



# The Princeton University Student Health Plan

---

2021-2022 Student Health Plan Document

# TABLE OF CONTENTS

|   |         |
|---|---------|
| Section 1   |         |
| Plan Administration and General Information.....        | Page 3  |
| Section 2   |         |
| Definitions.....  | Page 7  |
| Section 3   |         |
| Eligibility, Effective Date of Individual Coverage..... | Page 15 |
| Section 4   |         |
| Termination of Coverage, Extension of Benefits.....     | Page 18 |
| Section 5   |         |
| General Provisions.....                                 | Page 20 |
| Section 6   |         |
| Coverage.....   | Page 24 |
| Section 7   |         |
| Exclusions and Limitations.....                         | Page 50 |
| Section 8   |         |
| Schedule of Benefits.....                               | Page 54 |

**STUDENT HEALTH PLAN**  
**SECTION 1 – PLAN ADMINISTRATION AND GENERAL INFORMATION**

**Plan Governance**

The extent of coverage for each individual is governed at all times by the complete terms of this **PLAN DOCUMENT** approved by Princeton University.

**Plan Changes**

Princeton University reserves the right to change **Plan** benefits and limitations, fees, eligibility requirements, and enrollment dates at any time during the **Plan Year**.

**ID Cards for Medical Benefits and Prescription Drug Plan**

After enrolling in the **Plan**, **covered person(s)** receive personal identification (ID) cards, one for medical benefits from the Claims Administrator, Aetna Student Health (Aetna) and one for the prescription drug plan from OptumRx.

- These cards are valid for the **Plan Year** in which the student and/or dependent is enrolled.
- The ID cards should be carried at all times and presented at the time of service to the **hospital**, the **provider** providing the medical care, or a participating **pharmacy** for prescriptions.
- The **covered student** and/or **dependent** should ask the **hospital/provider** or **pharmacy** to contact Aetna and/or OptumRx to confirm their eligibility/coverage at the number specified on the ID card.

**Physician/Hospital Network**

Access to a Preferred Provider Organization (PPO) is available to **Plan covered person(s)** through Aetna as identified on the back of the **Plan** ID card.

A list of **Preferred Care Providers** is available on the claims administrator's website at: [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). Neither **Plan covered person(s)** nor University Health Services (UHS) clinicians who provide **referrals** are obligated to use the **Preferred Care Providers**. **Covered person(s)** are reminded that off-campus medical treatment (except **emergency care** and care outside this geographic area), must be pre-authorized by UHS clinicians, whether or not the **covered person** uses a **Preferred** or **Non Preferred Care Provider**. Use of an **Exclusive Mental Health Network Provider** does not require a **referral** from UHS clinicians.

**When Referrals Are Required**

The **Plan** requires all **covered persons** to receive **referral** authorization from University Health Services (UHS) before being referred for off-campus medical care, except as specified by this **Plan**. Failure to secure the required **referral** may result in **covered person** being responsible for expenses. Authorized **referrals** are effective for 12 months from the date of issue. Complementary Medicine **referrals** are required prior to treatment and then every 10 visits.

**When Referrals Are Not Required**

- A **referral** is not required for Pediatric or OB-GYN off-campus care, including well woman visits.
- In the event of a life-threatening emergency illness or **injury** requiring hospitalization or ER services.
- A **referral** is based on condition, **not care provider**. The covered enrollee is not required to obtain a new **referral** from UHS if they are being treated by multiple **providers** for the same condition identified on the original **referral**. **Providers** can verify if a **referral** is on file by calling Aetna Student Health, Provider Services at: **1-877-480-4161**.
- To use the \$125 preventative dental visit benefit under this **Plan**.
- To use the Pediatric Dental or Vision benefits.
- For outpatient mental health services with an off-campus mental health provider including an **Exclusive Mental Health Network Provider**.

- For covered enrollees who maintain In Absentia status and/or **covered students** and **covered dependents** residing and receiving services outside Mercer County, New Jersey,
- Covered enrollees provided with the 90 days' extension of coverage due to disability, or
- When off-campus care is needed during published Princeton University break periods (i.e., fall recess, spring recess and summer break) – see specific dates below:

| <b>2021-2022 PRINCETON UNIVERSITY PUBLISHED BREAKS (No referrals needed)</b> |  |
|--|--|
| <b>FALL CLASSES START</b>  | <b>September 1, 2021</b>                 |
| <b>FALL RECESS</b>   | <b>October 16-24, 2021</b>               |
| <b>THANKSGIVING RECESS</b>   | <b>November 23-28, 2021</b>              |
| <b>WINTERSESSION</b>   | <b>January 10-23, 2022</b>               |
| <b>SPRING CLASSES START</b>  |  |
|  | <b>January 24, 2022</b>                  |
| <b>SPRING RECESS</b>   | <b>March 5-13, 2022</b>                  |
| <b>SUMMER BREAK 2021</b>   | <b>May 24, 2022 to September 6, 2022</b> |

### **How to Request Referrals**

For assistance with **referrals** contact UHS at 609-258-3141 to speak with a clinician.

### **Right of Reimbursement and Subrogation**

If payment is made relating to an **injury** or an illness of a **covered person** for which any party whatsoever, other than the **covered person**, may be liable for any reason (including by contract, negligence, or strict liability), then the **Plan** shall have separate rights of both reimbursement and subrogation.

### **Reimbursement**

Each **covered person** agrees to reimburse and promptly repay to Princeton University all amounts paid relating to an **injury** or an illness of a **covered person** if the **covered person**, or any authorized representative, obtains a recovery relating to that **injury** or illness in any form (and described in any way) from anyone by settlement, award, judgment, or otherwise.

The **covered person** shall not, however, be obligated to repay an amount in excess of that recovered. In the event that the third party administrator makes an overpayment to a **covered person**, the **covered person** will be responsible for making reimbursement of the overpayment.

### **Subrogation**

The **Plan** shall be subrogated to all of the **covered person's** rights of recovery against anyone, for an amount not exceeding the aggregate amount of benefits paid or to be paid by the **Plan** to or on behalf of the **covered person**. This means that the **Plan** may enforce, by its own suit or as a co-plaintiff with the **covered person**, a claim against anyone who may be liable to the **covered person** for the **covered person's injury** or illness.

### **Obligations of Covered Person(s)**

- 1) Each **covered person** agrees to execute instruments and papers, furnish information and reasonable assistance and take other actions requested by the **Plan** to facilitate repayment to the **Plan** under its rights of reimbursement and subrogation.
- 2) If a **covered person** believes that anyone other than the **covered person** may have caused the **covered person's injury** or illness, or may otherwise be liable for it, the **covered person** or an authorized representative shall promptly notify the **Plan** of this belief and provide all relevant information.

- 3) If a claim is asserted in a letter or a complaint, or otherwise by or on behalf of a **covered person** against anyone relating to the **covered person's injury** or illness, the **covered person**, or an authorized representative, shall immediately give the **Plan** notice of that claim. Failure to give such notice within 30 days of the assertion of such a claim shall make the **covered person** immediately and unconditionally liable to reimburse to the **Plan** the total amount of benefits paid by the **Plan** relating to the **injury** or illness that gave rise to the claim. The **covered person**, or an authorized representative, shall immediately advise the **Plan** of the terms of any judgment, award, settlement, or other resolution of such a claim and provide appropriate reimbursement to the **Plan** as stated above. All notices required to be provided to the **Plan** by 2) and 3) above shall be directed to:

**The Student Health Plan Office**

Princeton University/University Health Services

McCosh Health Center, Washington Road

Princeton, New Jersey 08544-1004

Tel (609) 258-3138

Fax (609) 258-9191

Email: [shpo@princeton.edu](mailto:shpo@princeton.edu)

- 4) Princeton University may, in its sole discretion, request that a document confirming some or all of the conditions specified above be signed by or on behalf of the **covered person** in advance of any payment of benefits under the **Plan**, and the **Plan** is not obligated to process any claims submitted under the **Plan** until the signed document is returned to the **Plan**.

**Assistance and Information Claims/Prescription Drug Plan Coordinators**

The University utilizes a claims coordinator and prescription drug plan coordinator to process claims payments and prescription claims. **Covered persons** should contact the applicable coordinator to obtain assistance and make inquiries regarding claim or prescription status. Please refer to your prescription drug plan card or health insurance ID card for **Plan** information, the claims coordinator's name and phone number or see our website at: <http://uhs.princeton.edu/student-health-plan>.

**The Student Health Plan Office, Princeton University**

To obtain assistance from the SHP Office, students should write, call, fax, or send an email to:

**The Student Health Plan Office**

Princeton University/University Health Services

McCosh Health Center, Washington Road

Princeton, New Jersey 08544-1004

Tel: (609) 258-3138

Fax: (609) 258-9191

Email: [shpo@princeton.edu](mailto:shpo@princeton.edu)

Website: <http://uhs.princeton.edu/student-health-plan>

**Walk-in Hours and Appointments**

Students may also stop by the Student Health Plan Office in Room G24 in the lower level of the McCosh Health Center. Walk-in hours are Monday, Tuesday, Thursday and Friday from 9:00am to 4:30 pm and Wednesday from 10:30am to 4:30 pm.

**How to File a Claim**

In most instances, bills for services are submitted by the **provider** directly to the claims administrator. However, there are times when **covered person(s)** must complete claim forms and submit them with itemized bills and receipts (out-of-network services). To submit a claim, follow this procedure:

- If you wish to electronically file a claim with Aetna, please fill out the [Aetna Student Health Claim](#) form, save and download to your computer and follow these [instructions](#), or
- Obtain a claim form from the Student Health Plan Office or website (see below **Claim Forms** for instructions).
- Complete the information on the claim form.
- Attach all medical, **hospital** or **physician** bills. **Covered person(s) should make a copy.** Make sure the information contains the name of the patient, the date of service, the diagnosis, and the procedure code number and charge.
- Claims should be filed within 12 months of the date of service. Send in all bills.
- Mail the claim in the preaddressed envelope to the claims coordinator.

### **Claim Forms**

Claim forms are available on the SHP website at <http://uhs.princeton.edu/student-health-plan>, at UHS in the appointment/reception area, and in the Student Health Plan Office. A claim form may also be obtained from the Aetna website at: [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

### **Recovery of Overpayments**

If a benefit payment is made by the **Plan**, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the **Plan** has the right to require the return of the overpayment. The **Plan** has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the **Plan**. Another way that overpayments are recovered is by reducing future payments to the **provider** by the amount of the overpayment. These future payments may involve this **Plan** or other health plans that are administered by the **Plan's** third-party administrator -- Aetna. Under this process, Aetna reduces future payments to **providers** by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the **provider**. Payments to **providers** under this **Plan** are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna. This right does not affect any other right of recovery the **Plan** may have with respect to overpayments

## SECTION 2 – DEFINITIONS

**Accident:** an occurrence which (a) is unforeseen; (b) is not due to or contributed to by **sickness** or disease of any kind; and causes **injury**.

**Actual Charge:** the charge made for a covered service by the **provider** who furnishes it.

**Ambulatory Surgical Center:** A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

**Anesthesia Services:** Include general anesthesia, intravenous conscious sedation, non-intravenous conscious sedation, and analgesia (nitrous oxide).

**Appeal:** A request from a **covered person** to either the claims administrator or the prescription plan to review a claim coverage/denial decision. See **Section 5, General Provisions** for a complete description of the internal and external procedures.

**Brand-Name Prescription Drug** is a **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medispan or any other similar publication, with no generic equivalent.

**Clinical Trials:** an “approved clinical trial” means a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

**Copay:** The fixed amount the **covered person** pays directly to a **provider** for a covered service or directly to a **pharmacy** for each prescription kit or refill, at the time it is dispensed. See **Section 8, Schedule of Benefits** for **Plan** specific **Copays**.

**Covered Dental Expenses:** those charges for any treatment, service, or supplies covered by this **Plan** which are:

- not in excess of the **reasonable and customary** charges; or
- not in excess of the charges that would have been made in the absence of this coverage; and
- incurred while this **Plan** is in force as to the **covered person**.

**Covered dependent:** a **covered student’s dependent** who is insured under this **Plan**.

**Covered Medical Expense:** those charges for any treatment, service, or supplies covered by this **Plan** which are:

- not in excess of the **reasonable and customary** charges; or
- not in excess of the charges that would have been made in the absence of this coverage; and
- incurred while this **Plan** is in force as to the **covered person** except with respect to any expenses payable under the Extension of Benefit Provisions.

**Covered person:** a **covered student** and any **covered dependent** while coverage under this **Plan** is in effect.

**Covered student:** a student of Princeton University who is insured under this **Plan**.

**Deductible:** the amount of the **Covered Medical Expenses and Prescription Drug Expense** that are paid by each Individual or Family during the **Plan Year** before benefits are paid. See **Section 8, Schedule of Benefits** for **Plan** specific **deductibles**.

**Dental provider:** This is any **dentist**, group, organization, dental facility, or other institution, or person.

**Dentist:** a legally qualified **dentist**. Also, a **physician** who is licensed to do the dental work he or she performs.

**Dependent:** (a) the **covered student's** spouse residing with the **covered student**; or (b) the **covered student's** children under the age of 26 years.

**Durable Medical Equipment:** Durable Medical Equipment is equipment which is:

- Designed and able to withstand repeated use;
- Used primarily and customarily for a medical purpose;
- Generally not useful to a person in the absence of an illness or **injury**; and
- Suitable for use in the home.

**Durable Medical Equipment** includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, wheelchairs, and braces, including orthotic braces. Among other things, **Durable Medical Equipment** does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

**Elective Treatment:** medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the **covered person's** effective date of coverage. **Elective treatment** includes; but is not limited to:

- vasectomy;
- breast reduction not associated with transgender diagnosis;
- submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis;
- treatment for weight reduction

**Emergency Admission:** One where the **physician** admits the **covered person** to the **hospital** or **residential treatment facility** right after the sudden and at that time, unexpected onset of a change in a person's physical or mental condition which:

- requires confinement right away as a full-time inpatient; and
- if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in, loss of life or limb; or significant impairment to bodily function; or permanent dysfunction of a body part.

**Emergency Care:** This means the first treatment given in a **hospital's** emergency room right after the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which:

- requires **hospital** level care because:
  - the care could not safely and adequately have been provided other than in a **hospital**, or adequate care was not available elsewhere in the area at the time and place it was needed; and
- if the **hospital** level care was not given could, as determined by Aetna, reasonably be expected to result in: loss of life or limb; or significant impairment to bodily function; or permanent dysfunction of a body part.

**Emergency care** also means the dispensing of **prescription drugs** which are needed immediately because of an **injury** or illness. **Emergency care** includes benefits for the coverage of trauma services at any designated Level I or Level II trauma center as **medically necessary**, which shall be continued at least until, in the judgment of the attending **physician**, the **covered person** is medically stable, no longer requires critical care, and can be transferred safely to another facility. It also includes benefits for the coverage of a medical screening examination provided upon a **covered person's** arrival in a **hospital**, as required to be performed by the **hospital** in accordance with federal and state legislation, but only as necessary to determine whether an **emergency medical condition** exists. It also includes service provided by a dental or oral surgeon to treat lacerations, trauma and fractures.

**Emergency Medical Condition:** This means a recent and severe medical condition, including, but not limited to, severe pain which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition **sickness**, or **injury**, is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman who is having contractions, an **emergency medical condition** exists where: there is inadequate time to affect a safe transfer to another **hospital** before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

**Exclusive Mental Health Network Provider:** a health care provider that is a member of the **Exclusive Mental Health Provider Network (EPN)** to furnish services or supplies for a **negotiated charge**; and is included in the EPN directory as an exclusive mental health provider for the services covered by the EPN.

**Exclusive Mental Health Provider Network (EPN):** this means the network of mental health providers that Princeton has organized to provide out-patient mental health benefits on a negotiated fee basis.

**Generic Prescription Drug** is a **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name that is accepted by the U.S. Food and Drug Administration (FDA) as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication.

**Home Health Agency:**

- an agency licensed as a **home health agency** by the state in which **home health care** services are provided; or
- an agency certified as such under Medicare.

**Home health aide:** a certified or trained professional who provides services through a **home health agency** which are not required to be performed by an RN, LPN, or LVN, primarily to aid the **covered person** in performing the normal activities of daily living while recovering from an **injury** or **sickness**; and are described under the written **Home Health Care Plan**.

**Home Health Care:** Health services and supplies provided to a **covered person** on a part-time, intermittent, visiting basis, including full-time nursing care and full-time **home health aide** services needed for a short time. Such services and supplies must be provided in such person's place of residence while the person is confined as a result of **injury** or **sickness**. Also, a **physician** must certify that the use of such services and supplies is to treat a condition as an alternative to confinement in a **hospital** or **skilled nursing facility**.

**Hospice:** a facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors, and volunteers. The team acts under an independent **hospice** administration and it helps the patient cope with physical, psychological, spiritual, social, and economic stresses. The **hospice** administration must meet the standards of the National Hospice Organization and any licensing requirements.

**Hospice benefit period:** a period that begins on the date the attending **physician** certifies that the **covered person** is a terminally ill patient. It ends after 6 months (or such later period for which treatment is certified) or on the death of the patient; if sooner.

**Hospital:** a facility which meets all of these tests:

- it provides in-patient services for the care and treatment of injured and sick people; and
- it provides **room and board** services and nursing services 24 hours a day; and
- it is run as a **hospital** under the laws of the jurisdiction in which it is located.

**Hospital** does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; or (c) as a nursing or rest home. The term "**hospital**" includes an alcohol and drug addiction treatment facility during any period in which it provides effective treatment of alcohol and drug addiction to the **covered person**.

**Injury:** bodily **injury** caused by an **accident**. This includes related conditions and recurrent symptoms of such **injury**.

**Intensive Care Unit:** a designated ward, unit, or area within a **hospital** for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such **hospital**.

**Jaw Joint Disorder:** This is a Temporomandibular Joint Dysfunction or any similar disorder in the relationship between the jaws or jaw joint, and the muscles, and nerves.

**Mail Order Pharmacy:** an establishment where **prescription drugs** are legally dispensed by mail.

**Medically Necessary:** a service or supply that is necessary and appropriate for the diagnosis or treatment of a **sickness** or **injury** based on generally accepted current medical practice. In order for a treatment, service, or supply to be considered **medically necessary**, the service or supply must:

- Be care or treatment which is likely to produce as significant a positive outcome as any alternative service or supply; both as to the **sickness** or **injury** involved and the person's overall health condition.
- It must be no more likely to produce a negative outcome than any alternative service or supply; both as to the **sickness** or **injury** involved and the person's overall health condition.
- Be a diagnostic procedure which is indicated by the health status of the person.
- It must be as likely to result in information that could affect the course of treatment as any alternative service or supply; both as to the **sickness** or **injury** involved and the person's overall health condition.
- It must be no more likely to produce a negative outcome than any alternative service or supply; both as to the **sickness** or **injury** involved and the person's overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, the **Plan** will take into consideration:

- information relating to the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to the **Plan's** attention.

In no event will the following services or supplies be considered to be **medically necessary**:

- Those that do not require the technical skills of a medical, a mental health, or a dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any person who is part of his or her family, any healthcare **provider**, or healthcare facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's **sickness** or **injury** could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **physician's** or a **dentist's** office, or other less costly setting.

**Negotiated Charge:** the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this **Plan**.

**Non-Occupational Disease:** a **non-occupational disease** is a disease that does not: arise out of (or in the course of) any work for pay or profit; or result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the **covered student**: is covered under any type of Workers' Compensation law; and is not covered for that disease under such law.

**Non-Occupational Injury:** a **non-occupational injury** is an accidental bodily **injury** that does not arise out of (or in the course of) any work for pay or profit; or result in any way from a disease that does.

**Non-Preferred Care:** a health care service or supply furnished by a health care provider that is not a **Preferred Care Provider**.

**Non-Preferred Care Provider:** a health care provider that has not contracted to furnish services or supplies at a **negotiated charge**.

**Non-Preferred Brand Drug** is a **brand-name prescription drug** that does not appear on the preferred brand drug list.

**Non-Preferred Prescription Drug Expense:** an expense incurred for a **prescription drug** that is not a preferred **prescription drug** expense.

**One Sickness:** a **sickness** and all recurrences and related conditions which are sustained by a **covered person**.

**Orthodontic Treatment:** any medical service or supply, or dental service or supply furnished to prevent or to diagnose or to correct a misalignment of the teeth, the bite, or the jaws or jaw joint relationship, whether or not for the purpose of relieving pain. Not included are the installations of a space maintainer or a surgical procedure to correct malocclusion.

**Out-of-Pocket Maximum:** The amount that must be paid by the **covered person** and/or their **covered dependents** before **Covered Medical Expenses** and **Covered Prescription Expenses** will be payable at 100% for the remainder of the **Plan Year**. The Out-of-Pocket Limit applies to all Network Cost Sharing that **covered persons** must pay as **copayments**, **deductibles** and coinsurance for services and supplies provided by **providers** in a **Plan Year**. See **Section 8, Schedule of Benefits** for **Plan** specific **Out-of-Pocket Maximum** amounts.

The following expenses do not apply toward meeting the **Out-of-Pocket Maximum**:

- expenses that are not **Covered Medical Expenses**;
- expenses for **prescription drugs**; and
- expenses that are not paid because a required precertification for the services(s) or supply was not provided as required under the **Plan**.

**Partial hospitalization:** continuous treatment consisting of not less than three hours and not more than twelve hours in any twenty-four hour period under a program based in a **hospital**.

**Pharmacy:** an establishment where **prescription drugs** are legally dispensed.

**Physician:** (a) legally qualified **physician** licensed by the state in which he or she practices; and (b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment.

**Plan (SHP):** Princeton University Student Health Plan as explained in this **Plan** Document.

**Plan Year:** The **Plan Year** commences on September 1 of each year.

**Preferred Care:** care provided by:

- a **covered person's primary care physician** or a **Preferred Care Provider** on the **referral** of the **primary care physician**; or
- a health care provider that is not a **Preferred Care Provider** for an **emergency medical condition** when travel to a

- Preferred Care Provider** or referral by a **covered person's primary care physician** prior to treatment, is not feasible; or
- a **Non-Preferred Urgent Care Provider** when travel to a **Preferred Urgent Care Provider** for treatment is not feasible, and if authorized by the **Plan**.

**Preferred Care Provider:** a health care provider that has contracted to furnish services or supplies for a **negotiated charge** but only if the **provider** is with Aetna's consent, included in the **directory** as a **Preferred Care Provider** for:

- the service or supply involved; and
- the class of **covered persons** of which you are a member.

**Prescriber:** any person; while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

**Prescription:** an order of a **prescriber** for a **prescription drug**. If it is an oral order, it must be promptly put in writing by the **pharmacy**.

**Prescription Drugs:** any of the following:

- A drug, biological, non-standard infant formula, or compounded **prescription** which, by law, may be dispensed only by **prescription**.
- Injectable insulin, disposable needles and syringes.

**Primary Care Physician:**

This is the **Preferred Care Provider** who is:

- selected by a person from the list of **Primary Care Physicians** in the directory;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's **Primary Care Physician**.

For the purposes of this definition, a **Primary Care Physician** also includes UHS.

**Provider** is any recognized health care professional, **pharmacy** or facility providing services within the scope of their license.

**Recognized Charge:** Only that part of a charge which is recognized is covered. The **recognized charge** for a service or supply is the lowest of:

- The **provider's** usual charge for furnishing it; and
- The charge Aetna determines to be appropriate; based on factors such as the cost of providing the same or a similar service or supply; and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the **recognized charge** percentage made for that service or supply. In some circumstances, Aetna may have an agreement, either directly or indirectly, through a third party, with a **provider** which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the **recognized charge** is the rate established in such agreement.

In determining the **recognized charge** for a service or supply that is:

- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of **providers** in the area.

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the **provider**;
- The range of services or supplies provided by a facility; and
- The **recognized charge** in other areas.

**Referral:** as required by the **Plan**, a **referral** is an authorization by UHS for a **covered person** to receive care from a specialist or to receive other off-campus medical services. **Referrals** are effective for a 12 month period from the date of issue.

**Residential treatment facility:** a treatment center which provides residential care and treatment for emotionally disturbed individuals, and is a licensed, certified or state approved facility under a program which meets the minimum standards or care of the Joint Commission.

**Respite Care:** care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill **covered person**.

**Room and Board:** charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

**Self-injectable Drug(s)** are **prescription drugs** that are intended to be self- administered by injection to a specific part of the body to treat certain chronic medical conditions.

**Semi-private Rate:** the charge for **room and board** which an institution applies to most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

**Service Area:** the geographic area; as determined by Aetna in which the **Preferred Care Providers** are located.

**Sickness:** disease or illness including related conditions and recurrent symptoms of the **sickness**. **Sickness** also includes pregnancy, and complications of pregnancy. All **injuries** or **sickness** due to the same or a related cause are considered one **injury** or **sickness**.

**Skilled Nursing Facility:** a lawfully operating institution engaged mainly in providing treatment for people convalescing from **injury** or **sickness**. It must have:

- organized facilities for medical services;
- 24 hours nursing service by RNs;
- a capacity of six or more beds;
- a daily medical record for each patient; and
- a **physician** available at all times.

**Specialty Drug:** a specialty **prescription drug** that (i) treats unique populations, (ii) requires close therapy management and monitoring, (iii) requires special handling and/or storage, and (iv) is produced through biotechnologies. A **Specialty Drug** is generally administered orally, as an injection, or as an infusion.

**Surgery Center:** this is a freestanding **ambulatory surgical facility** that is licensed, set up, equipped and run to provide general surgery.

**Surgical assistant:** a medical professional trained to assist in surgery in both the preoperative and postoperative periods under the supervision of a **physician**.

**Totally Disabled:** due to disease or **injury**, the **covered person** is not able to engage in most of the normal activities of a person of like age and sex in good health.

**Urgent Admission:** One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or

- an **injury** caused by an **accident**, which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

**Urgent Care Provider:** This is a freestanding medical facility which provides unscheduled medical services to treat an **urgent condition** if the **covered person's physician** is not reasonably available. Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

**Urgent Condition:** This means a sudden illness, **injury**, or condition that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the **covered person's** health;
- includes a condition which would subject the **covered person** to severe pain that could not be adequately managed without urgent care or treatment;
- does not require the level of care provided in the emergency room of a **hospital**; and
- requires immediate outpatient medical care that cannot be postponed until the **covered person's physician** becomes reasonably available.

**Walk-in Clinic:** a clinic with a group of **physicians**, which is not affiliated with a **hospital**, that provides diagnostic services, observation, treatment, and rehabilitation on an outpatient basis.

## SECTION 3 - ELIGIBILITY, EFFECTIVE DATE OF INDIVIDUAL COVERAGE

### Eligible Persons

#### Student Coverage Eligibility

All active undergraduate and graduate students, who are enrolled at Princeton University and who actively, attend classes for at least the first 31 days, after the date when coverage becomes effective.

### Enrollment

**Students:** All active degree-enrolled graduate students are automatically enrolled in the SHP – there is no enrollment process for the SHP medical coverage for degree-enrolled graduate students. All actively enrolled undergraduate students will be automatically enrolled in this **Plan**, unless the student waives out of the **Plan** through the MyUHS online enrollment portal by the specified enrollment deadline dates listed in the next section of this **Plan** Document.

**If you withdraw from school within the first 31 days of a coverage period, you will not be covered under this Plan and the full premium will be refunded, less any claims paid.**

**Dependents:** dependents of a **covered student** who meet the definition of a **dependent** under this **Plan** listed below.

#### Dependent Coverage Eligibility

Eligible **dependents** include a student's spouse and your eligible children up to 26 years of age (including stepchildren, foster children, and legally adopted children, providing the student is fully enrolled and eligible for coverage).

Dependent coverage takes effect on the same day that the student enrollee's coverage becomes effective if they have been enrolled in the plan during the annual open election period or within 31 days of an applicable Qualifying Status Event change.

Dependent coverage may also be extended if the student enrollee is eligible for the 90-day Extension Due to Medical Disability or an Extension of Coverage for Approved Leaves Without Comparable Coverage and has completed the required application and/or payment of fees in accordance with the extension of coverage policies described in this plan document.

### Ineligible Dependents

- Civil union or domestic partners
- Common law spouses where common law marriage exists
- Ex-spouses, even if there is a Qualified Domestic Relations Order (QDRO) requiring you to provide health insurance coverage
- Former stepchildren of ex-spouses, even if you are required to provide health coverage as dictated under a Qualified Medical Child Support Order (QMCSO)
- Ex-civil union or ex-domestic partners, even if there is a QDRO requiring you to provide health insurance coverage
- Ex-civil union or ex-domestic partners' children, even if there is a QDRO requiring you to provide health insurance coverage
- Extended family members – mother, father, siblings, grandparents, in-laws, etc. – under any circumstances
- Children who are extended family members – grandchildren, nieces, nephews, etc., except when you are the legal guardian

### Verifying Your Dependent

You must provide dependent verification documentation for each **dependent** at the time of enrolling your **dependents** by uploading your documentation through the MyUHS online enrollment portal. If the proper documentation is not provided

within 31 days from the effective date of your coverage, your **dependent** will be removed from your coverage. Please review the chart of permissible documentation for the required dependent verification documentation.

**Permissible Documentation for Dependent Verification**

| Dependent Type  | Documentation Required   |
|---|--|
| Spouse  | Marriage certificate <sup>1</sup> and most recently filed tax return with Social Security numbers and all financial information redacted, (i.e., blacked out by the student) |
| Biological Child Who Is Under the Age 26 <sup>2</sup> | Birth certificate <sup>3</sup>   |
| Adopted Child   | Legal adoption papers  |
| Stepchild   | Birth certificate, including names of biological parents, and student’s marriage certificate   |
| Legal Ward  | Legal guardianship papers showing full financial support and custody responsibilities  |
| Foster Child  | Official placement papers  |

*We reserve the right to request additional documentation as necessary.*

*Copies of certificates are acceptable if information is legible.*

<sup>1</sup> Foreign nationals must provide current visa documentation showing marriage.

<sup>2</sup> Coverage will exist through the **plan year** in which the child turns 26.

<sup>3</sup> Foreign nationals must provide current visa documentation showing date of birth of child.

**Coverage Periods**

**Students:** Coverage for all insured students enrolled for coverage in the **Plan** for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

| Coverage Period | Coverage Start Date | Coverage End Date | Enrollment/Waiver Deadline |
|-----------------|---------------------|-------------------|----------------------------|
| Annual          | 08/01/2021          | 07/31/2022        | 06/30/2021                 |
| Fall            | 08/01/2021          | 01/31/2022        | 06/30/2021                 |
| Spring/Summer   | 02/01/2022          | 07/31/2022        | 12/09/2021                 |

**Eligible Dependents:** Coverage for **dependents** eligible under the **Plan** for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated below. Coverage for insured **dependents** terminates in accordance with the Termination Provisions.

| Coverage Period | Coverage Start Date | Coverage End Date | Enrollment/Waiver Deadline |
|-----------------|---------------------|-------------------|----------------------------|
| Annual          | 08/01/2021          | 07/31/2022        | 06/30/2021                 |
| Fall            | 08/01/2021          | 01/31/2022        | 06/30/2021                 |

**Coverage Start Date of Insurance**

The coverage of each person who applies for coverage hereunder on or before the deadline Date hereof shall take effect on the Coverage Start Date of this **Plan** (August 1 through July 31 of each **Plan Year**).

Coverage for each person applying for coverage hereunder after the Effective Date shall take effect on the date he or she both submits an election and pays the premium for the insurance.

**Dependent** insurance of a **covered student** becomes effective on the date the **covered student** becomes effective, or the date of the **dependent's** enrollment, whichever is later. Otherwise, the insurance becomes effective on the date the **covered student** acquires a **dependent**.

A Qualifying Status Event change allows a student enrollee to add coverage for dependent/s or make changes to enrollment status during the year outside of the annual open election period within 31 days of the qualifying event.

Dependent Qualifying Status Event Changes include:

- Marriage or divorce
- Birth or Adoption of a child
- Death of spouse or child
- Loss of other health plan coverage by a dependent

A newborn child shall be insured for **injury, sickness**, premature birth, and medically diagnosed congenital defects, and birth abnormalities from the moment of birth, for an initial period of thirty-one days. To continue the insurance beyond this initial 31 day period, the **covered student** must notify the SHP Office at Princeton University of the birth, and pay any additional premium required for the child's insurance within the 31 day period.

Coverage is provided for a child legally placed for adoption with a **covered student** from the moment of placement, for an initial period of thirty-one days, provided the child lives in the household of the **covered student** and is dependent upon the **covered student** for support. Notification of placement of such child and payment of any additional premium, if necessary, is required within 31 days from placement. To continue the insurance beyond this initial 31 day period, the **covered student** must notify the SHP Office at Princeton University of the placement of such child, and pay any additional premium required for the child's insurance within the 31 day period.

**Changes for Covered Student**

**Status Change** - If, at any time, the **covered student's** status changes so as to warrant an amount of coverage other than that for which the **covered student** is then covered, the amount of his or her coverage will be changed as follows: An increase or reduction will be effective on the date of the status change.

**Schedule or Benefit Level Change** - If, at any time, any schedule or the level of any benefit is changed so as to warrant an amount of coverage other than that for which the **covered student** is then covered, the amount of coverage will be changed to the new amount.

**All Changes** - A retroactive change in a **covered student's** status will not result in a retroactive change in coverage. Any change in coverage will be effective on the date the change in status is made.

---

1

## Covered Dependent

**Status, Schedule, or Benefit Level Change** - If, for any reason and at any time, a **dependent's** status, any schedule, or the level of any benefit for a **dependent** is changed so as to warrant an amount of coverage for a **dependent** other than that then in force, the amount of a **dependent's** coverage will be changed to the new amount.

## SECTION 4 - TERMINATION OF COVERAGE

### Termination of Student Health Plan (SHP) Coverage

#### Undergraduate Students

Coverage ends the July 31st that falls after graduation in May unless a condition listed under **Termination of SHP Benefits Specific to All Enrollees** occurs first (see below). Coverage under the SHP would end on the earlier of the two dates.

For Out-of-Phase students, SHP eligibility is dependent upon the conferment of the student's degree. If the student finishes their classes at the end of the Fall semester and their degree is conferred by the trustees meeting in January, they are SHP eligible until January 31st. If the student is granted an April confer date, the SHP is then extended to April 30<sup>th</sup>. SHP termination follows their degree confer date.

#### Graduate Students (The extension of SHP benefits applies to degree candidates only.)

Graduate students who are currently enrolled and covered by the SHP, and who in a given semester complete all of the requirements for their program (for Ph.D. students, this means the successful completion of the Final Public Oral Examination; for master's students, the successful completion of all program requirements, including a master's thesis and/or project where applicable) may be eligible for an extension of SHP coverage for up to 3 months after the date their student status ends. Student status ends on the first of the month following the successful completion of the FPO for graduate students and the successful completion of the program's requirements for master's students.

For example, if a Ph.D. candidate completes her FPO on November 11th, student status ends on December 1st, and SHP coverage would be extended through February 28th, unless a condition listed under **Termination of SHP Benefits Specific to All Enrollees** occurs first (see below).

Another example: if an M.P.A. student graduates in May, SHP coverage would be extended through August 31st, unless a condition listed under **Termination of SHP Benefits Specific to All Enrollees** occurs first (see below).

To be eligible for the SHP extension, the student **must** have fulfilled these two conditions:

- Been enrolled in Regular, In Absentia, or DCE status at the time of their FPO (for Ph.D. students) or the completion of their program requirements (for master's students) and,
- Been enrolled in the SHP at the time of FPO defense date or completion of program requirements.

**SHP extensions for qualifying students are made automatically by the SHP Office once the Graduate School has forwarded the student's official status. Students do not need to contact the SHP to initiate the extension if they fulfilled the above conditions.**

**Termination of SHP Benefits Specific to All Enrollees Occurs in the Following Situations:**

- Termination of enrolled student status for reasons such as withdrawal, leave of absence with comparable coverage, suspension, or completion of non-degree study (refunds for the cost of the SHP for undergraduate students is prorated based upon the date of departure from Princeton University; refunds for the cost of the SHP for dependents of enrollees is based upon the termination date of SHP coverage for the student);
- The date the enrollee becomes insured as an employee under any other group policy (including a transfer to a Princeton University appointment, i.e., **PGRA**), franchise, or the date the enrollee begins active service in the armed forces of any country.
- The date the eligible enrollee with an Approved Student Leave of Absence status without Comparable Coverage status fails to submit application and/or payment for the Extension of Coverage benefit in accordance with the extension of coverage policies described in this plan document.
- **Dependent** enrollee coverage terminates if:
  - the student enrollee's coverage terminates as outlined above;
  - on the date a dependent child reaches the age of 26;
  - for the spouse/civil union partner, the date the marriage ends in divorce or annulment;
  - on the date a dependent no longer meets the definition of a dependent;
  - if a student enrollee or the student enrollee's dependent has performed an act that constitutes fraud or the student has made an intentional misrepresentation of material fact in writing on his or her enrollment application, in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the SHP Office to the student enrollee and/or the student enrollee's dependent, as applicable. However, if a student enrollee makes an intentional misrepresentation of material fact in writing on his or her enrollment application, the SHP Office will rescind coverage if the facts misrepresented would have led the office to refuse to issue the coverage. Rescission means that the termination of the coverage will have a retroactive effect of up to your enrollment in the plan. If termination is a result of the student enrollee's action, coverage will terminate for the student enrollee and any dependents. If the termination is a result of the dependent's action, coverage will terminate for the dependent.
- The date the University terminates the plan as applicable.

**EXTENSION OF COVERAGE FOR AN APPROVED STUDENT LEAVE OF ABSENCE FOR RETURNING STUDENTS**

Student enrollees on an Approved Student Leave of Absence who do not have comparable coverage to the SHP available, may continue SHP coverage for a period of up to 12 months, in two six-month increments, from the date of the approved Student Leave of Absence. Coverage for the first six-months will be provided at no expense to the enrollee. Coverage for the additional six-months is available to the enrollee as long as application and payment for the coverage is received by the SHP Office at least 45 days before the end of the first 6-month period. **See fee schedule.** Student enrollees may receive an approved Leave of Absence (LOA) based on Graduate/Undergraduate guidelines as referenced below.

Graduate

Graduate students can consult with their department advisor/DGS as well as a member of the academic affairs staff at the Graduate School while reviewing the following site at: [Leave of Absence | Graduate School \(princeton.edu\)](#).

Undergraduate

The undergraduate student is required to first consult with their residential dean to initiate the Leave of Absence. Information can be located at: [Academic Standing, Leaves of Absence, and Reinstatement | Undergraduate Announcement \(princeton.edu\)](#).

For subsequent approved leaves of absence/s, enrollees may extend coverage for an additional two six-month periods at their expense (for a total of 24-months over their time at Princeton), as long as they are enrolled on the plan at the time of the subsequent leave and do not have access to comparable coverage to the SHP.

Extension of coverage for an approved Student Leave of Absence without Comparable Coverage requires that notification of the student enrollee's status or condition be provided to the Student Health Plan Office ([shpo@princeton.edu](mailto:shpo@princeton.edu)) by the applicable dean's office in conjunction with the enrollee's completed application and attestation to not having comparable coverage. For subsequent six-month periods, the application and attestation and payment for the six-month period will be submitted to the SHP Office. The Extension of Coverage for Approved Student Leave without Comparable Coverage Application and Attestation Form is available on the SHP website at: [Student Health Plan | University Health Services \(princeton.edu\)](#) under the **Forms** section.

#### **90-DAY EXTENSION OF COVERAGE DUE TO MEDICAL DISABILITY**

Coverage continues if a **covered person** is disabled or becomes confined to a **hospital** or is undergoing specialty treatment for an identified condition and this condition has been documented in the person's medical records by the **providers** at University Health Services within 30 days prior to the termination of the SHP. The condition must be due to an accidental bodily **injury** or illness incurred before the coverage would have terminated. Such coverage continues, subject to the provisions of the SHP for treatment of the disabling condition, until 90 days after the date of normal termination of coverage. Coverage for the additional 90 days is available to the enrollee as long as payment for the coverage is received by the SHP Office within 30 days prior to the termination of the SHP. **See fee schedule.**

#### **INCAPACITATED DEPENDENT CHILDREN**

Coverage may be continued for incapacitated **dependent** children who reach the age at which coverage would otherwise cease. The **dependent** child must be unmarried and not in a domestic or civil union partnership, chiefly dependent for support upon the **covered student** and be incapable of self-sustaining employment because of an intellectual or physical handicap.

Proof of the child's incapacity and dependency must be furnished to the SHP Office at Princeton University by the **covered student** within 31 days after the date coverage would otherwise cease. Such child will be considered a **covered dependent**, so long as the **covered student** submits proof to the SHP Office each year, that the child remains physically or intellectually handicapped and unable to earn his/her own living.

The child's coverage under this provision will end on the earlier of:

- the date specified under the provision entitled **Termination of Dependent Coverage**; or
- the date the child is no longer incapacitated and dependent on the **covered student** for support.

## SECTION 5 - GENERAL PROVISIONS

### TIME OF PAYMENT OF CLAIMS

- 1) Upon satisfactory proof of loss, the **Plan** will remit payment for claims submitted by a **covered person** or their health care provider for **covered medical expenses** no later than 30 calendar days following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program, whichever is earlier, if the claim is submitted by electronic means and no later than 40 calendar days following receipt if the claim is submitted by other than electronic means, if:
  - a) the health care provider is eligible at the date of service;
  - b) the person who received the health care service was covered on the date of service;
  - c) the claim is for a service or supply covered under this **Plan**;
  - d) the claim is submitted with all the information requested by the **Plan** on the claim form or in other instructions that were distributed in advance to the **provider** or **covered person** in accordance with New Jersey laws; and
  - e) The **Plan** has no reason to believe that the claim has been submitted fraudulently.
- 2) If all or a portion of the claim is not paid within the timeframes provided above because:
  - a) The claim submission is incomplete because the required substantiating documentation has not been submitted to The **Plan**;
  - b) The diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
  - c) Aetna disputes the amount claimed; or
  - d) There is strong evidence of fraud by the **provider** and the **Plan** has initiated an investigation into the suspected fraud, Aetna shall notify the **provider**, by electronic means and the **covered person** in writing within 30 days of receiving an electronic claim, or notify the **covered person** and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:
    - i) The claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim;
    - ii) The claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;
    - iii) Aetna disputes the amount claimed in whole or in part with a statement as to the basis of that dispute; or
    - iv) Aetna finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with Aetna's fraud prevention plan, or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.
- 3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, Aetna shall electronically notify the **provider** or its agent within seven days of that determination and request any information required to complete adjudication of the claim.
- 4) Any portion of a claim that meets the criteria established in paragraph 1) of this section shall be paid by the **Plan** in accordance with the time limit established in paragraph 1) of this section.
- 5) The **Plan** shall acknowledge receipt of a claim submitted by electronic means from a health care provider no later than 2 working days following receipt of the transmission of the claim.
- 6) If the **Plan** has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan, or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.
- 7) When a **primary care provider** provides care to a **covered person**, or care is provided by a **preferred care provider**, an **Exclusive Mental Health Network provider** or licensed health professional on **referral** by your **primary care provider** (**preferred care services or supplies**), the **preferred care provider** will be responsible for filing claims, except at the patient's option, the patient may file the claim. When the **covered person** seeks care with a **non-preferred care provider** for services and/or supplies, the **covered person** or the **non-preferred care provider** is responsible for filing the claim.

## **ASSIGNMENT OF BENEFITS**

When a **covered person** submits a claim and they assign their right to receive reimbursement for **covered medically necessary** services to an out of network provider, the **Plan** is required to pay benefits in line with the assignment of benefits by remitting payment directly to the health care provider in the form of a check payable to the health care provider, or in the alternative, to the health care provider and the **covered person** as a joint payee, with signature lines for each of the payees.

Any payment made solely to the **covered person** rather than the health care provider under these circumstances shall be considered unpaid, and unless remitted to the health care provider within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in that act.

## **RECORDS**

Princeton University will submit to the prescription administrator and the claims administrator within 30 days after the effective date of each **covered person's** enrollment: (1) the name of each student and **dependent** who applied for coverage hereunder; and (2) the effective date of coverage. This includes, but is not limited to, information needed to enroll **covered persons**, process terminations, and effect changes in family status.

Princeton University represents that all enrollment and eligibility information that has been or will be supplied is accurate. Princeton University acknowledges that the prescription administrator and claims administrator can and will rely on such enrollment and eligibility information in adjusting claims.

## **CLAIM REVIEW AND APPEALS PROCEDURE**

**Covered person(s)** are entitled to a full and fair review of any claim concerning the level of reimbursement for any specific treatment or the denial of any treatment under this **Plan**. A request for an appeal to a claim must be submitted to the claims administrator, Aetna or the prescription administrator, OptumRx within 180 days after receipt of the Explanation of Benefits (EOB) statement or prescription receipt.

For a medical/mental health claim, address your **appeal** to:

### **Aetna Student Health**

P.O. Box 14464  
Lexington, KY40513  
Attn: Appeals Unit  
Tel: 1-800-437-6511

For a prescription claim **appeal**, address your written **appeal** to:

### **OptumRx**

P.O. Box 5252  
Lisle, IL 60532-5252  
Tel: 1-877-615-6319

## **INTERNAL REVIEW, STAGE 1 APPEAL**

A **covered person** can file an Internal Review, Stage 1 **Appeal** by calling or writing either Aetna or OptumRx. At the Internal Review Stage 1 **Appeal** level, a **covered person** may discuss the **appeal** directly with Aetna or OptumRx.

To submit an Internal Review, Stage 1 **Appeal**, the **covered person** must provide the following information:

- 1) the name(s) and address(es) of the **covered person(s)** or **Provider(s)** involved;
- 2) the **covered person's** ID number;
- 3) the date(s) of service;
- 4) the details regarding the actions in question;
- 5) the nature of and reason behind the **appeal**;

6) the remedy sought; and

7) the documentation to support the **appeal**

Aetna or OptumRx will decide Internal Review, Stage 1 **Appeals** within 72 hours in the case of a claim denial involving:

- (a) an Urgent Care Claim or an Emergency;
- (b) an Inpatient Admission;
- (c) the availability of medical care;
- (d) the continuation of an Inpatient Facility stay; or
- (e) a claim for medical services for a **covered person** who has received **emergency care**, but who has not been discharged from a Facility.

Aetna or OptumRx will decide all other Internal Review, Stage 1 **Appeals** within 30 calendar days of receipt of the required documentation. Aetna or OptumRx will provide the **covered person** with:

- (a) written notice of the outcome;
- (b) the reasons for the decision; and
- (c) if the initial denial is upheld, instructions for filing an Internal Review, Stage 2 **Appeal**.

#### **INTERNAL REVIEW, STAGE 2 APPEAL**

If a **covered person** is not satisfied with Aetna's or OptumRx's Internal Review, Stage 1 **Appeal** decision, the **covered person** can file for, orally or in writing, an Internal Review, Stage 2 **Appeal** of the claim denial to the Princeton University SHP Office at: Washington Road, McCosh Health Center – Room #G09, Princeton, NJ 08544-1004. Tel: 1-609-258-3138, Fax: 1-609-258-9191, [shpo@princeton.edu](mailto:shpo@princeton.edu). The **covered person** must submit to the SHP Office all of the information provided for the Internal Review, Stage 1 **Appeal**.

The SHP Office will acknowledge the filing of the Internal Review, Stage 2 **Appeal** in writing within ten business days of receipt. The SHP Office will then provide written notice of the final decision on the **appeal** within 72 hours in the case of a claim denial involving:

- (a) an Urgent Care Claim or an Emergency;
- (b) an Inpatient admission;
- (c) the availability of medical care;
- (d) the continuation of an Inpatient Facility stay; or
- (e) a Claim for medical services for a **covered person** who has received **emergency care**, but who has not been discharged from a Facility.

The SHP Office will decide all other Internal Review, Stage 2 **Appeals** of claim denials within 30 business days.

If the Internal Review, Stage 2 **Appeal** is denied, the SHP Office will provide the **covered person** with written notice of the reasons for the denial, together with a written notice of his/her right to proceed to an external **appeal**. The SHP Office will include: (a) specific instructions as to how the **covered person** may arrange for such an external **appeal**; and (b) any forms needed to start the **appeal**.

#### **FORMULARY EXCEPTION PROCESS**

If a **prescription drug** is not on the **Plan** Formulary, a **covered person** or the **covered persons** prescribing **provider** may request a Formulary exception for a clinically-appropriate **prescription drug** in writing or telephonically. If coverage is denied, under the Optum standard or expedited Formulary exception process, **covered persons** are entitled to an external **appeal** as outlined below.

#### **STANDARD REVIEW OF A FORMULARY EXCEPTION**

Optum will make a decision and notify the **covered person** or **designee** and the prescribing **provider**, no later than 72 hours after Optum receives the request. If Optum approves the request, the **Plan** will cover the **prescription drug** while the **covered person** is taking the **prescription drug**, including any refills.

#### **EXPEDITED REVIEW OF A FORMULARY EXCEPTION**

If the **covered person** is suffering from a health condition that may seriously jeopardize the **covered person's** health, life or ability to regain maximum function or if the **covered person** is undergoing a current course of treatment using a non-Formulary **prescription drug**, the **covered person** may request an expedited review of a Formulary exception. The request should include a statement from the **covered**

**person's** prescribing **provider** that harm could reasonable come to the **covered person** if the requested drug is not provided within the timeframes of the **Plan's** standard Formulary exception process. Optum will make a decision and notify the **covered person** or the **covered person's** designee and the prescribing **provider** no later than 24 hours after Optum's receipt of the request. If Optum approves the request, the **Plan** will cover the **prescription drug** while the **covered person** suffers from the health condition that may seriously jeopardize the **covered person's** health, life or ability to regain maximum function or for the duration of the **covered person's** current course of treatment using the non-Formulary **prescription drug**.

#### **EXTERNAL APPEAL**

A **covered person** (or a **provider** acting for the **covered person**, with the **covered person's** consent) who is dissatisfied with the results of the internal review **appeal** process at either Stage 1 or Stage 2 with respect to a claim denial, can pursue an external **appeal** with an IURO assigned by the State of New Jersey Department of Banking and Insurance (the DOBI). The **covered person's** right to such an **appeal** depends on the **covered person's** having complied with the **Plan's** Internal Review Stage 1 **Appeal** process. The **covered person** is not required to complete the Internal Review Stage 2 **Appeal** process before pursuing an external **appeal**. To start an external **appeal**, the **covered person** or **Provider** must submit a written request within four months from receipt of the **Plan's** Internal Review Stage 1 or Stage 2 **Appeal** decision.

The **covered person** must use the required forms and include both:

- (a) a **\$25.00** check made payable to "New Jersey Department of Banking and Insurance"; and
- (b) an executed release to enable the IURO to obtain all medical records pertinent to the **appeal**, to:

**New Jersey Department of Banking and Insurance Consumer Protection Services**  
**Office of Managed Care**  
**P.O. Box 329**  
**Trenton, New Jersey 08625-0329**  
**(888) 393-1062**

The \$25.00 fee will be refunded to the **covered person** if the IURO reverses the **Plan's** claim denial.

Upon receipt of the request for the **appeal**, together with the executed release and the appropriate fee, if any, the DOBI shall immediately assign the **appeal** to an IURO to conduct a preliminary review and accept it for processing. But this will happen only if the IURO finds that:

1. the person is or was a **covered person** on the **Plan**;
2. the service or supply which is the subject of the **appeal** reasonably appears to be a Covered Service or Supply under this **Plan**, and
3. the **covered person** has furnished all information needed by the IURO and the DOBI to make the preliminary determination. This includes the **appeal** form, a copy of any information furnished by the **Plan** regarding the Final Internal Review **Appeal** Decision, and the fully executed release.

Upon completion of this review, the IURO will immediately inform the **covered person** or **provider**, in writing, as to whether or not the **appeal** has been accepted for review. If it is not accepted, the IURO will give the reasons. If the **appeal** is accepted, the IURO will notify the **covered person** and/or his/her **provider** of the right to submit in writing, within five business days, any further information to be considered in the review. The IURO will provide Princeton University's SHP Office with any such information within one business day after its receipt.

The IURO will complete its review and issue its decision in writing within 45 calendar days from its receipt of the request for the review. The time frame will be reduced to 48 hours (for (a) through (g)) or 24 hours (for (h)) if the **appeal** involves any of the following:

- (a) An Urgent Care Claim or an Emergency
- (b) An Inpatient admission.
- (c) The availability of medical care.
- (d) The continuation of an Inpatient Facility stay.

- (e) A Claim for medical services for a **covered person** who has received **emergency care**, but who has not been discharged from a Facility.
- (f) A medical condition for which the standard time frame would seriously jeopardize the life or health of the **covered person** or his/her ability to regain normal function.
- (g) Formulary exception process request
- (h) An expedited review of a formulary exception.

When the IURO completes its review, it will state its findings in writing and make a determination of whether the **Plan's** denial, reduction, or termination of benefits deprived the **covered person** of **Medically Necessary** and Appropriate treatment. If a decision made within either 24 or 48 hours is not in writing, the IURO will provide a written confirmation within either 24 or 48 hours after the verbal decision.

If the IURO determines that the denial, reduction, or termination of benefits deprived the **covered person** of **Medically Necessary** and Appropriate treatment, this will be conveyed to the **covered person** and/or **provider** and the Princeton University SHP Office. The IURO will also describe the **Medically Necessary** and Appropriate services that should be received. This determination is binding upon the **Plan** and the **covered person**, except to the extent that other remedies are available to either party under state or federal law. If all or part of the IURO's decision is in favor of the **covered person**, the **Plan** will provide coverage for those Covered Services and Supplies that are determined to be **Medically Necessary** and Appropriate.

And within ten business days of its receipt of a decision in favor of the **covered person**, (or sooner, if the medical facts of the case indicate a more rapid response), the Princeton University SHP Office will send a written report to the IURO, the **covered person** and/or **provider**, and the DOBI that describes how the **Plan** will implement the IURO's determination.

## SECTION 6 - COVERAGE

### MEDICAL EXPENSE BENEFITS

Medical Expense Benefits Coverage is expense-incurred coverage only and not coverage for the disease or **injury** itself. This means that the **Plan** will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for medical expenses incurred before coverage has commenced or after coverage has terminated, even if the expenses were incurred as a result of an **accident, injury, or sickness** which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

The **Schedule of Benefits** shows the **deductible**; covered percentages; and maximum benefits that apply to **Covered Medical Expenses** described in this Section.

### BASIC ACCIDENT EXPENSE BENEFITS

**Accident** Expense Benefits are payable for **Covered Medical Expenses** incurred by each **covered person**. Such expense must be incurred as a result of accidental **injury**.

**Covered Medical Expenses** include expenses for **hospital**, surgical, or medical treatment, services or supplies incurred by a **covered person** by reason of **injury**. The benefits will be provided to the same extent that benefits are provided under this **Plan** for expenses incurred on account of **sickness**. An expense is incurred on the date the service is performed or the supply is purchased.

**Covered Medical Expense** incurred for services and supplies:

- (a) must be **medically necessary**;
- (b) must be prescribed or ordered by the attending **physician**; and
- (c) will not include amounts in excess of the **reasonable and customary** charge.

All **Accident** Expense Benefits are subject to all of the terms of this **Plan**.

Proof must be received that the **Covered Medical Expenses** were solely the result of an **injury** sustained by the **covered person**.

### BASIC SICKNESS EXPENSE BENEFITS

**Covered Medical Expenses** include the Basic **Sickness** Expense Benefit Provisions which follow, when expenses are incurred by a **covered person** by reason of **sickness**.

**Covered Medical Expense** incurred for services and supplies:

- (a) must be **medically necessary**;
- (b) must be prescribed or ordered by the attending **physician**; and
- (c) will not include amounts in excess of the **reasonable and customary** charge.

All **Sickness** Expense Benefits are subject to all of the terms of this **Plan**.

## HOSPITAL EXPENSE

### Hospital Room and Board Expense

**Covered Medical Expenses** include **Hospital Room and Board** Expense incurred by a **covered person** for the period of confinement as an inpatient including expense for an **intensive care unit**, and for a birthing center for treatment in connection with pregnancy. However, the covered **room and board** expense does not include any charge in excess of the usual/customary expense of daily **room and board**.

### Miscellaneous Hospital Expense

**Miscellaneous Hospital Expense** includes, among others, expenses incurred during a **hospital** confinement for:

- anesthesia and operating room;
- laboratory tests and X-rays;
- oxygen tent; and
- drugs, medicines, dressings.

## SURGICAL EXPENSE

**Covered Medical Expenses** include charges incurred by a **covered person** for surgery provided by a **hospital** on an inpatient or outpatient basis. When **injury** or **sickness** requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, **Covered Medical Expenses** are paid on a tiered structure for secondary and tertiary surgeries.

The Covered Percentage, **copay** per **covered person**, are shown on the **Schedule of Benefits**.

When surgery is performed in the outpatient department of a **hospital**, **Covered Medical Expenses** include **hospital** services provided within 24 hours of the covered surgical procedure.

## ANESTHETIC EXPENSE

If, in connection with such operation, the **covered person** requires the services of an anesthetist who is not employed or retained by the **hospital** in which the operation is performed, the expenses incurred will be **Covered Medical Expenses**. The maximum benefit for Anesthetic Expense is shown on the **Schedule of Benefits**.

## ASSISTANT SURGEON EXPENSE

If, in connection with such operation, the **covered person** requires the services of an Assistant Surgeon, the expenses incurred will be **Covered Medical Expenses**.

The Anesthesia Maximum and the Assistant Surgeon Maximum are shown on the **Schedule of Benefits**.

## IN-HOSPITAL NON-SURGICAL PHYSICIAN'S FEES EXPENSE

**Covered Medical Expenses** include charges incurred by a **covered person** who is confined as an inpatient in a **hospital** for a surgical procedure for the services of a **physician** who is not the **physician** who may have performed surgery on the **covered person**.

## OUTPATIENT EXPENSE

**Covered Medical Expenses** include charges incurred by a **covered person** for the use of: diagnostic X-ray; laboratory services; Consultant or Specialist Expense; **durable medical and surgical equipment**; or an emergency or operating room. These include expenses incurred for: an **ambulatory surgical center**; **hospital** outpatient department; outpatient **physician's** office visit; and **walk-in clinic** visit.

The Maximum Benefit per **Plan Year**; Maximum Benefit per Visit; Maximum Number of Visits per **Injury** or **Sickness**; **Copay** per **Injury** or **Sickness**; **Copay** per Visit; and **Copay** per **Plan Year** are shown on the **Schedule of Benefits**.

## RECONSTRUCTIVE BREAST SURGERY

The **Plan** provides coverage for breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas in a manner determined by consultation with the attending **Physician** to be appropriate. The **Plan** will also cover implanted breast prostheses following a mastectomy or partial mastectomy.

## THERAPY EXPENSE

**Covered Medical Expenses** also include expenses incurred by a **covered person** for: respiratory therapy, chelation therapy, chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; radiation therapy; tests and procedures; physiotherapy (for rehabilitation only after a surgery); and expenses incurred at a radiological facility.

**Covered Medical Expenses** also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. The Covered Percentage; **Copay** per visit; Maximum Benefit per Condition; and Maximum Number of Visits per **Plan Year** are shown on the **Schedule of Benefits**.

## OUTPATIENT PHYSICIAN OFFICE VISIT EXPENSE (including specialists)

Subject to the **Exception** below:

If a **covered person** requires the services of a **physician** in the **physician's** office while not confined as an inpatient in a **hospital**; **Covered Medical Expenses** include the charges made by the **physician**. Not more than the Visit Maximum will be paid for any visit; and not more than the Maximum Number of Visits will be covered per condition or per **Plan Year**.

The Covered Percentage; **Copay** per visit; Number of visits to which the **Copay** applies; Maximum Number of Visits per condition; Maximum Number of Visits per **Plan Year**; Maximum Benefit per Visit; and the Maximum Benefit per Condition are shown on the **Schedule of Benefits**.

**Exception:** If the services are in connection with surgery and the **physician** is the surgeon who performed the surgery, no benefits are payable under this provision.

## EMERGENCY ROOM VISIT EXPENSE

Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for:

Services received in the emergency room of a **hospital** while the **covered person** is not a full-time inpatient of the **hospital**. The treatment received must be for **emergency services** for an **emergency medical condition**. There is no coverage for **elective treatment**; routine care; or care for a non-emergency illness.

The Covered Percentage; **Copay** per visit; and Maximum Benefit per condition are shown on the **Schedule of Benefits**. Not more than the applicable Maximum Amount will be paid for outpatient expenses in a **Plan Year**.

## HOSPITAL OUTPATIENT DEPARTMENT EXPENSE

**Covered Medical Expenses** includes treatment rendered in a Hospital Outpatient Department. **Covered Medical Expenses** do not include Emergency Room/Urgent Care Treatment, **Walk-in Clinic**, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including **physician**, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this **Schedule of Benefits**.

The Covered Percentage; **Copay** per visit; and Maximum Benefit per condition are shown on the **Schedule of Benefits**. Not more than the applicable Maximum Amount will be paid for outpatient expenses in a **Plan Year**.

## WALK-IN CLINIC VISIT EXPENSE

**Covered Medical Expenses** for services rendered in a **Walk-in Clinic**, expenses are payable as outlined in the **Schedule of Benefits**.

The **Preferred Care** Covered Percentage, **Copay** and Maximum Benefit per **Condition** are shown on the **Schedule of Benefits**. The **copay** will be waived if prior **referral** is obtained from UHS.

The **Non-Preferred Care** Covered Percentage, **Copay and** Maximum Benefit per **Condition** are shown on the **Schedule of Benefits**.

Not more than the applicable Maximum Amount will be paid for all outpatient expenses in a **Plan Year**.

## AMBULATORY SURGICAL EXPENSE

Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for expense incurred for outpatient surgery performed in an **ambulatory surgical center**. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery.

The **Preferred Care** Covered Percentage, **Copay** and Maximum Benefit per **Plan Year** are shown on the **Schedule of Benefits**.

The **Non-Preferred Care** Covered Percentage, **Copay** and Maximum Benefit per **Plan Year** are shown on the **Schedule of Benefits**.

## LABORATORY AND X-RAY EXPENSE

Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for diagnostic X-rays and laboratory services incurred on an outpatient basis.

The **Preferred Care** Covered Percentage and **Copay** are shown on the **Schedule of Benefits**.

The **Non-Preferred Care** Covered Percentage and **Copay** are shown on the **Schedule of Benefits**.

## NUTRITIONAL COUNSELING

Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for Nutritional counseling for management of disease with specific criteria that can be verified (including diabetes), subject to the terms and conditions of this **Plan**.

## OUTPATIENT PHYSICAL & OCCUPATIONAL THERAPY EXPENSE

Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for physical therapy when provided by a licensed physical therapist.

The **Preferred Care** Covered Percentage, **Copay**, Maximum Number of Visits per **Plan Year**, Visit Maximum and Maximum Benefit per **Plan Year** are shown on the **Schedule of Benefits**.

The **Non-Preferred Care** Covered Percentage, **Copay**, Maximum Number of Visits per **Plan Year**, Visit Maximum and Maximum Benefit per **Plan Year** are shown on the **Schedule of Benefits**

## CLINICAL TRIALS

Benefits are payable for **Covered Medical Expenses** and routine patient costs incurred by a **covered person** for their participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if the **covered person** is:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a **provider** who has concluded that the **covered person's** participation in the approved clinical trial would be appropriate or the **covered person** provides medical and scientific information indicating that the **covered person's** participation would be appropriate.

All other **clinical trials**, including when the **covered person** does not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External **Appeal** sections of this **Plan**.

The **Plan** does not cover the costs of investigational drugs or devices; the costs of non-health services required by the **covered person** to receive the treatment; the cost of managing the research; or the costs that would not be covered under this **Plan** for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II, III or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

## DURABLE MEDICAL AND SURGICAL EQUIPMENT EXPENSE

Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** as a result of the rental or purchase of **durable medical and surgical equipment**.

**Durable Medical Equipment** is equipment which is:

- Designed and able to withstand repeated use;
- Used primarily and customarily for a medical purpose;
- Generally not useful to a person in the absence of an illness or **injury**; and
- Suitable for use in the home.

All equipment and supplies must be prescribed by a **physician**. Coverage for such items includes the fittings and adjustment of such devices.

**Durable Medical Equipment** includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, wheelchairs, braces, including orthotic braces.

Among other things, **Durable Medical Equipment** does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

The **Plan** will cover the cost of repair or replacement when made necessary by normal wear and tear. The **Plan** does not cover the cost of repair or replacement that is the result of misuse or abuse. The **Plan** does not cover equipment designed for comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment). The **Preferred Care** and **Non-Preferred Care** Covered Percentage, **Copay**, and Maximum Benefit per **Plan Year** are shown on the **Schedule of Benefits**.

#### **AMBULANCE EXPENSE**

When a **covered person** requires the use of a professional ambulance in an emergency, this **Plan** will pay for the charges incurred. **Covered Medical Expenses** for the service are limited to charges for ground transportation to the nearest **hospital** equipped to render treatment for the condition. Air transportation is covered only when **medically necessary**. Subject to the Ambulance **Copay**, not more than the applicable Maximum Amount per **sickness** will be paid.

The Covered Percentage, **Copay** per trip, and Maximum Benefit per trip, Maximum Benefit per **Injury** or **Sickness**, and Maximum Benefit per **Plan Year** are shown in the **Schedule of Benefits**. The annual **deductible** is waived for this benefit.

#### **PRESCRIBED MEDICINES EXPENSE**

If a **covered person** requires medicine, and if a **prescription drug** is dispensed by a **pharmacy** to a person for treatment of a **sickness** or **injury**, a benefit will be paid; benefits will be paid in accordance with the **Schedule of Benefits** section.

Coverage is included and a benefit will be paid, determined from the **Schedule of Benefits** section, for specialized non-standard infant formulas when the covered infant has been diagnosed as having multiple food protein intolerance, and when the covered infant has not been responsive to trials of standard non-cow milk based formulas, including soybean and goat milk.

The **Plan** covers **medically necessary prescription drugs** that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a **provider** authorized to prescribe and within the **provider's** scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed **pharmacy**.

Covered **prescription drugs** include, but are not limited to:

- Self-injectable/administered **prescription drugs**.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins;
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a **Physician** or other licensed **provider** has issued a written order. The written order must state that the enteral formula is **medically necessary** and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid

metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo obstruction; and multiple severe food allergies.

- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- **Prescription drugs** prescribed in conjunction with treatment or services covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Certificate.
- Off-label cancer drugs so long as the **prescription drug** is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs including over-the-counter drugs for which there is a written order and **prescription drugs** prescribed by a **provider**.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

The **copay** per prescription, **deductibles** and maximum **copay** per **Plan Year** are shown in the Schedule of Benefits. For the procedure to follow for a Formulary Exception or Expedited Review, see Section 5.

## HOME HEALTH CARE EXPENSES

**Home health care** expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home, except where another place is mentioned below; and
- the care starts within 14 days after discharge from a **hospital** as an inpatient; and
- the care is for the same condition that caused the **hospital** stay or one related to it.

**Home health care** expenses are charges for:

- Part-time or intermittent nursing care given or supervised by a RN. An LPN will be covered if the services of a RN cannot be obtained. If full-time nursing care is needed for a short time, it will be covered for up to 3 days in a calendar year.
- Part-time or intermittent **home health aide** services for patient care. If full-time **home health aide** services are needed for a short time, they will be covered for up to 3 days in a calendar year.
- Physical, occupational, and speech therapy.
- Medical social work.
- Nutrition services.

The following items and services are covered only to the extent that they would have been if the person had been confined in a **hospital**:

- Medical appliances and equipment.
- Drugs and medications prescribed by a **physician**.
- Lab services.
- Special meals.
- Diagnostic and therapeutic services. These include surgical services. They must be given in: a **physician's** office; or a **hospital's** outpatient department; or any other health care facility which is licensed.

There is a maximum to the number of visits covered in a calendar year. Each visit by a member of a **home health care team** to a person's home is one visit. Each visit by a person to a **physician's** office, a **hospital's** outpatient department of any other licensed health care facility, as prescribed in the **home health care plan**, is one visit.

### Limitations to Home Health Care Expenses

This section does not cover charges made for:

- Services or supplies not a part of the **home health care plan**.
- Services of a person who is a member of your or your wife's or husband's family.
- Transportation.

The Covered Percentage and the Maximum Visits per **Plan Year** are shown on the **Schedule of Benefits**.

### ROUTINE COLORECTAL CANCER SCREENING EXPENSE

Even though not incurred in connection with a **sickness** or **injury**, **covered medical expenses** include charges incurred by a **covered person** age 35-50 years of age or older and persons of any age who are considered to be at High Risk for Colorectal Cancer for the following colorectal cancer and adenomatous polyps screening examination and laboratory tests:

- Annual guaiac-based fecal occult blood test (gFOBT) with high test sensitivity for cancer;
- Annual immunochemical-based fecal occult blood test (FIT) with high test sensitivity for cancer;
- Stool DNA (sDNA) test with high test sensitivity for cancer;
- A flexible sigmoidoscopy every five years;
- A colonoscopy every ten years;
- A double contract barium enema every five years;
- A computed tomography colonography (virtual colonoscopy) every five years;
- Any combination of the above;
- The most reliable, medically recognized screening test available.

The method and frequency of the screening to be utilized shall be in accordance with the most recent published guidelines of the American Cancer Society and as determined **medically necessary** by the **covered person's physician**, in consultation with the **covered person**.

Benefits are payable for **covered medical expenses** on the same basis as any other **sickness**. The **Covered Percentage** is shown in the **Schedule of Benefits**.

High Risk for Colorectal Cancer means a person who has:

- Family history of familial adenomatous polyposis;
- Family history of hereditary non-polyposis colon cancer;
- Chronic inflammatory bowel disease;
- Family history of breast, ovarian, endometrial, colon cancer or polyps; or
- A background, ethnicity, or lifestyle, such that the **physician** treating the person believes the person is at elevated risk for colorectal cancer.

### MAMMOGRAM EXPENSE BENEFIT

Even though not incurred in connection with a **sickness** or **injury**, benefits are payable for charges for mammograms. The charges must be incurred while a **covered person** is insured for these benefits.

Benefits will be paid for Expenses incurred for the following:

- (1) A baseline mammogram for women between the ages of 35 through 39;
- (2) A mammogram on an annual basis for women 40 years of age and older; and
- (3) In the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed **medically necessary** by the **physician**.

The Covered Percentage or **Copay per screening** is shown on the **Schedule of Benefits**.

## **DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPEMENTAL DISABILITIES**

We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a **covered person's** primary diagnosis is autism or another developmental disability, we provide coverage for the following **medically necessary** therapies as prescribed through a treatment plan and subject to the benefit limits set forth below:

- a) occupational therapy where occupational therapy refers to treatment to develop a **covered person's** ability to perform the ordinary tasks of daily living;
- b) physical therapy where physical therapy refers to treatment to develop a **covered person's** physical function; and
- c) speech therapy where speech therapy refers to treatment of a **covered person's** speech impairment.

Coverage for occupational therapy, physical therapy, and speech therapy is not limited for Autism. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. These therapy services are covered whether or not the therapies are restorative.

If a **covered person's** primary diagnosis is autism, and the **covered person** is under 21 years of age, in addition to coverage for the therapy services as described above, we also cover **medically necessary** behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan to the same extent as for any other medical condition under this **Plan**. Behavioral therapy services are covered whether or not the therapy is restorative.

The treatment plans referred to above must be in writing, signed by the treating **physician**, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. We may request additional information if necessary to determine the coverage under this **Plan**. We may require the submission of an updated treatment plan once every six months unless we and the treating **physician** agree to more frequent updates.

If a **covered person** is:

- a) eligible for early intervention services through the New Jersey Early Intervention System;
- b) has been diagnosed with autism or other developmental disability; and
- c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis; or related structured behavior services.

The portion of the family cost share attributable to such services is a **Covered Charge** under this **Plan**. The **deductible**, coinsurance or **copayment** as applicable to a **physician** visit for treatment of an illness or **injury** will apply to the family cost share.

The therapy services a **covered person** receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Developmental Disabilities provision.

## **WELL NEWBORN NURSERY CARE EXPENSE**

Even though not incurred in connection with a **sickness** or **injury**, **Covered Medical Expenses** include charges incurred by a **covered person** for routine care of a **covered person's** newborn child as follows:

- **hospital** charges for routine nursery care during the mother's confinement; but for not more than 2 days for a normal delivery;
- **physician's** charges for circumcision; and
- **physician's** charges for visits to the newborn child in the **hospital** and consultations; but for not more than 1 visit per day.

The Covered Percentage and Maximum Benefit per confinement are shown on the **Schedule of Benefits**.

#### **WELL BABY CARE AND WELL CHILD CARE EXPENSES**

Even though not incurred in connection with a **sickness** or **injury**, **expenses** for well-baby care and well child care incurred for routine preventive and primary care services rendered to a **covered dependent** child on an outpatient basis are covered by the **Plan** and include **Preventive and Primary Care Services** rendered to a **dependent** child of a **covered person** from the date of birth through the attainment of 19 years of age. Such services include:

- initial **hospital** check-ups;
- other **hospital** visits;
- physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, laboratory tests and appropriate and necessary immunizations as recommended by the American Academy of Pediatrics, the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and immunizations and boosters as required by ACIP.

Coverage for such services shall be provided only to the extent that such services are provided by or under the supervision of a **physician** or other licensed professional. **Covered Medical Expenses** are not subject to **copays**, **deductibles** or coinsurance when provided by a **Preferred Care Provider**.

#### **ORTHOTIC OR PROSTHETIC APPLIANCES EXPENSE**

**Covered Medical Expenses** includes charges for orthotic or prosthetic appliances from a licensed orthotist or prosthetist or any certified pedorthist if determined **medically necessary** by the **covered person's physician**.

Reimbursement for orthotic and prosthetic appliances is made at the same rate as such appliances under the federal Medicare reimbursement schedule. Coverage is provided under the same terms and conditions as for any other **illness**.

The Covered Percentage or **Copay** per item is shown on the **Schedule of Benefits**.

For the purposes of this section:

**Orthotic Appliance** means a brace or support but does not include fabric and elastic and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

**Prosthetic Appliance** means any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs, or other devices which could not by their use have a significantly detrimental impact upon the muscular skeletal functions of the body.

#### **HEARING AID EXPENSE**

**Covered Medical Expenses** include, coverage for **medically necessary** expenses (including fittings, exams and hearing tests, dispensing fees, modifications and repairs, ear molds, and headbands for bone-anchored hearing implants) when **medically necessary** and as prescribed or recommended by a **covered person's physician** or audiologist. Coverage for Hearing Aids is limited to one Hearing Aid per ear, per **Plan Year**.

## MATERNITY EXPENSE BENEFITS

**Covered Medical Expenses** include charges incurred by a **covered person** for a normal childbirth, while insured. Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness**.

**Covered Medical Expenses** include:

- (a) In-patient care for a minimum of 48 hours following vaginal delivery for the mother and her newly born child; or
- (b) In-patient care for a minimum of 96 hours following cesarean section for the mother and her newly born child.

Any decision to shorten such minimum coverages shall be made by the attending **physician**, in consultation with the mother. In such cases covered services may include: home visits; parent education; and assistance and training in breast or bottle-feeding.

Complications of pregnancy, including spontaneous and non-elective abortions are considered a **sickness** and are covered under this benefit. Voluntary or elective abortions are covered.

**The copays, coinsurance and deductibles** are shown in the **Schedule of Benefits**.

## PRE-CERTIFICATION REQUIREMENTS

The **covered person** must obtain pre-certification for certain types of expenses to avoid a reduction in benefits paid for that care. Pre-certification is required for the following:

- **For surgical procedures pertaining to transgender diagnosis.**

To obtain pre-certification, contact UHS at 609-258-3141. If pre-certification is not obtained, services are not covered.

## PRE-ADMISSION TESTING EXPENSE

**Covered Medical Expenses** include expenses incurred by a **covered person** for pre-admission testing charges made by a **hospital, surgery center, licensed diagnostic lab facility, or physician**, in its own behalf, to test a person while an outpatient before scheduled surgery if:

- the tests are related to the scheduled surgery;
- the tests are done within the 7 days prior to the scheduled surgery;
- the person undergoes the scheduled surgery in a **hospital or surgery center**; this does not apply if the tests show that surgery should not be done because of his or her physical condition;
- the charge for the surgery is a **Covered Medical Expense** under this **Plan**;
- the tests are done while the person is not confined as an inpatient in a **hospital**;
- the charges for the tests would have been covered if the person was confined as an inpatient in a **hospital**;
- the test results appear in the person's medical record kept by the **hospital or surgery center** where the surgery is to be done; and
- the tests are not repeated in or by the **hospital or surgery center** where the surgery is done.

If the person cancels the scheduled surgery, benefits are paid at the Covered Percentage that would have applied in the absence of this benefit.

The **Copay**; Covered Percentage; and Maximum Benefit per **Plan Year** are shown in the **Schedule of Benefits**.

## Dental Services after Injury

**Covered Medical Expenses** include charges incurred by a **covered person** for services of a **dentist** or dental surgeon for removal of one or more partially or fully-impacted wisdom teeth as a result of an **injury**.

The **Plan** will pay for the charges made by the **dentist** or dental surgeon. Not more than the Maximum Benefit will be paid.

**Covered Medical Expenses** also include expenses for the treatment of the mouth, teeth, and jaws; but only those for services rendered and supplies needed for the following treatment of, or related to conditions, of the mouth, jaws, jaw joints; or supporting tissues (this includes bones, muscles, and nerves).

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 due to **injury**.

Any such teeth must have been:

- Free from decay; or
- In good repair; and
- Firmly attached to the jaw bone at the time of the **injury**.

The treatment must be done in the calendar year of the **accident** or the next one. If Crowns (caps); Dentures (false teeth); Bridgework; or In-mouth appliances are installed due to such **injury**, **Covered Medical Expenses** include only charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Not included are charges:

- To remove; repair; replace; restore; or reposition teeth lost or damaged in the course of biting or chewing;
- To repair; replace; or restore fillings; crowns; dentures; or bridgework;
- For periodontal treatment;
- For dental cleaning; in-mouth scaling; planning; or scraping;
- For myofunctional therapy; that is: muscle training therapy; or training to correct or control harmful habits.

## Other Dental Related Treatment

**Covered Medical Expenses** include charges incurred by a **covered person** for services of a Dentist or Dental Surgeon for the treatment of the following:

- Treatment of a fracture; dislocation; or wound.
- Diagnosis and treatment of oral tumors, cysts and the surgical removal of bony impacted teeth.
- Alter the jaw; jaw joints; or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Treatment of jaw joint problems (Temporomandibular Joint Dysfunction).

For **covered persons** who are severely disabled or are a Child under the age of 6, the **Plan** will cover:

- general anesthesia and Hospitalization for dental services; and
- dental services rendered by a **dentist** regardless of where the dental services are provided for a medical condition covered by the **Plan** which requires Hospitalization or general anesthesia.
- Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.

The Covered Percentage; Maximum Benefit per **Plan Year**; Maximum Benefit per Tooth; and the **Copay** per visit are shown on the **Schedule of Benefits**.

#### **ELECTIVE SURGICAL - SECOND OPINION EXPENSE**

To the extent that this **Plan** provides coverage for surgery, this **Plan** shall provide coverage for expenses incurred for a second opinion consultation by a specialist on the need for non-emergency surgery which has been recommended by the **covered person's physician**. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Not more than the Maximum Benefit will be paid per **Plan Year**. The **Plan** must receive a written report on the second opinion consultation.

The Covered Percentage; **Copay** per visit; and the Maximum Benefit per **Plan Year** are shown on the **Schedule of Benefits**.

Expenses incurred for third surgical opinions will be covered to the same extent as those for a second surgical opinion, if the second surgical opinion does not confirm that the surgical procedure is medically advisable.

#### **CONSULTANT EXPENSE**

**Covered Medical Expenses** include the expenses incurred by a **covered person** in connection with the services of a consultant. No more than the Maximum Benefit shown on the **Schedule of Benefits** will be paid per **Plan Year**.

The services must be requested by the attending **physician** for the purpose of confirming or determining to confirm or determine a diagnosis.

Coverage may be extended to include treatment by the consultant, if so stated in the **Schedule of Benefits**.

The Covered Percentage; **Copay** per visit; and Maximum Benefit per **Plan Year** are shown on the **Schedule of Benefits**.

#### **LICENSED NURSE EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person**; who is confined in a **hospital** as a resident bed-patient; and requires the services of a registered nurse or a licensed practical nurse.

The Covered Percentage, Daily Maximum Benefit; Maximum Benefit per Day; Maximum Benefit per condition, per **Plan Year**; Maximum Benefit per **Plan Year**; and the Maximum Number of Visits per **Plan Year** are shown on the **Schedule of Benefits**.

Not more than the Daily Maximum Benefit per shift will be paid. For purposes of determining this maximum; a shift means 8 consecutive hours.

#### **SKILLED NURSING FACILITY EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for confinement in a **skilled nursing** facility for treatment rendered:

- in lieu of confinement in a **hospital** as a full time inpatient; or
- within 24 hours following a **hospital** confinement and for the same or related causes(s) as such **hospital** confinement.

**Covered Medical Expenses** will not include any charge in excess of the **skilled nursing facility's** daily **room and board** maximum for semi-private accommodations or expenses for confinement in excess of the maximum number of days of confinement.

The Covered Percentage; Daily Room and Board Maximum Benefit; Maximum Number of Days of Confinement – per **injury** or **sickness**; and the **Copay** per visit are shown on the **Schedule of Benefits**.

#### **REHABILITATION FACILITY EXPENSES**

**Covered Medical Expenses** include charges incurred by a **covered person** for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of; and be for the same or related cause(s) as; a period of **hospital** or **skilled nursing facility** confinement. Not more than the maximum days of confinement will be covered.

**Covered Medical Expenses** will not include any charge in excess of the rehabilitation facility's daily **room and board** maximum for semi-private accommodations or expenses for confinement in excess of the maximum number of days of confinement.

The Covered Percentage; Daily **Room and Board** Maximum Benefit; Maximum Number of Days of Confinement per **Plan Year**; and the **Copay** per days of confinement are shown on the **Schedule of Benefits**.

#### **SECOND SURGICAL OPINION EXPENSE**

To the extent that this **Plan** provides coverage for surgery; this **Plan** shall provide coverage for expenses incurred for a second opinion consultation by a specialist on the need for non-elective surgery which has been recommended by the **covered person's physician**. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required x-rays and diagnostic tests done in connection with that consultation. Not more than the Maximum Benefit will be paid per **Plan Year**. The **Plan** must receive a written report on the second opinion consultation.

Any **board and room** charges made in connection with this provision will be covered under the **Hospital** Expense Benefits section of this **Plan**.

The Covered Percentage; Maximum Benefit per **Injury** or **Sickness**; and **Copay** are shown on the **Schedule of Benefits**.

#### **HIGH COST PROCEDURES EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for High Cost Procedures that are required as a result of **injury** or **sickness**. Expenses for High Cost Procedures; which must be provided on an outpatient basis; may be incurred in the following:

- (a) A **physician's** office; or
- (b) **Hospital** outpatient department, or emergency room; or
- (c) Clinical laboratory; or
- (d) Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located.

**Covered Medical Expenses** for High Cost Procedures include charges for the following procedures and services:

- (a) C.A.T. Scan;
- (b) Magnetic Resonance Imaging.

The Covered Percentage; Maximum Benefit per **Plan Year**; and **Copay** per visit are shown on the **Schedule of Benefits**.

#### **DERMATOLOGICAL EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for diagnosis and treatment of skin disorders; excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.

**Covered Medical Expenses** do not include cosmetic treatment and procedures.

The Covered Percentage; Maximum Benefit per **Plan Year**; and the **Copay** per visit are shown on the **Schedule of Benefits**.

#### **ALLERGY TESTING EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for diagnostic testing of allergies and immunology services:

- laboratory tests;
- **physician** office visits; (including those to administer injections);
- prescribed medications for testing of the allergy; including any equipment used in the administration of prescribed medication; and
- other **medically necessary** supplies and services;

The Covered Percentage; **Copay**; the Maximum Benefit per **Plan Year**; and the Maximum Benefit for injections and serums are shown on the **Schedule of Benefits**.

#### **FAMILY PLANNING EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for the following; although they are not incurred in connection with the diagnosis or treatment of a **sickness** or **injury**:

Charges by a **physician** or **hospital** for a tubal ligation for voluntary sterilization.

**Covered Medical Expenses** do not include the reversal of a sterilization procedure.

The Covered Percentage; Maximum Benefit per **Plan Year**; and the **Copay** per visit are shown on the **Schedule of Benefits**.

#### **PODIATRIC EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for podiatric services; provided on an outpatient basis following an **injury**.

The Covered Percentage; **Copay**; and Maximum Benefit per **Plan Year** are shown on the **Schedule of Benefits**.

#### **ROUTINE FOOT CARE EXPENSE**

Expenses for routine foot care, such as trimming of corns; calluses; and nails; are not **Covered Medical Expenses** unless provided in conjunction with the treatment of metabolic or peripheral vascular disease.

#### **NON-PRESCRIPTION ENTERAL FORMULA EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person**; for non-**prescription** enteral formulas for which a **physician** has issued a written order; and are for the treatment of malabsorption caused by:

- Crohn's Disease;
- ulcerative colitis;
- gastroesophageal reflux;
- gastrointestinal motility;
- chronic intestinal pseudo obstruction; and
- inherited diseases of amino acids and organic acids.

**Covered Medical Expenses** for inherited diseases of: amino acids; and organic acids; will also include food products modified to be low protein.

The Covered Percentage; Maximum Benefit per **Plan Year**; and **Copay** per formula are shown on the **Schedule of Benefits**.

#### **COMPLIMENTARY MEDICINE EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for chiropractic care, acupuncture, massage therapy, biofeedback and pain management. These services must be administered by a healthcare provider who is a legally qualified professional, practicing within the scope of their license.

The Covered Percentage; Maximum Number of visits per **Plan Year** are shown on the **Schedule of Benefits**.

#### **TRANSFUSION OR DIALYSIS OF BLOOD EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for the transfusion or dialysis of blood; including the cost of: whole blood; blood components; and the administration thereof.

The Covered Percentage; Maximum Benefit per **Plan Year**; and **Copay** per visit are shown on the **Schedule of Benefits**.

#### **TRANSGENDER RELATED EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for **medically necessary** surgery, mental health, **prescription drugs** and other related services that are **Covered Medical Expenses** under this **Plan**. All surgical procedures require pre-certification.

#### **URGENT CARE EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for treatment by an **urgent care provider**. A **covered person** should not seek medical care or treatment from an **urgent care provider** if their **illness; injury; or condition; is an emergency condition**. The **covered person** should go directly to the emergency room of a **hospital** or call 911 (or the local equivalent) for ambulance and medical assistance.

**Urgent Care Covered Medical Expenses include charges incurred by a covered person for an urgent care provider to evaluate and treat an urgent condition.**

When travel to a **preferred care provider** for treatment of an **urgent condition** is not feasible; a **covered person** may call Aetna to request authorization to see a non-preferred **urgent care provider** so that such treatment may be paid at the preferred level of benefits. If it is not feasible to request authorization prior to treatment; then it should be done as soon as possible after treatment but not later than:

- the next day during normal business hours; or
- if the **covered person** is confined in a **hospital** directly after receiving urgent care; not later than 48 hours following the start of the confinement unless it is not possible for the **covered person** to request authorization within that time. In that case, it must be done as soon as reasonably possible.

However:

- if the treatment is received; or
- the confinement occurs on a Friday or Saturday, authorization must be requested within 72 hours following treatment or the start of the confinement.

If the **covered person** does not request authorization from Aetna to see a non-preferred **urgent care provider**; charges incurred for urgent care will be paid at the non-preferred covered percentage after the non-preferred **copay**.

The **covered person** should contact their **primary care physician** after medical care is provided to treat an **urgent condition**.

Non-Urgent Care: No benefit will be paid under any other part of this **Plan** for charges made by an **urgent care provider** to treat a non-urgent condition.

Non-urgent care includes; but is not limited to; the following:

- routine or preventive care (this includes immunizations);
- follow-up care;
- physical therapy;
- elective surgical procedures; and
- any lab and radiologic exams which are not related to the treatment of the **urgent condition**.

A separate preferred urgent care **copay** applies to each visit for urgent care by a **covered person** to a preferred **urgent care provider**. This does not apply if the **covered person** is admitted to a **hospital** as an inpatient right after a visit to an **urgent care provider**.

The Covered Percentage; **Copay** per visit; and Maximum Benefit per Visit or Condition are shown on the **Schedule of Benefits**.

#### **TREATMENT OF MENTAL AND NERVOUS DISORDERS EXPENSE (Non-Biologically Based) AND DRUG ADDICTION TREATMENT EXPENSE**

Except as provided below, expenses for treatment of non-biologically based mental and nervous disorders and drug addiction; are payable on the same basis as any other **sickness**.

##### **Inpatient Benefits**

**Covered Medical Expenses** include charges incurred by a **covered person**; during **partial hospitalization** or while the **covered person** is confined as a full-time inpatient in a **hospital** or **residential treatment facility**; for the treatment of non-biologically based mental and nervous disorders and drug addiction.

The Covered Percentage Daily **Room and Board**; Daily **Room and Board** Maximum; Covered Percentage Miscellaneous Expense; **Copay** per **covered person**, per **Injury** or **Sickness**; **Copay** per **covered person**, per **Plan Year**; Inpatient Maximum Days per Condition; Inpatient Maximum Days per **Plan Year**; Inpatient Benefit Maximum Days per **Plan Year**; **Partial Hospitalization** Maximum Days per Condition; **Partial Hospitalization** Maximum Days per **Plan Year**; and the **Partial Hospitalization** Benefit Maximum per **Plan Year** are shown on the **Schedule of Benefits**.

##### **Outpatient Benefits**

**Covered Medical Expenses** include charges for non-biologically based mental and nervous disorders and drug addiction; while the **covered person** is not confined as a full-time inpatient in a **hospital**.

The Covered Percentage Daily **Room and Board**; Daily **Room and Board** Maximum; Covered Percentage Miscellaneous Expense; **Copay** per **covered person**, per **Injury** or **Sickness**; **Copay** per **covered person**, per **Plan Year**; Inpatient Maximum Days per Condition; Inpatient Maximum Days per **Plan Year**; Inpatient Benefit Maximum Days per **Plan Year**; **Partial Hospitalization** Maximum Days per Condition; **Partial Hospitalization** Maximum Days per **Plan Year**; and the **Partial Hospitalization** Benefit Maximum per **Plan Year** are shown on the **Schedule of Benefits**.

#### **TREATMENT OF BIOLOGICALLY BASED MENTAL AND NERVOUS DISORDERS EXPENSES**

Expenses for treatment of biologically based mental and nervous disorders; are payable on the same basis as any other **sickness** except as otherwise set forth in the **Schedule of Benefits**.

Biologically based mental and nervous disorders are mental or nervous conditions that are caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to:

- schizophrenia;
- schizoaffective disorder;
- major depressive disorder;
- bipolar disorder;
- paranoia and other psychotic disorders;
- obsessive-compulsive disorder;
- panic disorder; and
- pervasive development disorder or autism.

#### **TREATMENT OF ALCOHOL EXPENSE**

Expenses for treatment of alcohol and drug addiction are payable on the same basis as any other **sickness** except as otherwise set forth in the **Schedule of Benefits**.

#### **PAP SMEAR SCREENING EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for an annual Pap smear screening. Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness**.

#### **LEAD POISONING SCREENING EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for screening by lead measurement for lead poisoning in children, including confirmatory blood lead poisoning as specified by New Jersey law.

Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness**. The annual **deductible** is waived for this expense.

#### **INFERTILITY TREATMENT EXPENSES**

**Covered Medical Expenses** include expenses incurred by a **covered person** for services and supplies for the diagnosis and treatment of infertility.

**Infertility** means: A recognized disease or condition that results in the abnormal functioning of the reproductive system, such that:

- A person is not able to impregnate another person;
- A person is not able to conceive after two years of unprotected intercourse, if the female partner is less than 35 years of age; or conceive after one year of unprotected intercourse if the female partner is 35 or more years of age;
- One of the partners is determined to be medically sterile.

Infertility must not be caused by a voluntary sterilization or a hysterectomy.

**Covered Medical Expenses** include, but are not limited to, the following:

- Expenses for the Diagnosis and Treatment of Infertility. These include:  
**Physicians'** services; Diagnosis and diagnostic tests; **Prescription drugs**;
- Expenses for Artificial Insemination only and standard dosages, lengths of treatment and cycles of therapy of **Prescription Drugs**. See Benefits Summary for limitations on **Prescription Drug** coverage.

**Expenses will be covered on the same basis as for disease.** Services must be performed at medical facilities that meet standards established by: the American Society for Reproductive Medicine; or the American College of Obstetricians and Gynecologists.

**Exclusions:** No charges are covered for:

- Home ovulation predictor kits, sperm testing kits and supplies;
- Cryopreservation or storage of cryopreserved sperm, eggs or embryos; except as otherwise set forth in the **Schedule of Benefits**.
- Reversal of prior voluntary sterilization procedures;
- Fees associated with donor egg or sperm programs;

#### **HYPODERMIC NEEDLES EXPENSE**

**Covered Medical Expenses** include expenses incurred by a **covered person** for hypodermic needles and syringes used in the treatment of diabetes.

The Covered Percentage; Maximum Benefit per **Plan Year**; and the **Copay** per **accident** or **sickness** are shown on the **Schedule of Benefits**.

#### **DIABETIC EQUIPMENT AND SELF-MANAGEMENT EDUCATION EXPENSE**

Certain expenses incurred in connection with the treatment of diabetes are **Covered Medical Expenses**. Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness** if a **physician**, nurse practitioner, or clinical nurse specialist:

- diagnoses diabetes; or
- diagnoses a significant change in the person's diabetic symptoms or condition that requires a change in the person's self-management of the disease; or
- determines that a person who is a diabetic needs reeducation or refresher education.

Charges for the following will be included as Other Medical Expenses to the extent they are not already covered under any part of this **Plan**.

Equipment - Charges for:

- blood glucose monitors, including monitors for the legally blind; and
- test strips for glucose monitors; and
- visual reading and urine testing strips; and
- insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances, insulin infusion devices, and oral agents for controlling blood sugar; and Self-Management

Education - Charges made by:

- a **physician**, nurse practitioner, clinical nurse specialist; or
- a pharmacist or dietitian who is legally qualified by the State of New Jersey to provide diabetic management education; for diabetic self-management education. "Diabetic self-management education" is training designed to instruct a person in the self-management of diabetes. It may include training in self-care or diet.

Charges incurred for the following are not included:

- a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
- a general program not just for diabetics; or
- a program made up of services not generally accepted as necessary for the management of diabetes.

## ROUTINE PHYSICAL EXAMS EXPENSE

**Covered Medical Expenses** include the expenses incurred by a **covered student** or a **covered dependent** for a routine physical exam performed by a **physician**. If charges made by a **physician** in connection with a routine physical exam given to a child who is a **covered dependent**, are **Covered Medical Expenses** under any other benefit section, no charges in connection with that physical exam will be considered **Covered Medical Expenses** under this section. A routine physical exam is a medical exam given by a **physician**, for a reason other than to diagnose or treat a suspected or identified **injury** or **sickness**. Included as a part of the exam are:

- X-rays; lab; and other tests given in connection with the exam; and
- Materials for the administration of immunizations for infectious disease and testing for tuberculosis.
- For all persons age 20 and older:
  - annual tests to determine blood hemoglobin blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level;
  - an annual consultation with a health care provider to discuss lifestyle behaviors and promote health and well-being including, but not limited to: smoking control; nutrition and diet recommendations; exercise plans; lower back protection; weight control; immunization practices; breast self-examination; testicular self-examination and seat belt usage in motor vehicles.
- For all persons age 35 and older, a glaucoma eye test every five years.
- For all persons age 40 and older, an annual stool exam for the presence of blood.
- For all persons age 45 or older, a left-sided colon exam of 35 to 60 centimeters every five years.
- For all women age 20 and older, pap smears.
- For all women age 40 and older, mammograms.

The **copay** per visit and per immunization are shown on the **Schedule of Benefits**.

For a child who is a **covered dependent**:

- The physical exam must include at least:

A review and written record of the patient's complete medical history;

A check of all body systems; and

A review and discussion of the exam results with the patient or with the parent or guardian.

- For all exams given to **covered dependent** under age 2; **Covered Medical Expenses** will not include charges for the following:

More than 6 exams performed during the first year of the child's life;

More than 2 exams performed during the second year of the child's life.

- For all exams given to a **covered dependent** from age 2 up to age 6; **Covered Medical Expenses** will not include charges for more than one exam in 12 months in a row.
- For all exams given to a **covered dependent** from age 6 and over; **Covered Medical Expenses** will not include charges for more than one exam in 24 months in a row.

For all exams given to a **covered student** or a spouse who is a **covered dependent**; **Covered Medical Expenses** will not include charges for more than one exam in 12 months in a row.

Also included as **Covered Medical Expenses** are:

- charges made by a **physician** for one annual routine gynecological exam; and
- an annual consultation with a **physician** to discuss lifestyle behaviors that promote health and well-being including but not limited to: smoking control, nutrition and diet recommendations, exercise plans; lower back protection, weight control, immunization practices, breast self-exams, testicular self-exams, and proper seat belt usage.

Not covered are charges for:

- Services which are for diagnosis or treatment of a suspected or identified **injury** or **sickness**.
- Exams given while the **covered person** is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Appliances; equipment; or supplies.
- Psychiatric; psychological; personality; or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Vision; hearing; or dental exams.
- A **physician's** office visit in connection with immunizations or testing for tuberculosis.

The **copay** is shown on the **Schedule of Benefits**.

#### **ROUTINE COLORECTAL CANCER SCREENING EXPENSE**

Even though not incurred in connection with a **sickness** or **injury**; **Covered Medical Expenses** include charges incurred by a **covered person** for colorectal cancer examination and laboratory tests; for any person age 50 or more; or any person under age 50 who is considered to be a high risk for colorectal cancer; for the following:

- A screening fecal occult blood test;
- A flexible Sigmoidoscopy;
- A barium enema;
- A colonoscopy; or
- Any combination of the above; or
- The most reliable, medically recognized screening test available.

The method and frequency of the screening to be utilized shall be in accordance with American Cancer Society guidelines. Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness**.

#### **ROUTINE PROSTATE CANCER SCREENING EXPENSE**

Although not incurred in connection with a **sickness** or **injury**; **Covered Medical Expenses** include charges incurred by a **covered person** for the screening of cancer as follows:

- For a male age 40 or over; one digital rectal exam and a prostate specific antigen test each **Plan Year**.
- At any age, for men having a prior history of prostate cancer, a digital rectal exam and a prostate specific antigen test.

The **copay** is shown on the **Schedule of Benefits**.

#### **CHEMOTHERAPY/AUTOLOGUS BONE MARROW TRANSPLANT EXPENSE**

**Covered Medical Expenses** include the expenses incurred by a **covered student** or a **covered dependent** for the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants when performed by institutions approved by the National Cancer Institute or in line with protocols consistent with the guidelines of the American Society of Clinical Oncologists.

Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness**.

#### **TREATMENT OF HEMOPHILIA**

**Covered Medical Expenses** incurred in connection with the treatment of routine bleeding episodes associated with hemophilia which includes:

- Purchase of blood products;

- Blood infusion equipment required for home treatment of routine bleeding episodes, when such home treatment program is under the supervision of a State approved hemophilia treatment center;
- Blood products include Factor VIII, Factor IX and cryoprecipitate; and blood infusion equipment including syringes and needles.

The benefit shall be provided to the same extent as for any **sickness** under the **Plan**.

#### **HOME TREATMENT OF BLEEDING DISORDERS**

Home treatment of bleeding disorders associated with hemophilia must be provided by a **designated** health care provider. A **designated** health care provider means a **provider** has been approved by the New Jersey Department of Banking and Insurance to contract with carriers for the purpose of rendering services for the home treatment of bleeding episodes associated with hemophilia.

#### **PREVENTIVE CARE**

Preventive Care Benefits are provided by the **Plan** in full compliance with the Patient Protection and Affordable Care Act (PPACA). Required Benefits are provided at 100% reimbursement and are not subject to **copays**, coinsurance or **deductibles** as specified in the **Schedule of Benefits** for services provided by **Preferred Care Providers**. **Preventative Care Benefits** are provided by the **Plan** in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ([HRSA](http://www.hrsa.gov)), or if the items have an "A" or "B" rating from the United States Preventative Services Task Force ([USPSTF](http://www.uspreventiveservicestaskforce.org)), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ([ACIP](http://www.cdc.gov/acip)), or if the services are recommended by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents ([AAP](http://www.aap.org)). However, **copays**, coinsurance and **deductibles** may apply to other services provided during the same visit and preventative services.

The **Plan** also provides certain preventive care benefits and services that exceed requirements of the PPACA as specified in this **Plan** Document and in compliance with the State of New Jersey Essential Health Benefits Benchmark Plan. For specific benefits covered, see the following links:

- A list of the comprehensive guidelines supported by HRSA is available <https://www.hrsa.gov/womens-guidelines/index.html>.
- A listing of the items or services with an "A" or "B" rating from USPSTF are available at <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>.
- Immunizations recommended by ACIP are available at <http://www.cdc.gov/vaccines/schedules/index.html>.
- Services as recommended in the AAP are available at [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf).

#### **PEDIATRIC ROUTINE VISION**

Includes charges made by an ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing. Benefits are limited to 1 exam per policy year.

##### **Low Vision Services**

**Covered Medical Expenses** include:

- One comprehensive low vision evaluation every 5 years.
- Low vision aids such as high-power spectacles, magnifiers and telescopes and **medically necessary** follow-up care.

As used in this provision, low vision means a significant loss of vision, but not total blindness.

##### **Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses**

Includes charges for the following vision care services and supplies:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses.
- Eyeglass frames, prescription lenses or prescription contact lenses.
- Contact lenses, glasses, or plastic lenses including single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses; polycarbonate prescription lenses with scratch resistance coating and low vision items.

Coverage includes charges incurred for:

- Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses.
- Aphakic prescription lenses prescribed after cataract surgery has been performed.
- **Medically necessary** contacts for Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders and Irregular Astigmatism.

As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.

### PREVENTIVE DENTAL EXPENSE

Benefits are limited to a maximum of \$125 per Policy Year. The annual **deductible** is waived for this benefit.

### PEDIATRIC DENTAL BENEFITS

**Covered dental expenses** include charges made by a **dental provider** for the dental services including **anesthesia services** listed within this **Plan**.

Benefits are provided to **covered persons** under the age of 19 (from birth to age 18). **Covered persons** have the freedom to choose the **dental provider** of their choice.

A **covered person's** dental services and supplies must meet the following rules to be covered by the **Plan**:

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the **Plan**.
- A **covered person** must be covered by the **Plan** when they incur the expense.

### Preventive Services and Diagnostic Services Oral Exams

#### (Deductible waived)

- One complete initial oral exam per **provider** or location (includes initial history and charting of teeth and supporting structures).
- Periodic or routine oral exams; twice in 12 months.
- Periodic or routine oral exams for children with special needs, 4 times in 12 months.

#### X-rays

- Single tooth x-rays; no more than one per visit.
- Bitewing x-rays; once in 12 months.
- Full mouth x-rays; once in 36 months per **provider** or location.
- Panoramic x-rays; once in 36 months per **provider** or location.

#### Routine Dental Care

- Routine cleaning, minor scaling, and polishing of the teeth; twice in 12 months or up to four times per year for children with special health care needs.
- Fluoride treatments (including fluoride varnishes); twice in 12 months or up to four times per year for children with special health care needs.
- Sealants; once per tooth in three years per **provider** or location (sealants over restored tooth surfaces not covered).
- Space maintainers.

## Basic Restorative Services

### Fillings

- Amalgam (silver) fillings or Composite resin (white) fillings (for primary, back teeth, payment for a composite filling will not be more than the amount allowed for an amalgam filling).

### Bridges

- Bridges.

### Root Canal Treatment

- Root canals.
- Vital pulpotomy.
- Once per tooth.
- Root end surgery.

### Crowns

- Prefabricated stainless steel crowns.

### Gum treatment

- Periodontal scaling and root planning or periodontal surgery.

### Prosthetic maintenance

- Repair of partial or complete dentures and bridges; once in 12 months
- Reline or rebase partial or complete dentures; once in 24 months
- Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth

### Oral surgery

- Simple tooth extractions; once per tooth
- Erupted or exposed root removal; once per tooth
- Surgical extractions; once per tooth
- Other necessary oral surgery
- Care of abscesses
- Cleft palate treatment
- Cancer treatment

## Major Restorative Services

### Crowns

- Metal only crowns.
- Resin crowns.
- Porcelain/ceramic crowns.
- Porcelain fused to metal/high noble crowns.

### Tooth replacement

- Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months
- Fixed prosthetics (bridges); only if there is no other less expensive adequate dental service.

### Other necessary services

- Occlusal guards when necessary; once in calendar year
- Fabrication of an athletic mouth guard

## Orthodontic Services

- **Medically necessary** orthodontic care, including retainers.
- Braces for a **covered person** who has a severe and handicapping malocclusion
- Related orthodontic services for a **covered person** when **medically necessary** qualifies

## SECTION 7 - EXCLUSIONS AND LIMITATIONS

This **Plan** does not cover nor provide benefits for:

- Expense incurred as a result of dental treatment; except for treatment resulting from **injury to sound; natural teeth** or for extraction of partially and fully impacted wisdom teeth as provided elsewhere in this **Plan** or under the Preventive Dental Benefit section and the Pediatric Dental Benefit section.
- Expense incurred for services normally provided without charge by UHS.
- Expense incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses; contact lenses (except when required after cataract surgery); or other vision or hearing aids or **prescriptions** or examinations except as required for repair caused by a covered **injury unless otherwise covered in this Plan** or as provided under the Pediatric Vision Benefit section.
- Expense incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in a riot in any way; including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense so long as they are not taken against persons who are trying to restore law and order.
- Expense incurred as a result of an **injury** or **sickness** due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
- Expense incurred as a result of an **injury** sustained or **sickness** contracted while in the service of the Armed forces of any country, upon the **covered student** entering the Armed Forces of any country.
- Expense incurred for treatment provided in a governmental **hospital** unless there is a legal obligation to pay such charges in the absence of insurance.
- Expense incurred for **elective treatment** or elective surgery except as specifically provided elsewhere in this **Plan** Document and performed while this **Plan** is in effect. **Elective treatment** includes but is not limited to:
  - vasectomy;
  - breast reduction (except for transgender diagnosis);
  - submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis;
- Expense incurred for cosmetic surgery, reconstructive surgery or other services and supplies which improve, alter; or enhance appearance whether or not for psychological or emotional reasons (except with a transgender dysphoria diagnosis); 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 harelip, webbed finger or toes; or
  - as a direct result of: disease; or surgery performed to treat a disease or **injury**.

This exclusion does not apply when reconstructive surgery is needed, as specifically described under the Breast Reconstruction Expense Benefit provision of this **Plan** or to treat a congenital deformity, birth defect in persons who have been covered under this **Plan** from the moment of birth, or in persons diagnosed with gender dysphoria and undergoing transgender surgery.

- Expense incurred as a result of commission of a felony when the commission contributes to the loss.
- Expense incurred after the date insurance terminates for a **covered person** except as may be specifically provided in the Extension of Benefits provision of this **Plan** Document.
- Expense incurred for services normally provided without charge by Princeton University and covered by the Princeton University fee for services.
- Expense incurred for any services rendered by a member of the **covered person's** immediate family or a person who lives in the **covered person's** home.
- Expense incurred for experimental or investigative procedures; except for the treatment of Wilm's tumor.
- Expense incurred for **custodial care**. **Custodial care** means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed;
- by whom they are recommended; or
- by whom or by which they are performed.
- Expense incurred for the removal of an organ from a **covered person** for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a **covered person** to a spouse, child, brother, sister, or parent.
- Expense incurred by a **covered person**; not a United States citizen; for services performed within the **covered person's** home country; if the **covered person's** home country has a socialized medicine program.
- Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy (does not include acupuncture, massage, biofeedback or chiropractic services).
- Expense for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment; even if such items are prescribed by a **physician**.
- Expense for services or supplies provided for the treatment of obesity and/or weight control, unless specifically provided in this **Plan**.
- Expense for incidental surgeries; and standby charges of a **physician**.
- Expense for treatment and supplies for programs involving cessation of tobacco use, unless specifically provided in this **Plan**.
- Expense for services and supplies for or related to Advanced Reproductive Technology (ART) Benefits. **Advanced Reproductive Technology** are services or supplies to enhance fertility that involve harvesting, storage and/or manipulation of eggs and sperm including:
  - In vitro fertilization (IVF);
  - Zygote intra-fallopian transfer (ZIFT);
  - Gamete intra-fallopian transfer (GIFT);
  - Cryopreserved embryo transfers; and
  - Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.
  - Embryo Transfer
  - Donor sperm, surrogate motherhood or sterilization reversal.
- Expense for elective sterilization or its reversal or elective abortion; unless specifically provided for in this **Plan**.
- Expense incurred for a treatment; service; or supply; which is not **medically necessary**; for the diagnosis, care or treatment of the **sickness** or **injury** involved. This applies even if they are prescribed; recommended; or approved; by the person's attending **physician**; or **dentist**.

In order for a treatment; service; or supply; to be considered **medically necessary**; the service or supply must:

- be care; or treatment; which is likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the **sickness** or **injury** involved; and the person's overall health condition;
- be a diagnostic procedure which is indicated by the health status of the person; and be as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the **sickness** or **injury** involved; and the person's overall health condition; and
- as to diagnosis; care; and treatment; be no more costly (taking into account all health expenses incurred in connection with the treatment; service; or supply); than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances; this **Plan** will take into consideration: information relating to the affected person's health status; reports in peer reviewed medical literature; reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; generally recognized professional standards of safety and effectiveness in the United States for diagnosis; care; or treatment; the opinion of health professionals in the generally recognized health specialty involved; and any other relevant information brought to the **Plan's** attention.

In no event will the following services or supplies be considered to be **medically necessary**:

- those that do not require the technical skills of a medical; a mental health; or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person; any person who cares for him or her; or any person who is part of his or her family; any healthcare provider; or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's **sickness or injury** could safely and adequately; be diagnosed; or treated; while not confined; or those furnished solely because of the setting; if the service or supply could safely and adequately be furnished in a **physician's** or a **dentist's** office; or other less costly setting.

Any exclusion above will not apply to the extent that coverage is specifically provided by name in this Plan or coverage of the charges is required under any law that applies to the coverage.

## COORDINATION OF BENEFITS

The words shown below have special meanings when used in this section. Please read these definitions carefully.

**"Allowable Expense"** means the charge for any health care service, supply or other item of expense for which the **covered student** is liable when the health care service, supply or other item of expense is covered at least in part under any of the **Plans** involved, except where a statute requires another definition, or as otherwise stated below.

When **This Plan** is coordinating benefits with a plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, **Allowable Expense** is limited to like items of expense.

**The Plan** will not consider the difference between the cost of a private **Hospital** room and that of a semi-private **Hospital** room as an **Allowable Expense** unless the stay in a private room is **Medically Necessary**.

When **This Plan** is coordinating benefits with a plan that restricts **COB** to a specific coverage, **This Plan** will only consider corresponding services, supplies or items of expense to which **COB** applies as an **Allowable Expense**.

**"Claim Determination Period"** means a calendar year or portion of a calendar year, during which a **covered student** is covered by **This Plan** and at least one other **Plan** and incurs one or more **Allowable Expense(s)** under such **Plans**.

**"Coordination of Benefits (COB)"** means a provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more **Plans**. It avoids claims payment delays by establishing an order in which **Plans** pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a **Plan** when, by the rules established by this provision, it does not have to pay its benefits first.

**"Plan(s)"** means coverage with which **COB** is allowed. **Plan** includes:

- i. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- ii. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- iii. Group or group-type coverage through a Health Maintenance Organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- iv. Group **hospital** indemnity benefit amounts that exceed \$150 per day;
- v. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

**"Plan(s)"** shall not include:

- i. Individual or family insurance contracts or subscriber contracts;
- ii. Individual or family coverage through an HMO or under any other prepayment, group practice and

- individual practice plans;
- iii. Group or group-type coverage where the cost of the coverage is paid solely by the **covered person** except that coverage being continued pursuant to Federal or State continuation law shall be considered a plan;
- iv. Group **hospital** indemnity benefit amounts of \$150.00 per day or less;
- v. School accident-type coverage;
- vi. A State plan under Medicaid.

"**This Plan**" is the part of this **Document** that provides benefits for health care expenses.

"**Primary Plan(s)**" means a **Plan** whose benefits for a **covered person's** health care coverage must be determined without taking into consideration the existence of any other **Plan**. There may be more than one **Primary Plan**. A **Plan** will be the **Primary Plan** if: the **Plan** has no order of benefit determination rules, or it has rules that differ from those contained in this **Certificate**; or all **Plans** which cover the **covered person** use order of benefit determination rules consistent with those contained in this **Certificate** and under those rules, the **Plan** determines its benefit first.

"**Reasonable Charge**" means an amount that is not more than the usual or customary charge for the service or supply as determined by **This Plan**, based on a standard which is most often charged for a given service by a **provider** within the same geographic area.

"**Secondary Plan(s)**" means a **Plan** which is not a **Primary Plan**. If a **covered person** is covered by more than one **Secondary Plan**, the order of benefit determination rules of this **COB** section shall be used to determine the order in which the benefits payable under the multiple **Secondary Plans** are paid in relation to each other. The benefits of each **Secondary Plan** may take into consideration the benefits of the **Primary Plan** or **Plans** and the benefits of any other **Plan** which, under this **Certificate**, has its benefits determined before those of that **Secondary Plan**.

#### **Primary and Secondary Plan:**

When a claim is submitted, the SHP is considered the primary plan and pays benefits per the plan provisions as described herein. When the **covered person** does not maintain any other insurance (*exception—auto and/or boating insurance*), the SHP is automatically considered the primary plan. If the **covered person** maintains another insurance plan in conjunction with the SHP, the SHP is automatically considered the secondary plan; and as such, benefits paid per the SHP provisions, as described herein, would not exceed the allowable plan expenses. No plan pays more than it would without the coordination provision. **This Plan** considers each **Plan** separately when coordinating payments.

The **Primary Plan** pays or provides services or supplies first, without taking into consideration the existence of a **Secondary Plan**. If a **Plan** has no **COB** provision, or if the order of benefit determination rules differ from those set forth in this **Certificate**, it is the **Primary Plan**.

A **Secondary Plan** takes into consideration the benefits provided by a **Primary Plan** when, according to the rules set forth below, the **Plan** is the **Secondary Plan**. If there is more than one **Secondary Plan**, the order of benefit determination rules determine the order among the **Secondary Plans**. The **Secondary Plans** will pay up to the remaining unpaid **Allowable Expenses**, but no **Secondary Plan** will pay more than it would have paid if it had been the **Primary Plan**.

## SECTION 8 – SCHEDULE OF BENEFITS

### Eligibility

Subject to the terms contained within this **Plan**, benefits are eligible for students and eligible **dependents** only for the coverages listed below. The coverage section of this **Plan** contains a complete description of the benefits available.

No person may be covered as both a **student** and as a **dependent**, and no person may be covered as a **dependent** of more than one **student**.

| <b>Annual Plan Deductibles</b> | <b><u>Preferred Care and Non Preferred Care<br/>Combined</u></b> |
|--------------------------------|--|
| Medical Individual             | \$200  |
| Medical Family                 | \$400  |
| Prescription Individual        | \$100  |
| Prescription Family            | \$200  |

***Annual Plan Deductible is waived for: Preventive Care Preferred Medical and Prescription Drug Expenses (including Generic Contraceptives), Preferred Care Office Visits, Preferred Care Laboratory or Screening Expenses, Ambulance Expense, Human Leukocyte Antigen Testing, Lead Poisoning Screening, Preventive Dental Expense, and Mental Health visits within the Princeton University Exclusive Mental Health Provider Network (EPN).***

### Pre-Certification Requirements

The **covered person** must obtain pre-certification for certain types of expenses to avoid a reduction in benefits paid for that care. To obtain pre-certification, contact UHS.

The Basic **Sickness** Expense Benefits section of this **Plan** contains details of the types of care affected, how to get certification, and the effect on benefits for failure to obtain certification.

| <b>Out-of-Pocket Maximums</b>           | <b><u>Preferred Care and Non Preferred Care<br/>Combined</u></b> |
|---|--|
| Medical Individual Out-of-Pocket        | \$5,000  |
| Medical Family Out-of-Pocket            | \$10,000   |
| Prescription – Individual Out-of-Pocket | \$1,350  |
| Prescription – Family Out-of-Pocket     | \$2,700  |

Once the Individual or Family **Out-of-Pocket Limit** has been satisfied, **Covered Medical Expenses** and/or **Prescription Drug** Expenses will be payable at 100% for the remainder of the Coverage Period, up to any benefit maximum, that may apply.

### Benefits Payable

After any applicable **deductible**, the Health Expense Benefits payable under this **Plan**, during the Coverage Period, are paid at the Covered Percentage which applies to the type of **Covered Medical Expense** and/or **Prescription Drug Expense** which is incurred. Benefits may vary depending upon whether a **Preferred Care Provider** is utilized. A **Preferred Care Provider** or **Exclusive Mental Health Network Provider**, is a health care provider who has agreed to provide services or supplies at a **negotiated charge**.

If any expense is covered under one type of **Covered Medical Expense**, it cannot be covered under any other type.

## Eligible Medical Expenses

**Covered Medical Expenses** are payable on the same basis as any other **Sickness**.

| <b>Inpatient Hospitalization Benefits</b>   | <b>Preferred Care</b>        | <b>Non-Preferred Care</b>                        |
|---|------------------------------|--|
| <b>Room and Board Expense</b>   | 90% of the Negotiated Charge | 70% of Recognized Charge for a semi-private room |
| <b>Miscellaneous Hospital Expense</b><br>Includes but not limited to: operating room, laboratory tests/x-rays, oxygen tent, and drugs, medicines, dressings | 90% of the Negotiated Charge | 70% of the Recognized Charge                     |
| <b>Non-Surgical Physicians Expense</b><br>Non-surgical services of the attending Physician, or a Consulting Physician                                       | 90% of the Negotiated Charge | 70% of the Recognized Charge                     |
| <b>Surgical Expenses</b>  | <b>Preferred Care</b>        | <b>Non-Preferred Care</b>                        |
| <b>Surgical Expense (Inpatient and Outpatient)</b>  | 90% of the Negotiated Charge | 70% of the Recognized Charge                     |
| <b>Surgical Expense Primary Surgery</b>   | 90% of the Negotiated Charge | 70% of the Recognized Charge                     |
| <b>Surgical Expense Secondary Surgery (subsequent surgery on same date of service as primary surgery)</b>   | 50% of the Negotiated Charge | 50% of the Recognized Charge                     |
| <b>Surgical Expense Tertiary + (three or more surgeries on same date of service as primary &amp; secondary)</b>   | 25% of the Negotiated Charge | 25% of the Recognized Charge                     |
| <b>Anesthesia Expense (Inpatient and Outpatient)</b>  | 90% of the Negotiated Charge | 70% of the Recognized Charge                     |
| <b>Assistant Surgeon Expense (Inpatient and Outpatient)</b>   | 90% of the Negotiated Charge | 70% of the Recognized Charge                     |
| <b>Ambulatory Surgical Expense</b>  | 90% of the Negotiated Charge | 70% of the Recognized Charge                     |
| <b>Outpatient Expenses</b>  | <b>Preferred Care</b>        | <b>Non-Preferred Care</b>                        |
| <b>Hospital Outpatient Department Expense</b>   | 90% of the Negotiated Charge | 70% of the Recognized Charge                     |
| <b>Walk-in Clinic Visit Expense</b>   | 90% of the Negotiated Charge | 70% of the Recognized Charge                     |

| Outpatient Expenses <i>(continued)</i>  | Preferred Care  | Non-Preferred Care                                       |
|---|---|--|
| <p><b>Emergency Room Expense</b><br/> <b>Important Note:</b> Non-Preferred Care Providers do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Send Aetna the bill at the address listed on the back of your ID card and Aetna will resolve any dispute with the provider over that amount. Make sure your member ID number is on the bill.</p> | 90% of the Negotiated Charge  | 90% of the Recognized Charge                             |
| <p><b>Urgent Care Expense</b></p>   | 90% of the Negotiated Charge  | 70% of the Recognized Charge                             |
| <p><b>Ambulance Expense</b></p>   | 90% of the Negotiated Charge<br><b>Deductible Waived</b>                                | 70% of the Recognized Charge<br><b>Deductible Waived</b> |
| <p><b>Physician's Office Visit Expense</b><br/> This benefit includes visits to specialists.</p>  | After a \$10 per visit Copay, 100% of the Negotiated Charge<br><b>Deductible Waived</b> | 70% of the Recognized Charge                             |
| <p><b>Laboratory Expense</b></p>  | 100% of the Negotiated Charge<br><b>Deductible Waived</b>                               | 70% of the Recognized Charge                             |
| <p><b>Laboratory Expense</b><br/> Treatment of Mental and Nervous Disorders</p>   | 100% of the Negotiated Charge<br><b>Deductible Waived</b>                               | 70% of the Recognized Charge                             |
| <p><b>X-ray Expense</b></p>   | 90% of the Negotiated Charge  | 70% of the Recognized Charge                             |
| <p><b>High Cost Procedures Expense</b><br/> Includes CT scans, MRIs, PET scans and Nuclear Cardiac Imaging Tests</p>  | 90% of the Negotiated Charge  | 70% of the Recognized Charge                             |

| <b>Outpatient Expenses (continued)</b>  | <b>Preferred Care</b>  | <b>Non-Preferred Care</b>    |
|---|--|------------------------------|
| <b>Therapy Expense</b><br>Includes Physical, Occupational, Respiratory and Chelation Therapy  | 90% of the Negotiated Charge   | 70% of the Recognized Charge |
| <b>Complementary Medicine Expense</b><br>Includes:<br>Requires initial referral and after every 10 visits<br><b>Pain Management, Chiropractic</b> (Limited to 30 visits per year with 2 modalities per visit), <b>Acupuncture, Massage Therapy &amp; Biofeedback</b> (Limited to 30 combined visits per year).  | 90% of the Negotiated Charge<br>\$20 visit copay for Chiropractic care | 50% of the Recognized Charge |
| <b>Cognitive Therapy Expense</b><br>Includes Speech and Cognitive Therapy   | 90% of the Negotiated Charge   | 70% of the Recognized Charge |
| <b>Durable Medical and Surgical Equipment Expense</b>   | 90% of the Negotiated Charge   | 50% of the Recognized Charge |
| <b>Enteral formulas and nutritional supplements</b>   | 90% of the Negotiated Charge   | 70% of the Recognized Charge |
| <b>Infant formulas</b>  | 90% of the Negotiated Charge   | 70% of the Recognized Charge |
| <b>Infant pasteurized donated breast milk</b>   | 90% of the Negotiated Charge   | 50% of the Recognized Charge |
| <b>Prosthetic or Orthotic Expense</b><br>Includes charges for orthotic or prosthetic appliances from a licensed orthotist or prosthetist or any certified pedorthist, if determined medically necessary by the covered person's physician. Benefits for orthotic and prosthetic appliances are paid at the higher of the federal Medicare reimbursement schedule or the Negotiated Charge. Coverage is provided under the same terms and conditions as for any other illness. | 90% of the Negotiated Charge   | 70% of the Recognized Charge |
| <b>All other orthotic and prosthetic devices</b>  | 90% of the Negotiated Charge   | 70% of the Recognized Charge |

| <b>Outpatient Expenses (continued)</b>  | <b>Preferred Care</b>         | <b>Non-Preferred Care</b>    |
|---|-------------------------------|------------------------------|
| <b>Dental Injury Expense</b>  | 90% of the Negotiated Charge  | 70% of the Recognized Charge |
| <b>Dental Expense for Impacted Wisdom Teeth</b>   | 90% of the Negotiated Charge  | 70% of the Recognized Charge |
| <b>Allergy Testing &amp; Treatment Expense</b>  | 90% of the Negotiated Charge  | 70% of the Recognized Charge |
| <b>Diagnostic Testing for Learning Disabilities Expense</b><br>Once a person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Plan.  | 90% of the Negotiated Charge  | 70% of the Recognized Charge |
| <b>Preventive Care</b><br>Preventive Care Benefits are provided by the <b>Plan</b> in full compliance with the PPACA and New Jersey Essential Health Benefits Benchmark Plan. For specific benefits covered, see the following links: <ul style="list-style-type: none"> <li>• Evidence-based items that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force <a href="https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/">https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</a></li> <li>• Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents <a href="https://www.aap.org/en-us/Documents/periodicity_schedule.pdf">https://www.aap.org/en-us/Documents/periodicity_schedule.pdf</a></li> <li>• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration <a href="https://www.hrsa.gov/womens-guidelines/index.html">https://www.hrsa.gov/womens-guidelines/index.html</a></li> <li>• The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention <a href="http://www.cdc.gov/vaccines/schedules/index.html">http://www.cdc.gov/vaccines/schedules/index.html</a>.</li> </ul> <b>Copays, deductible and co-insurance waived for all Preferred Care Preventive Medical Services.</b> |                               |                              |
| <b>Routine Physical Exam</b><br>Includes routine vision & hearing screenings given as part of the routine physical exam, routine tests and related lab fees.  | 100% of Negotiated Charge     | 70% of Recognized Charge     |
| <b>Preventive Care Immunizations</b><br>Includes travel immunizations and flu shots   | 100% of the Negotiated Charge | 70% of the Recognized Charge |

| Preventive Care <i>(continued)</i>   | Preferred Care                | Non-Preferred Care           |
|--|-------------------------------|------------------------------|
| <b>Childhood Immunizations and, Screening for Lead Poisoning</b>   | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <b>Treatment for Lead Poisoning</b><br>Screenings by blood lead measurement for lead poisoning for children, including: <ul style="list-style-type: none"> <li>• Confirmatory blood lead testing, as specified by the New Jersey Department of Health.</li> <li>• Medical evaluation.</li> <li>• Any necessary medical follow-up treatment for lead poisoned children.</li> </ul>  | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <b>Health Wellness Promotion Programs</b> Recommended immunizations for all adults Annual: <ul style="list-style-type: none"> <li>• Blood tests and lifestyle behavior counseling for covered persons age 20 and over</li> <li>• A pap smear for female covered persons age 20 and over</li> <li>• Stool examination for presence of blood for covered persons age 40 or over</li> <li>• A mammogram for female covered persons age 40 or over</li> </ul> Every 5 years: <ul style="list-style-type: none"> <li>• Glaucoma test for covered persons age 35 and over</li> <li>• A left-sided colon examination of 35 or 60 centimeters for covered persons age 45 and over</li> </ul> | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <b>Well Woman Preventive Visits</b><br>Routine well woman preventive exam office visit, including Pap smears, including laboratory and diagnostic services. Does not require a referral.   | 100% of the Negotiated Charge | 70% of the Recognized Charge |

| Preventive Care <i>(continued)</i>  | Preferred Care                | Non-Preferred Care           |
|---|-------------------------------|------------------------------|
| <p><b>Preventive Care Screening and Counseling Services for Sexually Transmitted Infections</b></p> <p>Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.</p>   | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet</b></p> <p>Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits and/or risk factor reduction intervention;</li> <li>• Nutritional counseling; and</li> </ul> <p>Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.</p> | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs</b></p> <p>Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.</p>   | 100% of the Negotiated Charge | 70% of the Recognized Charge |

| Preventive Care <i>(continued)</i>  | Preferred Care                | Non-Preferred Care           |
|---|-------------------------------|------------------------------|
| <p><b>Preventive Care Screening and Counseling Services for Use of Tobacco Products</b></p> <p>Screening and counseling services to aid a covered person to stop the use of tobacco products.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits;</li> <li>• Treatment visits; and</li> <li>• Class visits; to aid a covered person to stop the use of tobacco products.</li> </ul> <p>Tobacco product means a substance containing tobacco or nicotine including:</p> <ul style="list-style-type: none"> <li>• Cigarettes;</li> <li>• Cigars;</li> <li>• Smoking tobacco;</li> <li>• Snuff;</li> <li>• Smokeless tobacco; and</li> </ul> <p>Candy-like products that contain tobacco.</p> | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Preventive Care Screening and Counseling Services for Depression Screening</b></p> <p>Screening or test to determine if depression is present.</p>  | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Preventive Care Routine Cancer Screenings</b></p> <p>Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies (removal of polyps performed during a screening procedure is a covered medical expense); and Lung cancer screenings.</p>  | 100% of the Negotiated Charge | 70% of the Recognized Charge |

| <b>Preventive Care (continued)</b>   | <b>Preferred Care</b>         | <b>Non-Preferred Care</b>    |
|--|-------------------------------|------------------------------|
| <p><b>Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer</b><br/>Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.</p>   | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Preventive Care Prenatal Care</b><br/>Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.</p> | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Preventive Care Lactation Counseling Services</b><br/>Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.</p>  | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Preventive Care Breast Pumps and Supplies</b></p>  | 100% of the Negotiated Charge | 50% of the Recognized Charge |

| Preventive Care <i>(continued)</i>   | Preferred Care                       | Non-Preferred Care                  |
|--|--------------------------------------|-------------------------------------|
| <p><b>Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient)</b></p> <p>Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting.</p> <p><b>Voluntary Sterilization</b></p> <p>Includes charges billed separately by the provider for female voluntary sterilization procedures &amp; related services &amp; supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.</p> | <p>100% of the Negotiated Charge</p> | <p>70% of the Recognized Charge</p> |

| Preventive Care <i>(continued)</i>   | Preferred Care                | Non-Preferred Care           |
|--|-------------------------------|------------------------------|
| <p><b>Contraceptives</b> can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.</p>   | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Routine Prostate Cancer Screening</b><br/>Includes charges incurred by a covered person for one digital rectal exam and one prostate specific antigen test each Plan Year for the screening of cancer as follows: for a male age 50 or over or, a male age 40 and over with a family history.</p>  | 100% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Pediatric Routine Vision (Coverage is limited to covered persons through age 18)</b> Includes charges made by an ophthalmologist or optometrist for a routine vision exam. The exam will include refraction &amp; glaucoma testing. Benefits are limited to 1 exam per policy year.</p> <p><b>Low Vision Services</b><br/>Covered medical expenses include:</p> <ul style="list-style-type: none"> <li>• One comprehensive low vision evaluation every 5 years.</li> <li>• Low vision aids such as high power spectacles, magnifiers and telescopes and medically necessary follow-up care.</li> </ul> <p><b>Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses</b></p> <p>In a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.</p> | 100% of the Actual Charge     | 70% of the Recognized Charge |

| Preventive Care <i>(continued)</i>   | Preferred Care   | Non-Preferred Care  |
|--|--|---|
| <p><b>Preventive Dental Expense</b> Benefits are limited to a maximum of \$125 per Plan Year.</p>  | <p>100% of the Actual Charge</p> <p><b>Deductible Waived</b></p>     | <p>100% of the Actual Charge</p> <p><b>Deductible Waived</b></p>    |
| <p><b>Pediatric Dental Benefits:</b> The Pediatric dental benefits described below are limited to covered persons who are under the age of 19 (from birth through age 18).</p>   |  |   |
| <p>Preventive &amp; Diagnostic Services</p> <p>Oral Exams</p> <ul style="list-style-type: none"> <li>• One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures).</li> <li>• Periodic or routine oral exams; twice in 12 months.</li> <li>• Periodic or routine oral exams for children with special needs, 4 times in 12 months.</li> </ul> <p>X-rays</p> <ul style="list-style-type: none"> <li>• Single tooth x-rays; no more than one per visit.</li> <li>• Bitewing x-rays; once in 12 months.</li> <li>• Full mouth x-rays; once in 36 months per provider or location.</li> <li>• Panoramic x-rays; once in 36 months per provider or location.</li> </ul> | <p>100% of the Negotiated Charge</p> <p><b>Deductible waived</b></p> | <p>70% of the Recognized Charge</p> <p><b>Deductible waived</b></p> |
| <p>Routine Dental Care</p> <ul style="list-style-type: none"> <li>• Routine cleaning, minor scaling, and polishing of the teeth; twice in 12 months or up to four times per year for children with special health care needs.</li> <li>• Fluoride treatments (including fluoride varnishes); twice in 12 months or up to four times per year for children with special health care needs.</li> <li>• Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered).</li> <li>• Space maintainers</li> </ul>   | <p>100% of the Negotiated Charge</p> <p><b>Deductible waived</b></p> | <p>70% of the Recognized Charge</p> <p><b>Deductible waived</b></p> |

| Pediatric Dental Benefits <i>(continued)</i>   | Preferred Care                      | Non-Preferred Care                  |
|--|-------------------------------------|-------------------------------------|
| <p><b>Basic Restorative Services</b></p> <p>Fillings</p> <ul style="list-style-type: none"> <li>• Amalgam (silver) fillings or Composite resin (white) fillings (for primary, back teeth, payment for a composite filling will not be more than the amount allowed for an amalgam filling).</li> </ul> <p>Bridges</p> <ul style="list-style-type: none"> <li>• Bridges.</li> </ul> <p>Root Canal Treatment</p> <ul style="list-style-type: none"> <li>• Root canals.</li> <li>• Vital pulpotomy.</li> <li>• Once per tooth.</li> <li>• Root end surgery.</li> </ul> <p>Crowns</p> <ul style="list-style-type: none"> <li>• Prefabricated stainless steel crowns.</li> </ul> <p>Gum treatment</p> <ul style="list-style-type: none"> <li>• Periodontal scaling and root planning or periodontal surgery.</li> </ul> <p>Prosthetic maintenance</p> <ul style="list-style-type: none"> <li>• Repair of partial or complete dentures and bridges; once in 12 months</li> <li>• Reline or rebase partial or complete dentures; once in 24 months</li> <li>• Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth</li> </ul> <p>Oral surgery</p> <ul style="list-style-type: none"> <li>• Simple tooth extractions; once per tooth</li> <li>• Erupted or exposed root removal; once per tooth</li> <li>• Surgical extractions; once per tooth (approval required for complete, boney impactions)</li> <li>• Other necessary oral surgery</li> <li>• Care of abscesses</li> <li>• Cleft palette treatment</li> <li>• Cancer treatment</li> </ul> | <p>70% of the Negotiated Charge</p> | <p>50% of the Recognized Charge</p> |

| <b>Pediatric Dental Benefits (continued)</b>   | <b>Preferred Care</b>   | <b>Non-Preferred Care</b>    |  |
|--|---|------------------------------|--|
| <b>Major Restorative Services</b><br>Crowns <ul style="list-style-type: none"> <li>• Metal only crowns.</li> <li>• Resin crowns.</li> <li>• Porcelain/ceramic crowns.</li> <li>• Porcelain fused to metal/high noble crowns.</li> </ul> Tooth replacement <ul style="list-style-type: none"> <li>• Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months</li> <li>• Fixed prosthetics (bridges); only if there is no other less expensive adequate dental service.</li> </ul> Other necessary services <ul style="list-style-type: none"> <li>• Occlusal guards when necessary; once in calendar year</li> <li>• Fabrication of an athletic mouth guard</li> </ul> | 50% of the Negotiated Charge  | 50% of the Recognized Charge |  |
| <b>Orthodontic Services</b> <ul style="list-style-type: none"> <li>• Medically necessary orthodontic care including retainers.</li> <li>• Braces for a covered person who has a severe and handicapping malocclusion</li> <li>• Related orthodontic services for a covered person when medically necessary qualifies</li> </ul>  | 50% of the Negotiated Charge  | 50% of the Recognized Charge |  |
| <b>Treatment of Mental and Nervous Disorders</b>   | <b>Preferred Care</b>   | <b>Non-Preferred Care</b>    | <b>Exclusive Mental Health Provider Network</b>                                |
| <b>Mental Health Inpatient Expense</b>   | 90% of the Negotiated Charge  | 70% of the Recognized Charge | N/A  |
| <b>Mental Health Outpatient Expense</b>  | After a \$10 per visit Copay, 100% of the Negotiated Charge<br><b>Deductible waived</b> | 70% of the Recognized Charge | After \$20 per visit Copay, 100% of Negotiated Fee<br><b>Deductible Waived</b> |
| <b>Alcoholism and Drug Addiction Treatment</b>   | <b>Preferred Care</b>   | <b>Non-Preferred Care</b>    | <b>Exclusive Mental Health Provider Network</b>                                |
| <b>Inpatient Expense</b>   | 90% of the Negotiated Charge  | 70% of the Recognized Charge | N/A  |
| <b>Outpatient Expense</b>  | After a \$10 per visit Copay, 100% of the Negotiated Charge<br><b>Deductible waived</b> | 70% of the Recognized Charge | After \$20 per visit Copay, 100% of Negotiated Fee<br><b>Deductible Waived</b> |

**Medical Evacuation, Repatriation & Medical Services Received Abroad: (Medical services received outside the US must be paid by the covered person(s) first, and then a claim can be filed with Aetna Student Health for reimbursement. Claim forms are available online.)**

|  |  |                                     |
|--|--|-------------------------------------|
| <p><b>Medical Evacuation</b><br/>Benefits are paid up to \$50K for medical evacuation to country of origin.</p>  | <p>90% of the Negotiated Charge<br/>(The evacuation must, in the opinion of the claims administrator, be medically necessary because appropriate health services are not otherwise available.)</p> | <p>70% of the Recognized Charge</p> |
| <p><b>Repatriation</b><br/>Benefits are paid up to \$25K for preparing and transporting the remains of the deceased to his or her country of origin.</p>               | <p>90% of the Negotiated Charge</p>  | <p>70% of the Recognized Charge</p> |
| <p><b>Maternity Benefits</b></p>   | <p><b>Preferred Care</b></p>   | <p><b>Non-Preferred Care</b></p>    |
| <p><b>Maternity Expense</b><br/>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy</p>   | <p>\$10 per office visit copay.<br/><br/>All other expenses, 100% of Negotiated Charge.</p>  | <p>70% of the Recognized Charge</p> |
| <p><b>Breast Feeding Durable Medical Equipment – Breast Pumps</b><br/>Plan covers purchase of a breast pump as medically necessary durable medical equipment (DME)</p> | <p>100% of the Negotiated Charge</p>   | <p>50% of the Recognized charge</p> |
| <p><b>Well Newborn Nursery Care Expense</b></p>  | <p>100% of the Negotiated Charge</p>   | <p>70% of the Recognized Charge</p> |

## Prescription Drug Coverage

The prescription plan is administered by OptumRx. Please see page 3 for separate individual and family deductibles and out-of-pocket maximums for the prescription plan.

Additional information may be obtained at:

<https://uhs.princeton.edu/student-insurance/student-health-plan/prescription-program>.

The prescription drug deductible and copays do not apply to the following:

- Preventive Care Drugs and Supplements
- Risk Reducing Breast Cancer Prescription Drugs
- Contraceptives (Generic, unless a Generic equivalent is not available, or the **covered person** is granted a medical exception.)

For each generic drug prescription filled, the **Plan** provides 100% coverage. See [OptumRx](#) for list of Preventive Drugs.

Some brand and specialty prescriptions require prior authorization. When prior authorization is obtained, the preferred brand copay will apply for non-preferred and specialty brand prescriptions.

Specialty medications, usually limited to a 30-day supply, are only covered through the OptumRx specialty pharmacy, BrivoRx. OptumRx will allow for a one-month supply at a retail pharmacy for the first prescription. Contact OptumRx directly to access specialty medication.

| Benefit Description   | Preferred Care | Non-Preferred Care |
|---|----------------|--------------------|
| <b>Retail/Specialty Pharmacy</b>  |                |                    |
| <b>30 day supply</b>  |                |                    |
| Generic   | \$5 copay      | \$5 copay          |
| Preferred Brand   | \$20 copay     | \$20 copay         |
| Non-Preferred Brand   | \$70 copay     | \$70 copay         |
| <b>90 day Home Delivery Supply</b>  |                |                    |
| Generic   | \$10 copay     | \$10 copay         |
| Preferred Brand   | \$40 copay     | \$40 copay         |
| Non-Preferred Brand   | \$140 copay    | \$140 copay        |
| <b>Preventive Care Drugs, Supplements, Contraceptives, Risk Reducing Breast Cancer Prescription Drugs</b> |                |                    |
| <b>30 day supply</b>  |                |                    |
| Generic   | \$0 copay      | \$0 copay          |
| Preferred Brand   | \$20 copay     | \$20 copay         |
| Non-Preferred Brand   | \$70 copay     | \$70 copay         |
| <b>90 Day Home Delivery Supply</b>  |                |                    |
| Generic   | \$0 copay      | \$0 copay          |
| Preferred Brand   | \$40 copay     | \$40 copay         |
| Non-Preferred Brand   | \$140 copay    | \$140 copay        |

| Additional Benefits   | Preferred Care   | Non-Preferred Care  |
|---|--|---|
| <b>Infertility Treatment</b><br>Only Artificial Insemination and standard dosages, lengths of treatment and cycles of therapy of prescription drugs are covered.  | Covered Medical Expenses:<br>90% of the Negotiated Charge  | Covered Medical Expenses:<br>70% of the Recognized Charge   |
| <b>Routine Foot Care Expense</b><br>Routine foot care is excluded, except for the following: open cutting operations to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; removal of nail roots; treatment of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease. | 90% of the Negotiated Charge                               | 70% of the Recognized Charge                                |
| <b>Diabetic Equipment and Self-Management Education Expense</b>   | 90% of the Negotiated Charge                               | 70% of the Recognized Charge                                |
| <b>Temporomandibular Joint Dysfunction Expense</b>  | 90% of the Negotiated Charge                               | 70% of the Recognized Charge                                |
| <b>Elective Abortion Expense</b>  | 90% of the Negotiated Charge                               | 70% of the Recognized Charge                                |
| <b>Hospice Benefit</b>  | 90% of the Negotiated Charge                               | 70% of the Recognized Charge                                |
| <b>Home Health Care Expense</b><br><i>(Limited to 60 visits per year)</i>   | 90% of the Negotiated Charge                               | 70% of the Recognized Charge                                |
| <b>IUD &amp; Other Birth Control Devices</b>  | 100% of the Negotiated Charge                              | 70% of the Negotiated Charge                                |
| <b>Licensed Nurse Expense</b>   | 90% of the Negotiated Charge                               | 70% of the Recognized Charge                                |
| <b>Skilled Nursing Facility Expense</b>   | 90% of the Negotiated Charge for the semiprivate room rate | 70% of the Recognized Charge for the semi-private room rate |

| <b>Additional Benefits (continued)</b>  | <b>Preferred Care</b>   | <b>Non-Preferred Care</b>  |
|---|---|--|
| <b>Rehabilitation Facility Expense</b>  | 90% of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semiprivate accommodations  | 70% of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semiprivate accommodations |
| <b>Hearing Aids Expense</b><br>Includes coverage for medically necessary expenses (including fittings, exams and hearing tests, dispensing fees, modifications and repairs, ear molds, and headbands for bone-anchored hearing implants) incurred in the purchase of hearing aids. This benefit is limited to 1 hearing aid per ear, per plan year. | 90% of the Negotiated Charge  | 70% of the Recognized Charge   |
| <b>Sickle cell anemia treatment</b>   | Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered |  |
| <b>Home Hemophilia treatment</b>  | Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered |  |
| <b>Wilm's tumor treatment</b>   | Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered |  |
| <b>Podiatric (foot care) treatment - Physician and specialist non-routine foot care treatment</b>   | Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered |  |
| <b>Bariatric Surgery Expense</b>  | 90% of the Negotiated Charge  | 70% of the Recognized Charge   |
| <b>Nutritional Counseling</b>   | 90% of the Negotiated Charge  | 70% of the Recognized Charge   |
| <b>Private Duty Nursing Expense</b>   | 90% of the Negotiated Charge  | 70% of the Recognized Charge   |

| Additional Benefits <i>(continued)</i>  | Preferred Care               | Non-Preferred Care           |
|---|------------------------------|------------------------------|
| <p><b>Human Organ Transplant Expense</b><br/>Includes Transplants: cornea, kidney, lung, liver, heart, pancreas, intestine, allogenic bone marrow. Costs associated with the transplant, including inpatient services, and practitioner services. Inpatient hospital costs of donors associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. Benefits do not include: Travel, accommodations, or comfort items.</p>   | 90% of the Negotiated Charge | 70% of the Recognized Charge |
| <p><b>Autism Disorders Expense</b><br/>Includes:<br/>1) coverage for the screening and diagnosing of autism or other developmental disabilities,<br/>2) coverage, as prescribed through a treatment plan, for medically necessary occupational therapy, physical therapy and speech therapy when the covered person's primary diagnosis is autism or another developmental disability, and<br/>3) coverage, as prescribed through a treatment plan, for medically necessary behavioral interventions, based on principles of applied behavioral analysis (ABA), when the covered person is under age 21 and their primary diagnosis is autism</p> | 90% of the Negotiated Charge | 70% of the Recognized Charge |

| Additional Benefits <i>(continued)</i>  | Preferred Care  | Non-Preferred Care  |
|---|---|---|
| <p><b>Human Leukocyte Antigen Testing Expense</b><br/>Includes expenses arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B &amp; DR antigens for utilization in bone marrow transplantation<br/>The testing must be performed in a facility that is:<br/>A. accredited by the American Society for Histocompatibility &amp; Immunogenetics, or its successor, &amp;<br/><br/>B. certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time; &amp;<br/>Benefits are limited to individuals who, at the time of testing, complete &amp; sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.</p> | <p>90% of the Negotiated Charge<br/><br/><b>Deductible Waived</b></p> | <p>70% of the Recognized Charge<br/><br/><b>Deductible Waived</b></p> |
| <p><b>Transgender Related Expense</b><br/>Covered Medical Expenses include charges incurred by a covered person for medically necessary surgery, mental health, prescription drugs and other related services that are Covered Medical Expenses and Covered Prescription Drugs under this plan. All surgical procedures require pre-certification.</p>  | <p>90% of the Negotiated Charge</p>                                   | <p>70% of the Recognized Charge</p>                                   |
| <p><b>Dermatological Treatment</b></p>  | <p>90% of the Negotiated Charge</p>                                   | <p>70% of the Recognized Charge</p>                                   |
| <p><b>Transfusion or Kidney Dialysis of blood</b></p>   | <p>90% of the Negotiated Charge</p>                                   | <p>70% of the Recognized Charge</p>                                   |