Healthcare & Retirement
BENEFITS 2022
at Princeton under the Affordable Care Act
This communication is intended to be a Summary of Material Modifications (SMM) for the healthcare, retirement, and other benefits plans and programs. It briefly describes your benefits plans including any changes effective January 1, 2022. Although Princeton intends to continue these benefits, the University reserves the right to amend or terminate these plans at any time. You can find full details regarding coverage, eligibility, and limitations in the Summary Plan Descriptions (SPDs) on our website. You may also request to receive a paper copy of an SPD by contacting the Benefits Team.

As a requirement of the Patient Protection and Affordable Care Act (PPACA), Princeton must provide a Summary of Benefits Coverage (SBC) to all participants and their dependents. The SBC is designed to provide you with a summary about a health plan’s benefits and coverage to help you better understand and evaluate your health insurance choices. An SBC for the CDHP is available on our website. You may request a paper copy of the SBC by contacting the Benefits Team.

Federal and state regulations require Princeton to provide you with certain information about your rights and responsibilities regarding benefits. This information is referred to as “administrative notices” and begins on page 15 of this booklet. These notices are also available on our website.

If there are any discrepancies between the information in this publication, verbal representations, and the plan documents, the plan documents always govern.

You are entitled to receive this SMM under the Employee Retirement Income Security Act of 1974 (ERISA). You also have other important rights under ERISA. These are explained in more detail on our website.

**CONTACT US**

Human Resources Benefits Team
(609) 258-3302
benefits@princeton.edu
hr.princeton.edu/thrive

**PROVIDER INFORMATION**

<table>
<thead>
<tr>
<th>Healthcare Plans</th>
<th>Group Number/Plan ID</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Directed Health Plan</td>
<td>Aetna</td>
<td>486819</td>
<td>(800) 535-6689</td>
</tr>
<tr>
<td>Teladoc</td>
<td>NA</td>
<td>(855) 835-2362</td>
<td>teladoc.com/princeton</td>
</tr>
<tr>
<td>Fertility and Family Planning</td>
<td>Kindbody</td>
<td>NA</td>
<td>(609) 632-1581</td>
</tr>
<tr>
<td>MSK Direct</td>
<td>MSK</td>
<td>NA</td>
<td>(844) 303-2123</td>
</tr>
<tr>
<td>OptumRx</td>
<td>PURPRNCEM</td>
<td>(877) 629-3117</td>
<td>optumrx.com</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Retirement Plan</th>
<th>Group Number/Plan ID</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement Savings Plan</td>
<td>TIAA (Main)</td>
<td>102862</td>
<td>(800) 842-2776</td>
</tr>
<tr>
<td>TIAA (PPPL)</td>
<td>102866</td>
<td>(800) 842-2776</td>
<td>tiaa.org</td>
</tr>
<tr>
<td>CAPTRUST</td>
<td>NA</td>
<td>(800) 967-9948</td>
<td>captrustadvice.com</td>
</tr>
</tbody>
</table>
DEPENDENT ELIGIBILITY AND VERIFICATION

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

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 insurance 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 you are required to provide health insurance coverage as dictated under a QMCSO
• 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

DEPENDENT VERIFICATION PROCESS

For each dependent you are enrolling in one or more of Princeton’s healthcare plans, you must provide the required dependent verification documentation within 31 days from the effective date of your coverage. Otherwise, your dependents will be removed from your healthcare coverage. Please submit copies of documents by fax to (609) 258-5920 or email to DependentVerification@princeton.edu. All documentation is handled confidentially, but you may also send documents via SecureSend, securesend.princeton.edu. You will log in to SecureSend with your NetID and password. You can also call the Benefits Team at (609) 258-3302 to make arrangements.

**DEPENDENT VERIFICATION DOCUMENTATION**

<table>
<thead>
<tr>
<th>Dependent Type</th>
<th>Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Marriage certificate(^1) and most recently filed tax return with Social Security numbers and all financial information redacted, i.e., blacked out, by the employee</td>
</tr>
<tr>
<td>Biological child(^2)</td>
<td>Birth certificate(^3)</td>
</tr>
<tr>
<td>Adopted child(^2)</td>
<td>Legal adoption papers</td>
</tr>
<tr>
<td>Stepchild(^2)</td>
<td>Birth certificate including names of biological parents and employee’s marriage certificate</td>
</tr>
<tr>
<td>Legal ward(^2)</td>
<td>Legal guardianship papers showing full financial support and custody responsibilities</td>
</tr>
<tr>
<td>Foster child(^2)</td>
<td>Official placement papers</td>
</tr>
</tbody>
</table>

\(^1\) Foreign nationals can provide current visa documentation showing marriage in lieu of a marriage certificate.

\(^2\) Must be under age 26 at the time of enrollment. Once enrolled, coverage can continue through the calendar year in which the child turns 26.

\(^3\) Foreign nationals can provide current visa documentation listing dependent child(ren) in lieu of a birth certificate(s).
MAKING CHANGES TO YOUR BENEFITS

The Internal Revenue Service (IRS) limits when you can add coverage for dependents or make changes to your healthcare, flexible spending account, and life insurance elections during the year. You have the following opportunities to elect or make changes to your benefits:

• During the Annual Benefits Open Enrollment period in the fall (changes effective January 1 of the following year) or
• Within 31 days, or 90 days for the birth or adoption of a child, of a Qualifying Status Event described below

For more information, review the Notice of Special Enrollment Rights on page 45 or visit our website.

QUALIFYING STATUS EVENT CHANGES

• Marriage or divorce
• Birth or adoption of a child
• Death of a spouse or child
• A loss or gain of benefits eligibility for yourself, a spouse, or a child
• Transition from full-time to part-time status, or vice versa, that changes eligibility for benefits for you or a spouse
• You or a spouse take or return from an unpaid leave of absence
• Any significant change in your family’s healthcare plan coverage through a spouse’s healthcare plan

If you experience a Qualifying Status Event, you must contact the Benefits Team at benefits@princeton.edu or 609-258-3302 to make changes to your coverage within 31 days, or 90 days for the birth or adoption of a child, of the date of the event. Since these changes must comply with IRS regulations, you must provide proper documentation for your change, such as a birth certificate or divorce decree, and your benefits changes must be consistent with the nature of the Qualifying Status Event.

Changes for all Qualifying Status Events, except for those as a result of the birth or adoption of a child, are effective the first of the month coincident with or next following the date of the event. In the case of birth or adoption, the effective date is retroactive to the date of the birth or adoption.

CHANGES PERMITTED DURING THE YEAR WITHOUT A QUALIFYING STATUS EVENT

• Elect, change, or terminate participation in the Retirement Savings Plan
MSK DIRECT

When you are faced with cancer, reliable information and comprehensive care are crucial. The experts at Memorial Sloan Kettering (MSK) are there to help. With MSK Direct, you have direct access to a team of dedicated professionals who specialize in cancer. The team includes experienced nurses, social workers, and MSK Care Advisors who are there to guide you through the process of getting care at MSK and oversee your experience every step of the way.

The staff at MSK Direct:
• Offer you a timely and convenient appointment with an appropriate specialist within two business days of speaking with a representative (subject to availability of your medical records, your ability to travel to MSK, clinical considerations, and health insurance coverage for care at MSK)
• Answer your questions, coordinate the services you receive, and help you navigate critical steps throughout your cancer care experience
• Optimize your care experience
• Help you gather necessary medical records before your first appointment
• Introduce you to MSK facilities and the clinical teams that will be handling your care
• Continue to be a resource for you throughout your experience at MSK

To learn more about the program, visit our website or MSK’s website at mskcc.org/direct/princeton. You can call Princeton University’s dedicated MSK Direct line toll-free at (844) 303-2123, Monday through Friday, 8:30 a.m. to 5:30 p.m. EDT. Messages left outside these hours of operation will be returned the next business day.

ELIGIBILITY AND COST

All Princeton University faculty, staff, retirees, and their loved ones have access to MSK Direct at no additional cost.

Your out-of-pocket costs for the services you receive from MSK vary depending on the health insurance plan in which you are enrolled. UnitedHealthcare and Aetna participants have access to MSK as an in-network provider. If you are not a member of UnitedHealthcare or Aetna, you need to contact MSK Direct to verify your health plan’s coverage.

FERTILITY AND FAMILY PLANNING

Kindbody’s fertility and family planning services are available to you and your spouse enrolled in a Princeton University medical plan. It provides medical coverage and prescriptions for up to four fertility cycles per a member’s lifetime. Additional plan details are:

• Fertility services are covered in-network only at Kindbody Clinics or Kindbody’s Centers of Excellence network of partner clinics; there is no out-of-network coverage. A local clinic is located in Princeton at 16 Chambers Street. Current partner clinics include RMA and IRMS locations in New Jersey. Partner clinics are subject to change, so contact Kindbody for a current list.

• The comprehensive suite of services available include fertility assessment, pre-conception genetic carrier screening, in vitro fertilization (IVF), intrauterine insemination (IUI), and medically necessary fertility preservation.

• The applicable deductible, coinsurance, and/or copayment are based on the Princeton medical plan you elected and on the place of service.

• All patients are assigned a dedicated and expert Patient Care Navigator who provides clinical guidance and emotional support 24/7.

To verify your eligibility and register for the Kindbody benefit, activate your account at www.kindbody.com/princeton-benefit. You will need to provide the access code PRINCETON (case sensitive) and your Princeton Benefits ID number located in HR Self Service under Benefit Details.

If you have any questions, contact Kindbody at (833) 216-2345 or employeebenefits@kindbody.com. Patient Care Navigators will explain the details of the coverage, and will assist with finding a network provider. Visit our website for additional details.
**Institutes of Quality**
Princeton offers access to Aetna Institutes of Quality (IOQs). IOQs provide access to leading healthcare facilities, physicians, and services with demonstrated success in care and a commitment to continuous improvement to support safe, specialized, and cost-effective services. Aetna can provide the information you need and help guide you to a IOQ that meets your specific needs.

**Deductible**
This is the amount of money you may be responsible for paying in a calendar year, depending on your medical plan, before any expenses are covered for certain services. Copays and any amounts above 180% of the Medicare allowable rate for out-of-network services do not count toward deductibles.

**Out-of-Network Coverage and Recognized Charge**
You may seek care from a licensed or certified physician or facility outside of the CDHP network. However, not all services are covered out-of-network and for services that are covered, they can cost as much as five times more than in-network services. For this reason, when you choose to use out-of-network providers, the maximum amount our plans will allow to be charged for a service is limited and determined by our insurance carriers using data provided by Medicare. This amount is called the recognized charge or out-of-network plan rate. The recognized charge is calculated at 180% of the Medicare allowable rate for most services. In addition to your applicable out-of-network coinsurance, you will be responsible for costs above 180% of Medicare’s allowable rate.

**Out-of-Pocket Maximum (OPM)**
This is the maximum amount of money you pay for eligible medical services in a calendar year. The OPMs for in- and out-of-network coverage accumulate independently of each other. The OPM includes copayments, deductibles, and coinsurance amounts paid. Charges incurred that go above 180% of the Medicare allowable rate if you choose to go out-of-network are not included in the OPM. You can find more details in the Summary Plan Descriptions (SPDs) or contact Aetna for more information.
MEDICAL PLANS

PREVENTIVE SERVICES
Preventive services in the CDHP, e.g., annual exams, colonoscopies, and mammographies, are covered at 100% in-network before deductible. For additional details, refer to the SPD on our website.

URGENT CARE CENTERS
When you have an emergency that is not life-threatening, e.g., a sprain, broken bone, or are in need of stitches, you can seek medical attention at an in-network urgent care center. The cost is much less than an emergency room and wait times are often shorter.

HOW TO FIND IN-NETWORK PROVIDERS
To find an in-network provider, follow the steps below. To find a fertility or family planning provider you must contact Kindbody.

Aetna (CDHP)
1. Go to aetna.com/dse/princeton
2. Enter the location (zip code or city/state) for the area you want to search
3. Select your medical plan from the list provided
4. Enter the name of the provider or search by category

INSTITUTES OF QUALITY
Aetna offers Institutes of Quality (IOQs) for CHD, behavioral health, transplant services, bariatric surgery, and orthopedic procedures for joints and spine. Although Aetna does not offer an IOQ for cancer-related services, Aetna members have access to MSK Direct. For information, contact Aetna.

Princeton provides an enhanced travel and lodging benefit for you and a family member whenever you use a IOQ for certain medical procedures. For information, contact the Benefits Team.

MEDICAL PLAN ID CARDS
If you enroll in or make any changes to your medical coverage, you receive a new ID card, mailed to your home address within three to four weeks of your election. You can print a temporary ID card from your provider’s website at aetna.com/dse/princeton. You receive a separate ID card for the Prescription Drug Plan.

PRECERTIFICATION
Various services, such as inpatient stays, certain tests, procedures, outpatient surgery, and hi-tech radiology, require precertification by Aetna. If you do not use a participating network provider (hospital, doctor, etc.), you are responsible for obtaining precertification. If you do not receive precertification, you do not receive any benefits from the CDHP. In-network providers are responsible for handling precertification, so there is no additional out-of-pocket cost to you as a result of a network provider’s failure to precertify services.
TELADOC

Employees and their dependents enrolled in a Princeton Medical Plan have access to the Teladoc telemedicine services listed below. To register for any of the services below, go to teladoc.com/princeton, call (855) TELADOC (835-2362), or download the latest Teladoc app from the Apple App Store or Google Play.

GENERAL MEDICINE

Teladoc’s general medicine service is a convenient and affordable option that allows you to talk to a U.S. board certified doctor 24 hours a day, 7 days a week, who can diagnose, recommend treatment, and prescribe medication (when appropriate), for many medical issues. Individuals enrolled in the CDHP will pay approximately $49 per visit until the annual deductible is met at which point visits will be covered at 100%. Conditions commonly treated:

- Bladder/urinary tract infection
- Bronchitis
- Cold/flu
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus issues
- Sore throat
- And more...

MENTAL HEALTH

Teladoc’s mental health service is a convenient option that allows participants age 18 and older to video conference with a licensed health provider – including psychiatrists, psychologists, and counselors – who can provide both therapy and medication management. Visits are covered at the same cost as in-network in-person mental health visits. Conditions commonly treated:

- Depression
- Anxiety
- Bipolar disorder
- Substance abuse

DERMATOLOGY

Teladoc’s board certified dermatologists will diagnose skin issues and treat common conditions like: acne, psoriasis, eczema, rosacea, rash, poison ivy, skin infections, dermatitis, and more. Participants will be provided with a diagnosis and treatment plan within two business days or less. The visits are covered at the same cost as in-network in-person specialist visits.

How it Works:

Step 1. Request a consult, provide a description and upload images of your condition into your account online or via the Teladoc app.

Step 2. A licensed dermatologist will review your photos, make a diagnosis and provide a treatment plan within 2 business days.

Step 3. Receive an email or electronic message with your diagnosis and treatment plan. Prescriptions are sent to your local pharmacy when medically necessary.

UTILIZING PREFERRED LABS AND SPECIALISTS

Preferred Labs

Quest Diagnostics and LabCorp are the preferred labs for Aetna. These labs charge less and perform a wide variety of services. If you use any other in-network lab, you are charged more and have to meet the annual deductible. There is no coverage for out-of-network lab services. Employees enrolled in Aetna have access to the Quest lab located in the Princeton University McCosh Health Center.
Consumer Directed Health Plan (CDHP)

The Consumer Directed Health Plan (CDHP) is administered by Aetna and provides three levels of coverage: in-network preferred, in-network non-preferred, and out-of-network. Prescription drug coverage is integrated with the CDHP.

Preventive medical care is covered at 100% in-network before deductible, and coverage begins immediately for prescriptions used to treat certain chronic conditions; all other services are covered after you meet your deductible(s). This plan also includes the option for the Health Savings Account (HSA) through a bank.

For most in-network services, you must first meet a deductible of $1,500 for individual coverage, or $3,000 for family coverage, with your medical and prescription expenses before the CDHP starts to pay for most covered services. There is no individual deductible when you elect family coverage. If one or more family members are covered in addition to yourself, you must reach the family deductible before coverage begins. However, there is an individual out-of-pocket maximum (OPM). Therefore, once any individual covered under the plan incurs expenses that exceed the individual OPM ($3,000), covered expenses for that individual are reimbursed at 100% through the end of the calendar year, even if the full family OPM ($6,000) has not yet been met. The remaining family members would have to satisfy the remaining portion of the family OPM before their expenses are reimbursed at 100%.

If you choose to go out-of-network, costs above 180% of the Medicare allowable rate are your responsibility.

Eligibility Requirements to Open an HSA

To contribute to an HSA, you must be enrolled in a qualified high deductible health plan (HDHP). You cannot contribute to an HSA if you are enrolled in TRICARE or any part of Medicare or if you or your spouse have a Healthcare Flexible Spending Account (HFSA) or Health Reimbursement Account (HRA). In addition, you cannot contribute to an HSA if you had Veterans Affairs (VA) medical benefits in the prior three months (unless you have a service-connected disability) or if someone claimed you as a dependent on their tax return. These rules are set by the Internal Revenue Service (IRS). For more information, view IRS Publication 969 on the IRS website.

AETNA  aetna.com/dse/princeton  (800) 535-6689  CDHP Group #: 486819
MEDICAL PLAN BENEFITS OVERVIEW

This is intended to provide an overview of the plan benefits. Details about the plans, including Summary Plan Descriptions (SPDs) and Summary of Benefits Coverages (SBCs), are available on our website. The dollar or percentage amounts in the chart below reflect the patient-paid portion of the incurred medical costs. The plans includes prescription drug coverage.

<table>
<thead>
<tr>
<th>Consumer Directed Health Plan (CDHP)</th>
<th>In-Network Preferred</th>
<th>In-Network Non-Preferred</th>
<th>Out-of-Network 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible (Individual / Family)</strong></td>
<td>$1,500 / $3,000</td>
<td>$3,000 / $6,000</td>
<td>$6,000 / $12,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (OPM) (Individual / Family)</strong></td>
<td>$3,000 / $6,000</td>
<td>$3,000 / $6,000</td>
<td>$6,000 / $12,000</td>
</tr>
<tr>
<td><strong>Physician Visits</strong></td>
<td>Teladoc General Medicine</td>
<td>$49 until deductible is met, then $0</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Primary Care Physician (PCP)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Standard Specialists</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Tiered Specialists</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td>Urgent Care Center</td>
<td>$0 after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency Room (no coverage for nonemergencies)</td>
<td>$0 after deductible</td>
<td>$0 after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>Medical and Surgical Procedures3</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Mental Health3</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>Surgical Procedures3 (Independent Facility / Hospital)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Laboratory</td>
<td>$0 after deductible / 40% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Radiology (X-Ray) (Independent Facility / Hospital)</td>
<td>$0 after deductible / 20% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hi-Tech Radiology (MRI, CAT, etc.)3 (Independent Facility / Hospital)</td>
<td>$0 after deductible / 20% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive Care and Immunizations4</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>20% after deductible</td>
<td>25% after deductible</td>
</tr>
<tr>
<td></td>
<td>Annual Eye Exam / Prescription Eyeglasses and/or Contact Lenses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physical Therapy (100 visits per CY)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Chiropractic Care (20 visits per CY)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Acupuncture (20 visits per CY)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

1 If you choose to go out-of-network, costs above 180% of the Medicare allowable rate are your responsibility. Refer to the Summary Plan Description (SPD) for more information.
2 For a list of preferred labs, refer to page 6.
3 Coverage requires precertification; refer to page 5.
4 Includes seven well-baby visits in the first year of a child's life.
The Princeton medical plan provides prescription coverage through OptumRx. For more details, refer to the Summary Plan Description ( SPD) on our website.

**IF YOU CHOOSE:**

<table>
<thead>
<tr>
<th>THEN:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Directed Health Plan (CDHP)</td>
<td>Coverage is provided after the medical plan’s annual deductible(s) are met. Exceptions for immediate coverage are preventive drugs and IRS-designated drugs for chronic conditions. For details, refer to <strong>Prescription Coverage Under the CDHP</strong> or on page 18.</td>
</tr>
</tbody>
</table>

**THREE-TIER FORMULARY**

A formulary is a list of prescribed medications—both generic and brand-name—that have proven to be both clinically and cost effective. Prescriptions on the formulary are categorized into three tiers and those tiers determine your cost for a particular medication. There are preferred products in every therapeutic class in the formulary.

Refer to our website for the list of formulary medications. If your current prescription is not a generic or preferred medication on the formulary, contact OptumRx to find the best way to minimize your costs.

**SPECIALTY MEDICATIONS**

Specialty medications may only be covered through the OptumRx Specialty Services Pharmacy. OptumRx allows for a one-month supply at a retail pharmacy on the first prescription fill, if needed. Contact the OptumRx Specialty Services Pharmacy at (844) 265-1761 to access specialty medication.

**APPEALS**

If your physician prescribes a non-preferred or excluded medication due to negative results you experienced when using a preferred or generic medication, such as an allergic reaction, you may be eligible for coverage through a clinical exception. Your physician can file a prior authorization (PA) request on your behalf with OptumRx. If the tier-lowering PA is approved for a non-preferred drug, you pay the preferred copayment. If the tier-lowering PA is approved for an excluded drug, you pay the non-preferred copayment.

**HOME DELIVERY (MAIL ORDER)**

If you take certain prescriptions on a monthly basis, you can purchase a three-month supply through mail order at the same cost of a two-month supply at retail. Contact OptumRx to make arrangements.

**PRESCRIPTION DRUG PLAN COPAYMENTS**

<table>
<thead>
<tr>
<th></th>
<th>Retail Pharmacy</th>
<th>Mail Order</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>30-Day Supply</strong></td>
<td><strong>90-Day Supply</strong></td>
<td><strong>30-Day Supply</strong></td>
</tr>
<tr>
<td>Generic</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$25</td>
<td>$50</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$40 or member pays the difference</td>
<td>$80 or member pays the difference</td>
</tr>
</tbody>
</table>

**PATIENT SAFETY, EFFICIENCY, AND EFFECTIVENESS**

Princeton University participates in prior authorization, step therapy, quantity duration, and compound medication programs, as well as other programs. An OptumRx pharmacist may need to verify a prescription with the prescribing physician before filling it to ensure patient safety, efficiency, or effectiveness of the prescribed product. In these instances, OptumRx verifies the patient meets the criteria for the prescription, informs the prescribing physician of other
medications that may interact with the new prescription, explains quantity limits based on FDA regulations, etc. If the pharmacist and prescribing physician agree, the prescription is filled and covered. If the pharmacist and prescribing physician do not agree, the prescribing physician may appeal on your behalf with OptumRx.

**PREVENTIVE ITEMS AND SERVICES**

Certain prescriptions intended to prevent illness and disease, as well as contraceptives, are covered at 100%. This applies to generic and preferred brand drugs as well as some over-the-counter (OTC) drugs (prescription required). A list of preventive drugs is available on our website. This is not a comprehensive list and is subject to change as Affordable Care Act (ACA) guidelines are updated or modified. You may contact OptumRx for more information and updates.

**MEMBER PAYS THE DIFFERENCE**

This program may impact participants who are taking a non-preferred medication. If you or your physician chooses a brand name drug that has a generic equivalent, you pay the difference between the cost of the brand name drug and the generic drug, plus the generic copay. To find the generic equivalent for the brand name drug you are taking, talk to your prescribing physician or contact OptumRx. The prescribing physician may also file a prior authorization (PA) for a clinical exception on your behalf with OptumRx.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Gross Cost</th>
<th>Member Pays the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipitor</td>
<td>$220</td>
<td>$205</td>
</tr>
<tr>
<td>Generic</td>
<td>$20</td>
<td>$5</td>
</tr>
</tbody>
</table>

**OUT-OF-POCKET MAXIMUM (OPM)**

If you are enrolled under the CDHP, your OPM is integrated with your medical plan coverage. Therefore, your OPM combines your eligible prescription plan expenses plus your eligible medical plan expenses. Once you have reached your annual OPM, your eligible medical and prescription plan expenses are covered at 100% through the end of the calendar year.

**PRESCRIPTION COVERAGE UNDER THE CDHP**

Prescription drug coverage is integrated with the CDHP medical coverage. This means that you pay for your non-preventive prescription drugs until you meet the CDHP deductible.

**Drugs that Bypass the Deductible**

There are certain prescription drugs that are considered “preventive” under federal guidelines. For preventive prescription drugs, you pay only the appropriate copays as they are not subject to the CDHP deductible. These copays count toward the out-of-pocket maximum (OPM). The list below, which is subject to change, provides some of the therapeutic classes of prescription drugs considered preventive under federal guidelines. Contact OptumRx for more information and an updated list.

**Asthma**
- Inhaled corticosteroids

**Cancer**
- Breast cancer

**Cardiovascular/Heart Disease**
- Angiotensin Converting Enzyme (ACE) inhibitors
- Anti-anginal agents

**Central Nervous System**
- Antipsychotics
- Smoking deterrents

**Depression**
- Selective Serotonin Reuptake Inhibitors (SSRIs)

**Diabetes**
- Insulin and other glucose lowering agents

**Gastrointestinal**
- Acid suppression (ulcer)

**HIV/AIDS**
- Antiretrovirals

**Musculoskeletal**
- Osteoporosis

**Respiratory**
- Asthma/COPD

**Transplant**
- Anti-rejection

**Vitamins and Electrolytes**
- Pediatric vitamins with fluoride
- Prenatal vitamins

**Women’s Health**
- Birth control
- Estrogens

The OptumRx mobile app provides easy, on-the-go access to your personalized health information and prescriptions. Download the OptumRx app from the Apple App Store or Google Play.

**PRESCRIPTION PLAN ID CARD**

These cards are mailed to your home address within three to four weeks of your medical plan election. You can print a temporary ID card at optumrx.com.

**OPTUMRX APP**

The OptumRx mobile app provides easy, on-the-go access to your personalized health information and prescriptions. Download the OptumRx app from the Apple App Store or Google Play.

**Out-of-Pocket Maximum (OPM)**

If you are enrolled under the CDHP, your OPM is integrated with your medical plan coverage. Therefore, your OPM combines your eligible prescription plan expenses plus your eligible medical plan expenses. Once you have reached your annual OPM, your eligible medical and prescription plan expenses are covered at 100% through the end of the calendar year.
COMMUTER BENEFITS PROGRAM

Through PayFlex’s Commuter Benefits Program, employees who travel to work using public transportation—trains, buses, subways, or van pools—can save tax dollars on commuting expenses. Monthly commuting expenses are deducted pretax from your paycheck and commuter-related products can be ordered online and mailed directly to your home.

Through the Commuter Benefits Program, you are able to:

• Order transit vouchers or monthly transit passes
• Pay for parking or order parking vouchers
• Add funds to a transit fare card or PayFlex commuter debit card
• Manage a PayFlex commuter debit card and/or parking reimbursements online

PAYMENT INFORMATION AND MONTHLY MAXIMUMS

The incurred costs of your commuting expenses are deducted pretax from your paycheck the month after you place an order.

In 2022, the maximum pretax limits for both parking and transit expenses is $280.

You can place orders in excess of the pretax limit; however, you need to pay for any expenses that exceed the pretax limit with your own personal credit card.

ELIGIBLE PARKING EXPENSES

For parking expenses to qualify under this program, the parking must be located on or near:

• Your work location or
• A location from which you commute to work, either by mass transit, commercial commuter highway vehicle, qualifying non-commercial commuter highway vehicle, or carpool

Expenses may also include transportation in a commuter highway vehicle, at the cost of transportation between your residence and place of employment, provided the vehicle:

• Has a seating capacity of at least six adults plus driver and
• Is reasonably expected to be used for at least 80% of the mileage for commuter trips in which the vehicle is at least half full, not including the driver; use of limos and taxis ineligible

HOW TO GET STARTED

There is no annual open enrollment period; you can sign up or make changes on a monthly basis. To participate:

1. Go to PayFlex’s website
2. Select Employee Account Login
3. If you are already registered, enter your username and password. If you are a new user, select Register Now and enter your Member ID.
4. After logging in, click on Commuter Benefits to set up your order. A recurring order feature allows you to choose the months that you wish to receive the product throughout the year.

For detailed instructions on placing orders for commuting needs, view the PayFlex Quick Reference Guide on our website.

MONTHLY ENROLLMENT DEADLINE

Regardless of the commuter benefits that you select, you must place your orders by the 10th of each month prior to the month in which you need them. For example, if you need transit passes for March, you have to place the order through PayFlex no later than February 10. Any orders placed after February 10 are not accepted for the month of March.

WHEN YOUR EMPLOYMENT OR PARTICIPATION IN THE PROGRAM ENDS

If your employment ends or you stop participating in either program, your unclaimed contributions are forfeited.

PAYFLEX ID NUMBER

When registering on the PayFlex website, use your Princeton Benefits ID number located in HR Self Service under Benefit Details.
RETIREMENT SAVINGS PLAN

As a 403(b) plan, the Retirement Savings Plan allows you to save additional monies for your retirement on a pretax or after-tax basis. If you save pretax and are a resident of New Jersey or Pennsylvania, these contributions are not exempt from state tax when they are deducted from your pay. For additional information about the Plan, refer to the Summary Plan Description (SPD) on our website.

PARTICIPATION AND VESTING
You are eligible to participate in the Plan on your date of hire. You must be receiving pay directly from Princeton or be a postdoctoral research fellow, regardless of duty time. You are always 100% vested in your Retirement Savings Plan.

CONTRIBUTIONS
Contributions may be made pretax or after-tax and are subject to limits set by the Internal Revenue Code. In 2022, the limit is $20,500 for the calendar year. If you are age 50 or older during the calendar year, you may contribute an additional amount, equal to $6,500 in 2022.

Contributions cannot exceed the maximum limit permitted by the Internal Revenue Service in the calendar year. There is no required minimum contribution. You can start, stop, increase, or decrease your contributions at any time through HR Self Service.

After-Tax Contributions (Roth)
You have the option to make contributions on an after-tax basis. Upon distribution, your contributions and earnings on those contributions are distributed tax-free provided that you receive the payout after age 59½ and it has been at least five years since making your first Roth contribution. The limit on Roth contributions is the same as the pretax limit, and the two plans are combined for the purposes of the annual limit. Additional information about Roth contributions is available on our website.

ROLLOVERS
The Princeton Retirement Saving Plan accepts rollovers from previous employer’s qualified retirement plans and Individual Retirement Accounts (IRAs).

INVESTMENT ALLOCATIONS
You can choose to allocate funds among a variety of investments. If you do not choose investments, your contributions default into the Vanguard Target to Retirement Fund closest to the year you reach age 65.

LOANS AND DISTRIBUTIONS
The Retirement Savings Plan offers three options for withdrawal of funds while you are employed: a loan, a hardship withdrawal, or an in-service distribution.

Loan
The loan program is administered by TIAA. The minimum loan is $1,000. The maximum number of loans allowed from your account, at any one time, is three. If you have more than three loans outstanding, you are not eligible for additional loans until you have less than three outstanding. The total of your outstanding loans cannot exceed $50,000 or 50% of your account, whichever is less.

Hardship Withdrawal
Should you have a financial hardship due to certain qualified reasons, you may be able to take a hardship withdrawal from your account to meet that need. Qualified reasons include buying your primary residence, preventing eviction, paying medical expenses or educational expenses for you or your immediate family, or paying funeral expenses for your immediate family.

In-Service Distribution
You may take an in-service distribution from your account at anytime after you reach age 59½ or are approved for LTD.

Termination of Employment
Upon termination of employment, you may take the account in cash or roll it over to an IRA or other qualified plan. If you take your distribution in cash and are under age 59½, you may be subject to a tax penalty in addition to ordinary income taxes.

TIAA
We encourage you to register online with TIAA, our recordkeeper for all investment funds, to:
• Establish your account, login, and password
• Name your beneficiaries
• Select your investment allocations

TIAA
tiaa.org/princeton
(800) 842-2776

Speak with a counselor or schedule an on-campus appointment

VANGUARD
meetvanguard.com
(800) 662-0106 x 14500

Speak with a counselor

CAPTRUST
captrustadvice.com
(800) 967-9948

Speak with a counselor
**WORKERS’ COMPENSATION PLAN**

Princeton University provides coverage under the Workers’ Compensation Plan at no cost to you. The plan provides coverage for medical treatment and wage replacement for an approved absence from work if you suffer a work-related injury, illness, or disability.

Princeton’s plan complies with the New Jersey Workers’ Compensation Law, is self-insured, and is managed by an independent workers’ compensation claims administrator under the direction of the University’s Office of Risk Management.

For more information about workers’ compensation benefits and procedures, contact the Benefits Team or visit our website.

**AMOUNT OF BENEFIT**

The University’s Workers’ Compensation Plan provides benefits-eligible faculty and staff with income replacement at 80% of base pay in effect at the time of the injury or illness for up to 26 weeks. Casual hourly and short-term professional employees are paid at the lesser of the State weekly maximum for the New Jersey Workers’ Compensation Law or 80% of weekly wages. Union employees should refer to their collective bargaining agreement.

**TAXATION OF BENEFITS**

The amount of the statutory benefit, up to the State weekly maximum, is not taxable. For 2022, the weekly maximum is $1,065.

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**DISABILITY COVERAGE**

**Short Term Disability Plan**

Princeton University provides coverage under the Short Term Disability Plan at no cost to you and provides income replacement when you are unable to perform your normal job duties due to an illness, an injury, or a disability that is not related to work.

**BENEFITS AND APPLICATION**

For more detailed information about the Short Term Disability Plan, eligibility, benefits, and application process, visit our website.

**TAXATION OF BENEFITS**

The short term disability benefit is taxable for federal and FICA purposes. State income taxation varies by state.

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**LEAVES OF ABSENCE**

**New Jersey Family Leave Insurance**

The New Jersey Family Leave Insurance (NJFLI) law provides eligible employees with up to 12 weeks of paid leave to bond with their child after birth or adoption, or to care for an eligible family member with a serious health condition. NJFLI may provide up to 85% of an employee’s average weekly wages, up to a maximum amount that is set each calendar year by the state of New Jersey. NJFLI benefits are approved and paid through the state. Under state law, the University withholds a state tax from employees’ paychecks to finance this program. A notice issued by the New Jersey Department of Labor and Workforce Development is on page 58. For more detailed information, on NJFLI, visit our website.
TAXATION OF YOUR BENEFITS

Certain benefits offered to you by Princeton University may be offered pretax, after-tax, or subject to imputed income on your W-2. The list below outlines how certain benefits affect your taxable income.

FORM 1095-C

The Affordable Care Act (ACA) requires certain employers to offer healthcare coverage to full-time employees and their dependents. Those employers must send an annual statement describing the healthcare coverage available to certain employees. As a result, the Internal Revenue Service (IRS) created the Form 1095-C, an annual statement that reports the healthcare coverage offered by your employer and utilized by you during the calendar year.

If you were a full-time employee for at least one month in 2021, or if you were a part-time employee who elected healthcare coverage through Princeton in 2021, you will receive your 1095-C from Princeton University on or about February 1, 2022.

One requirement of this document is to include Social Security numbers (SSNs) so that the IRS can tie information back to your tax records. You should make sure that you provide SSNs for yourself and/or your enrolled dependents(s) and that they are accurate. Contact the Benefits Team for assistance.

NEW JERSEY INDIVIDUAL HEALTH INSURANCE MANDATE

The New Jersey Individual Health Insurance Mandate requires New Jersey residents without health coverage to pay a tax penalty. Under the law, New Jersey residents who are subject to the mandate and their dependents must have minimum essential coverage during each month of the year.

Princeton is required to report to the state the coverage status for full-time and part-time employees who elected healthcare coverage in 2021. This information is reported to New Jersey on the IRS Form 1095-C in 2022. Additional states outside of New Jersey have implemented individual health insurance mandates. If you work outside of New Jersey, you should check with your state government for information.

DEFINITIONS OF “DEPENDENT” FOR TAX PURPOSES

Under the definition in Section 152 of the Internal Revenue Code, dependents are defined as:

- Members of your household who maintain their principal place of residence in your home and
- You will furnish over half of their support for the year; in making this calculation, the amount you contribute toward their support must be compared with the amounts received for support by them from all other sources, including any amounts supplied by them and any earnings and
- For the current year, no other taxpayer can claim them as qualifying children for federal income tax purposes

We suggest that you consult a tax advisor to determine whether you may claim a dependent for tax purposes before you certify that you can.

IMPUTED INCOME

The Internal Revenue Service (IRS) regulations require that you pay taxes on the cost or value of certain benefits provided by your employer, even though no money is received. This imputed income is added to your taxable income on your W-2 each year. Certain benefits are subject to imputed income.

MEDICAL PLANS

Your premiums are paid pretax and your claims are not taxable income. The employer’s subsidy of your medical premium is shown on your W-2. This is not taxable income to you; however, new healthcare regulations require that the subsidy be shown on your W-2.

RETIREMENT SAVINGS PLAN

The limits for calendar year 2022 are $20,500 if you are under age 50 and $27,000 if you are over age 50. If you split your contributions between pre- and after-tax the maximums are aggregated for the annual limits.

Pretax Savings

Contributions and related gains or losses are tax-deferred for federal income tax. If you live in Pennsylvania or New Jersey, the contributions are subject to state income tax. If you live in New York, your contributions are also tax-deferred for state income tax. All contributions are subject to FICA taxes.

After-tax Savings

Contributions are made after-tax and the earnings grow tax-free. Withdrawals after age 59½ are tax-free if the distribution is no earlier than five years after contributions were first made.
Continuing your healthcare coverage may be necessary if your employment with the University ends or if you no longer are eligible for benefits due to reduced hours. You can buy group healthcare coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) for yourself and your eligible dependents for up to 18 months, or longer in certain cases. You are eligible to elect COBRA coverage in the following situations:

Continued healthcare coverage will be available to you for up to 18 months if:

- Your employment terminates (other than for gross misconduct), or
- Your hours are reduced and, as a result, you are no longer eligible for healthcare coverage.

Continued healthcare coverage will be available to your eligible dependents for up to 36 months if:

- You die, or
- You get divorced, or
- Your dependents no longer qualify as covered dependents under the terms of our group policy contract.

Continued healthcare coverage will be available to your eligible dependents for up to 36 months from the date you became eligible for Medicare if you become eligible for Medicare and are no longer an active employee but your spouse is under 65.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. The Marketplace offers one-stop shopping to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premium. To find out more about the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit healthcare.gov or call (800) 318-2596.

For more information about COBRA, visit our website.

ACA Section 1557 Notice

The Princeton University Group Benefit Plan (the “Plan”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The full notice is posted on our website. You may request to receive a paper copy of the notice by contacting the Benefits Team.
Women’s Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1988 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same copayments, deductibles, and coinsurance provisions applicable to other medical and surgical benefits provided under the plan. Please refer to your Summary Plan Description ( SPD) for copayment, deductible, and coinsurance information applicable to the plan in which you choose to enroll.

If you would like more information on WHCRA benefits, contact the Benefits Team.

Newborns’ and Mothers’ Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours.

Health Insurance Marketplace Notice

As a requirement of the Patient Protection and Affordable Care Act (PPACA), Princeton University must provide the Health Insurance Marketplace, formerly known as the Exchanges, notice to all employees, found on pages 54 and 55. For benefits-eligible employees, Princeton University offers options for healthcare coverage that meet the minimum value standards of the PPACA and are intended to be affordable. In addition, Princeton makes a significant contribution toward the cost of healthcare premiums, and your contributions are deducted pretax from your pay. If you have any questions on the healthcare coverage offered by Princeton University or on the notice, contact the Benefits Team at benefits@princeton.edu or (609) 258-3302.
Notice of Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to apply for healthcare coverage with Princeton University. You should read this information even if you waive coverage.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in Princeton University offered healthcare coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents’ other coverage). However, you must contact the Benefits Team within 31 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage or within 90 days following the birth or adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children’s Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends, or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

The 60-day period for requesting enrollment applies only in these two listed circumstances relating to Medicaid and state CHIP. As described above, a 31-day period applies under the plan for all changes, except for birth or adoption, which allows for a 90-day period. To request special enrollment or obtain more information, contact the Benefits Team.

Universal Availability Notice
Princeton University Retirement Savings Plan 403(b)

You are eligible to participate in the Princeton University Retirement Savings Plan. This supplemental retirement plan allows you to contribute pre-tax or after-tax monies directly from your paycheck and invest in a variety of investment funds. You are responsible for choosing your investment funds from those offered under the plan. Information about the investment options is available at tiaa.org/princeton.

If you would like to enroll in the Retirement Savings Plan for the first time or change your current deferral election, you may do so at any time during the year.

To enroll in the Retirement Savings Plan, you must send an email to benefits@princeton.edu and request the enrollment information. If you do not make an investment choice your contributions will default into the Vanguard Target to Retirement Fund closest to the year you reach age 65.

If you have questions, contact Jane Edgar at (609) 258-9109 or the Benefits Team.

Your Rights and Protections Against Surprise Medical Bills

The Princeton University offered medical plans comply with the provisions of the “No Surprises Act.” When you get emergency care or get treated by an out-of-network provider at an in-network facility or ambulatory surgical center, you are protected from surprise billing or balance billing. The full notice is posted on our website. You may request to receive a paper copy of the notice by contacting the Benefits Team.
Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Notice of Privacy Practices for Employees, Retirees and Eligible Dependents
Participating in the Princeton University Health Care Plans
If you have any questions about this notice or our privacy practices, contact the Privacy Officer at (609) 258-3349.

EFFECTIVE SEPTEMBER 2018
DISCLOSURE LIMITATIONS OF YOUR HEALTH INFORMATION

Princeton University sponsors various healthcare plans, including the following plans for employees and their eligible dependents: Aetna Consumer Directed Health Plan, Aetna HMO Plan, Aetna Princeton Health Plan, Aetna J-1 Visa Plan, United Healthcare Princeton Health Plan, OptumRx Prescription Drug Plan, and the following plans for retirees and their eligible dependents: Aetna HMO Plan (only pre-65 retirees), Aetna Princeton Health Plan (only pre-65 retirees), United Healthcare Princeton Health Plan (only pre-65 retirees), P-84 Plan, Standard Plan, Premium Plan, Princeton Medicare Plan and OptumRx Prescription Drug Plan. Princeton University also sponsors a cafeteria plan/flex spending account through Pay Flex.¹

The Princeton University health plans listed above (hereinafter referred to collectively as “the PLAN”) are required by law to maintain the privacy of your “Protected Health Information” (as described below), to provide you with notice of their legal duties and privacy practices with respect to your Protected Health Information, and to comply with the terms of the notice currently in effect.

Protected Health Information generally includes information received or created by the PLAN that identifies you and relates to your physical or mental health or condition, the health care you receive, or payment for your care. We refer to your Protected Health Information as your “health information” in this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We use and disclose your health information to carry out our responsibilities as a health plan. We are permitted to use and disclose your health information without your authorization in the following circumstances:

• For payment purposes. We may use or disclose your health information for payment purposes, such as paying doctors and hospitals for covered services. Payment purposes also includes determining eligibility for benefits, reviewing services for medical necessity, performing utilization review, obtaining premiums, coordinating benefits, subrogation of claims or collection activities.

• For healthcare operations. We may use or disclose your health information to conduct our healthcare operations (such as using health information to do a cost analysis of the PLAN, to coordinate or manage care, to assess and improve the quality of healthcare services or to review the qualifications and performance of providers). Healthcare operations also includes our business activities, such as underwriting, placing or replacing coverage, determining coverage policies, arranging for legal and audit services, and obtaining accreditations and licenses. However, we do not use or disclose genetic information for any underwriting purposes, including determining eligibility for benefits or premiums.

• For treatment purposes. We may use or disclose health information. For example, we may disclose health information to a doctor who is determining how to treat your health condition or to ensure that you receive the services that you need. We may also use your health information to contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

• To the plan sponsor. We may also disclose your health information to the plan sponsor of the PLAN (Princeton University) provided that the plan sponsor certifies that the information provided will be maintained in a confidential manner and not used for employment-related decisions or for other employee benefit determinations or in any other manner not permitted by law.

• Other Princeton health plans. The PLAN also participates in an organized health care arrangement with other Princeton University-sponsored health plans, and we may disclose your health information to these other plans to coordinate the operation of the plans to better serve the participants and beneficiaries of the plans.

We may also use and disclose your health information without your authorization in these limited circumstances:

• When we are required to do so by federal, state or local law. For example, we must disclose your health information to the U.S. Department of Health and Human Services upon request if they wish to determine if the PLAN is in compliance with federal privacy laws.

• In connection with a judicial or administrative proceeding, such as pursuant to a court order or in response to a subpoena, discovery request or other lawful process under certain circumstances.

¹ To the extent you have questions about the privacy practices of the Vision Benefits Plan or the Dental Benefits Plan, we direct you to MetLife and Aetna (contact information on page 48).
• To law enforcement under certain circumstances, such as to identify or locate a suspect, fugitive, material witness or missing person.

• To certain government authorities or agencies, such as military authorities if you are member of the armed forces, correctional facilities if you are an inmate, authorized federal officials for intelligence and national security purposes or social/protective service agencies if we reasonably suspect abuse, neglect, or domestic violence.

• In connection with a worker’s compensation program or similar program that provides benefits for work-related injuries or illness.

• If necessary to prevent a serious and imminent threat to your health and safety or the health and safety of the public or another person.

• For public health activities, such as reporting births, deaths, child abuse or neglect, to prevent or control communicable diseases, injuries or disabilities, reporting reactions to medications or problems with products or to enable product recalls.

• To a healthcare oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations, and inspections.

• To coroners, medical examiners and funeral directors or to facilitate organ, eye, or tissue donation.

• To our business partners (such as third-party administrators and other plan administrators) so that they can provide services to us or perform functions on our behalf. These business partners must agree in writing to safeguard your health information and are required by law to secure and protect the privacy of your health information.

• To researchers provided that certain established measures are taken to protect your privacy.

• To assist in disaster relief efforts.

• To your personal representative, if any. A personal representative has legal authority to act on your behalf regarding your health care and health care benefits. For example, an individual named in a durable power of attorney or a parent or guardian of an unemancipated minor are personal representatives.

• To a person involved in your care or who helps pay for your care, such as a family member or friend, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to determine if the disclosure is in your best interest. Special rules apply regarding when we can disclose health information to family members and others involved in a deceased individual’s care.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

Other than as set forth above, the PLAN cannot disclose your health information without a written authorization from you or your personal representative. For example, except in limited circumstances, we must obtain your authorization to use or disclose psychotherapy notes about you, to sell your health information or to use or disclose your health information for marketing activities.

If you authorize the PLAN to use and disclose your health information, you may revoke that authorization at any time by writing the Privacy Officer. However, your written revocation will not apply to actions we already took based on your authorization.

ADDITIONAL RESTRICTIONS

Certain federal and state laws may prohibit or limit the use and disclosure of certain health information, including highly confidential information. “Highly confidential information” may include information relating to: HIV/AIDS, mental health, genetic tests, alcohol and drug abuse, sexually transmitted diseases and reproductive health. If a use or disclosure of health information is prohibited or materially limited by other laws that apply to the PLAN, we intend to meet the requirements of those more stringent laws. For more information on more stringent laws that may apply to your health information, contact the Privacy Officer.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Your rights regarding your health information include:

• The right to request restrictions. You may request that we limit the way we use or disclose your health information. This includes the right to ask that we not disclose your health information to family members or friends involved in your care. Such a request must be in writing and directed to the Privacy Officer. We will consider your request, but we are not required to agree to it.

• The right to request to receive confidential communications. You may ask that we send you information by alternative means or at alternative locations – for example, at a specified phone number or mailing address or email address. You must make this type of request (or change or cancel an earlier request) in writing to the Privacy Officer. We will honor all reasonable requests.

• The right to request access to your health information. You have the right to see and obtain a copy of your health information contained in your medical/billing record. Such a request must be in writing and directed to the Privacy Officer. To the extent we maintain your health information electronically, you can ask that we provide you the information in an electronic form or format. You can also direct us to send your health information to a third-party. We may charge you a reasonable, cost-based fee for a copy of your health information. In certain situations, we may deny your request to access your health information, but we will tell you why we denied it. You have the right to ask for a review of our denial.

• The right to request an amendment to your health information. You may ask us to correct or amend your health information contained in your medical/billing record. Such a request must be in writing and directed to the Privacy Officer and must specify the reason for the request. We may deny your request, but you may respond by filing a written statement of disagreement and ask that the statement be included with your record.
• **The right to request a list of disclosures.** You have the right to request a list of certain disclosures of your health information. Such a request must be made in writing to the Privacy Officer. You are entitled to one such list in any 12-month period at no charge. If you request any additional lists within a 12-month period, we may charge you a fee.

• **The right to be notified of a breach.** We are required to notify you in the event of a breach of your unsecured health information.

• **The right to request a paper copy of this Notice.** You can request a paper copy of this Notice at any time, even if you agreed to receive this Notice electronically. You can also view and/or print a copy of this Notice from our website at hr.princeton.edu/benefits-administrative-notices.

**CHANGES TO THIS NOTICE**

The PLAN may change the terms of this Notice from time to time, and it will make the terms of the revised Notice effective for all health information it maintains. You may obtain the most current Notice by visiting our website at hr.princeton.edu/benefits-administrative-notices or by contacting the Privacy Officer. If we make a material change to this Notice, we will use one of our periodic mailings to inform members then covered by the PLAN about the revised Notice.

**QUESTIONS OR COMPLAINTS**

If you have any questions about this Notice, please contact the Privacy Officer. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer, Princeton University's Office of Human Resources or the third-party administrator for the PLAN. Contact information is listed below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. We will not take any action against you for filing a complaint.

**PRIVACY OFFICER**

To exercise any of your HIPAA rights, please contact the PLAN’s designated Privacy Officer.

Assistant Vice President, Risk Management
701 Carnegie Center, Suite 439
Princeton, NJ 08540
(609) 258-3349
(609) 258-3448 (fax)

**OTHER HIPAA CONTACTS**

You can also contact the Office of Human Resources or the third-party administrator for your PLAN to discuss the privacy of your health information. The contact information for the Office of Human Resources and various third-party administrators is listed below.

**Princeton University, Office of Human Resources**

100 Overlook Center
Princeton, NJ 08540
benefits@princeton.edu
(609) 258-3302
(609) 258-5920 (fax)

**Aetna**
*(Consumer Directed Health Plan, Princeton Health Plan, HMO Plan, J-1 Visa Plan, and Retiree Healthcare Plans)*

Member Services (800) 535-6689

**UnitedHealthcare**
*(Princeton Health Plan)*

Chief Privacy Officer at UnitedHealthcare
UHG Center, 2nd Floor West, Mail Route MN008 W211, 9900 Bren Road East
Minnetonka, MN 55343
Member Services (877) 609-2273

**OptumRx**
*(Prescription Drug Plan)*

Attn: Member Services
P.O. Box 3410
Lisle, IL 60532-8410
Member Services (877) 629-3117
Member Services (Post-65 Retiree) (855) 209-1299
Member Services (Pre-65 Retiree, Pre-65 Dependent or P-84 Plan Member) (877) 629-3117

**PayFlex Systems USA, Inc.**
*(Healthcare Flexible Spending Account)*

Member Services (800) 284-4885

**MetLife**
*(MetLife Basic Option PPO Plan, MetLife High Option PPO Plan, and MetLife Vision Plan)*

Member Services (Dental Plans) (866) 832-5756
Member Services (Vision Plan) (855) 638-3931

**Aetna**
*(Aetna DMO Plan)*

Member Services (877) 238-6200
New Jersey Earned Sick Leave
Notice of Employee Rights

Under New Jersey’s Earned Sick Leave Law, most employees have a right to accrue up to 40 hours of earned sick leave per year. Go to https://nj.gov/labor/ to learn which employees are covered by the law.

New employees must receive this written notice from their employer when they begin employment, and existing employees must receive it by November 29, 2018. Employers must also post this notice in a conspicuous and accessible place at all work sites, and provide copies to employees upon request.

YOU HAVE A RIGHT TO EARNED SICK LEAVE.

Amount of Earned Sick Leave
Your employer must provide up to a total of 40 hours of earned sick leave every benefit year. Your employer’s benefit year is:

Start of Benefit Year: July 1
End of Benefit Year: June 30

Rate of Accrual
You accrue earned sick leave at the rate of 1 hour for every 30 hours worked, up to a maximum of 40 hours of leave per benefit year. Alternatively, your employer can provide you with 40 hours of earned sick leave up front.

Date Accrual Begins
You begin to accrue earned sick leave on October 29, 2018, or on your first day of employment, whichever is later. Exception: If you are covered by a collective bargaining agreement that was in effect on October 29, 2018, you begin to accrue earned sick leave under this law beginning on the date that the agreement expires.

Date Earned Sick Leave is Available for Use
You can begin using earned sick leave accrued under this law on February 26, 2019, or the 120th calendar day after you begin employment, whichever is later. However, your employer can provide benefits that are more generous than those required under the law, and can permit you to use sick leave at an earlier date.

Acceptable Reasons to Use Earned Sick Leave
You can use earned sick leave to take time off from work when:

- You need diagnosis, care, treatment, or recovery for a mental or physical illness, injury, or health condition; or you need preventive medical care.
- You need to care for a family member during diagnosis, care, treatment, or recovery for a mental or physical illness, injury, or health condition; or your family member needs preventive medical care.
- You or a family member have been the victim of domestic violence or sexual violence and need time for treatment, counseling, or to prepare for legal proceedings.
- You need to attend school-related conferences, meetings, or events regarding your child’s education; or to attend a school-related meeting regarding your child’s health.
- Your employer’s business closes due to a public health emergency or you need to care for a child whose school or child care provider closed due to a public health emergency.

Family Members
The law recognizes the following individuals as “family members:”

- Child (biological, adopted, or foster child; stepchild; legal ward; child of a domestic partner or civil union partner)
- Grandchild
- Sibling
- Spouse
- Domestic partner or civil union partner
- Parent
- Grandparent
- Spouse, domestic partner, or civil union partner of an employee’s parent or grandparent
- Sibling of an employee’s spouse, domestic partner, or civil union partner
- Any other individual related by blood to the employee
- Any individual whose close association with the employee is the equivalent of family
Advance Notice
If your need for earned sick leave is foreseeable (can be planned in advance), your employer can require up to 7 days’ advance notice of your intention to use earned sick leave. If your need for earned sick leave is unforeseeable (cannot be planned in advance), your employer may require you to give notice as soon as it is practical.

Documentation
Your employer can require reasonable documentation if you use earned sick leave on 3 or more consecutive work days, or on certain dates specified by the employer. The law prohibits employers from requiring your health care provider to specify the medical reason for your leave.

Unused Sick Leave
Up to 40 hours of unused earned sick leave can be carried over into the next benefit year. However, your employer is only required to let you use up to 40 hours of leave per benefit year. Alternatively, your employer can offer to purchase your unused earned sick leave at the end of the benefit year.

You Have a Right to be Free from Retaliation for Using Earned Sick Leave
Your employer cannot retaliate against you for:

- Requesting and using earned sick leave
- Filing a complaint for alleged violations of the law
- Communicating with any person, including co-workers, about any violation of the law
- Participating in an investigation regarding an alleged violation of the law, and
- Informing another person of that person’s potential rights under the law.

Retaliation includes any threat, discipline, discharge, demotion, suspension, or reduction in hours, or any other adverse employment action against you for exercising or attempting to exercise any right guaranteed under the law.

You Have a Right to File a Complaint
You can file a complaint with the New Jersey Department of Labor and Workforce Development online at nj.gov/labor/wagehour/complnt/filing_wage_claim.html or by calling 609-292-2305 between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday.

Keep a copy of this notice and all documents that show your amount of sick leave accrual and usage.
You have a right to be given this notice in English and, if available, your primary language.
For more information visit the website of the Department of Labor and Workforce Development: nj.gov/labor.
**Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
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</thead>
</table>
| Website: [http://myalhipp.com/](http://myalhipp.com/)  
Phone: 1-855-692-5447 | Health First Colorado Website:  
[https://www.healthfirstcolorado.com/](https://www.healthfirstcolorado.com/)  
Health First Colorado Member Contact Center:  
1-800-221-3943/ State Relay 711  
Health Insurance Buy-In Program (HIBI):  
[https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program](https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program)  
HIBI Customer Service: 1-855-692-6442 |

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<thead>
<tr>
<th>ALASKA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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| The AK Health Insurance Premium Payment Program  
Website: [http://myakhipp.com/](http://myakhipp.com/)  
Phone: 1-866-251-4861  
Email: CustomerService@MyAKHIPP.com  
Medicaid Eligibility:  
[http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx](http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx) | Website:  
Phone: 1-877-357-3268 |

<table>
<thead>
<tr>
<th>ARKANSAS – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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</table>
| Website: [http://myarhipp.com/](http://myarhipp.com/)  
Phone: 1-855-MyARHIPP (855-692-7447) | Website:  
[https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp](https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp)  
Phone: 678-564-1162 ext 2131 |
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Medicaid Phone</th>
<th>CHIP Website</th>
<th>CHIP Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALIFORNIA</strong></td>
<td><a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CAUCont.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CAUCont.aspx</a></td>
<td>916-440-5676</td>
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<td><strong>INDIANA</strong></td>
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<td><strong>IOWA</strong></td>
<td><a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a></td>
<td>1-800-338-8366</td>
<td><a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a></td>
<td>1-800-257-8563</td>
</tr>
<tr>
<td><strong>MONTANA</strong></td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
<td>1-800-694-3084</td>
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<tr>
<td><strong>KANSAS</strong></td>
<td><a href="http://www.kdheks.gov/hcf/default.htm">http://www.kdheks.gov/hcf/default.htm</a></td>
<td>1-800-792-4884</td>
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<tr>
<td><strong>NEVADA</strong></td>
<td><a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a></td>
<td>1-800-992-0900</td>
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<tr>
<td><strong>LOUISIANA</strong></td>
<td><a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/laHIPP">www.ldh.la.gov/laHIPP</a></td>
<td>1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</td>
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<tr>
<td><strong>NEW HAMPSHIRE</strong></td>
<td><a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a></td>
<td>603-271-5218, Toll free number for the HIPP program: 1-800-852-3345, ext 5218</td>
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<tr>
<td><strong>MAINE</strong></td>
<td><a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a></td>
<td>1-800-442-6003, TTY: Maine relay 711</td>
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<tr>
<td><strong>NEW JERSEY</strong></td>
<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td>609-631-2392, CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
<td>1-800-701-0710</td>
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<tr>
<td><strong>MASSACHUSETTS</strong></td>
<td><a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a></td>
<td>1-800-862-4840, TTY: Maine relay 711</td>
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<tr>
<td><strong>NEW YORK</strong></td>
<td><a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
<td>1-800-541-2831</td>
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<tr>
<td><strong>NORTH CAROLINA</strong></td>
<td><a href="http://medicaid.ncdhhs.gov/">http://medicaid.ncdhhs.gov/</a></td>
<td>919-855-6180</td>
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<tr>
<td>State</td>
<td>Program(s)</td>
<td>Website</td>
<td>Phone</td>
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<tr>
<td>OKLAHOMA</td>
<td>Medicaid and CHIP</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742</td>
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<tr>
<td>UTAH</td>
<td>Medicaid and CHIP</td>
<td>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a></td>
<td>1-877-543-7669</td>
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<tr>
<td>OREGON</td>
<td>Medicaid</td>
<td>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a></td>
<td>1-800-699-9075</td>
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</tr>
<tr>
<td>VERMONT</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.greenmountaincare.org">http://www.greenmountaincare.org</a></td>
<td>1-800-250-8427</td>
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<tr>
<td>RHODE ISLAND</td>
<td>Medicaid and CHIP</td>
<td>Website: <a href="https://www.coverva.org/hipp/">https://www.coverva.org/hipp/</a></td>
<td>1-855-242-8282</td>
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<tr>
<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
<td>Website: <a href="http://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">http://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a></td>
<td>1-855-699-8447</td>
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<tr>
<td>TEXAS</td>
<td>Medicaid</td>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
<td>1-800-440-0493</td>
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</tr>
<tr>
<td>NORTH DAKOTA</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
<td>1-844-854-4825</td>
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<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td>Website: <a href="https://www.dhs.pa.gov/providers/Providers/Pages/">https://www.dhs.pa.gov/providers/Providers/Pages/</a></td>
<td>1-800-692-7462</td>
<td></td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
<td>Website: <a href="https://www.coverva.org/hipp/">https://www.coverva.org/hipp/</a></td>
<td>1-855-242-8282</td>
<td></td>
</tr>
<tr>
<td>SOUTH DAKOTA</td>
<td>Medicaid</td>
<td>Website: <a href="https://www.dss.sd.gov">https://www.dss.sd.gov</a></td>
<td>1-888-828-0059</td>
<td></td>
</tr>
<tr>
<td>WISCONSIN</td>
<td>Medicaid and CHIP</td>
<td>Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a></td>
<td>1-800-362-3002</td>
<td></td>
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<tr>
<td>TEXAS</td>
<td>Medicaid</td>
<td>Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a></td>
<td>1-800-251-1269</td>
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</tbody>
</table>

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

- **U.S. Department of Labor**
  Employee Benefits Security Administration
  www.dol.gov/agencies/ebsa
  1-866-444-EBSA (3272)

- **U.S. Department of Health and Human Services**
  Centers for Medicare & Medicaid Services
  www.cms.hhs.gov
  1-877-267-2323, Menu Option 4, Ext. 61565

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137 (expires 1/31/2023).
New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment–based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-­stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November each year for coverage starting as early as the immediately following January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5%1 of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.2

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Team at (609) 258–3302 or benefits@princeton.edu.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit Healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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1 As that percentage is adjusted by inflation from time to time.
2 An employer–sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Princeton University
4. Employer Identification Number (EIN): 21-0634501
5. Employer address: Office of Human Resources, 100 Overlook Center
6. Employer phone number: (609) 258-3302
7. City: Princeton
8. State: NJ
9. Zip code: 08540
10. Who can we contact about employee health coverage at this job? The Benefits Team in the Office of Human Resources.
11. Phone number (if different from above): 
12. Email address: benefits@princeton.edu

The health coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.
Important Notice from Princeton University About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it with your other important papers. This notice has information about your current prescription drug coverage with Princeton University and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Princeton University has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can you Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Part D drug plan.

What Happens to your Current Coverage if you Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your Princeton University coverage will not be affected. As a benefits-eligible employee you and your eligible dependents can keep your prescription plan coverage if you elect Medicare Part D and this plan will coordinate with the Part D coverage.

Please remember that your prescription drug plan through Princeton University is part of your medical plan coverage. If you decide to enroll in a Medicare prescription drug plan and request to drop your Princeton University prescription drug coverage, be aware that you may also be dropping your medical plan coverage. If you do drop your medical and prescription plan coverage, you are your dependents will be able to re-enroll in a Princeton University medical plan at a later date.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will you Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your coverage with Princeton University and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For more information about this notice or your current Princeton University prescription drug coverage, please contact the Benefits Team in the Office of Human Resources at (609) 258-3302 or via e-mail at benefits@princeton.edu.**

NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if Princeton University changes its prescription drug plan coverage. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember:** Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 2021
Name of Entity/Sender: Princeton University
Contact--Position/Office: Linda Nilsen, Assistant Vice President, Human Resources
Address: Office of Human Resources, 100 Overlook Center, Princeton, NJ 08540
Phone Number: (609) 258-3302
New Jersey law provides up to 6 weeks of family leave insurance benefits. Beginning July 1, 2020, the law will allow up to 12 weeks of continuous family leave or 56 days of intermittent leave. Employees who are covered by family leave insurance can apply for benefits to:

- bond with a child within 12 months of the child’s birth or placement by adoption or foster care. The applicant, or the applicant’s spouse or domestic or civil union partner, must be the child’s biological, adoptive or foster parent, unless a surrogate carried the child.
- care for a family member with a serious health condition. Supporting documentation from a health care provider is mandatory.
- care for a victim of domestic violence or a sexually violent offence or for a victim’s family member.

“Family member” means a child, parent, parent-in-law, sibling, grandparent, grandchild, spouse, domestic partner, civil union partner, and any other person related by blood to the employee or with whom the employee has a close association that is the equivalent of a family relationship.

“Child” means a biological, adopted, or foster child, stepchild or legal ward of a parent. A child gained by way of a valid written contract between the parent and a surrogate (gestational carrier) is included in this definition.

**State Family Leave Insurance Plan** ("state plan")

You can get program information and an application for family leave benefits (form FL-1) online at myleavebenefits.nj.gov, by phone at 609-292-7060, or by mail: Division of Family Leave Insurance, P.O. Box 387, Trenton, NJ 08625-0387.

New mothers who receive temporary disability benefits through the state plan for their pregnancy will get instructions on how to file for family leave benefits after the child is born.

**Private Family Leave Insurance Plan** ("private plan")

An employer may provide family leave insurance through a private insurance carrier, if this Division approves the plan. If your employer has an approved private plan, your employer must provide information about coverage and provide the forms to apply for benefits.

**Who pays for Family Leave Insurance?**

Payroll contributions from employees finance this program. Family leave insurance coverage under the state plan will require contributions to be deducted from employee wages. The deductions must be noted on the employee’s pay envelope, paycheck, or on some other form of notice. In 2018, the taxable wage base for family leave insurance benefits is the same as the taxable wage base for unemployment and temporary disability insurance.
Qualified Default Investment Alternative (QDIA)

Annual Notice for the
Princeton University Retirement Plan and
Princeton University Retirement Savings Plan

Federal regulations require that plan sponsors provide retirement plan participants with notices regarding their plan features. This annual Qualified Default Investment Alternative (QDIA) notice describes your rights and responsibilities in connection with the default investment alternative provided under each plan listed above. No action is required by you at this time, unless you would like to make changes to your elections in the plan.

Direct your investments
You may direct the investment of your contributions to one or more of the plan's available funds, which include a broad range of investment alternatives, intended to allow you to achieve a diversified portfolio. All investing is subject to risk, including possible loss on the money you invest. Diversification does not ensure a profit or protect against a loss.

Your plan's default fund
Your plan also designates a default fund, where your contributions will be invested if you have not made an affirmative investment election. The plan's default fund is the Vanguard Target to Retirement Funds. If you did not make an investment election, you would default into the Vanguard Target to Retirement Fund which is chosen by using the date-specific fund nearest your expected year of retirement (i.e., the year you reach age 65). Enclosed are the fund fact sheets for the Vanguard Target to Retirement Funds, which includes information about your default fund, such as the investment objective, fees and expenses, and risk and return characteristics.

Investments in Vanguard Target to Retirement Funds are subject to the risks of their underlying funds. The year in the fund name refers to the approximate year (the target date) when an investor in the fund would retire and leave the workforce. The fund will gradually shift its emphasis from more aggressive investments to more conservative ones based on its target date. An investment in a Vanguard Target to Retirement Fund is not guaranteed at any time, including on or after the target date.

Change your investments
You can redirect your future contributions and change the way your plan account balance is invested anytime, subject to each fund's trading restrictions and any purchase fees (if applicable). If you make an exchange out of the default fund, you cannot put money back into the same fund online or by phone within 30 days; however, you can always make an exchange via U.S. mail.

For more information about directing the investment of your plan account, please refer to your plan's "Summary Plan Description." For help determining an appropriate investment mix based on your investment goals, risk tolerance, and time horizon, contact TIAA at www.tiaa.org/princeton.

Connect with TIAA.
You can access your account, research funds, or make changes in any of these ways:

- **Online.** Log in to www.tiaa.org/princeton to view your account, see the latest performance data, make transactions and access retirement planning tools.
  - If you are new to TIAA, click Register for Access and follow the on-screen instructions to access your new account and view your investments.
  - You will need your plan number: (Princeton University Retirement Plan: 102861; Princeton University Retirement Savings Plan: 102862).
- **By phone.** Call 800-842-2776 weekdays 8 a.m. to 10 p.m. and Saturdays 9 a.m. to 6 p.m. (ET).

For more information on the funds offered, including investment objectives, risks, charges, and expenses, please call TIAA at 800-842-2776 to obtain a prospectus. The prospectus contains this and other important information about the fund. Read and consider the prospectus information carefully before you invest. You can also download TIAA fund prospectuses at www.tiaa.org/princeton.
Princeton is a diverse community with a range of personal needs and goals. To help all our faculty and staff thrive, we offer an expansive array of benefits designed to support your physical, mental, and financial wellness.

Helping You Thrive, Today & Tomorrow

BENEFITS 2022