

Princeton University
Post-65 Retiree Medicare Plan
Summary Plan Description

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Introduction

Princeton University offers the Princeton Medicare Plan administered by Aetna. Coverage is available to you and your dependents as long as you and they meet the eligibility requirements, defined in this section of the Summary Plan Description Handbook.

The Plan is coordinated with Medicare and assumes that you are covered under both Part A and Part B of Medicare.

The Plan provides separate coverage for non-Medicare eligible dependents, such as your spouse and dependent children who are under age 65, without coordination with Medicare.

Generally, here is how the Plan works:

- At age 65, Medicare becomes your primary medical insurance plan.
- The Princeton Medicare Plan provides secondary coverage assuming that you are enrolled in Parts A and B of Medicare.
- You submit claims through Medicare first. After Medicare reimburses you or the physician the maximum allowable amount, you can submit the balance to Aetna for consideration.
- You are responsible for a deductible before Aetna will pay benefits. Once you meet the deductible, Aetna covers 50% of unreimbursed Medicare expenses.
- Prescription drug benefits are provided through OptumRx.

There are separate benefits provided to eligible dependents who are under age 65. For more information, see the appendix.

Eligibility

This section describes retiree and dependent eligibility for the post-65 Princeton Medicare Plan.

Retiree Eligibility

You are eligible to participate in the Plan if you meet the eligibility criteria to retire from Princeton University. To receive retiree benefits you must be benefits-eligible and meet one of the following conditions:

1. Hired on or before December 31, 2002 **and**
 - Are age 55, **and**
 - Have at least 10 years of service as a benefits-eligible employee.

2. Hired, rehired, or became newly benefits-eligible, on or after January 1, 2003, **and**
 - Are at least age 55, **and**
 - Have at least 10 years of service as a benefits-eligible employee, **and**
 - Meet the “rule of 75” where age plus benefits-eligible service equals 75.

3. Hire or rehired, or become newly eligible for benefits, on or after January 1, 2019. In addition to meeting the requirements of rule #2 above, your eligibility to retire will be governed by the break in service rules that govern our retirement plan. Therefore, if you have a break in benefits-eligible service of more than five years, our prior service will not count.

Years of service do not need to be consecutive, except as noted above. Service as a casual hourly or short term professional, appointments on the visiting staffs, and any non-benefits-eligible service are not counted towards the 10-year service requirement.

You become eligible on the date you retire. Please note that if both you and your spouse are retirees of Princeton University, you each must elect your own individual coverage. Retirees eligible for their own medical coverage at retirement are not permitted to be a covered dependent under the other spouse’s Princeton University retiree medical plan.

You may also be eligible to participate if you are an active employee on a Long Term Disability Leave and are receiving benefits from the University’s Long Term Disability Plan, and you become Medicare eligible.

Dependent Eligibility

You may elect coverage for dependents who qualify as eligible dependents at the time of retirement. The Plan does not permit any new dependents to be added to a retiree’s coverage, including newborns and adopted children. If you are an eligible retiree, you may enroll certain family members including your:

Eligible dependents includes a spouse and eligible children until December 31 of the year in which they turn 26. Eligible children include biological, step, adopted, and foster children or children for whom you are the legal guardian. Coverage is available to eligible children regardless of student, residential, or marital status; however the spouse and/or children of an eligible child are not eligible for coverage. Children who are physically or mentally challenged and become disabled before the end of the year in which they turn 26 may still be eligible for coverage.

Surviving Spouses and Surviving Qualified Dependent Children

If you die while you are retired and you are a participant in this Plan, your covered surviving spouse will be offered coverage for his or her lifetime and covered eligible dependent children will continue to be covered for as long as they remain qualified dependents. If your spouse is less than age 65, he or she will be eligible for the dependent under age 65 benefits. Once he or she reaches age 65, benefits will be provided as described in this section for retirees and dependents who are age 65 or over.

Qualified Dependent Children

If your qualified dependent child is the sole survivor, your child will be covered until he or she no longer meets the eligibility requirements for coverage as a dependent. See *Dependent Eligibility* for more information.

Effective Date of Coverage & Enrollment Process

Retiree

Coverage in the Post-65 Retiree Medicare Plan begins either:

- on your date of retirement which is always the first of a month, assuming you are age 65 or older, or
- on the first of the month in which you turn 65 as a retiree already covered under one of Princeton University's health care plans.

You must submit a completed *Post-65 Retiree Medicare Plan Election Form for Retirees Age 65 and Over* within 31 days of your retirement date or the date you turn 65 as a retiree.

When you retire, your health coverage as an active employee is not automatically carried over to the Post-65 Retiree Medicare Plan. As a prospective retiree or a retiree turning age 65, you will be offered the choice to continue health coverage in the Post-65 Retiree Medicare Plan or to waive coverage. If you waive coverage or do not submit a completed election form within 31 days of your retirement date or by the 1st of the month in which you turn 65, you will not be covered under the Post-65 Retiree Medicare Plan. You will not be given the opportunity to enroll in the Plan at a future date.

Surviving Spouses and Qualified Dependents

Surviving spouses and qualified dependents remain covered under the deceased's health plan through the end of the month in which the death occurred. In order to continue medical plan coverage, your surviving spouse must complete a new election form. Your surviving spouse will have 31 days from the date of your death to elect health coverage.

Coverage as an individual or an individual and child(ren) begins the first of the following month in which your death occurred, regardless of the health plan your spouse elects. If your death occurs on the first of the month, coverage for your surviving spouse and dependents, if any, will be effective the first of the month in which you died.

Active Employees on Long Term Disability Leave

If you are on a long term disability leave and are approved for Medicare, you will be given the opportunity to elect coverage under the Post-65 Retiree Medicare Plan. In order to continue medical plan coverage, you must complete a new healthcare plan election form, otherwise your coverage under Princeton University's group health plans will terminate.

If your Medicare coverage begins the first of the month, your coverage under the Post-65 Retiree Medicare Plan begins as of the first of that month. If your Medicare coverage begins after the first of the month, your coverage under Princeton's Plan is effective as of the first of the next month.

Cost

Premiums

If you participate in the Plan, the University charges you a monthly premium both for yourself and your dependents, if any. The cost of coverage is subject to change each January 1. The premium is also adjusted when your spouse turns age 65 or becomes Medicare eligible before age 65. **It is your responsibility to notify your Office of Human Resources within 31 days of your spouse becoming eligible for Medicare.**

The cost for coverage for your surviving spouse is equivalent to the rate charged for individual coverage or individual and child(ren) coverage and depends on the Plan your spouse elects.

You are responsible to pay the Medicare premiums to the Social Security Administration. This is a separate payment from the premiums you are paying for coverage under this Plan.

Billing

You will receive a monthly bill from ECSI, our third party administrator, for your monthly premium. In order to maintain your coverage, you will need to pay your premium through this billing process.

If the University does not receive the premiums, your coverage will be terminated. Termination of coverage is effective the last day of the month in which a premium is not received. In the event you need to contact the billing department, please call 609-258-1825.

Changing Your Coverage

As a participant in the Post-65 Retiree Medicare Plan, there are a limited number of changes you are permitted to make to your coverage each year during the annual open enrollment period or if a qualified family or job status change occurs. The types of changes you are permitted to make follow:

Annual Open Enrollment

Once a year, during the annual open enrollment period in the fall, you are permitted to elect to continue coverage for yourself and your dependents, or waive coverage. No other changes are permitted at open enrollment.

You should note that if you waive coverage in the Post-65 Retiree Medicare Plan, you will not be able to elect coverage again in the future.

Qualifying Events

You are permitted to change your dependents or waive coverage between annual open enrollment periods only if you have a qualifying change in family or job status. For the Post-65 Retiree Medicare Plan, a qualifying change in family or job status means:

- divorce or the ending of a domestic partnership,
- a change in the number of your dependents either through eligibility requirements or death, or
- a change in your employment status from retiree to full time benefits eligible employee at Princeton University or vice versa.

Any change you make in your benefits must be consistent with the change in your family or job status, as determined by the University as plan administrator and consistent with the guidelines published by the Internal Revenue Service (IRS). For example, if you divorce during the year, you are permitted to change the level of health care plan coverage from individual and spouse to individual only coverage. You are only permitted to change plans during the annual open enrollment period for coverage beginning the following January 1.

If you experience a qualifying change in family or job status and wish to change your benefit coverage, you must submit the appropriate enrollment forms and documents to your Office of Human Resources within 31 days of the qualifying event.

Qualified Medical Child Support Order (QMCSO)

You may enroll your dependents in the health care plan if you are required by a qualified medical child support order (QMCSO), as legally defined, to provide coverage for your dependents. If you are not enrolled in a plan at that time, you may also enroll. Coverage is effective on the date specified in the QMCSO.

How the Plan Works

The Post-65 Retiree Medicare Plan is an indemnity, fee for service plan. This means that you may choose any provider you wish and are not restricted to a specific group of doctors or hospitals. You have the responsibility to abide by the payment arrangements set by the health care provider.

If You Are Medicare Eligible

Since the Plan coordinates with Medicare, it is to your advantage to choose a doctor who participates in the Medicare Program. Benefits under the Plan will be reduced by any Medicare benefits you are eligible to receive, whether or not you actually receive Medicare benefits. For that reason, it is very important for you to participate in both Part A and Part B of Medicare. If you are not enrolled in Part A and Part B of Medicare, please contact the Social Security Administration at 1-800-772-1213 immediately.

Please note that the Medicare deductibles for Part A and Part B are subject to change each year.

If You Are A Non Medicare Eligible Dependent

The Plan does not use the Medicare offset for your dependents who are not eligible to participate in Medicare.

If You Opt out of Medicare

If you are eligible for Medicare but decide not to participate in the Medicare Program, your expenses for services provided by the Plan are handled as follows:

For Part A Services: The Plan will treat your claim as if Medicare paid 100% less the Medicare Part A deductible.

For Part B Services: The Plan will treat your claim as if Medicare paid 80% of the Medicare Allowable Expense (MAE) less the Medicare Part B deductible. Please see *Medicare Allowable Expense vs. Reasonable and Customary Limit*.

If your Doctor Opts Out of Medicare

The Princeton Plan treats the expense as if Medicare paid 80% of the MAE. You do not receive reimbursement on the portion that Medicare would have paid.

For Services Medicare Does Not Cover

The Plan will treat your claim according to Plan provisions.

If You Live or Travel Abroad

For claims incurred outside of the United States, the Plan will treat you as if you were a non-Medicare eligible Plan participant.

Annual Deductible

You must meet an annual deductible before the Plan begins to reimburse you for expenses. The annual deductible is \$300 for individuals, with a maximum of \$600 per family.

Transfer of Deductible

If you begin coverage in the Post-65 Retiree Medicare Plan after the first of the calendar year, you have the opportunity to carry over any deductible amount you have already accrued in the PPO Plan or the POS Plan. You may offset the annual deductible you are required to meet in the Post-65 Retiree Medicare Plan for the remainder of your first year of participation. The carry over is not automatic. If you wish to carry over your deductible, it is your responsibility to contact your Office of Human Resources.

Example: Anne turns 65 in April. While covered under the PPO from January 1 – March 31 she incurred \$148 in medical expenses. Of the \$148, \$135 was eligible for meeting the in-network deductible of \$300. Effective April 1 when Anne moves to the Post-65 Retiree Medicare Plan, the \$135 in expenses applied to her PPO annual deductible may be carried forward toward the annual deductible in this Plan. However, in order for Anne to have her PPO deductible applied toward her Post-65 Retiree Medicare Plan deductible, she contacted her Office of Human Resources and supplied the proper paperwork, her most recent copy of her Explanation of Benefits (EOB) from her former health plan.

Coinsurance Payments

Part A Medicare Eligible Claims

Since Medicare pays 100% of the allowable charge set by Medicare for hospitalization after your Part A Medicare deductible is met, the Post-65 Retiree Medicare Plan does not provide reimbursement for services covered under Part A of Medicare.

Part B Medicare Eligible Claims

Medicare pays 80% of the allowable charge set by Medicare after you have met your Medicare annual deductible. You are responsible for paying the remaining 20%. This allowable charge, the Medicare Allowable Expense (MAE), is the maximum amount Medicare sets for a service.

As secondary payer, the Post-65 Retiree Medicare Plan will reimburse you 50% of the remaining 20% Medicare coinsurance. You are responsible for the remaining charges

and any balance not eligible for reimbursement by Medicare. Please see the *Coordination of Medicare* section.

Non-Medicare Eligible Claims

The Plan pays 50% of charges up to the Reasonable and Customary (R&C) Limits. You are responsible for the remaining 50% plus any costs above the R& C Limits.

Annual Coinsurance Limit

The Annual Coinsurance limit is the maximum amount you pay in out-of-pocket expenses toward the deductible and in coinsurance payments each calendar year. When you have reached your annual coinsurance limit, the Plan pays 100% of the amount that Medicare does not pay. The coinsurance limit is \$4,000 for individuals, with a maximum of \$8,000 per family.

Medicare Allowable Expense vs. Reasonable and Customary Limit

On a regular basis, Medicare determines the amount of the MAE for health services covered under the Medicare Program. Medicare's reimbursement of 80% is based on the MAE.

Reimbursements for health services you receive that are covered by the Post-65 Retiree Medicare Plan but are not eligible for Medicare reimbursement are based on Reasonable and Customary (R&C) limits. To set the R&C limits, Aetna determines a reasonable charge for a particular service in your area. Aetna collects data about surgical, medical, x-ray and lab expenses from the Health Insurance Association of America (HIAA) and sorts the data by zip code and type of provider. Aetna sets the R&C limit by using the most frequently occurring charge at the 85th percentile. If you are charged an amount that exceeds the R&C limit by more than \$10.00, you must pay the difference.

Coordination with Medicare

In the Post-65 Retiree Medicare Plan, Medicare is your primary medical insurance plan or primary payer. The Plan does not reimburse you for any expenses that would have been paid by Medicare. For services that are not covered by Medicare, but that are covered under the Post-65 Retiree Medicare Plan, the Plan pays 50% of the expense up to the R&C Limit.

Services Not Covered by either Medicare or the Plan

The services listed below **are not covered by either** Medicare or the Post-65 Retiree Medicare Plan:

- routine eye care including eyeglasses
- custodial care

- orthopedic shoes except for diabetics
- cosmetic surgery
- routine dental care
- dentures
- routine foot care

Services Not Covered By Medicare But Covered by the Plan

The following services are not covered by Medicare but are eligible for reimbursement from the Post-65 Retiree Medical Plan:

- routine physical exams
- health care provided outside the United States.
- chiropractic services
- benefits for family planning, pregnancy and maternity
- hearing exams – coverage is limited to one exam per calendar year
- hearing aids – the plan will reimburse 100% up to a maximum reimbursement of \$1500 every three years

What is Covered

The **Benefits Summary** provides an overview of your covered medical expenses under the Post- 65 Retiree Medicare Plan. It summarizes the provisions of the Plan related to benefit amounts, maximum amounts, coinsurance payments and deductibles. More detailed information may be found under the section, *Description of Plan Provisions*.

Plan Provision	Post-65 Retiree Medicare Plan
Annual Deductible The amount you pay each year before the plan begins reimbursing you for covered medical expenses. The family deductible is cumulative.	\$300 individual, maximum \$600 per family
Coinsurance Payments The percentage of medical expenses paid by you and the plan <i>after you meet your deductible</i> .	The University pays 50% of the remaining allowable Medicare Expense; your obligation is the remaining 50%.
Annual Coinsurance Limit The maximum amount of out-of-pocket expenses you are required to pay for the year.	\$4000 individual; maximum \$8,000 per family
Lifetime Maximum	There is an unlimited medical lifetime maximum

The Plan pays 50% of the 20% Medicare coinsurance after the deductible is met for each of the following services:

- Hospital expenses
- Skilled Nursing/Convalescent facility expenses, up to 120 days per calendar year
- Home health care expenses, up to 120 visits per calendar year
- Hospice care expenses, up to 60 days per lifetime for inpatient services with a \$10,000 outpatient maximum
- Private duty nursing care, up to 70 shifts per calendar year
- Durable medical and surgical equipment

Description of Plan Provisions

In the following sections, unless noted otherwise, the description of reimbursements assumes that you are participating in Medicare and the Plan pays as a secondary payer to Medicare.

In the event you have questions about the provisions of the Plan, please call Aetna Customer Service at 1-800-535-6689 or your Office of Human Resources.

Preventive Health Care Benefits

You may be reimbursed for the following services:

- routine physical exams (including any outpatient lab work/x-rays ordered at the time of the visit) for you and your spouse and dependents once each calendar year
- prostate specific antigen
- breast examination and/or mammogram
- pelvic examination
- materials for the administration of immunizations for infectious disease and testing for tuberculosis
- annual routine gynecological exam

Hospital Care

The covered expenses for both inpatient and outpatient hospitalization include charges made by the hospital for providing you with room (semi-private) and board as well as other hospital services. If you elect to stay in a private room, you will be reimbursed as if you had stayed in a semi-private room. The Plan covers 50% of the charges after you have met your annual deductible.

Convalescent Facilities

If your doctor indicates that 24-hour skilled nursing care is needed for you to regain physical and mental functions after a hospital stay, the Plan will cover 50% of the charges, after you have met the annual deductible, for care in a licensed skilled nursing or convalescent facility for up to 120 days per calendar year. This includes:

- room and board
- use of special treatment rooms
- x-rays and lab work
- physical, occupational or speech therapy
- oxygen and other gas therapy
- other medical services
- medical supplies

Benefits will be paid for up to the maximum number of days per "convalescent period." The convalescent period starts on the first day you are confined to a convalescent facility if all the three following conditions are met:

- You were hospitalized for at least three days for treatment of a disease or injury.
- You were admitted to the facility within 14 days of leaving the hospital.
- Your confinement is for services that are needed for you to recover from the condition that caused you to be hospitalized.

Services not covered under the Plan include admissions for:

- chronic brain syndrome
- senility

- mental retardation

Home Health Care

Home health care services provide you with an alternative to a lengthy stay in a hospital or skilled nursing facility. The Plan will cover up to 120 certified home health care visits per calendar year. A “visit” is any visit in your home by an R.N., therapist or home health care aide for up to four consecutive hours of care. As long as the home health care program is approved by Aetna, the Plan covers 50% of the cost after you have met your annual deductible for the following services:

- part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) if an R.N. is not available
- part-time or intermittent home health aide services for patient care
- physical, occupational or speech therapy
- medical supplies and laboratory services prescribed by a physician
- lab services provided by or for a home health agency

Services not covered under the Plan include:

- services that are not part of your home health care plan
- services of a social worker (non medical services)
- services that are or could be provided by a person who usually lives with you or who is a member of your or your spouse’s/partner’s family
- transportation

Hospice Care

Hospice care refers to medical care that is provided in your home, a hospital or in a hospice agency when you are terminally ill. The Plan covers 50% of the charges after you have met your deductible. If your doctor confirms that your life expectancy is less than six months, you are eligible for hospice care benefits. The following expenses are covered by the Plan:

- hospice room and board and supplies for the patient for pain control and other acute and chronic symptom management
- part-time or intermittent nursing care by a RN or LPN for up to eight hours in any one day
- medical social services under the direction of a physician
- psychological and dietary counseling
- consultation or case management services by a physician
- physical and occupational therapy
- part-time or intermittent home health aide services for up to eight hours in any one day
- medical supplies

- drugs and medicines prescribed by a physician

Services not covered under the Plan include:

- bereavement or pastoral counseling
- funeral arrangements
- financial or legal counseling
- homemaker or caretaker services
- respite care

Mental Health & Treatment of Alcoholism or Drug Abuse

The Post-65 Retiree Medicare Plan covers inpatient and outpatient care for mental health and substance abuse treatment. A residential treatment facility is covered on an inpatient basis. The most commonly used Mental Health Benefits are:

- assessment
- diagnosis
- treatment planning
- medical management
- individual, family and group psychotherapy in a hospital or facilities treatment center¹
- psychological education
- psychological testing

Expenses for the effective treatment of alcoholism or drug abuse at a treatment facility are covered the same as any other disease. If you are a full-time inpatient in a hospital that has a separate treatment facility section, the hospital charges will be considered treatment facility expenses and not hospital expenses. Covered services and supplies are subject to limitations. The Plan pays 50% of the eligible charges after meeting the deductible if you are an inpatient. The Plan pays 80% (no deductible required) of the eligible charges for outpatient visits.

National Medical Excellence Program (NME)

The NME program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an NME patient's local geographic area. When care is directed to a facility more than 100 miles from the person's home, the Plan will pay a benefit for travel and lodging expenses.

¹ The Plan does not cover counseling or therapy primarily for marital, family or sexual problems on an out-patient basis.

Prescription Drug Benefits

The Prescription Drug Program is administered Optum Rx and is independent of the Post-65 Retiree Medicare Plan. The copay for Retail Pharmacy (30 day supply) prescriptions are \$5 for generic, \$25 for brand name and \$40 for multisource drugs. The copay for Mail Order (90 day supply) prescriptions are \$10 for generic, \$50 for brand name and \$80 for multisource drugs. Please see the Prescription Plan SPD for additional information.

What's Not Covered

The Plan does not cover the following services and supplies:

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

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

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

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

- Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

If Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
 - Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy
 - Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
 - Those for services of a resident physician or intern rendered in that capacity.
 - Those that are made only because there is health coverage.
 - Those that a covered person is not legally obliged to pay.
 - Those, as determined by Aetna, to be for custodial care.
 - Those for services and supplies:
 - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
 - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; if provided on other than a group basis. in addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
 - Those for or related to any eye surgery mainly to correct refractive errors.
 - Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
 - Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
 - Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:
 - sildenafil citrate;
 - phentolamine;
 - apomorphine;
 - alprostadil; or
 - any other drug that:
 - is in similar or identical class,
 - has a similar or identical mode of action or exhibits similar or identical outcomes.
- This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies as described in this section.
- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies as described in this section.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.

- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures as described in this section.
- Those for routine physical exams, routine vision exams, routine dental exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies as described in this section.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a physician as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as a result of a disease or injury.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
 - Improve the function of a part of the body that is not a tooth or structure that supports the teeth; and is malformed as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or as a direct result of disease; or surgery performed to treat a disease or injury.
 - Repair an injury. Surgery must be performed in the calendar year of the accident which causes the injury; or in the next calendar year.
- Those to the extent they are not reasonable charges, as determined by Aetna.
- Those for the reversal of a sterilization procedure.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

Those excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Claims Information

For most services, you do not have to submit a claim form. You simply pay your copay at the time of service.

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

Review Procedure for Denied Claims

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

Other Important Information

Coordination of Benefits

The Plan utilizes a coordination of benefits feature that applies when an individual is covered under more than one (1) 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.

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.

The University reserves the rights to amend, suspend, or terminate the Post-65 Retiree Medicare 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.

ERISA and Legal Information

This section covers legislation that pertains to your benefit coverage including: important information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), the primary law governing benefits plans and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any subsequent amendments or legislation that affect either law. Some of the information in this section will not apply directly to you as a retiree, however, federal law requires the University to provide you with this information in writing.

ERISA Information

Princeton University is required by federal law to provide you with specific information about the administration and funding of its benefit plans, your legal rights in its plans, and how to file and appeal claims.

Employer Identification Number: 21-0634501

Plan Number: 603

Type of Plan: Medical

Plan Administrator: The Plan Administrator is responsible for the administration of the Princeton University benefit plans. The Princeton University Benefits Committee is the administrator for all of its plans. As such, the Benefits Committee has discretionary authority to interpret plan provisions, construe terms, determine eligibility for benefits and otherwise make all decisions and determinations regarding plan administration. By participating in any Princeton University plan, you accept the Plan Administrator's authority. You may contact the Benefits Committee by sending a letter to the Princeton University Benefits Committee, c/o Assistant Vice President for Human Resources, Princeton University, Office of Human Resources, 100 Overlook Center, Suite 301, Princeton, NJ 08540.

Claims Administrator: For some of the plans, the University, as plan administrator, has delegated authority to an insurance company to act as Claims Administrator. The University delegates its authority to the Claims Administrator to apply the plan's provisions for benefit claims determinations. The following chart includes the names, addresses, and phone numbers of the companies responsible for administering claims under the Plan. Use this chart as a reference when you need to contact a plan administrator regarding a claim. Detailed information about filing a claim under a particular plan may be found in the appropriate section of this book.

	Address	Phone
Post-65 Retiree Medicare Plan	PO Box 981106 El Paso, TX 79998-1106	800-535-6689

	Address	Phone
OptumRx Prescription Drug Plan	PO Box 29044 Hot Springs, AR 71903	877-629-3117

Plan Year: January 1 through December 31

Agent for Service of Legal Process: Benefits Committee

Source of Contributions: Employer (Self-funded Plan) and Employee/Retiree

Limitations on Rights: Participation in a plan does not give you the right to remain employed by the University. Also, you may not sell, transfer or assign either voluntarily or involuntarily the value of your benefit under any plan.

Plan Amendment or Termination: The University intends to continue each of the benefit plans. However, it reserves the right to terminate or amend any Plan at any time and for any reason.

Appendix – Benefits for Eligible Dependents under Age 65

The table shows the benefits coverage for your eligible dependents who are under age 65:

Plan Features	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-Of-Network)
Plan Deductible (per calendar year; applies to all covered services; excludes deductible carryover.)	\$300 Individual \$600 Family	\$600 Individual \$1200 Family
Deductible Carryover	None	None
Coinsurance Limit (includes deductible; once Family Coinsurance Limit is met, all family members will be considered as having met their coinsurance for the remainder of the calendar year.)	\$4,000 Individual \$8,000 Family	\$4,000 Individual \$8,000 Family
Lifetime Maximum	Unlimited	Unlimited
Physician Services (except Mental Health/Alcohol/Drug)		
Office Visits (non-surgical) to Non-Specialist (Internist, General Physician, Family Practitioner or Pediatrician)	80% after deductible	60% after deductible
Specialist (office visits)	80% after deductible	60% after deductible
Routine Physicals/Immunizations Children: six exams in first 12 months of life; two exams in the 13 th – 24 th months of life; one exam every 12 months of life thereafter up to age 18; one exam every 24 months for children age 18 and older. Includes coverage for immunizations. Adults: one exam every 24 months up to age 65. Includes coverage for immunizations.	100%; deductible waived	60% after deductible
Routine Ob/Gyn Exam (1 routine exam per calendar year; including 1 pap smear and related fees)	100%; deductible waived	60% after deductible

Plan Features	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-Of-Network)
Routine Mammography One mammogram per calendar year for covered females age 40 and above	100%; deductible waived	60% after deductible
Routine Annual Digital Rectal Exam (DRE) and Prostate Antigen Test (PSA) for covered males age 40 and older	100%; deductible waived	60% after deductible
Surgery	80% after deductible	60% after deductible
Physician In-Hospital Services	80% after deductible	60% after deductible
Allergy Testing	80% after deductible	60% after deductible
Allergy Injections	80% after deductible	60% after deductible
Other Physician Services	80% after deductible	60% after deductible
Hospital Services		
Inpatient coverage	80% after deductible	60% after deductible
Outpatient coverage	80% after deductible	60% after deductible
Emergency Room	100% after \$60 Emergency Room copay (waived if confined); calendar year deductible waived	100% after \$60 Emergency Room copay (Emergency Room copay waived if confined); calendar year deductible waived
Non-emergency use of the Emergency Room	50% after deductible	50% after deductible
Diagnostic X-ray & Laboratory (If performed as a part of a physician's office visit and billed by the physician; expenses are covered at 100% subject to the physician's office visit copay.)	80% after deductible	60% after deductible
Convalescent Facility	80 % after deductible up to 120 days per calendar year*	60 % after deductible up to 120 days per calendar year*

Plan Features	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-Of-Network)
<p>Home Health Care (Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health care aide is one visit)</p>	80 % after deductible up to 120 visits per calendar year*	60% after deductible up to 120 visits per calendar year*
<p>Private Duty Nursing – Outpatient (Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care maximum shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.)</p>	80 % after deductible up to 70 eight-hour shifts per calendar year*	60% after deductible up to 70 eight-hour shifts per calendar year*
<p>Hospice Care Inpatient coverage</p>	80 % after deductible up to a maximum benefit of 60 days*	60% after deductible up to a maximum benefit of 60 days*
<p>Outpatient coverage</p>	80% after deductible up to a maximum benefit of \$10,000*	60% after deductible up to a maximum benefit of \$10,000*
<p>Short-Term Rehabilitation (acute conditions only)</p>	80 % after deductible	60% after deductible
<p>Ambulance</p>	80 % after deductible	60% after deductible
<p>Durable Medical Equipment <i>*Maximums are a combined limit for preferred and non-preferred services</i></p>	80 % after deductible	60% after deductible
<p>Maternity (Coverage includes voluntary sterilization and voluntary abortion.)</p>	Payable as any other covered expense	Payable as any other covered expense
<p>Infertility Services</p> <ul style="list-style-type: none"> • Diagnosis and treatment of the underlying cause of infertility; • Artificial Insemination (limited to 6 courses of treatment in members lifetime*); • Ovulation Induction (limited to 6 courses of treatment in members lifetime*); 	Payable as any other expense	Payable as any other expense

Plan Features	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-Of-Network)
<p>Advanced Reproductive Technology, which includes:</p> <ul style="list-style-type: none"> • In vitro fertilization (IVF) • Zygote intra-fallopian transfer (ZIFT) • Gamete intrafallopian transfer (GIFT) • Cryopreserved embryo transfers • Intracytoplasmic sperm injection (ICSI) or ovum microsurgery <p>Limited to \$20,000, in members lifetime (combined maximum for both in and out of network benefits)</p>	<p>Payable as any other expense</p>	<p>Payable as any other expense</p>
<p>Mental Health Services</p>		
<p>Inpatient coverage</p>	<p>80% after deductible</p>	<p>60 % after deductible</p>
<p>Residential Treatment Center</p>	<p>80% after deductible</p>	<p>60% after deductible</p>
<p>Outpatient coverage</p>	<p>80% no deductible</p>	<p>60% after deductible</p>
<p>Alcohol/Drug Abuse</p>		
<p>Inpatient coverage</p>	<p>80% after deductible</p>	<p>60% after deductible</p>
<p>Outpatient coverage</p>	<p>80% after deductible</p>	<p>60% after deductible</p>
<p><i>National Advantage Program</i></p>	<p>Not Applicable</p>	<p><u>Included</u></p>
<p>National Medical Excellence Program® (NME)</p>	<p>Included</p>	<p>Not Applicable</p>
<p>A program to help eligible members access covered treatment for solid organ and bone marrow transplants and coordinate arrangements for treatment of members with certain rare or complicated conditions at certain tertiary care facilities across the country when those services are not available locally. May also include travel expenses for the member and a companion.</p>		

Plan Features	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-Of-Network)
Inpatient precertification and concurrent review	Provider initiated	Member initiated
Penalty to employee for failure to precertify	None	\$200 penalty. Applies per occurrence
Applies to inpatient hospital, treatment facility, skilled nursing facility, home health care, hospice care, & private duty nursing care		
Claim Submission	Provider initiated	Member initiated
Value-Added Programs		
Members have access to the following special programs:		
<ul style="list-style-type: none"> • Vision One®4 program for discounts on eyeglasses, contact lenses, Lasik – the laser vision corrective procedure and nonprescription eyewear. • Alternative Health Care Programs are made up of three distinct segments. • Natural Alternatives - offers special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapist and nutritional counselors. 5 • Vitamin Advantage™ a savings program for over-the-counters vitamins as well as nutritional supplements • Natural Products – a savings program for many health-related products. • Fitness program for savings on health club memberships and home exercise equipment. 		

⁴ Vision One is a registered trademark of Cole Vision.

⁵ Availability varies by service area.