Kidney Resource Services (KRS)
- Organ/Tissue Transplants
- Prescription Drug Benefits
- Preventive Care
- Gender Confirming Coverage
- Travel

Advanced Radiologic Imaging

An advanced radiologic imaging procedure in the hospital outpatient department is 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.

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 Injections	<u>Allergy Testing office visit:</u> You pay a \$30 copay per visit for a preferred network specialist, or a \$60 copay per visit for a non-preferred specialist. <u>Allergy Serum alone:</u> You pay \$0 if no office visit charged <u>Allergy injection alone:</u> You pay \$0 if no office visit charged	You pay 40% after deductible

	In-Network	Out-of-Network
	<u>Allergy serum and injection billed on same day:</u> You pay \$30 copay if office visit charged by a preferred specialist, or a \$60 copay if office visit is charged by a non-preferred specialist. You pay \$0 if no office visit charged	

Family Planning Benefits and Infertility Services

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

- Sterilization
- Health services and associated expenses for abortion
- Contraceptive 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 PHP covers the first two visits per calendar year for contraceptive counseling at 100% in-network, and at 60% 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 60% 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 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.

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

For in-network, you will pay a copay for the initial office visit to diagnose the pregnancy. The copay for a preferred specialist is \$30, and the copay for a non-preferred specialist is \$60. You will pay a \$0 copay for your in-network prenatal care office visits. You will pay 40% for out-of-network providers after you have met your out-of-network deductible.

Hospitalization

You will pay 10% coinsurance (in-network) and 40% coinsurance (out-of-network) after you satisfy the applicable deductible for facility services and supplies associated with the birth of your baby. The patient costs for tiered specialist fees will correspond to the tier of the specialist utilized. Therefore, you will pay 10% coinsurance for the preferred specialist fees, or 20% for non-preferred 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. Prior authorization is required for longer lengths of stay. If the mother agrees, the attending physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.
- Birth center and nurse-midwife services
- Routine well-baby care given for the duration of the baby's confinement

Pregnancy may be subject to the requirement to obtain notification. Please see the *Prior Authorization* section on Page 26.

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 Care Coordination at the phone number listed on your member ID card during your first trimester, but no later than one month prior to the anticipated childbirth.

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

Mental Health and Substance Use Disorder Services

The PHP covers inpatient, residential treatment and outpatient care for mental health and substance use disorder treatment. Prior authorization is required for inpatient and residential treatment. The copay and coinsurance amounts apply as shown in the *Benefits Summary*. Mental health services include but are not limited to:

- Assessment
- Individual, family and group psychotherapy

- Diagnosis
- Treatment planning
- Medication management
- Psychological education
- Psychological testing

Mental health and substance use disorder services are administered by United Behavioral Health, which can be reached at 1-877-609-2273.

Telemental Health services are 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 go to www.myuhc.com and click on Find a Provider, then click on Behavioral Health Directory, All UnitedHealthcare Plans, People, Provider Type, and Telemental Health Providers.

Marriage Counseling

The PHP covers marriage counseling/marital therapy/couples counseling when at least one party in the relationship has a diagnosed behavioral health disorder, such as but not limited to:

- Adjustment disorder
- Alcoholism
- Anxiety
- Depression

The plan does not cover therapy solely for improving the relationship, in absence of a diagnosed behavioral health disorder.

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 (833) 881-1468 or visit www.member.ableto.com/princeton

Dental - Oral Surgery Services

Generally, 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.
- 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 under this plan.
- The injury was not caused, directly or indirectly, by biting or chewing, and initial treatment begins within three months of the 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.

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 only 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 that is required for activities of daily living and vocational needs, if applicable.

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. The three year replacement limit does not apply to prosthetic devices.

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

Durable Medical Equipment will not be covered out-of-network. If you are not able to locate an in-network provider for Durable Medical Equipment, you may request a GAP exception by calling UnitedHealthcare. A GAP exception must be requested prior to receiving services under the plan.

Prosthetic Devices

External prosthetic devices that replace a limb or an external body part are covered only in-network and 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 that is required for activities of daily living and vocational needs, if applicable.

The prosthetic device must be ordered or provided by, or under the direction of a physician.

Prosthetic Devices will not be 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. Prior authorization is required. 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.

Other reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly.

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.

Panniculectomy, abdominoplasty, thighplasty, brachioplasty, and mastopexy are covered when deemed medically necessary. Services are not covered when determined that the procedure is not medically necessary or is for cosmetic reasons.

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 UnitedHealthcare at the Customer Service telephone number on your ID card for more information about benefits for mastectomy-related services.

Cancer Resource Services

UnitedHealthcare will arrange for access to certain of its network providers that participate in the Cancer Resource Services Program for the provision of oncology services. UnitedHealthcare may refer you to Cancer Resource Services, or you may self-refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.

In order to receive benefits under this program, Cancer Resource Services must provide the proper notification to the network provider performing the services. This is true even if you self-refer to a network provider participating in the program.

Benefits are provided for cancer clinical trials and related treatment and services. Such treatment and services must be recommended and provided by a physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given. If you or a covered dependent are eligible, you will receive assistance with travel and lodging arrangements when necessary.

Congenital Heart Disease Services

Congenital Heart Disease (CHD) services may be received at a Congenital Heart Disease Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the CHD services when the service meets the definition of a Covered Health Service, and is not an experimental or investigational service or an unproven service. However, if the condition is life threatening (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may consider an otherwise experimental or investigational service to be a Covered Health Service. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, although unproven, the service has significant potential as an effective treatment for the condition.

Prior authorization is required for all CHD services, including outpatient diagnostic testing, in utero services and evaluation.

- Congenital heart disease surgical interventions.
- Interventional cardiac catheterizations.
- Fetal echocardiograms.
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be a proven procedure for the involved diagnoses.

Contact UnitedHealthcare at the telephone number on your ID card for information about CHD services.

Kidney Resource Services (KRS)

UnitedHealthcare will arrange for access to certain of its network providers participating in the Kidney Resource Services Program for End Stage Renal Disease (ESRD) and chronic kidney disease. You may be referred to KRS by UnitedHealthcare, or you may self-refer to KRS by calling 888-936-7246 and selecting the KRS prompt. In order to receive the highest level of benefits, you must contact KRS prior to obtaining Covered Health Services. The services include Covered Health Services and supplies rendered for the treatment and/or diagnosis relating to ESRD or chronic kidney disease.

In order to receive benefits under this program, KRS must provide the proper notification to the network provider performing the services. This is true even if you self-refer to a network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

When these services are not performed in a KRS facility, the appropriate in-network and out-of-network deductibles and coinsurance apply.

Organ/Tissue Transplants

Transplant benefits include the evaluation, hospital and physician fees, organ acquisition and procurement, transplant procedures, and follow up care for a period of up to one year after treatment. Prior authorization is required. UnitedHealthcare has designated a network of nationally recognized hospitals that perform major organ and tissue transplant procedures. The PHP covers transplants at these designated transplant facilities with all benefits payable at 90% of covered expenses after satisfying the annual deductible. When a transplant or any related care is performed at a facility other than a designated transplant facility, it is treated as any other surgical procedure and the appropriate in-network and out-of-network deductibles and coinsurance apply.

Qualified procedures include but are not limited to transplants of the heart, lung, liver, kidney, pancreas and small bowel, bone marrow transplants (either from you or from a compatible donor) and stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. If you or a covered dependent are eligible, you will receive assistance with planning, treatment and, when necessary, travel and lodging arrangements.

Benefits are also available for cornea transplants that are provided by a physician at a hospital. For cornea transplants, the appropriate in-network and out-of-network deductibles and coinsurance apply.

Under the Plan there are specific guidelines regarding benefits for transplant services. Contact UnitedHealthcare at the telephone number on your ID card for information about these guidelines.

Organ/tissue transplants are subject to the Prior Authorization requirement. Please see the *Prior Authorization* section on Page 31.

Travel and Lodging Expenses

UnitedHealthcare will assist the patient and family with travel and lodging arrangements for utilizing a Center of Excellence (COE) related to:
Congenital Heart Disease (CHD), Obesity surgery services, Transplantation services and Cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a COE designated facility.

Expenses for travel and lodging for the transplant recipient and a companion are available under the Plan as follows:

- Transportation of the patient (provided he or she is not covered by Medicare) and one companion who is traveling to and/or from the site of the CHD service, the obesity services and Cancer-related treatments for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.

Eligible Expenses for lodging and transportation for the patient (while not a Hospital inpatient) and one companion:

- Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people. Princeton University will pay an amount above this rate, up to a per diem rate of \$250 for one person or up to \$500 for two people. UHC will let Princeton know when a claim for travel and/or lodging falls into this category, and the additional taxable reimbursement will be added to your pay.

If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the \$250 for one person or up to \$500 for two people per diem rate, processed as described above.

Travel and lodging expenses are only available for Congenital Heart Disease (CHD), Obesity surgery services, Transplantation services and Cancer-related treatments at COE designated facilities. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

Airfare at coach rate.

Taxi or ground transportation.

Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A combined overall maximum Benefit of \$10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all cancer treatments, and transplant procedures, and CHD treatments and obesity surgery services during the entire period that person is covered under this Plan.

Prescription Drug Benefits

The Prescription Drug Program is administered by OptumRx and is independent of UnitedHealthcare. See the Prescription Plan SPD for information.

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 UnitedHealthcare.

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

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

- Routine immunizations and routine physical exams (including any outpatient lab work/x-rays ordered at the time of the visit) once each calendar year
- 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

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 UHC.

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 7 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. If you are unable to locate an in-network provider for electrolysis, you may request a

GAP exception by calling UnitedHealthcare. A GAP exception must be requested prior to receiving services under the plan.

- 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 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 UnitedHealthcare 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

Travel

UnitedHealthcare has a national network of physicians, hospitals, and healthcare 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 Human Resources Benefits Team 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 experiences 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 as described under the in-network portion of the Plan.

Care Coordination

You and your physician make decisions about medical services and supplies that you should receive.

When you choose to receive services from non-network providers, we urge you to confirm with Care Coordination that the services you plan to receive are Covered Health Services, even if prior authorization is not required. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The cosmetic procedures exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reduction and reconstruction (except for after cancer surgery, gender confirming surgery, or breast reduction to treat a physiologic functional impairment); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. See page 34 for more information.
- The Experimental, Investigational or Unproven Services exclusion (see Page 31).
- Any other limitation or exclusion of the Plan.

Prior Authorization

Prior authorization is required before you receive certain Covered Health Services. In general, network providers are responsible for notifying Care Coordination before they provide these services to you. When you choose to receive certain Covered Health Services from out-of-network providers, you are responsible for notifying Care Coordination to receive prior authorization before you receive these Covered Health Services.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products (which are typically provided under medical coverage, rather than prescription coverage), which United Healthcare determines to be:

- Medically Necessary;
- Included in the Sections: Benefits Summary and/or Additional Plan Benefits described as a Covered Health Service
- Provided to a Covered Person who meets the Plan’s eligibility requirements, and
- Not otherwise excluded in this SPD.

Medically Necessary

Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse disorder, condition, disease or its symptoms, that are all of the following as determined by United Healthcare or its designee, within United Healthcare’s sole discretion are considered medically necessary.

The services must be:

- in accordance with *General Accepted Standards of Medical Practice*,
- clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s), service site or supply that is at least likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

The services for which you must prior authorization are:

- Non-emergent air ambulance services
- Cellular and Gene Therapy
- Clinical Trials
- Congenital Heart Disease (CHD) Surgeries
- Cochlear Implants
- Durable Medical Equipment and prosthetic devices greater than \$1,000
- Diabetes Services – If equipment is in excess of \$1,000
- Gender Dysphoria – Surgery and certain non-surgical treatments
- Genetic Testing and Genetic Testing for BRCA (Genetic Testing is a Covered Health Service if the genetic testing is determined to be Medically Necessary following genetic counseling when ordered by a physician and authorized in advance by United Healthcare.)
- Home Health Care
- Hospice Care
- Hospital – Inpatient Stay
- Maternity Services – If inpatient stay exceeds 48 hours following a normal delivery or 96 hours following a cesarean section delivery.
- Mental Health, Neurobiological Disorders, and Substance Use Outpatient and Inpatient – Certain treatments
- Obesity Surgery
- Outpatient Hi-Tech Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine
- Reconstructive Procedures

- Rehabilitation Services Outpatient
- Skilled Nursing Facility/Inpatient Rehabilitation
- Sleep Studies – Outpatient Diagnostic Services
- Surgery – Inpatient
- Certain outpatient surgeries; contact UHC for a current list.
- Therapeutic Treatments – Outpatient
- Transplantation Services

This list is subject to change; contact UHC by calling the number on your ID card for an up to date list of services that require Prior Authorization.

When to Receive Prior Authorization

For out-of-network services, in order to request Prior Authorization, you must notify Care Coordination of the scheduled service at least five working days prior to the date of service or admission. 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. For non-scheduled services, you must notify Care Coordination within one business day or as soon as is reasonably possible.

Emergency Care – When emergency care is required and results in admission to an out-of-network hospital or similar facility, your representative or physician must call Care Coordination within two working days of the date the stay begins. A working day is a day UnitedHealthcare is open for business. It does not include Saturday, Sunday, or a state or federal holiday. If it is not reasonably possible to call Care Coordination within two working days, notification must be made as soon as possible. When emergency care has ended, Care Coordination must be called before any additional services are received.

Pregnancy - Pregnancy is subject to the following notification time periods:

- **Inpatient Hospitalization for Delivery of Child:** For out-of-network benefits only, Care Coordination must be notified for prior authorization 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:** For out-of-network benefits only, non-emergency hospitalization during pregnancy but before the admission for delivery requires notification as shown above under *Inpatient Admission to a Hospital*.

Home Health Care - For out-of-network benefits only, you must request Prior Authorization by notifying Care Coordination at least five working days before receiving services.

Hospice Care - For out-of-network benefits only, you must request Prior Authorization by notifying Care Coordination at least five working days before receiving services.

Reconstructive Procedures - For out-of-Network benefits only, you must request Prior Authorization by notifying Care Coordination at least five working days before receiving services to verify that they are Covered Health Services for which benefits are available.

Organ/Tissue Transplants - For in-network or out-of-network benefits, you must request Prior Authorization by notifying Care Coordination as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

To notify United Healthcare, call the Customer Service telephone number on your ID card.

Notification for Inpatient Mental Health and Substance Use Disorder Services

Inpatient Services - For a scheduled admission, you must request Prior Authorization by notifying the Mental Health/ Substance Use Disorder Administrator five working days before admission, or as soon as reasonably possible for non-scheduled admissions (including emergency admissions). If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, you will be responsible for 100% of the charges for out-of-network services.

Prior Authorization Non-Notification Penalty (for Out-of-Network procedures)

There is a penalty of no coverage for out-of-network services for failing to call within the required timeframe. You will be responsible for 100% of the charges, and the penalty amount will not be applied toward your annual out-of-pocket maximum.

Appeals

If you or your physician does not agree with Care Coordination's determination on a pre-service request for benefits, you can appeal. Your request that Care Coordination reconsider the decision must be made in writing to: United Healthcare, P. O. Box 30432, Salt Lake City, UT 84130-0432 or by phone to: 1-877-609-2273 within 60 days of the decision.

If you, the physician, and Care Coordination still cannot find an acceptable solution, the decision can be re-appealed. Another health care professional will review the facts of the case and make a final decision.

What's Not Covered

How Headings in this Section are Used

To help you find specific exclusions more easily, this section uses headings. The headings combine services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

The Plan Does not Pay Benefits for Exclusions

The Plan will not pay benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in this SPD. If you have a question about whether a service or supply will be covered, contact UnitedHealthcare directly at 1-877-609-2273.

Alternative Medicine

- Acupressure, massage therapy, and Rolfing.
- Aroma therapy.
- Hypnotism.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

- Television, telephone or internet access.
- Beauty/barber or guest service.
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers.
- Devices and computers to assist in communication and speech.

Cosmetic or Reconstructive Surgery/Physical Appearance

- Reconstructive surgery or treatment primarily to change appearance, unless noted otherwise. It does not matter whether or not it is for psychological or emotional reasons. For limited coverage of reconstructive surgery after a mastectomy, see Reconstructive Procedures on page 20.
- Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure.
- Cosmetic Procedures as defined in this SPD. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
- Wigs or toupees except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury. Hair transplants, hair weaving or any drug if such drug is used in connection with baldness is not covered.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Dental Services

- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to preventive care, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak.
- 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.
- Upper and lower jawbone surgery except when required for direct treatment of acute traumatic injury or cancer; orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment for obstructive sleep apnea.
- Dental braces.
- Dental x-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: transplant preparation; initiation of immunosuppressives; or the direct treatment of acute traumatic injury, cancer or cleft palate.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

Drug(s)

- Self-injectable medications.
- Non-injectable medications given in a physician's office except as required in an emergency.
- Over the counter drugs and treatments.

Experimental or Investigational Service(s)

- Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
- Experimental or Investigational Services are Medical, surgical, diagnostic, psychiatric, mental health, substance abuse disorders or other health care services, technologies, supplies, treatments, procedures or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be:
 - Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use,
or
 - Subject to review and approval by any institutional review board for the proposed use, (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational)
or
 - The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- However, if you have a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment) UnitedHealthcare may consider an otherwise experimental or investigational service to be a Covered Health Service for that illness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that illness or condition.

Foot Care

- Routine foot care, except when needed for severe systemic disease or preventive foot care for covered persons with diabetes for which benefits are provided under the Plan. Routine foot care services that are not covered include cutting or removal of corns and calluses, nail trimming or cutting and debriding (removal of dead skin or underlying tissue).

- Hygienic and preventive maintenance foot care. Examples include cleaning and soaking the feet, applying skin creams in order to maintain skin tone and other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- Treatment for flat feet.
- Treatment of subluxation of the foot.

Medical Supplies and Appliances

- Prescribed or non-prescribed medical supplies. Examples include:
 Compression stockings, ace bandages, gauze and dressings.
 Urinary catheters.

This exclusion does not apply to:

- Ostomy bags and related supplies
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment in Additional Coverage Details* on page 34.
- Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment in Additional Coverage Details* on page 34.

Mental Health/Substance Use Disorder

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance use disorders that if, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.
- Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Mental Health Services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.

- Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
- Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain injury or cerebral vascular accident.

Nutrition and Fitness

- Megavitamin and nutrition-based therapy.
- Nutritional counseling for either individuals or groups except as specifically described in the *Benefit Summary*.
- Enteral feedings and other nutritional and electrolyte supplements that are taken orally, including infant formula and donor breast milk even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded.
- The following foods: foods to control weight treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an inpatient stay; and other dietary and electrolyte supplements.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
- Weight reduction or control programs unless there is a diagnosis of morbid obesity.
- Health education classes including, but not limited to asthma, smoking cessation, and weight control classes.

Organ Transplants

- Health services for organ, multiple organ and tissue transplants, except as described under *Additional Plan Benefits* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealth care's transplant guidelines.
- Any solid organ transplant that is performed as a treatment for cancer.
- Health services connected to the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan).
- Health services for organ and tissue transplants that are not described in this section.
- Health services for transplants involving mechanical or animal organs.

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence.
- Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a

free-standing or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider:

- Has not been actively involved in your medical care prior to ordering the service, or
- Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

Services Provided under Another Plan

- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.

Sleep

- Appliances for snoring.
- Medical and surgical treatment for snoring, except when associated with documented obstructive sleep apnea.

Travel

- Travel or transportation expenses, even though prescribed by a physician. Some travel expenses related to covered transplantation services may be reimbursed at the Plan's discretion.

Vision

- Eyeglasses, contact lenses, or eye refractions.
- Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery unless the covered person has a pre-surgical refractive error greater than eight diopters.

Other Services and Supplies

- Health services and supplies that do not meet the definition of a Covered Health Service as defined in this SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs which the Claims Administrator determines to be all of the following:

- Medically Necessary;
 - Described as a Covered Health Service in this Summary Plan Description (SPD); and
 - Not otherwise excluded in this Summary Plan Description under this section, *What's Not Covered*.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
 - Health Services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.
For the purpose of this exclusion, a “complication” is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a “complication” are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
 - Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
 - Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
 - In the event that a non-network provider waives copayments and/or the annual deductible for a particular health service, no benefits are provided for the health service for which the copayments and/or annual deductible are waived.
 - Charges in excess of eligible expenses or in excess of any specified limitation.
 - Growth hormone therapy.
 - Surrogate parenting.
 - Treatment of benign gynecomastia (abnormal breast enlargement in males).
 - Custodial care.
 - Domiciliary care.
 - Private duty nursing except when provided as a home health care benefit.
 - Respite care.
 - Rest cures.
 - Psychosurgery.
 - Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, sickness, stroke, cancer, autism spectrum disorders or a congenital anomaly. Speech/voice therapy is also covered for participants experiencing gender dysphoria.
 - Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
 - Any charge for services, supplies or equipment advertised by the provider as free.
 - Any charges prohibited by federal anti-kickback or self-referral statutes.

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 UnitedHealthcare. You will receive an Explanation of Benefits (EOB) showing the details of the charges and benefits you received. For covered health services provided by a Network provider, except your applicable cost share, you are not responsible for any difference between the eligible expenses and the amount the provider bills.

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 a UnitedHealthcare 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 UnitedHealthcare ID number or social security number.
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

Claims must be submitted within a period of 12 months following the date the expense was incurred. No benefits are payable for claims submitted after the 12-month period unless it can be shown that it was not reasonably possible to submit them in a timely manner.

See page 4 for information regarding Out-of-Network reimbursement.

How and When Claims are Paid

UnitedHealthcare generally 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, and then UnitedHealthcare will make payments directly to the provider of care.
- UnitedHealthcare 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.

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

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 the Summary Plan Description Handbook for an explanation of the claim review and appeal process.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Princeton University reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Princeton University (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

- UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate

overpaid amounts and other enumerated rights, including the right to commence a legal action.

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 PHP 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.

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 UnitedHealthcare Princeton Health 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 Reimbursement

This section includes information on how benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement. References to “you” or “your” in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.

- Making court appearances.
- Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or

your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any

other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.
- Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.
- If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.