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.
This communication is intended to be a Summary of Material Modifications (SMM) for the healthcare, life insurance, 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) and Certificates of Coverage on our website. You may also request to receive a paper copy of an SPD or Certificate of Coverage 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 each medical plan is available on our website. You may request a paper copy of any 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 43 of this booklet. All 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>Provider</th>
<th>Group Number/Plan ID</th>
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<td>My Health Coach</td>
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<td>NA</td>
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<td>(833) 216-2345</td>
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<td>OptumRx</td>
<td>PURRINGSM</td>
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<td>Group Long Term Care Plan</td>
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<td>(888) 416-3624</td>
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<td>Legal Services Plan</td>
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<td>Employee Assistance Program</td>
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<td>Backup Care Advantage Program</td>
<td>Bright Horizons</td>
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<td>(877) 242-2737</td>
</tr>
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</table>

For more details on work life programs, visit hr.princeton.edu/thrive or contact the Benefits Team at benefits@princeton.edu or (609) 258-3302.
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ELIGIBILITY

You are eligible for benefits if you are a regular or term biweekly- or monthly-paid employee who fills an approved budgeted position on the regular payroll. Regular and term employees are scheduled to work 50% or more of the normal workweek schedule (36\(\frac{1}{2}\) or 40 hours, depending on the position) for 4.5 months or more and receive pay directly from the University. Postdoctoral research fellows are eligible for benefits regardless of their duty time. Most benefits begin on your date of hire.

To determine in which benefits you are eligible to enroll or participate, review the Benefits Plan Eligibility Chart.

**NEW HIRES**

You must elect to enroll in a health plan within 31 days from your date of hire. Otherwise, you will have no health insurance coverage with Princeton University in 2022, unless you experience a qualifying status event. See page 4 for more details.
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
- Ex-civil union or ex-domestic partners’ children
- Ex-civil union or ex-domestic partners’ children
- 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, seckuresend.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

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<thead>
<tr>
<th>Spouse</th>
<th>Documentation Required</th>
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<tr>
<td></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>
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<table>
<thead>
<tr>
<th>Biological child(^2)</th>
<th>Birth certificate(^3)</th>
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<table>
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<tr>
<th>Adopted child(^2)</th>
<th>Legal adoption papers</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Stepchild(^2)</th>
<th>Birth certificate including names of biological parents and employee's marriage certificate</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Legal ward(^2)</th>
<th>Legal guardianship papers showing full financial support and custody responsibilities</th>
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</table>

<table>
<thead>
<tr>
<th>Foster child(^2)</th>
<th>Official placement papers</th>
</tr>
</thead>
</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).
ONLINE BENEFITS ENROLLMENT

Your online access to HR Self Service is available seven days a week between 8:00 a.m. and midnight.

STEP 1 TO ENROLL
To log in to HR Self Service, you need your netID, password, and be Duo-enabled. Duo is a two-factor authentication system implemented by the Office of Information Technology (OIT) to protect your personal information and Princeton data. If you are not currently Duo-enabled, you may enroll in Duo Self Service at princeton.edu/duoportal. If you require assistance with your netID, password, or Duo, contact the OIT Help Desk at helpdesk@princeton.edu or (609) 258-HELP (4357). If you need assistance with HR Self Service, contact the Benefits Team.

1. Go to princeton.edu/selfservice
2. Click Log In Here
3. Enter your netID and password
4. From HR Self Service, select Benefit Details
5. Select Benefits Enrollment
6. Make and submit your benefits elections

For more detailed instructions, visit our website.

WHAT YOU CAN DO DURING THE YEAR

From the Benefit Details menu, you can:
- View your current or future benefits elections
- Enroll or change your Retirement Savings Plan election
- Make a change to your benefits coverage due to a Qualifying Status Event
- Review and/or update your dependents’ personal information
- Review and/or update your life insurance beneficiary designations

RESOURCES

Benefits information is available on our website or by contacting the Benefits Team. If you do not have access to a computer, kiosks for online access and enrollment are available at the following locations:

- East Pyne
- Chancellor Green Rotunda
- Forbes College
- Kitchen
- Graduate College
- Loading Dock
- Madison Hall
- Hallway by Campus Dining
- Whitman
- Kitchen
- Wilcox Hall
- Kitchen

GO PAPERLESS

If you prefer to receive benefits communications by email instead of print, select “Go Paperless” in HR Self Service. Your selection takes effect immediately for all future communications except those that the Office of Human Resources determines necessary to communicate to you in paper form.

1. Go to princeton.edu/selfservice
2. Click Log In Here
3. Enter your netID and password
4. From HR Self Service, select Benefit Details and click on Go Paperless
5. Make your selection
6. Click Save

NEW HIRES

You have 31 days from your date of hire to enroll in or waive benefits. To enroll in benefits, click on Benefits Enrollment under the Benefit Details menu. You will see the benefits that you are eligible to elect. Review your benefits options carefully.
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 log in to HR Self Service at princeton.edu/selfservice 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. Once you log in to HR Self Service you will select Benefit Details and then Life Event to make your changes. If your Qualifying Status Event is not listed in HR Self Service, contact the Benefits Team for assistance.

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 or change beneficiary designations
- Elect, change, or waive coverage under supplemental, spousal, or child life insurance—evidence of insurability (EOI) form required when electing or increasing the supplemental and spousal life insurance coverage
- Elect, change, or terminate long term care coverage—EOI required when electing or increasing coverage
- Elect, change, or terminate participation in the Retirement Savings Plan
- Elect, change, or terminate the Health Savings Account (HSA) if enrolled in the CDHP
CASTLIGHT

If you are enrolled in a Princeton healthcare plan, you have access to Castlight, where you can keep track of all your healthcare benefits in one place, at no cost to you. With Castlight you can:

• Compare prices and quality ratings for doctors, hospitals, and medical services
• Know if your provider is in-network and how much you’ll pay before you get care
• Understand what’s covered by your plan and track your spending
• View breakdowns of your past medical and prescription expenses
• Read patient reviews of doctors and specialists

Register for Castlight at mycastlight.com/princeton or download the Castlight app from the Apple App Store or Google Play. To learn more, contact Castlight at (866) 207-6344 or visit our website.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP), offered through Carebridge, is available to help you and your eligible dependents cope with everyday circumstances and get referrals to address common questions.

EAP COUNSELING SERVICES

Carebridge provides eight free face-to-face, confidential counseling sessions, per issue, for each covered person. To talk with a licensed professional and begin counseling, contact Carebridge at (800) 437-0911. Counseling services are available 24/7 for issues related to:

• Anxiety
• Depression
• Grief and loss
• Relationship issues
• Substance abuse
• And more...

EAP REFERRAL SERVICES

Carebridge provides referral services to address common questions. For a referral, call Carebridge at (800) 437-0911 or visit myliferesource.com, access code TW8AE. Unlimited phone referrals and online access are available for questions on:

• Child and elder care resources
• Education planning
• Financial pressures
• Legal matters
• Pet services
• Relocation
• And more...

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.
**Health Advocate** helps you and your family members confidentially navigate the often complex healthcare system. The program provides you, your dependents, parents, and parents-in-law with unlimited access to a Personal Health Advocate (PHA), regardless of whether or not you or your eligible family members are enrolled in a healthcare plan at Princeton. PHAs are typically registered nurses, supported by medical directors and benefits and claims specialists who can get to the bottom of a wide variety of healthcare and insurance-related issues.

**HOW DOES HEALTH ADVOCATE WORK?**

When you need assistance, call Health Advocate at (866) 695-8622 to be assigned a PHA. Your PHA will review your situation, obtain the necessary information, and work to resolve your inquiry. A PHA can help:

- Resolve billing and claims issues
- Explain benefits coverage and health conditions
- Research treatments
- Find the right doctors, hospitals, and providers
- Schedule tests and appointments
- Secure second opinions
- Locate elder care services
- Navigate Medicare and plan transitions when you retire

Health Advocate is not affiliated with any insurance or third party providers, and all your medical and personal information remains confidential. To review all the services and resources available to you, visit [healthadvocate.com/princeton](http://healthadvocate.com/princeton) or our website.

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**TELADOC MEDICAL EXPERTS**

Teladoc Medical Experts, a service recognized for identifying expert physicians to bring best practice medicine to you, can help you make informed healthcare decisions with greater confidence and ensure you are getting the right care. This resource is confidential and provided at no additional cost to eligible employees, whether or not your health insurance is through the University.

**In-Depth Medical Review**

Teladoc Medical Experts collects your medical records, including images and tests, and reviews all the information and either confirms your diagnosis and treatment plan or suggests further tests and/or a change in your treatment.

**Ask the Expert**

If you have a basic question about a diagnosis or treatment, you can obtain personalized guidance from a medical expert.

**Find a Doctor**

Teladoc Medical Experts can locate an in-network physician in your area using their network of medical experts.

**Mental Health Navigator**

Access mental health support to identify or confirm a diagnosis, determine a treatment plan, and find mental health resources.

**Critical Care**

If admitted to a hospital, emergency room, intensive care unit, or neonatal intensive care unit for an acute medical event, Teladoc Medical Experts can review your case within 48 to 72 hours and send a nurse to help coordinate care, if needed. The Critical Care program provides support for acute medical events such as:

- Complications from the premature birth of a child
- Sepsis
- Spinal cord and brain injuries
- Traumas to multiple organs and/or body systems

To learn more about the program, visit our website. To access Teladoc Medical Experts, visit [teladoc.com/medical-experts](http://teladoc.com/medical-experts), call (800) 835-2362, or download the Teladoc app.

**TREATMENT DECISION SUPPORT PROGRAM**

The Treatment Decision Support Program is available to all employees who are enrolled in a Princeton University medical plan as well as their dependents. The program provides you with a $400 taxable cash incentive in your paycheck once you or your covered family members obtain a virtual second opinion from Teladoc Medical Experts prior to considering back, hip, or knee surgery.
Picwell is an online decision support tool designed to help you select a medical plan for you and your family. After responding to a few key questions, Picwell will use your answers to provide a personalized health cost prediction and ranking for each health plan you are eligible to elect, based on your unique health risks and preferences. Personal information obtained by Picwell is anonymous and is not stored or shared. Access Picwell at princeton.picwell.com from a computer or mobile device.

Note: While Picwell is meant to be a guide to help you make your enrollment decisions, it is not designed to account for every eligibility situation and healthcare plan rule. Only you can elect benefits to suit your needs. Picwell is a tool to assist with enrollment decisions, but actual benefits enrollment needs to be done through HR Self Service, or through Winston Benefits, if you want to enroll in voluntary benefits.

At the Employee Wellness Center @ 350 Alexander, you’ll find support to help you care for yourself and your family, so you can thrive at work and at home. Whatever challenges you’re facing, help is available. Schedule a free, confidential appointment with one of the resources below designed to meet your physical, mental, and financial wellness needs.

• My Health Coach for managing chronic conditions or reaching your health goals
• Carebridge, Princeton’s Employee Assistance Program, for counseling sessions
• Doctors In Your Office for annual physicals
• TIAA and CAPTRUST for financial advising
• Isles for budgeting, saving, and reducing debt

All meetings take place in private rooms to ensure confidentiality. Appointments are required. For your convenience, visitor parking is available onsite.
MY HEALTH COACH

My Health Coach, offered in partnership with TrestleTree, an accredited health transformation organization, provides you and your eligible dependents free, confidential assistance to achieve your personal health goals. You do not need to be enrolled in a health plan at Princeton to use this program. Health coaches are available to meet with you in person at the Employee Wellness Center or by phone. The health coaches have experience helping individuals manage medical conditions, such as heart disease, high blood pressure, and diabetes. They can also provide guidance for eating better, exercising more, weight loss efforts, smoking cessation, and stress reduction.

What Is a Health Coach?
A health coach is a healthcare professional who partners with you to transform your health goals into action. Your health coach provides guidance, support, and resources, and helps you overcome obstacles that may be keeping you from realizing optimal health. They help participants develop a personalized plan to achieve goals for healthy living regardless of where they are in the process. The health coaches can assist individuals in understanding their diagnosis, medical condition, and doctor’s treatment plan so they can make important changes to achieve optimal health and well-being.

INCENTIVE PROGRAMS
To help you manage certain health conditions, My Health Coach offers incentive programs that are confidential, voluntary, and offered at no additional cost to eligible employees and their dependents enrolled in a Princeton medical plan. The copay waivers described below are subject to restrictions for participants enrolled in the CDHP.

Diabetes Management Incentive Program
If you have been diagnosed with diabetes or pre-diabetes, the Diabetes Management Incentive Program provides you with a $250 taxable cash incentive in your paycheck and a copay waiver through OptumRx for certain generic and preferred brand drugs, as well as for supplies related to diabetes care.

Condition Management Incentive Program
If you have been diagnosed with high blood pressure, high cholesterol or obesity, the Condition Management Incentive Program provides you with a copay waiver through OptumRx for certain generic and preferred brand drugs related to the management of these conditions. An annual allowance of up to $50 for support tools is provided through My Health Coach to those with obesity, unless they are taking a medication eligible for the copay waiver.

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.

ADOPTION AND SURROGACY BENEFIT

Princeton’s adoption and surrogacy benefit provides eligible employees with a reimbursement up to a $20,000 lifetime limit per family. For information visit our website.
HEALTHCARE GLOSSARY AND PLAN INFORMATION

Coincassure
Once you have met your annual deductible, the cost of certain services are shared between you and your medical plan. The shared amount is called coinsurance and calculated by percent—you pay a percentage and the plan pays the remaining percentage of costs for services. You continue to pay coinsurance until you reach your out-of-pocket maximum for the year. For most out-of-network services, you are responsible to pay amounts that are above 180% of the Medicare allowable rate. You can find more details in the Summary Plan Descriptions (SPDs) or contact Aetna or UnitedHealthcare.

Contribution
You make contributions from pay to establish your participation in a healthcare plan and begin receiving coverage.

Copayment or Copay
You pay this fixed amount directly to a healthcare provider when you receive certain in-network services or products. For example, it is the amount you pay for a physician’s office visit or a prescription drug.

Centers of Excellence and Institutes of Quality
Princeton offers access to UnitedHealthcare Centers of Excellence (COEs) and Aetna Institutes of Quality (IOQs). COEs and 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. UnitedHealthcare and Aetna can provide the information you need and help guide you to a COE or 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.

In-Network Coverage
Using in-network doctors or facilities helps you and Princeton manage costs and ensure quality care. For this reason, we provide a higher level of coverage for inpatient and outpatient procedures when you use in-network providers.

Out-of-Network Coverage and Recognized Charge
You may seek care from a licensed or certified physician or facility outside of the CDHP, PHP or J-1 Visa Plans 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 or UnitedHealthcare for more information.

Precertification
Precertification, referred to as prior authorization under UnitedHealthcare, is authorization from your medical plan carrier that you must obtain before you receive care. If you are using an in-network provider, your physician is responsible for obtaining this authorization for you. However, if you go out-of-network, it is your responsibility to obtain precertification.
Princeton University offers several healthcare plan options. For an overview of coverage for each plan, refer to the medical plan comparison chart on pages 29 and 30 and the dental plan comparison chart on page 22. If you are on a J-1 Visa, refer to the medical comparison chart on page 15. The monthly contribution costs, which are deducted pretax from your pay, are below. In the event you are in an unpaid status, the University bills you directly.

You should review your options carefully by comparing plan features and costs and determining the network of providers available under each plan. Summary Plan Descriptions (SPDs) are available on our website.

### Monthly Faculty and Staff Contribution Rates

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>Employee</th>
<th>Employee and Child(ren)</th>
<th>Employee and Spouse</th>
<th>Employee and Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Consumer Directed Health Plan (CDHP)</td>
<td>$20</td>
<td>$61</td>
<td>$82</td>
<td>$122</td>
</tr>
<tr>
<td>Aetna or UnitedHealthcare Princeton Health Plan (PHP)</td>
<td>$124</td>
<td>$345</td>
<td>$438</td>
<td>$649</td>
</tr>
<tr>
<td>Aetna HMO Plan</td>
<td>Refer to the salary tiers below.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$75,000 and under</td>
<td>$76</td>
<td>$220</td>
<td>$296</td>
<td>$455</td>
</tr>
<tr>
<td>$75,001–150,000</td>
<td>$79</td>
<td>$233</td>
<td>$312</td>
<td>$477</td>
</tr>
<tr>
<td>$150,001 and over</td>
<td>$84</td>
<td>$242</td>
<td>$325</td>
<td>$498</td>
</tr>
<tr>
<td>Aetna J-1 Visa Plan</td>
<td>$0</td>
<td>$277</td>
<td>$368</td>
<td>$561</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Plan</th>
<th>Employee</th>
<th>Employee and Child(ren)</th>
<th>Employee and Spouse</th>
<th>Employee and Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>MetLife Basic Option PPO Plan</td>
<td>$19.97</td>
<td>$46.47</td>
<td>$42.64</td>
<td>$70.08</td>
</tr>
<tr>
<td>MetLife High Option PPO Plan</td>
<td>$64.74</td>
<td>$126.86</td>
<td>$130.64</td>
<td>$180.46</td>
</tr>
<tr>
<td>Aetna DMO Plan</td>
<td>$25.15</td>
<td>$49.05</td>
<td>$50.72</td>
<td>$70.09</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision Plan</th>
<th>Employee</th>
<th>Employee and Child(ren)</th>
<th>Employee and Spouse</th>
<th>Employee and Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>MetLife Vision Plan</td>
<td>$16.02</td>
<td>$26.25</td>
<td>$25.77</td>
<td>$42.32</td>
</tr>
</tbody>
</table>

1 Biweekly-paid employee deductions occur twice a month at the rate of half the amount noted on the chart above. If you receive a third paycheck in a month, deductions for healthcare insurance are not taken.

2 If your coverage is effective between the 1st and 15th of the month, you will be charged a full month premium. If your coverage is effective between the 16th and 31st, your contribution deductions will start the following month. For example, if your coverage effective date is May 10, you will be charged the full month premium for May. If your coverage is effective May 18, you will pay your premium beginning in June.

3 Your salary tier is based on your annual base salary as of January 1, 2022, or your date of hire, if later.

### Did You Know?

**Medical Necessity Required**

All services or supplies must be medically necessary or they are not covered. For example, physical therapy needs to result in significant improvement in the member’s condition to be covered. Refer to the Summary Plan Descriptions (SPDs) to determine if medical services are covered, excluded, or limited. Alternatively, contact Aetna or UnitedHealthcare for more details.

**Car Insurance Personal Injury Protection**

You should not elect your Princeton medical plan as your primary insurance coverage in the event of a motor vehicle accident. You should elect your motor vehicle PIP coverage as your primary coverage. If you do not elect PIP coverage as primary, and you are in a motor vehicle accident, your healthcare insurer has the right to subrogate, and any monies they paid out for claims are subject to reimbursement by you.
Princeton University offers several medical plan options. The medical plan comparison chart on pages 29 and 30 provides an overview of coverage by plan. If you are on a J-1 Visa, refer to the chart on page 15. The contribution costs, which are deducted pretax from your pay, are on page 10. If you are in an unpaid status, the University bills you directly. There are no preexisting condition exclusions for any of our medical plans. Additional details, including Summary Plan Descriptions (SPDs) and Summary of Benefits Coverages (SBCs), are available on our website.

To minimize your costs, consider using the following resources:

- Preferred Providers and Laboratories
- Independent Radiology Centers
- Independent Facilities for Outpatient Services
- Telemedicine
- Urgent Care Centers
- Centers of Excellence and Institutes of Quality
- Health Advocate, My Health Coach, Teladoc Medical Experts, and Castlight

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

All Princeton medical plans provide prescription coverage through OptumRx. Coverage varies depending on your medical plan election. For more details, refer to pages 17 and 18.

For information on the healthcare resources, including fertility and family planning resources, refer to pages 5–8.

To find an in-network provider call Health Advocate, use Castlight, or follow the steps below for your medical plan provider. Refer to page 12 for information on preferred labs and UHC tiered specialists. To find a fertility or family planning provider you must contact Kindbody, refer to page 8.

**PREVENTIVE SERVICES**

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.

**CENTERS OF EXCELLENCE AND INSTITUTES OF QUALITY**

UnitedHealthcare offers access to Centers of Excellence (COEs) for cancer/oncology care, congenital heart disease (CHD), bariatric procedures, ventricular assist devices, spine and joint, transplant solutions, and neonatal resource services. 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 or UnitedHealthcare.

**DECISION SUPPORT AND HEALTHCARE RESOURCES**

Princeton provides an enhanced travel and lodging benefit for you and a family member whenever you use a COE or 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 or myuhc.com. 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 or prior authorization by UnitedHealthcare. 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 or PHP. 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. Visits are covered at 100% for Individuals enrolled in the PHP or HMO. Individuals enrolled in the CDHP or J-1 Visa Plan 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.

UNITIZING PREFERRED LABS AND SPECIALISTS

Preferred Labs

Quest Diagnostics and LabCorp are the preferred labs for Aetna and UHC. 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 and UnitedHealthcare have access to the Quest lab located in the Princeton University McCosh Health Center.

UnitedHealthcare Preferred Specialists

UHC maintains a list of specialist categories with in-network preferred providers. These physicians have demonstrated higher quality and efficiency of patient care. Therefore, the costs are less.

You are charged a higher amount for utilizing an in-network non-preferred or out-of-network provider in these specialist categories. You are charged the in-network preferred copayment when you utilize in-network providers in other specialist categories not listed or in locations where no preferred providers are available. For information on costs for services, refer to the Medical Plan Benefits Comparison chart on page 30. Contact your provider or UHC, before you seek care from a specialist.

When utilizing specialists, first check to see if they are in a category that identifies in-network preferred specialist providers. Since a provider’s status can change, confirm the provider’s status prior to your appointment. Refer to page 11 for instructions on locating in-network providers in your area. UHC preferred providers are listed as Premium Tier 1. Listed in the table are the categories and locations, as of the printing of this book. For the most current list of categories and locations, contact UHC.

<table>
<thead>
<tr>
<th>UHC (Premium Tier 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories with In-Network Preferred Specialists</td>
</tr>
<tr>
<td>allergy; cardiology; endocrinology; family practice; gastroenterology; general surgery; internal medicine; nephrology; neurology; neurosurgery–spine; obstetrics and gynecology (OB/GYN); ophthalmology; orthopedics; otolaryngology—ear, nose, and throat (ENT); pediatric internal medicine; pediatrics; pulmonology; rheumatology; and urology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Locations with Limited or No Access to Preferred Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK, HI, ME, MT, VT, and WY</td>
</tr>
</tbody>
</table>
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; see pages 17 and 18 for details.

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). If you elect the HSA, Princeton will provide a contribution into your HSA to help boost your savings. If you are not eligible to contribute to an HSA per IRS regulations, you have the option to enroll in the Healthcare Flexible Spending Account (HFS). For information about the HSA and Princeton's contribution, refer to page 24, or for the HFS, refer to page 25.

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.

Princeton Health Plan (PHP)

The PHPs are administered by Aetna and UnitedHealthcare (UHC). The PHP is a point-of-service plan, which provides three levels of coverage: in-network preferred, in-network non-preferred, and out-of-network.

In-network coverage begins immediately for certain services, such as office visits and preferred provider lab tests; all other services are covered after you meet your deductible(s). Although you are not required to elect a primary care physician (PCP), we recommend you use a PCP for yourself and your family members to help manage care. You do not need a referral to visit a specialist, even if you choose a PCP. All out-of-network costs are subject to reasonable and customary limits.

In- and out-of-network coverages have independent deductibles and out-of-pocket maximums (OPMs). OPMs are based on your annual base salary as of January 1, 2022, or your date of hire, if later (see chart). Refer to the comparison chart on page 29-30 for an overview of the Aetna and UHC plans.

For details about the medical plans, visit our website. For a current physician directory, refer to How to Find In-Network Providers on page 11. While under the CDHP and PHP you can choose any provider you wish, you will receive a higher level of benefits when you select an in-network provider. For the CDHP and Aetna PHP, you can search for in-network providers in Aetna’s Choice POS II (open access) network. Under the UHC PHP, you can search for in-network providers in UHC’s Choice Plus network. For information on utilizing preferred labs and UHC specialists, see page 12 and the comparison chart on page 30.

NEW HIRES

You have 31 days from the date of hire to elect or waive coverage through HR Self Service. If elected, your coverage is effective on your date of hire. If no election is made, you will not have health insurance coverage with Princeton University in 2022 unless you experience a qualifying status event. See page 4 for more details.

AETNA
aetna.com/dse/princeton (800) 535-6689 CDHP/PHP Group #: 486819
UNITEDHEALTHCARE myuhc.com (877) 609-2273 PHP Group #: 196484
**HMO Plan**

The HMO plan is administered by Aetna and, in an HMO plan, you must select a primary care physician (PCP) from those within the HMO network to manage all your healthcare needs. To select your PCP, contact Aetna one week after enrolling. Until you make a PCP designation, Aetna designates one for you. Your PCP gives you the necessary referrals to visit a specialist. Healthcare services are covered only when provided by your selected PCP or specialist to whom you are referred. No claim forms are required.

Due to California state regulations, if you reside in California, you are not able to elect coverage under the HMO plan. California residents may elect coverage under the CDHP or PHP. However, if you are on a J-1 Visa and reside in California, your only option for coverage through Princeton is the J-1 Visa Plan.

For more information about the HMO, review the Patient Protection Model Disclosure on page 44 or visit our website.

**J-1 Visa Plan**

Employees here on a J-1 visa may elect coverage from either the Aetna HMO Plan or J-1 Visa Plan. The effective date of coverage for employees on a J-1 visa is the date of hire. The J-1 Visa Medical Plan Benefits comparison chart on page 15 provides an overview of coverage by plan.

The J-1 Visa Plan administered by Aetna is only available to non-U.S. citizens who are here on a J-1 visa. It is the default option for J-1 visa holders who do not elect a medical plan. Although you can utilize any hospital, facility, or physician of your choice, you can take advantage of Aetna's negotiated rates, which may lower your out-of-pocket expenses, if you select a physician in Aetna's Open Choice PPO network. Reimbursement through this plan does not begin until you or your dependents reach the annual deductible of $500 for individual or $1,000 for family. After reaching the deductible, you pay 20% for eligible services until you reach the out-of-pocket maximum of $2,500 for individuals or $5,000 for family. Reasonable and customary limits apply unless you use an in-network physician or facility. You must submit a claim form to Aetna to be reimbursed for expenses.

**J-1 VISA HOLDERS**

The U.S. government requires that you and your dependents have health insurance coverage for the entire time you are an exchange scholar at Princeton University. If you waive the medical coverage offered by Princeton, you must be covered for health insurance through your home country, institution, or private policy. Health insurance must provide you and your dependents with the following coverage:

- Medical benefits of at least $100,000 per accident or illness with a deductible not to exceed $500 per accident or illness
- At least $50,000 for expenses associated with a medical evacuation to your home country
- At least $25,000 for the repatriation of remains

J-1 Visa health insurance policies must be backed by the full faith and credit of the government of the exchange visitor’s home country or must be underwritten by an insurance company that meet certain requirements. For more information visit https://j1visa.state.gov/sponsors/how-to-administer-a-program/.

Princeton provides up to $50,000 toward expenses associated with a medical evacuation to your home country and up to $25,000 for the repatriation of remains.

For details about the medical plans, visit our website. For a current physician directory, refer to How to Find In-Network Providers on page 11. Under the HMO plan, you need to search for providers in Aetna’s HMO network. Under the J-1 Visa Plan, while you can choose any provider you wish, you will receive a higher level of benefits when you select a provider in Aetna’s Open Choice PPO Network.

**NEW HIRES**

You have 31 days from the date of hire to elect or waive coverage through HR Self Service. If elected, your coverage is effective on your date of hire. If no election is made, you will not have health insurance coverage with Princeton University in 2022 unless you experience a qualifying status event. See page 4 for more details. If you are on a J-1 visa and you do not waive coverage and no election is made, you are defaulted into the J-1 Visa Plan with individual coverage only.

<table>
<thead>
<tr>
<th>AETNA</th>
<th>aetna.com/dse/princeton</th>
<th>(800) 535-6689</th>
<th>HMO Group #: 866100</th>
</tr>
</thead>
<tbody>
<tr>
<td>AETNA</td>
<td>aetna.com/dse/princeton</td>
<td>(800) 535-6689</td>
<td>J-1 Visa Group #: 811281</td>
</tr>
</tbody>
</table>
**J-1 VISA MEDICAL PLAN BENEFITS COMPARISON**

This is intended to provide an overview of the plan benefits. Details are available on our website. The dollar or percentage amounts in the chart below reflect the patient-paid portion of the incurred medical costs. All plans include prescription drug coverage. Refer to pages 17 and 18 for details.

<table>
<thead>
<tr>
<th></th>
<th>HMO Plan In-Network Only</th>
<th>J-1 Visa Plan In- or Out-of-Network¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible (Individual / Family)</strong></td>
<td>$0</td>
<td>$500 / $1,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (OPM) (Individual / Family)</strong></td>
<td>$2,500 / $5,000</td>
<td>$2,500 / $5,000</td>
</tr>
<tr>
<td><strong>Physician Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teladoc General Medicine</td>
<td>$0</td>
<td>$49 until deductible is met, then $0</td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>$20 copayment</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Specialists</td>
<td>$25 copayment</td>
<td>20% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$25 copayment</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Emergency Room (no coverage for nonemergencies)</td>
<td>$175 copayment (waived if admitted)</td>
<td>20% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and Surgical Procedures</td>
<td>$175 copayment</td>
<td>20% after deductible²</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$175 copayment</td>
<td>20% after deductible²</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Procedures (Independent Facility / Hospital)</td>
<td>$0 / $75 copayment</td>
<td>20% after deductible²</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$0</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Radiology (X-Ray) (Independent Facility / Hospital)</td>
<td>$0 / $50 copayment</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Hi-Tech Radiology (MRI, CAT, etc.) (Independent Facility / Hospital)</td>
<td>$0 / $100 copayment</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Preventive Care and Immunizations³</td>
<td>$0</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$20 copayment</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Annual Eye Exam / Prescription Eyeglasses and/or Contact Lenses</td>
<td>$25 copayment / $70 reimbursement every 2 years⁴</td>
<td>Not covered</td>
</tr>
<tr>
<td>Physical Therapy (100) visits per CY</td>
<td>$15 copayment</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Chiropractic Care (20 visits per CY)</td>
<td>$25 copayment</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Acupuncture (20 visits per CY)</td>
<td>$25 copayment</td>
<td>20% 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 Coverage requires precertification; refer to page 11.

³ Includes seven well-baby visits in the first year of a child’s life.

⁴ 100% reimbursement provided for children up to age 18 for frames and lenses; limited to one pair of glasses each calendar year.
MENTAL HEALTH

Princeton University offers a variety of resources designed to help you manage your mental health. If you or an eligible dependent need support, these resources can help you get the care you need.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Plan, offered through Carebridge, provides confidential assistance for work, personal, or family issues. Carebridge professionals are available if you need immediate help coping with every life challenge, including anxiety, depression, grief, relationship issues, substance abuse, or grief counseling. This benefit includes up to eight face-to-face counseling sessions per issue and unlimited telephone counseling sessions and referrals.

Carebridge professionals are available 24/7 by calling (800) 437-0911. For more information, refer to page 5.

Eligibility and Cost

You and/or your dependents are eligible for this program, whether or not your health insurance is through Princeton. This program is provided at no cost to you.

TELADOC MENTAL HEALTH

Teladoc Mental Health is an easy-to-use, convenient option that allows you to video conference with a licensed health provider—including psychiatrists, psychologists, and counselors—who can provide both therapy and medication management. You choose your therapist, pick a convenient time, and talk to the therapist from the privacy of your home. You can arrange to speak with the same provider throughout the course of your care.

To register for this service, available 7 days a week, go to teladoc.com/princeton, download the Teladoc app from the Apple App Store or Google Play, or call (800) 835-2362.

Eligibility and Cost

You and/or your dependents must be enrolled in a Princeton medical plan to access this service. Participants must be 18 or over. Visits are covered at the same cost as in-network in-person mental health visits. Individuals enrolled in the PHP or HMO pay the PCP copay. Individuals enrolled in the CDHP or J-1 Visa Plan pay the coinsurance after the annual deductible is met.

MENTAL HEALTH NAVIGATOR

Teladoc Medical Experts Mental Health Navigator leverages a cross-functional team of leading psychologists, psychiatrists, and social workers to help you manage your mental health. They provide an expert second opinion on your diagnosis and provide an action plan for you to get on the path to wellness faster.

If your condition is not improving or you are unsure if your diagnosis and treatment plan are correct, Teladoc Medical Experts can help provide clarity and assurance on your next steps while navigating through the complex mental health system.

To access the program, call Teladoc Medical Experts at (800) 835-2362, visit teladoc.com/medical-experts, or download the Teladoc app.

Eligibility and Cost

You and/or your dependents are eligible for this program, whether or not your health insurance is through Princeton. This program is provided at no cost to you.

ABLETO

AbleTo provides virtual therapy and emotional support to assist you with the stress and anxiety that comes with a medical condition or life change. If you are struggling with a serious illness or a mental health issue, AbleTo can help you gain control of your condition instead of it controlling you. You will work with two AbleTo specialists for eight weeks—once a week with a therapist to address emotional challenges like depression, stress, and anxiety and once a week with a behavior coach to identify health goals and develop an action plan. Meetings are available in-person or by phone. Appointments are available in the evening and on weekends.

To access the program, go to member.ableto.com/princeton or call (855) 773-2354 (Aetna members) or (833) 881-1468 (United Healthcare members). Representatives are available Monday through Friday, 9:00 a.m. to 8:00 p.m.

Eligibility and Cost

You and/or your dependents must be enrolled in a Princeton medical plan to access AbleTo. There are no fees or copays for individuals enrolled in the Princeton Health Plan, HMO plan, or J-1 Visa Plan. CDHP participants must meet their deductible prior to services being covered. For CDHP participants, the initial consultation costs $300, and subsequent visits cost $275; visits are then covered at 100% after the deductible is met.

ADDITIONAL RESOURCES

Aetna and UnitedHealthcare offer their own telemental health services. To schedule an appointment for this service with Aetna (referred to as Televideo), call the in-network provider MDLive at (855) 824-2170 or go to mldive.com/bhcmm, call Inpathy at (800) 442-8938, or go to aetna.com/dse/princeton or call Aetna at (800) 535-6689. To schedule an appointment for this service with UnitedHealthcare, go to myuhc.com, click Find a Provider, click Behavioral Health Directory, People, Provider Type, and Telemental Health Providers. Visits are covered at the same cost as in-network mental health visits under your Princeton medical plan.
PRESCRIPTION DRUG PLAN

All Princeton medical plans provide prescription coverage through OptumRx. Coverage varies depending on your medical plan election. For more details, refer to the Summary Plan Description (SPD) on our website.

**IF YOU CHOOSE:**

<table>
<thead>
<tr>
<th>THEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Directed Health Plan (CDHP)</td>
</tr>
<tr>
<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>
<tr>
<td>All Other Princeton Medical Plans</td>
</tr>
<tr>
<td>Coverage begins immediately regardless of meeting your medical plan’s deductible.</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.

If you fill your maintenance medication through a retail pharmacy for more than three months, subsequent refills cost twice the retail pharmacy copayment. You should use retail pharmacies for short-term prescriptions, such as antibiotics.

OptumRx home delivery provides for automatic refills of your medication through a program called Hassle-Free Fill. This program automatically refills and delivers three-month supplies of your home delivery medication. To enroll, call OptumRx directly.

**PRESCRIPTION DRUG PLAN COPAYMENTS**

<table>
<thead>
<tr>
<th></th>
<th>Retail Pharmacy</th>
<th>Mail Order</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30-Day Supply</td>
<td>90-Day Supply</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

**NEW HIRES**

After you enroll in a medical plan, you will receive an ID card directly from OptumRx within three to four weeks from the date of your election. If you need an ID card sooner, go to OptumRx’s website at **optumrx.com** one week after you complete your medical plan enrollment to register and print a temporary ID card.

**OPTUMRX**

| optumrx.com                     | (877) 629-3117   | Prescription Group: PURPRNCEM |
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.

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

If you are enrolled under the Aetna or UnitedHealthcare PHP, HMO, or J-1 Visa Plan, you have a separate annual OPM under the prescription plan of $3,500 for an individual and $7,000 for family. Once the member and/or family OPM is satisfied, no additional copayments are required for the remainder of the calendar year.

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.

**COPAY CARD SOLUTIONS**

The Copay Card Solutions program leverages manufacturer copay assistance programs, commonly referred to as coupons, to reduce plan cost and offset member copays. The program has two components: 1) An Accumulator Adjustment, and 2) A Variable Copay Solution (VCS). The Accumulator Adjustment prevents coupon dollars from applying to members’ out-of-pocket costs. The VCS reduces member and plan costs by varying copays to capture the benefit of coupons when members participate in the program. The VCS program is for those enrolled in the HMO, PHP and J-1 Visa Plan, and specialty medications will be filled through the OptumRx Specialty Services Pharmacy. Contact OptumRx for details.

**GENETIC TESTING**

The effectiveness of some prescription medications depends on the genetic makeup of the patient. Princeton provides coverage at no cost for genetic testing. OptumRx contacts you when applicable.

**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.

**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.

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**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.

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Prevention Drugs</th>
</tr>
</thead>
</table>

**Asthma**
Inhaled corticosteroids

**Cancer**
Breast cancer

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

**Anticoagulants**
Cardiac glycosides
Cholesterol lowering agents
High blood pressure
Statins

**Central Nervous System**
Antipsychotics
Smoking deterrents

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

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

**Gastrointestinal**
Acid suppression (ulcer)

**HIV/AIDS**
Musculoskeletal
Osteoporosis
Osteoporosis and/or osteopenia anti-resorptive therapy

**Respiratory**
Asthma/COPD

**Transplant**
Anti-rejection

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

**Women’s Health**
Birth control
Estrogens
Princeton offers three supplemental health plans, through MetLife, to complement your medical plan coverage—accident, hospital indemnity, and critical illness. These insurances provide financial assistance through a lump-sum payment to spend how you like if you experience an unexpected medical event. This money can be used to cover out-of-pocket medical expenses or used to pay for food, utility bills, or any other unexpected expenses you have due to an illness or injury.

Additional information about these plans is available on our website. Once enrolled in a Supplemental Health Plan, you should contact MetLife directly at (800) 438-6388 to file a claim.

**POLICY FEATURES**

- Coverage available for yourself, a spouse, and covered child(ren)
- 24-hour coverage—paid benefits for accidents that occur on and off the job
- No health questions or physical exams required
- Premiums paid through after-tax payroll deductions
- Portable coverage—you take your policy with you if you leave Princeton

**Policy Features**

**ENROLLMENT AND DECISION SUPPORT**

To help you choose which supplemental health plan(s) are right for you and your family, licensed benefit counselors from Winston Benefits are available to provide more information or answer questions about the plans. Since these plans are administered directly through Winston Benefits, you cannot elect the plans through HR Self Service.

For more information or to enroll through Winston Benefits, call (855) 393-3601, Monday through Friday, 8:30 a.m. to 8:00 p.m., or visit myprincetonbenefits.com

**ACCIDENT MONTHLY RATES**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Employee</th>
<th>Employee &amp; Child(ren)</th>
<th>Employee &amp; Spouse</th>
<th>Employee &amp; Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Plan</td>
<td>$4.23</td>
<td>$8.55</td>
<td>$7.76</td>
<td>$10.71</td>
</tr>
<tr>
<td>High Plan</td>
<td>$9.12</td>
<td>$18.37</td>
<td>$16.64</td>
<td>$23.05</td>
</tr>
</tbody>
</table>

**HOSPITAL INDEMNITY MONTHLY RATES**

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Employee &amp; Child(ren)</th>
<th>Employee &amp; Spouse</th>
<th>Employee &amp; Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10.31</td>
<td>$17.77</td>
<td>$23.08</td>
<td>$31.95</td>
</tr>
</tbody>
</table>

**NEW HIRES**

You have 31 days from your date of hire to enroll through Winston Benefits. Coverage becomes effective the first of the month coincident with or next following your date of hire.

**WINSTON BENEFITS**

myprincetonbenefits.com  (855) 393-3601

**METLIFE**

metlife.com  (800) 438-6388
Critical Illness

Critical Illness insurance provides a lump-sum payment when you or a covered dependent is diagnosed with a covered illness. You have the option to elect coverage at an initial benefit amount of $10,000 or $20,000, which is paid upon the first diagnosis (coverage for a spouse or child is at 50% of the initial benefit). The Plan pays a recurrence benefit for certain covered conditions. However, a recurrence benefit is only available if an initial benefit has been paid for the covered condition.

**COVERED ILLNESSES**

- Alzheimer’s disease
- Heart attack
- Coronary artery bypass graft
- Full benefit cancer
  (not all types of cancer are covered and/or are covered at a partial benefit)
- Kidney failure
- Stroke
- Major organ transplant

The plan may also pay a partial benefit, equal to 25% of the initial benefit amount, for 22 listed conditions, which include:

- Multiple sclerosis
- Sickle cell anemia
- Systemic lupus erythematosus
- And more...

For more information, and for the full list of covered illnesses and conditions, visit our website or contact Winston Benefits.

---

**CRITICAL ILLNESS MONTHLY RATES BY AGE RANGE**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employee</td>
</tr>
<tr>
<td>&lt; 25</td>
<td>$0.09</td>
</tr>
<tr>
<td>25–29</td>
<td>$0.10</td>
</tr>
<tr>
<td>30–34</td>
<td>$0.17</td>
</tr>
<tr>
<td>35–39</td>
<td>$0.28</td>
</tr>
<tr>
<td>40–44</td>
<td>$0.47</td>
</tr>
<tr>
<td>45–49</td>
<td>$0.75</td>
</tr>
<tr>
<td>50–54</td>
<td>$1.14</td>
</tr>
<tr>
<td>55–59</td>
<td>$1.65</td>
</tr>
<tr>
<td>60–64</td>
<td>$2.42</td>
</tr>
<tr>
<td>65–69</td>
<td>$3.71</td>
</tr>
<tr>
<td>70+</td>
<td>$5.62</td>
</tr>
</tbody>
</table>

Multiply the benefit amount (e.g. $20,000) by the rates shown above, divide by $1,000, and round to two decimals to calculate the monthly rate. Your rates are based on your age as of January 1, or your date of hire, if later.

For example: If you elect $20,000 of coverage and are age 50, your monthly rate would be $20,000 x $1.14 = $22,800 / 1,000 = $22.80.

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**EXCLUSIONS**

Although there are no pre-existing conditions exclusions for this plan, you only receive an initial benefit payment if you are diagnosed with a covered condition on or after your effective date. Also, a recurrence benefit is only available if an initial benefit has been paid for a covered condition.
You have three dental plan options. For an overview of each plan, refer to the comparison chart on page 22. You pay the total cost for coverage on a pretax basis. You should review your options carefully by comparing the plan features and costs and determining the network of providers available under each plan. Details about the dental plans, including Summary Plan Descriptions (SPDs) for each dental plan, are available on our website. For a current directory of dentists, visit Aetna’s website at aetna.com/dse/princeton or MetLife’s website at metlife.com/mybenefits and select the PDP Plus network.

Due to the MetLife Dental Plan Lock-In period if you are electing or currently enrolled in the MetLife Basic or High Option Dental Plan, your coverage remains in effect through December 31, 2022. You will not have the option to change your dental plan coverage until the 2023 Open Enrollment period unless you experience a qualifying status event. If you are waived from coverage or enrolled in the Aetna DMO, you do not have the option to elect a MetLife dental plan until the 2023 Open Enrollment period. However, if you are waived from coverage, you may be eligible to enroll in a MetLife dental plan if you experience a qualifying event.

Not all treatments are covered. Contact Aetna or MetLife for verification of coverage and pretreatment estimate prior to receiving treatment.

Basic Option PPO Plan

The Basic Option PPO Plan administered by MetLife provides limited coverage for preventive and basic services only. It allows you to go in- or out-of-network; however, if you go out-of-network, reimbursement is based upon the in-network benefit rate. This plan covers all eligible preventive and diagnostic services at 100%, and basic services at 50%, up to a calendar year maximum of $2,000. Major and specialty services are not covered; however, you may receive a discount by utilizing an in-network provider.

High Option PPO Plan

The High Option PPO Plan administered by MetLife provides comprehensive coverage for preventive, basic, and major services. It offers you the opportunity to receive services from a network of dentists with whom MetLife has negotiated reduced-fee schedules. However, out-of-network benefits are also available and provide you with the option to see any dentist, and reimbursement is based on reasonable and customary limits. The plan covers eligible preventive, basic, and major services, after applicable coinsurance, at a percentage of costs, up to $2,000 annually per person for in-network services or $1,500 annually per person for out-of-network services.

DMO Plan

The DMO Plan administered by Aetna is an HMO-style plan that covers eligible preventive and basic services at 100%. Major services are covered at 60%. You must choose a primary care dentist from the Aetna DMO directory before you are able to utilize the coverage. All care must be coordinated through your primary care dentist. There is no coverage for out-of-network services.

DENTAL PLAN ID CARDS

If you elect MetLife dental plan coverage, ID cards are mailed to your home address within three to four weeks of your election. You can print a temporary ID card online at metlife.com/mybenefits. The Aetna DMO Plan does not issue ID cards since they are not needed for services.

NEW HIRES

You have 31 days from the date of hire to elect or waive coverage through HR Self Service. Coverage becomes effective on your date of hire. If you elect the MetLife Basic or High Option Dental Plan your coverage remains in effect through December 31, 2022. You do not have the option to change your dental coverage until the 2023 Open Enrollment period unless you experience a qualifying status event. If you waive coverage or enroll in the Aetna DMO, you will not have the option to elect the MetLife Basic or High Option Dental Plan until the 2023 Open Enrollment period. If you waive coverage, you may be eligible to enroll with MetLife if you experience a qualifying event. See page 4 for more details. If you elect coverage in the Aetna DMO Plan, you are required to elect a participating primary care dentist before you are able to utilize coverage. To elect a primary care dentist, contact Aetna.

<table>
<thead>
<tr>
<th>METLIFE</th>
<th>metlife.com/mybenefits</th>
<th>(866) 832-5756</th>
<th>PPO Group #: 0138262</th>
</tr>
</thead>
<tbody>
<tr>
<td>AETNA</td>
<td>aetna.com/dse/princeton</td>
<td>(877) 238-6200</td>
<td>DMO Group #: 397432</td>
</tr>
</tbody>
</table>

21 | Benefits 2022
## DENTAL PLAN BENEFITS COMPARISON

This is intended to provide an overview of the plan benefits. Details are available on our website. The dollar or percentage amounts in the chart below reflect the patient-paid portion of the incurred dental costs.

<table>
<thead>
<tr>
<th></th>
<th>Basic Option PPO Plan</th>
<th>High Option PPO Plan</th>
<th>DMO Plan¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network or</td>
<td>In-Network</td>
<td>Out-of-Network²</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$50 / $150 (out-of-network only)</td>
<td>$50 / $150 (for basic and major services)</td>
<td>$50 / $150 (for basic and major services)</td>
</tr>
<tr>
<td>(Individual / Family)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$1,500</td>
</tr>
<tr>
<td>Benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Preventive and Diagnostic Services³

- Examinations and Visits
- X-ray Services
- Cleanings
- Fluoride Treatments

Reimbursement based on 100% of in-network charge

### Basic Services

- Amalgam (Silver) Fillings
- Root Canal Therapy (Anterior teeth)
- Composite Fillings (Anterior teeth only)
- Stainless Steel Crowns
- Uncomplicated Extractions

Reimbursement based on 50% of in-network charge

### Major Services⁴

- High Noble Metal and Porcelain Inlays
- High Noble Metal Restorations
- Crowns
- Root Canal Therapy, (Molars)⁵
- Implants⁶

Not covered

May receive up to 35% discount from in-network provider

Check with the provider prior to receiving treatment

### Orthodontia⁴

- Orthodontics

Not covered

May receive up to 35% discount from in-network provider

Check with the provider prior to receiving treatment

### Basis of Reimbursement

Reimbursement

Maximum allowable charge

Negotiated fee

80th percentile of reasonable and customary charges

Negotiated fee

---

¹ You must select a primary care dentist directly with Aetna.
² Reimbursement is based on reasonable and customary charges so you may be balance billed.
³ Visit limitations may apply. Consult the Certificates of Coverage on our website for more details.
⁴ If you began treatment under the MetLife Basic Option PPO Plan for major or orthodontic services and are considering moving to the Aetna DMO Plan, these services are not covered by Aetna. The lifetime maximum includes amounts paid through all other plans.
⁵ Included in the basic services category for MetLife Basic and High Option Dental Plans
⁶ The Aetna DMO coverage for implants is limited to two paid occurrences per year. Coverage is limited to an endosteal implant, prefabricated abutment, and implant maintenance procedures. Other rules may apply. The MetLife High Option PPO also has limitations on coverage for implants. Request a predetermination of benefits from Aetna or MetLife prior to services being rendered.
**VISION PLAN**

You may enroll in the Vision Plan through MetLife. You pay the total cost for coverage on a pretax basis. MetLife offers the option of utilizing an in-network provider or going out-of-network to any provider you choose. For details about the Vision Plan, visit our website. For a current directory of vision care providers, visit MetLife’s website at [metlife.com/mybenefits](http://metlife.com/mybenefits) and choose the MetLife Vision PPO or call MetLife at (855) MET-EYE1 (638-3931). When you contact MetLife, you need to provide the group number 30051158-0008 and plan ID number MC0011.

**FRAMES AND LENSES**

In any calendar year, the Vision Plan provides:

- Two pairs of prescription glasses or
- One pair of prescription glasses and an allowance for contact lenses or
- Double your contact lens allowance

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**VISION PLAN BENEFITS**

This is intended to provide an overview of the plan benefits. Details are available on our website. The dollar or percentage amounts in the chart below reflect the patient-paid portion of the incurred vision costs.

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Comprehensive Vision Exam</td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Prescription Lenses</td>
<td>Single Vision Lined Bifocals Progressives Lined Trifocals Lenticular</td>
<td>$10 copayment¹ Applied to lenses and frames</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>All</td>
<td>100% with coverage up to $155 after a $10 copayment¹ 100% with coverage up to $85 after a $10 copayment at Costco, Walmart, or Sam’s Club</td>
</tr>
<tr>
<td>Prescription Contact Lenses</td>
<td>Evaluation Fees Fitting Costs</td>
<td>Copayment not to exceed $60</td>
</tr>
<tr>
<td></td>
<td>Materials</td>
<td>100% with reimbursement up to $140</td>
</tr>
</tbody>
</table>

¹ If purchasing lenses and frames together, one $10 copayment applies.

---

**METLIFE ID CARD**

If you elect vision plan coverage, you receive an ID card, mailed to your home address, within three to four weeks of your election. You can print a temporary ID card online at [metlife.com/mybenefits](http://metlife.com/mybenefits).

---

**NEW HIRES**

You have 31 days from your date of hire to elect or waive coverage through HR Self Service. Coverage becomes effective on your date of hire.
HEALTH SAVINGS ACCOUNT

If you elect coverage under the CDHP, you may also elect a Health Savings Account (HSA) administered by PayFlex. It is important to keep in mind that you can only use HSA funds after you have contributed them.

CONTRIBUTIONS

Princeton will contribute $200 for individual coverage and $400 for employee and child(ren), spouse, or family coverage into your HSA in a lump sum. You can also contribute money to your HSA on a pretax basis through payroll deductions. HSA contributions are limited by the IRS and pertain to both your contribution and Princeton’s contribution, as well as a spouse’s contributions. In 2022 the HSA contribution limit is $3,650 for an individual or $7,300 for employee and child(ren), spouse or family coverage. If you are 55 years old or older, you may contribute an additional $1,000.

You must be an active employee and enrolled in the HSA to receive the Princeton contribution amount. The amount of the Princeton contribution will be based on your coverage level as of January 1, or the effective date of the HSA enrollment, if later. A change in coverage level during the plan year will not result in an additional Princeton contribution. You are not required to contribute any funds in order to receive Princeton's contribution. Your unused balance accumulates year-after-year. You can manage your HSA at payflex.com.

ELIGIBLE EXPENSES

Expenses that may be paid through your HSA on a tax-free basis include most medical care and services; dental and vision care; prescription drugs; and premiums paid for COBRA, long-term care, and medical and prescription drug expenses as a retiree, including Medicare premiums. You can see a complete list of eligible expenses at irs.gov (Publications 969 and 502).

FEATURES

• Triple tax advantage – money is contributed tax-free, grows tax-free and distributions used for eligible expenses are tax-free
• You can invest your funds once your account balance reaches $1,000
• Unused money rolls over from year-to-year and is yours to keep, even if you leave or retire from Princeton
• Once funds are available in your HSA, the money can be used towards eligible expenses. The Princeton contribution is made in a lump sum following your enrollment into the HSA.
• You can elect, change, or terminate your HSA elections at anytime during the year by contacting the Benefits Team.

EXCLUSIONS

• Under IRS regulations, if you enroll in the HSA, you cannot participate in another healthcare flexible spending account (FSA). If your spouse participates in a healthcare FSA, then you are not eligible to establish or contribute to an HSA.
• You are not eligible to contribute to an HSA if you are covered by another medical plan that is not an IRS-qualified CDHP, e.g., a spouse’s non-CDHP.
• You are not eligible to contribute to an HSA if you are enrolled in Medicare.
• For civil union or domestic partners, IRS rules do not allow you to use your HSA to reimburse yourself for the expenses of your partner or your partner’s children.
• For other exclusions, contact the Benefits Team.

PAYFLEX ID NUMBER

When registering on the PayFlex website, you will need to provide your Princeton Benefits ID number located in HR Self Service under Benefit Details.

NEW HIRES

You have 31 days from your date of hire to elect coverage through HR Self Service. Coverage becomes effective the first of the month coincident with or next following your date of hire.

IMPORTANT REMINDERS ABOUT HSA CONTRIBUTIONS

Eligibility Requirements

The HSA eligibility rules and exclusions are set by the IRS. While we have listed some of the exclusions on this page, additional rules and exclusions may apply; please review A Consumer’s Guide to the Health Savings Account on our website for important information. You should also review IRS Publication 969 on the IRS website.

Customer Identification Program (CIP)

Due to the USA Patriot Act to open an HSA, federal regulation requires that all individuals go through Customer Identification Program (CIP) testing to verify their identity. There are four basic elements to the CIP review: legal name, Social Security number, date of birth, and residential address. If you fail the CIP review, PayFlex reaches out to you to let you know the reason for the failure, and what documents are required. You have 90 days to respond and provide the requested information to confirm your identity. If your identity is not confirmed within 90 days, any funds in your HSA are returned.

If you have questions about your HSA, contact PayFlex.
HEALTHCARE FLEXIBLE SPENDING ACCOUNT

The Healthcare Flexible Spending Account (HFSA) allows you to set aside money pretax to pay for health-related expenses not covered by insurance for you or your eligible dependents. The advantage this plan offers is that you pay no federal taxes on your contributions. For example, if you put in $1,000 and are in a 20% federal tax bracket, you might save $200 ($1,000 x 20% = $200). Contributions to the HFSA are subject to New Jersey State income tax.

To continue contributing to your HFSA from one calendar year to the next, you must make a new election each year during Annual Benefits Open Enrollment because elections cannot automatically carry over from year-to-year.

CONTRIBUTIONS

You may contribute between $100 and the IRS maximum into the account. In 2021, the IRS maximum pretax limit was $2,750. The pretax limit for 2022 was not released as of the printing of this booklet. Once the pretax limit is announced, it will be updated on our website.

ROLLOVER

Due to the Consolidated Appropriations Act, unused balances of $50 or more from 2021 will automatically rollover into your 2022 account as long as you are an active benefits-eligible employee - whether or not you elect a new amount for 2022. Amounts under $50 will be forfeited. You can use the rollover amount to be reimbursed for eligible expenses incurred in 2022 as well as expenses incurred in 2021, if submitted by March 31, 2022. Note: beginning in 2022, balances of $50 or more, up to a maximum of $550 will be eligible to be rolled over into 2023 per IRS regulations.

A participant must be active in the HFSA on the last day of the calendar year for the funds to be rolled over into the next calendar year. If your employment with Princeton ends, expenses you incur after your termination date are ineligible for reimbursement unless you continue your HFSA through COBRA.

Contact the Benefit Team or visit our website for further information.

PAYFLEX DEBIT CARD

PayFlex provides one debit card per family. You can order additional cards by contacting PayFlex.

When you use the card, it debits your HFSA automatically. PayFlex may contact you to request additional information to document certain services to substantiate the claim in accordance with IRS regulations.

ELIGIBLE EXPENSES

Expenses must be for you, a spouse, or eligible dependents. Expenses incurred for you or an eligible dependent through a benefit plan outside of Princeton University are eligible for reimbursement. For a list of eligible and ineligible expenses, visit PayFlex’s website.

For civil union or domestic partners, IRS rules do not allow you to use your HFSA to reimburse yourself for the expenses of your partner or your partner’s children.

REIMBURSEMENT

The annual contribution amount you elect is available to you on the effective date of the election. You may only be reimbursed for eligible expenses incurred during the calendar year and while you are contributing to the plan. If you terminate employment, expenses incurred after your termination date are not eligible for reimbursement.

You can view your account balance and claim activity on PayFlex’s website.

To pay for or be reimbursed for an eligible expense, you can use your PayFlex debit card, file a claim online, or submit your receipt along with an HFSA claim form to PayFlex. You can arrange for direct deposit of your reimbursement. Claim and direct deposit authorization forms are available on our website or on PayFlex’s website.

You have until March 31, 2023, to submit claims for eligible expenses you incur during the 2022 calendar year.

PAYFLEX ID NUMBER

When registering on the PayFlex website, you need to provide your Princeton Benefits ID number located in HR Self Service under Benefit Details.

NEW HIRES

You have 31 days from your date of hire to elect coverage through HR Self Service. Coverage becomes effective the first of the month coincident with or next following your date of hire. This is a calendar year election. For example, if you are hired on June 15, your HFSA election would be effective July 1 through December 31. You need to take this into account when estimating your expenses.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Care Flexible Spending Account (DFSA) allows you to set aside money pretax to pay for childcare expenses for dependent children 12 years and under. The DFSA is not a plan to cover your dependents’ healthcare expenses. Use the HFSA for your dependents’ healthcare expenses. The advantage this plan offers is that you pay no federal taxes on your contributions. For example, if you put in $1,000 and are in a 20% federal tax bracket, you might save $200 ($1,000 x 20% = $200). Contributions to the DFSA are subject to New Jersey State income tax. Generally, the IRS requires that both you and your spouse work to qualify to contribute to the DFSA, although there are specific exceptions.

To continue participation in the DFSA plan from one calendar year to the next, you must make a new election annually during Annual Benefits Open Enrollment because elections cannot automatically carry over from year-to-year.

CONTRIBUTIONS

You may contribute between $100 and $5,000 into the account—$2,500 if you are married and filing separately. The amount you elect is automatically deducted from your pay on a pretax basis and credited to your expense account. The IRS holds you responsible for ensuring that you and your spouse’s contributions do not exceed $5,000 in a tax year.

Depending on your household income, it might be advantageous to claim childcare expenses on your federal income tax return instead of electing a DFSA. The IRS does not permit you to claim the expenses on your tax return when you use a DFSA. Consult with a tax adviser about which option is best for you. The IRS does not allow you to roll over unused funds at the end of the year—any money in your account is forfeited.

Visit PayFlex’s website at payflex.com and select

Employees for tools to help you calculate contribution amounts and estimated savings.

ROLLOVER

Due to the Consolidated Appropriations Act, unused balances of $50 or more from 2021 will automatically rollover into your 2022 account as long as you are an active benefits-eligible employee – whether or not you elect a new amount for 2022. Amounts under $50 will be forfeited. A participant must be active in the DFSA on the last day of the calendar year for the funds to be rolled over. You can use the rollover amount to be reimbursed for eligible expenses incurred in 2022 as well as expenses incurred in 2021, if submitted by March 31, 2022. Note: beginning in 2022, per IRS regulations, rollover balances will no longer be permitted. Therefore, unused balances from 2022 will be forfeited.

ELIGIBLE EXPENSES

The account may be used to pay for eligible expenses for any dependents living with you including those who are physically or mentally unable to care for themselves and for whom you can claim as dependents as defined by Internal Revenue Code Section 152.

Eligible expenses include day care, a private nanny, preschool or nursery school, before- and after- school programs, and summer day camps.

In order to be eligible for reimbursement, eligible expenses must be incurred during the calendar year while you are contributing to the plan.

REIMBURSEMENT

You may only be reimbursed for eligible expenses incurred during the calendar year while you are contributing to the plan. If you terminate employment, expenses incurred after your termination date are not eligible for reimbursement. You can view your account balance and claim activity on PayFlex’s website.

To be reimbursed for an eligible expense, file a claim online or submit your receipt along with a DFSA claim form to PayFlex. You can arrange for direct deposit of your reimbursement. Claim and direct deposit authorization forms are available on our website or on PayFlex’s website.

You have until March 31, 2023, to submit claims for eligible expenses you incur during the 2022 calendar year; any money in your account at the end of the calendar year is forfeited.

PAYFLEX ID NUMBER

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

NEW HIRES

You have 31 days from your date of hire to elect coverage through HR Self Service. Coverage becomes effective the first of the month coincident with or next following your date of hire. This is a calendar year election. For example, if you are hired on June 15, your DFSA election would be effective from July 1 through December 31. You need to take this into account when estimating your expenses. The IRS holds you responsible for ensuring that you and your spouse’s contributions do not exceed $5,000 in a tax year when combined with multiple employers.

PAYFLEX

payflex.com

(800) 284-4885

FSA Plan ID: 120632
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 2021, the maximum pretax limits for both parking and transit expenses were $270. The pretax limits for 2022 were not released as of the printing of this booklet. Once new limits are announced, they will be updated on our website.

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

**ELIGIBLE TRANSIT EXPENSES**

An expense for transit passes, such as the cost of purchasing a pass, token, fare card, etc., that entitles you to transportation, must be either:

- On mass transportation or
- Provided by a person in the business of transporting passengers for hire and in a vehicle with a seating capacity of at least six adults plus driver; use of limos and taxis ineligible

Expenses may also include transportation in a commuter highway vehicle, at the cost 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

**DID YOU KNOW...**

Princeton offers financial incentives and other benefits for employees who use alternative transportation to commute (biking, walking, riding the train or bus, carpooling, or vanpooling) instead of a university parking permit. Learn more or request your own personalized commute plan by calling (609) 258-1339 or online at transportation.princeton.edu/revise-your-ride.

**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.
LIFE INSURANCE

Basic Life and Accidental Death and Dismemberment Insurance

Offered through The Hartford, Princeton University provides, at no cost to you, basic term life and accidental death and dismemberment (AD&D) insurance coverage until age 60 equal to one times your annual base salary, rounded up to the nearest $1,000, up to a maximum of $500,000. For example, if your annual base salary is $40,500, the basic term life and AD&D insurance benefit is $41,000. Life and AD&D insurance coverage increases automatically with salary increases.

For AD&D insurance, if you suffer the loss of your eyesight or a limb, or die as a result of an accident, this insurance pays a lump sum to you or your beneficiaries. For more information, visit our website. At age 60, basic life and AD&D coverage is reduced according to the chart.

WHEN YOU RETIRE OR TERMINATE EMPLOYMENT

Your enrollment in the basic life and AD&D insurance plans terminates the day your employment ends at Princeton. You have 31 days from your termination date to convert your basic term and/or supplemental life insurance coverage to an individual whole life policy. Rates for conversion can be expensive because no physical examination is required and the conversion is from a group term life insurance policy to an individual whole life policy.

Business Travel Accident Insurance

Princeton University provides, at no cost to you, business travel accident insurance coverage until age 60 equal to five times your annual base salary, rounded to the nearest $1,000, up to a maximum benefit of $500,000 should you die as a result of an accident while on authorized University business. At age 60, business travel accident coverage is reduced according to the schedule used for the basic life and AD&D coverage. This coverage applies only for travel on authorized University business—not travel to and from work.

Traveling on University Approved Business

When traveling on University-approved business outside of the U.S., benefits-eligible employees and accompanying family members are covered by an international travel medical policy. Employees are automatically enrolled into this policy. This coverage is provided for a period of up to 12 months, is separate from your regular medical coverage, and acts as your primary coverage when traveling outside of the U.S. For more information, contact Risk Management at riskmgt@princeton.edu.

NEW HIRES

Basic Life and Accidental Death and Dismemberment Insurance

You are automatically enrolled in the basic term life and AD&D insurance plan as of your date of hire. You should designate your beneficiaries in HR Self Service within 31 days of your date of hire. If you do not designate a beneficiary, The Hartford names your beneficiaries per its Preferential Beneficiary Arrangement, which designates that your life insurance is paid to your (1) surviving spouse, (2) surviving children in equal shares, (3) your surviving parents in equal shares, (4) your surviving brothers and sisters, or (5) your estate.

Business Travel Accident Insurance

You are automatically enrolled in this benefit on your date of hire. Your beneficiaries are the same beneficiaries selected under your basic term life and AD&D insurance coverage.

THE HARTFORD

mybenefits.thehartford.com

(877) 778-1383

Plan ID: 681431

hr.princeton.edu/thrive

Benefits 2022 | 28
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. All plans include prescription drug coverage; refer to pages 17 and 18 for details.

### Consumer Directed Health Plan (CDHP)

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Preferred</th>
<th>In-Network Non-Preferred</th>
<th>Out-of-Network</th>
<th>In-Network Preferred</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>$3,000 / $6,000</td>
<td>$0 / $0</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (OPM) (Individual / Family)</strong></td>
<td>$200 / $400</td>
<td>$750 / $1,500</td>
<td>$200 / $400</td>
<td>$0 / $0</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>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Primary Care Physician (PCP)</td>
<td>20% after deductible</td>
<td>50% 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>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Tiered Specialists</td>
<td>NA</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>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency Room (no coverage for nonemergencies)</td>
<td>$0 after deductible</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>Medical and Surgical Procedures</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>10% after deductible</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>10% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>Surgical Procedures (Independent Facility / Hospital)</td>
<td>$0 after deductible</td>
<td>40% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Laboratory</td>
<td>$0 after deductible / 20% after deductible</td>
<td>Not covered</td>
<td>$0 / 20% after deductible</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>
<td>$0 / 20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Hi-Tech Radiology (MRI, CAT, etc.) (Independent Facility / Hospital)</td>
<td>$0 after deductible / 20% after deductible</td>
<td>Not covered</td>
<td>$0 / 20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive Care and Immunizations</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>Not covered</td>
<td>$20 copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Annual Eye Exam / Prescription Eyeglasses and/or Contact Lenses</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>10% after deductible</td>
</tr>
<tr>
<td></td>
<td>Physical Therapy (100 visits per CY)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>10% 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>
<td>10% after deductible</td>
</tr>
<tr>
<td></td>
<td>Acupuncture (20 visits per CY)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>10% 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 and preferred United Healthcare Specialists under the tiered design, refer to page 12.
3. Patient costs for tiered specialists fees correspond to the tier of the specialist utilized to perform the medical or surgical procedure under the United Healthcare PHP.
4. Coverage requires precertification; refer to page 11.
5. Includes seven well-baby visits in the first year of a child’s life.
6. 100% reimbursement provided for children up to age 18 for frames and lenses; limited to one pair of glasses each calendar year.
**Benefits 2022**

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. All plans include prescription drug coverage; refer to pages 17 and 18 for details.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Princeton Health Plan (PHP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$200 / $400</td>
<td>$750 / $1,500</td>
</tr>
<tr>
<td>Non-PREFERRED</td>
<td>$20 copayment</td>
<td></td>
</tr>
<tr>
<td>Preferred</td>
<td>$0</td>
<td>NA</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PREFERRED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare Princeton Health Plan (PHP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$0</td>
<td>NA</td>
</tr>
<tr>
<td>Preferred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PREFERRED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PREFERRED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Only</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Based on salary (refer to page 13)

2 For a list of preferred labs and preferred United Healthcare Specialists under the tiered design, refer to page 12.

3 Patient costs for tiered specialists fees correspond to the tier of the specialist utilized to perform the medical or surgical procedure under the United Healthcare PHP.

4 Coverage requires precertification; refer to page 11.

5 Includes seven well-baby visits in the first year of a child’s life

6 100% reimbursement provided for children up to age 18 for frames and lenses; limited to one pair of glasses each calendar year

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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 $175 copayment (waived if admitted)

3 10% after deductible

4 20% after deductible

5 40% after deductible

6 $175 copayment

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For more information, refer to hr.princeton.edu/thrive.
SUPPLEMENTAL LIFE INSURANCE

Needs for life insurance differ for each individual or family, and those needs change over time. If you have not recently reviewed your life insurance needs, you may want to do so. Princeton's Supplemental Term Life Insurance Plan offers you the option to purchase additional life insurance to supplement the basic term life insurance provided by the University at the rates listed below—there is a cost estimator available online at thehartford.com/cost/princeton. The cost is deducted on an after-tax basis from your pay. You can elect supplemental life insurance for up to six and one-half times your annual base salary, with a maximum payout of $1.5 million. The maximum basic and supplemental life insurance payout is $2 million. To help you evaluate your needs, there is a life insurance calculator tool available for no cost online at thehartford.com/dm/coverageadvisor/life.html. We also recommend that you discuss this topic with your financial planner.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>$0.046</td>
</tr>
<tr>
<td>30–34</td>
<td>$0.058</td>
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<tr>
<td>35–39</td>
<td>$0.069</td>
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<tr>
<td>40–44</td>
<td>$0.081</td>
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<td>45–49</td>
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<td>50–54</td>
<td>$0.162</td>
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<td>55–59</td>
<td>$0.301</td>
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<tr>
<td>60–64</td>
<td>$0.451</td>
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<tr>
<td>65–69</td>
<td>$0.879</td>
</tr>
<tr>
<td>70+</td>
<td>$1.423</td>
</tr>
</tbody>
</table>

For example: If you earn $55,250 and have elected three times your base salary for supplemental life insurance and your age is 35, your monthly supplemental life insurance cost is calculated as follows: $55,250 x 3 = $165,750 rounded up to the nearest $1,000, which would be $166,000, divided by $1,000 x $0.069 = $11.45.

Some elections require evidence of insurability (EOI). The EOI form is available on our website and should be submitted directly to The Hartford. The Hartford notifies you of your approval or denial or requests more information. If approved, the Benefits Team notifies you to log in to HR Self Service and elect the approved supplemental life insurance level to activate your coverage.

During Open Enrollment, you may be able to elect up to one times your base salary or increase your supplemental life insurance by an additional one times your base salary provided the increase does not raise the amount of life insurance above $500,000 or three times your base salary. EOI is required for any election over three times your base salary or $500,000 in value.

You have the opportunity to elect supplemental life insurance at any time during the year. However, you are required to complete and submit an EOI form to The Hartford, except as noted below in Qualifying Status Event Changes.

If you are on long term disability, you may not increase your supplemental life insurance benefits until you return to active status. At age 60, supplemental life coverage is reduced using the same schedule that is used for the basic life and AD&D coverage on page 28.

You can waive your participation in supplemental life insurance at any time during the year by notifying the Benefits Team. If you waive your participation and were also enrolled in the spousal or child life insurance plans, those plans also terminate.

QUALIFYING STATUS EVENT CHANGES

Should you experience a qualifying status event, you may be able to elect up to one times your base salary or increase your supplemental life insurance by an additional one times your base salary provided the increase does not raise the amount of life insurance above $500,000 or three times your annual base salary. EOI is required for any election over three times your base salary or over $500,000 in value. You must notify the Benefits Team within 31 days, or 90 days for the birth or adoption of a child, of a qualifying status event.

WHEN YOU RETIRE OR TERMINATE EMPLOYMENT

Your enrollment in the Supplemental Life Insurance Plan terminates the day your employment ends at Princeton. You have 31 days from your termination date to convert your supplemental life insurance coverage to an individual whole life policy. Rates for conversion tend to be expensive because no physical examination is required, and the conversion is from Princeton University’s group term life insurance policy to an individual whole life policy.

NEW HIRES

You have 31 days from your date of hire to elect coverage up to three times your annual base salary or a maximum life insurance amount of $500,000 without providing EOI. Coverage becomes effective the first of the month coincident with or next following your date of hire.

THE HARTFORD  mybenefits.thehartford.com  (877) 778-1383  Plan ID: 681431
If you are enrolled in Princeton’s Supplemental Term Life Insurance Plan, you can also elect to cover your spouse with $10,000, $25,000, or $50,000 of spousal life insurance. The cost is deducted on an after-tax basis from your pay. If the amount you elect exceeds the amount of your supplemental life insurance, the spousal life insurance is incrementally decreased. For example, if the value of your own supplemental life insurance is $40,000, the highest value you may elect for spousal life insurance is $25,000.

You may elect spousal life insurance at any time during the year. However, you are required to complete and submit an EOI form for your spouse to Hartford. Hartford may require you to provide additional information and will determine whether additional coverage is approved. You have 31 days from the date of marriage to elect spousal life insurance without having to submit an EOI form.

The cost of spousal life insurance is based upon the spouse’s date of birth and utilizes the same rates as charged for supplemental life insurance listed on page 31.

If an employee’s spouse is also a benefits-eligible employee of Princeton University and eligible for coverage under the Supplemental Term Life Insurance Plan, the employee is not eligible for spousal life insurance. According to The Hartford’s standard practice, you are covered as either an employee or a dependent, not both. If, at the time of a claim, duplicate coverage exists, The Hartford pays only one benefit.

If you are enrolled in Princeton’s Supplemental Term Life Insurance Plan, you can also elect to cover eligible dependent children with $5,000 or $10,000 of child life insurance. The cost is deducted on an after-tax basis from your pay. You may elect child life insurance at any time, and you never need to provide EOI. For the definition of a dependent child, refer to page 2.

The cost per family unit is $.79/month for $10,000, or $.40/month for $5,000. You must cover all children for the same amount of life insurance—either $5,000 or $10,000. For example, if you have three children and you elect $10,000 of coverage, your monthly cost is $.79 for all three children.

If both parents are employees of Princeton University and eligible for benefits, only one parent may cover the children. If, at the time of a claim, duplicate coverage exists, The Hartford pays only one benefit.

**WHEN YOU RETIRE OR TERMINATE EMPLOYMENT**

Your enrollment in spousal and/or child life insurance through Princeton’s Supplemental Life Insurance Plan terminates the day your employment ends at Princeton. For details, see page 31.

### NEW HIRES

**Spousal Life Insurance**

You have 31 days from your date of hire to elect coverage without having to provide EOI. Coverage becomes effective the first of the month coincident with or next following your date of hire.

**Child Life Insurance**

You may elect child life insurance at any time, and you never need to provide EOI. Coverage becomes effective the first of the month coincident with or next following your date of election.

**THE HARTFORD**

mybenefits.thehartford.com (877) 778-1383 Plan ID: 681431
PRINCETON UNIVERSITY RETIREMENT PLAN

The Princeton University Retirement Plan (PURP) is a defined contribution plan to which the University contributes a percentage of your base salary to your retirement account after each pay period. You choose how you want the University’s contributions to be invested among a variety of investment funds. You may change your investments at any time. 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 the first day of the month coincident with or next following your date of hire and become fully vested in the Plan after 30 months of service.

Your employment with a previous employer may be eligible for credit toward the vesting requirement if the prior employer was classified as an exempt organization under Section 501(c)(3) of the Internal Revenue Code or if you were employed by a public college or university, which maintains a regular faculty and curriculum and has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried out. Service with a university outside of the United States is also recognized for vesting purposes.

The previous employer is defined as your most recent employer prior to joining the University. Employment at the previous employer cannot be credited if your employment terminated more than six months before you were hired at Princeton University. To be credited for previous service, you must have your previous employer complete the Princeton University Certification of Prior Employment for Waiver of Service form, available on our website.

CONTRIBUTIONS

The University provides contributions equal to 9.3% of your salary up to the Social Security wage base and 15% over the wage base. Contributions are:

• Calculated on base salary paid by or through the University and not by external funding or during leaves of absence without pay
• Continued until retirement, termination, or change to non-benefits-eligible status
• Subject to Internal Revenue Code limits

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.

DISTRIBUTIONS

Upon termination of employment the following distribution rules apply:

• Terminated vested participants under age 55 with a balance of $75,000 or less are eligible to take a cash distribution or roll their money into an IRA or other qualified plan. Participants with balances above $75,000 are not eligible to take a cash distribution but are eligible to roll their money into an IRA or other qualified plan.
• Terminated vested participants age 55 and older have no restrictions on distributions.

If you are under age 59½ and take a cash distribution, you may be subject to a tax penalty in addition to ordinary income taxes.

NEW HIRES

You are eligible to participate in the Plan on the first day of the month coincident with or next following your date of hire and become fully vested in the Plan after 30 months of service. Your employment with a previous employer, defined as your most recent employer prior to joining the University, may be eligible for credit toward the vesting requirement; see details above.

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
In addition to the contributions provided through the Princeton University Retirement Plan (PURP), it is important that you also save for your future. 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 2021, the limit was $19,500 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 2021. The contribution limits for 2022 were not released as of the printing of this booklet. Once new limits are announced, they are updated on our website.

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 59 ½ 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.

**START, STOP, INCREASE, OR DECREASE YOUR 403(b) CONTRIBUTIONS:**

1. Go to princeton.edu/selfservice
2. Click Benefit Details
3. Click Life Event

For more detailed instructions, visit our website.

**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.

**NEW HIRES**

Princeton University automatically enrolls you in the Retirement Savings Plan at 5% of your pay. You have the option to go online to change your election or waive out of the plan. You can change your savings election at any time during the year.

**TIAA**

tiaa.org/princeton

(800) 842-2776

Plan ID: 102862 or 102866 (PPPL)
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

RETIREE BENEFITS ELIGIBILITY
You can leave Princeton as a retiree and receive retiree benefits if you are a benefits-eligible employee and meet one of the following conditions:

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

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

3. Hired or rehired, or became newly eligible for benefits, on or after January 1, 2019. In addition to meeting the requirements of rule #2 above, your eligibility to retire is governed by the break-in-service rules that govern our retirement plan. Therefore, if you have a break in benefits-eligible service of more than five years, your prior service does not count. The break-in-service rules are outlined in the Princeton University Retirement Plan SPD on our website.

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

If you are a Princeton University retiree and are rehired as an active benefits-eligible employee, at the time that you end your active employment, you return automatically to retiree status.

For details, contact the Benefits Team or visit our website.
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.

You continue to receive contributions into the Princeton University Retirement Plan based on your income level prior to your workers’ compensation claim.

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.

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

Approved short term disability provides continued income to benefits-eligible employees according to a formula. You must apply within the first two weeks you are absent from work, and your medical provider must submit the necessary medical documentation.

You continue to receive contributions into the Princeton University Retirement Plan based on your short term disability income.

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.

NEW HIRES

You are automatically enrolled in the Short Term Disability Plan on your date of hire. A waiting period applies during your probationary period.
Long Term Disability Plan

CORE LONG TERM DISABILITY PLAN

Princeton University provides a Core Long Term Disability (LTD) Plan at no cost to you, administered by The Hartford. You are automatically enrolled in the Core LTD Plan on the first of the month coincident with or next following one year of service, as long as you are actively at work on this day. If you are disabled for more than 26 weeks, you may be eligible to apply for LTD benefits. The Core LTD Plan provides you with financial protection through income replacement equal to 60% of your pre-disability base salary earnings up to $10,000 per month. The benefits paid through the Core LTD Plan will be taxable per IRS regulations. Income you receive from Social Security and Workers’ Compensation, if applicable, offsets LTD benefits received.

Prior Employment and Waiving the Waiting Period

If your prior employer provided LTD benefits, Princeton may be able to waive the one-year wait period. The prior employer is defined as your most recent employer before joining the University. Employment may be credited only if your employment ended less than six months before your first day of employment at Princeton, and you were enrolled in its LTD plan.

To be credited for prior employment, you must have your former employer’s Human Resources department complete the Princeton University Certification of Prior Employment form located on our website.

For more information about plan benefits and the waiver application process, visit our website.

LTD BUY-UP PLAN

The LTD Buy-up Plan offered through The Hartford allows you to elect a higher level of LTD coverage to supplement the Core LTD Plan. If you elect the LTD Buy-up Plan, your coverage is 66.67% of your pre-disability base salary earnings up to a maximum monthly benefit of $15,000 per month. The buy-up rates are listed in the chart, and the cost is deducted on an after-tax basis from your pay. You have 31 days from the date that you become eligible for the Core LTD plan to elect the LTD Buy-up Plan without going through evidence of insurability (EOI) process. You have the opportunity to apply for the LTD Buy-up at any time during the year after you become eligible for the Core LTD Plan, but you are required to apply through The Hartford’s EOI process. All enrollments into the LTD Buy-up Plan are processed by Winston Benefits. The LTD Buy-up Plan ends upon your termination or retirement from Princeton. This plan is not portable and cannot be converted to an individual policy.

To enroll through Winston Benefits, call (855) 393-3601, Monday through Friday, 8:30 a.m. to 8:00 p.m., or visit myprincetonbenefits.com.

TAXATION OF BENEFITS

The Core LTD benefit is subject to federal and FICA tax and may be subject to certain state taxation. Per IRS regulations regarding a core/buy-up plan, a portion of the benefit payable under the buy-up plan is tax-free.

NEW HIRES

You are automatically enrolled in the Core LTD Plan on the first of the month coincident with or next following one year of service as long as you are actively at work on this day. The one-year waiting period may be waived if you were enrolled in an LTD plan with your prior employer. You have 31 days from the date that you become eligible for the Core LTD Plan to elect the LTD Buy-up Plan without going through EOI.
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.

Paid Family Leave

Princeton University provides paid family leave for eligible leaves, to care for a family member who has a serious health condition, to bond with a newborn, newly adopted child, or newly-placed foster child, or to care for a family member who has been a victim of domestic violence or a sexually violent offense. The definition of eligible family member includes: child, spouse, domestic partner, parent, sibling, grandparent, grandchild, and any other person related by blood or with whom you have a close association that is the equivalent of a family relationship. The paid leave counts concurrently against the Family Medical Leave Act (FMLA) and the New Jersey Family Leave Act (NJFLA). For more detailed information including eligibility requirements, review policy 3.1.11 Paid Family Leave on our website.

Arranging for Care Days

Employees with five years of benefits-eligible service are provided with a bank of five days to use to find and arrange care for aging and/or disabled eligible family members, including spouse, children, grandchildren, parents, parents-in-law, grandparents, grandparents-in-law, and siblings. Care services include, but are not limited to, nursing homes, assisted living facilities, and home care services. For more detailed information, including eligibility requirements, review policy 3.1.13 Arranging for Care Days on our website.

GROUP LONG TERM CARE PLAN

The Group Long Term Care Plan is available to eligible employees, their spouses, parents, grandparents, parents-in-law, and grandparents-in-law. Applicants must be U.S. citizens or permanent resident aliens, have a valid Social Security number or tax identification number, and provide a U.S. mailing address to apply for coverage. You or your family members pay the full cost on an after-tax basis and are billed directly by Genworth. Premium rates are subject to change in the future.

The Group Long Term Care Plan provides a variety of services, often referred to as “custodial care,” for people who are unable to care for themselves. Medicare and private health insurance plans or disability coverage typically do not provide coverage for long term care needs. Group long term care coverage is designed specifically to cover the costs associated with extended long term care.

To receive a rate quote, enroll online, or learn more about coverage, visit genworth.com/groupltre and use group ID Princeton and access code groupltre or call Genworth at (800) 416-3624. CNA previously provided coverage to Princeton employees. If you are covered by CNA, you can call (866) 357-8481. If you apply for long term care at any time during the year, you are required to complete a full medical questionnaire, which must be approved by Genworth.

NEW HIRES

Group Long Term Care Plan

Individuals between the ages of 18 and 65 who enroll within 31 days of the eligible employee’s hire date or upon becoming newly eligible for benefits can complete an abbreviated medical questionnaire for underwriting. Individuals over the age of 65, or those who do not apply within 31 days of their date of hire, must complete a full medical questionnaire for underwriting. Family members over the age of 75 are not eligible to apply. Coverage for eligible employees and their family members is subject to Genworth underwriting and approval is not guaranteed.

| GENWORTH | genworth.com/groupltre | (800) 416-3624 | Group ID: Princeton | Access Code: groupltre |
LEGAL SERVICES PLAN

MetLife Legal Plans provides you with access to legal representation or advice to help you with personal, confidential assistance for a wide range of services for a monthly fee of $12.80 for you, your spouse, and your dependent child(ren). There are some excluded services, including, but not limited to, employment-related matters, divorce, and trusts. While trusts are not a covered service, online digital estate planning services are available and provide guidance to create wills, power of attorney, trusts, and deeds. There are no copayments, claim forms, or usage limits when using one of their 14,000 network attorneys. You may also use an out-of-network attorney and be reimbursed based on a fee schedule for covered services. Once enrolled, you may not terminate the Plan mid-year. The coverage is portable if you terminate or retire from Princeton. If you want to continue the coverage, you must apply within 30 days of your last day of employment by calling (800) GET-MET8. The portable enrollment remains in effect for a 12-month period and must be pre-paid.

COVERED LEGAL SERVICES (including, but not limited to)

- Wills and estate planning
- Debt matters
- Defense of civil lawsuits
- Real estate matters
- Document review and preparation
- Traffic matters
- Adoption, guardianship, and juvenile matters
- Identity protection and credit monitoring

To learn more or to get an up-to-date listing of participating attorneys and a full list of covered services, visit legalplans.com and enter access code 9901339 or call the Client Service Center at (800) 821-6400.

For more information or to enroll, contact Winston Benefits at (855) 393-3601, Monday through Friday, 8:30 a.m. to 8:00 p.m., or visit myprincetonbenefits.com. If you want this coverage, you must elect it during your first 31 days of benefits eligibility or during the Annual Open Enrollment Period. Once enrolled, contact MetLife Legal Plans at (800) 821-6400 or visit members.legalplans.com/home.

EMPLOYEE CHILD CARE ASSISTANCE PROGRAM

The Employee Child Care Assistance Program (ECCAP) provides assistance to eligible faculty and staff members to help meet the cost of child care for prekindergarten-aged children. Eligibility rules and the amount of the awards are determined by the Princeton Child Care Assistance Committee and based on household income. The awards can be used to pay for child care arrangements from in-home care to licensed daycare centers. For more information, visit our website.

BACK-UP CARE ADVANTAGE PROGRAM

The Back-up Care Advantage Program provides faculty, staff, and graduate students with back-up care when you experience a temporary disruption in your child, adult, and/or elder caregiving arrangements that would otherwise prevent you from fulfilling work or study obligations. Princeton University partners with Bright Horizons to offer the Back-up Care Advantage Program, which is available 24 hours a day, 365 days a year, for infants through the elderly. For more information, visit our website.

NEW HIRES

Legal Services Plan

You have 31 days from your date of hire to enroll through Winston Benefits. Coverage becomes effective the first of the month coincident with or next following your date of hire. Once enrolled, you may not terminate the Plan mid-year.

METLIFE LEGAL PLANS  members.legalplans.com/home  (800) 821-6400
STAFF EDUCATIONAL ASSISTANCE PLAN

This tuition reimbursement program is available to assist you with the cost of your own undergraduate and graduate education. You are eligible the first of the month, coincident with or next following one year of benefits-eligible service. If you are on long term disability (LTD) leave, you are not eligible. For more information or to apply, visit our website.

BENEFIT OVERVIEW

• Covers 85% of tuition and mandatory educational fees at accredited institutions located in the United States, up to a maximum of $5,250 per plan year (July 1–June 30). Textbooks and/or mandatory online course materials are included as covered expenses.
• Reimbursement for up to two courses per semester/term; six per plan year
• Must be employed by the University and eligible for this program the day the course begins as well as the day it ends to be reimbursed
• Must be enrolled in an undergraduate or graduate degree program or eligible certificate program at an accredited institution in the United States
• Must receive a grade of C or better or Pass in a Pass/Fail course
• Application for course approval must be completed and submitted online through HR Self Service within 31 days of the start of the course
• Must request reimbursement within 90 days of the completion of a course through HR Self Service and upload an official copy of your grade and itemized bill to be reimbursed

CHILDREN’S EDUCATIONAL ASSISTANCE PLAN

A tuition grant program is available to assist with the cost of your eligible children’s undergraduate education. You are eligible after five years of benefits-eligible service; the program is governed by the break-in-service rules that govern our retirement plan. For more information or to determine if your child is eligible, visit our website.

BENEFIT OVERVIEW

• Covers 50% of tuition and mandatory educational fees up to a maximum annual benefit; the maximum annual benefit for academic year 2021-22 is $20,150
• Must be enrolled in a full-time, i.e., 12 credits or more, undergraduate degree program at an accredited 2- or 4-year institution in the United States

CHILDREN REQUIRING ACCOMMODATIONS

If you have a child with a disability that requires an academic accommodation, you may be eligible to receive a taxable grant. Under certain circumstances, consideration may also be given for a child with disabilities who is taking a part-time course load, is enrolled in a certificate program instead of a degree program, or is enrolled at a non-accredited institution. This grant is considered taxable income to you and subject to withholding. Contact the Benefits Team for more information.
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. For additional information, see page 2.

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.

PRINCETON UNIVERSITY RETIREMENT PLAN

Contributions and related gains or losses are tax-deferred for federal, state, and FICA tax purposes.

RETIREMENT SAVINGS PLAN

The limits for calendar year 2021 were $19,500 if you are under age 50 and $26,000 if you are over age 50. These amounts may be indexed for calendar year 2022. 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.

LIFE INSURANCE

Princeton provides, at no cost to you, basic term life insurance equal to one times your annual base salary. At age 60 the coverage is reduced by a published schedule. If this insurance is in excess of $50,000, the IRS requires that you pay taxes on the cost of any coverage over the $50,000 threshold. This cost is imputed income.
on your W-2 as determined by IRS tables showing the cost of term insurance at your attained age. By paying tax on coverage over $50,000, death benefits are not subject to federal estate tax upon your death.

**STAFF EDUCATIONAL ASSISTANCE PLAN**

Reimbursements up to $5,250 in a calendar year (January 1–December 31) are treated as nontaxable income by the IRS. Because the Plan is administered based on the University’s fiscal year (July 1–June 30), it may be possible to receive more than $5,250 in a calendar year. When this occurs, any reimbursements exceeding $5,250 in the calendar year are considered taxable income.

**EMPLOYEE CHILD CARE ASSISTANCE PROGRAM**

The grant that you receive for child care under the Employee Child Care Assistance Program (ECCAP) is considered taxable income. You can use the Dependent Care Flexible Spending Account to set aside money pretax for actual dependent care expenses. For more information on ECCAP, visit our website.

**BACKUP CARE ADVANTAGE PROGRAM**

The University subsidy for each hour of backup care utilized by a faculty or staff member was $32.44 per hour in 2021. The rate for 2022 was not released as of the printing of this booklet. Once the new rate is available, it will be updated on our website. The total value of the subsidy for the hours you used during the calendar year will be shown on your W-2.

If you used the Backup Care Program for child care and the total value of the subsidy plus the amount charged to your Dependent Care Expense Account equals more than $5,000 for the year, the amount over $5,000 is considered taxable income to you in that year.

If you use the Backup Care Program for elder care, the subsidy for each hour used during the year is reported as taxable income to you in that year. For more information on the Backup Care Program, visit our website.
**ADMINISTRATIVE NOTICES**

*Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*

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](http://healthcare.gov) or call (800) 318-2596.

For more information about COBRA, visit our website.

*Grandfathered Health Plan Notice*

Princeton University believes that the J-1 Visa medical plan is a grandfathered health plan under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Team or to Aetna member services using the phone number on your member ID card. In addition, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

*AACA 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 Creditable Coverage

If you are enrolled in the Aetna HMO Plan, the Aetna J-1 Visa Plan, or the Aetna or UnitedHealthcare Princeton Health Plan (PHP), the prescription drug coverage under these plans is at least as good as what is offered under Medicare Part D. Medicare calls this “Creditable Coverage.” As long as you are covered under a plan that has Creditable Coverage then you will not be penalized for enrolling at a later date as long as you enroll in Medicare Part D within 63 days of no longer having Creditable Coverage. The Notice of Creditable Coverage, found on pages 56 and 57, applies to benefits-eligible employees and their dependents who are Medicare eligible. No action is required on your part.

Patient Protection Model Disclosure

The Aetna HMO Plan requires the designation of a primary care physician (PCP). You have the right to designate any PCP who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. Until you make this designation, Aetna will designate one for you. For information on how to select a PCP, and for a list of participating primary care providers, contact Aetna at (800) 535-6689.

You do not need prior authorization from Aetna or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Aetna or go to aetna.com/dse/princeton.
**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](http://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
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.
• 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.

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 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 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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<tr>
<th>ALASKA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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<tr>
<th>ARKANSAS – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<tr>
<td>State</td>
<td>Medicaid/CHIP Website</td>
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<tr>
<td>CALIFORNIA</td>
<td>Website: <a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CAUCONT.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CAUCONT.aspx</a></td>
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<tr>
<td>IOWA</td>
<td>Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a></td>
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<tr>
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<tr>
<td>NEVADA</td>
<td>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a></td>
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<td>NEW HAMPSHIRE</td>
<td>Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a></td>
</tr>
<tr>
<td>NEW JERSEY</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
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<tr>
<td>NEW YORK</td>
<td>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
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<tr>
<td>NORTH DAKOTA</td>
<td>Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a></td>
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<td>VERMONT</td>
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<td>RHODE ISLAND</td>
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<td>WASHINGTON</td>
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<tr>
<td>OKLAHOMA</td>
<td>Med &amp; CHIP</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
  1-866-444-4EBSA (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.

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.

<table>
<thead>
<tr>
<th>3. Employer name:</th>
<th>4. Employer Identification Number (EIN):</th>
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<tbody>
<tr>
<td>Princeton University</td>
<td>21-0634501</td>
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<table>
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<tr>
<th>5. Employer address:</th>
<th>6. Employer phone number:</th>
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<tr>
<td>Office of Human Resources, 100 Overlook Center</td>
<td>(609) 258-3302</td>
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<tbody>
<tr>
<td>Princeton</td>
<td>NJ</td>
<td>08540</td>
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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:
• Visit www.medicare.gov.
• 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, 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
Your employer is subject to the Family Leave Insurance provisions of the New Jersey Temporary Disability Benefits Law

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.
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.
This communication is intended to be a Summary of Material Modifications (SMM) for the healthcare, life insurance, 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) and Certificates of Coverage on our website. You may also request to receive a paper copy of an SPD or Certificate of Coverage 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 each medical plan is available on our website. You may request a paper copy of any 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 43 of this booklet. All 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

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**Provider Information**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Group Number/Plan ID</th>
<th>Phone Number</th>
<th>Website</th>
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<tbody>
<tr>
<td>Winston Benefits</td>
<td>NA</td>
<td>(609) 535-6689</td>
<td>amga.com/dis/princeton</td>
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<td>Health Advocate</td>
<td>NA</td>
<td>(800) 535-6689</td>
<td>amga.com/dis/princeton</td>
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<td>Castlight</td>
<td>NA</td>
<td>(866) 695-8622</td>
<td>healthadvocate.com/princeton</td>
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<td>MSK Direct</td>
<td>NA</td>
<td>(844) 207-6344</td>
<td>mycastlight.com/princeton</td>
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<tr>
<td>Teladoc Medical Experts</td>
<td>NA</td>
<td>(800) 535-2362</td>
<td>teladoc.com/medical-experts</td>
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<tr>
<td>My Health Coach</td>
<td>TreatTree NA</td>
<td>(800) 237-0973</td>
<td>princeton.mytrestletree.com</td>
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**Healthcare Plans**

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<th>Provider</th>
<th>Group Number/Plan ID</th>
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<tbody>
<tr>
<td>Consumer Directed Health Plan</td>
<td>Aetna 486819</td>
<td>(800) 535-6689</td>
<td>aetna.com/dse/princeton</td>
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<tr>
<td>Princeton Health Plan</td>
<td>Aetna 486819</td>
<td>(800) 535-6689</td>
<td>aetna.com/dse/princeton</td>
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<tr>
<td>UnitedHealthcare HMO Plan</td>
<td>NA</td>
<td>(877) 216-2345</td>
<td>princeton.com</td>
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<tr>
<td>J-1 Visa Plan</td>
<td>Aetna 817281</td>
<td>(800) 535-6689</td>
<td>aetna.com/dse/princeton</td>
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<tr>
<td>Teledoc</td>
<td>NA</td>
<td>(800) 535-2362</td>
<td>teladoc.com/princeton</td>
</tr>
<tr>
<td>Fertility and Family Planning</td>
<td>KindBody NA</td>
<td>(866) 385-3931</td>
<td>mytrestletree.com</td>
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<tr>
<td>Prescription Drug Plan</td>
<td>OptumRx PURPINSYM</td>
<td>(877) 216-2345</td>
<td>princeton.com</td>
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<tr>
<td>PPO Dental Plans</td>
<td>MetLife 032623</td>
<td>(800) 535-6689</td>
<td>aetna.com/dse/princeton</td>
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<td>DMO Plan</td>
<td>Aetna 397432</td>
<td>(877) 238-6200</td>
<td>aetna.com/dse/princeton</td>
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<tr>
<td>Vision Plan</td>
<td>MetLife 3005158-0008</td>
<td>(800) 318-3931</td>
<td>aetna.com/dse/princeton</td>
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<tr>
<td>Supplemental Health Plans</td>
<td>MetLife NA</td>
<td>(800) 438-6388</td>
<td>aetna.com/dse/princeton</td>
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<tr>
<td>HSA, HFEA, DFSA, Commuter Benefits Program</td>
<td>PayFlex 120012</td>
<td>(800) 284-4869</td>
<td>payflex.com</td>
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<tr>
<td>Life Insurance Plans and Disability and Leave Benefits</td>
<td></td>
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<tr>
<td>Basic, Supplemental, Spousal, and Child Life Insurance</td>
<td>The Hartford 681431</td>
<td>(877) 778-1383</td>
<td>mybenefits.theartford.com</td>
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<tr>
<td>LTD and LD Buy-up Plans</td>
<td>The Hartford 681431</td>
<td>(877) 778-1383</td>
<td>mybenefits.theartford.com</td>
</tr>
<tr>
<td>Group Long Term Care Plan</td>
<td>Genworth NA</td>
<td>(877) 416-3624</td>
<td>genworth.com/princeton</td>
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**Retirement Plans**

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<th>Group Number/Plan ID</th>
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<tbody>
<tr>
<td>Princeton University Retirement Plan</td>
<td>TIAA (Men)</td>
<td>(800) 943-2778</td>
<td>tiao.org/princeton</td>
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<tr>
<td>Princeton University Retirement Plan</td>
<td>TIAA (PPPL)</td>
<td>(800) 943-2778</td>
<td>tiao.org/princeton</td>
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<tr>
<td>Retirement Savings Plan</td>
<td>TIAA (Men)</td>
<td>(800) 943-2778</td>
<td>tiao.org/princeton</td>
</tr>
<tr>
<td>Retirement Savings Plan</td>
<td>TIAA (PPPL)</td>
<td>(800) 943-2778</td>
<td>tiao.org/princeton</td>
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<tr>
<td>Investment Advice</td>
<td>CAPTRUST</td>
<td>(800) 967-9948</td>
<td>captrust.com</td>
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**Voluntary Plans**

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<tr>
<td>Legal Services Plan</td>
<td>MetLife Legal Plans</td>
<td>(800) 921-3402</td>
<td>members.lawplan.com</td>
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<tr>
<td>Employee Assistance Program</td>
<td>Cambridge</td>
<td>(800) 437-6911</td>
<td>metlife.com/princeton</td>
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<tr>
<td>Backup Care Advantage Program</td>
<td>Bright Horizons NA</td>
<td>(800) 318-3931</td>
<td>mytrestletree.com</td>
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</table>

For more details on work life programs, visit hr.princeton.edu/thrive or contact the Benefits Team at benefits@princeton.edu or (609) 258-3302.
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.