



**About Your Benefits
Summary Plan Description
Health and Welfare Plans**

Disclaimer

The Princeton University *About Your Benefits Summary Plan Description* contains summaries of the benefit plans offered by Princeton University. It replaces all previous books, summary plan descriptions, and any supplements previously published. This Handbook provides you with a description of your benefits; however, it is not intended to provide medical, legal, financial, tax or investment advice. Complete details of each benefit plan are found in the official plan documents and contracts that legally govern all aspects of the plans which are available for review in the Office of Human Resources. If there is any discrepancy between the documents and the summaries in this handbook, the plan documents will prevail. The University's benefit plans are intended to comply with all applicable federal and state laws. In the event of a conflict, the terms of the federal and state laws will govern. The benefits described in the *Benefits Handbook* are based on federal and state laws as of July 1, 2022.

Changes in the University benefit programs may occur as a result of future legislation or at the discretion of the University. If your benefits do change, you will be provided with updated information. Please contact the Benefits Team at (609) 258-3302 if you require further information about your benefits.

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July 1, 2022

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Introduction

This document summarizes the following benefit plans offered by Princeton University:

- Health Care Plan (which provides medical, dental, prescription, Employee Assistance Program (EAP), health benefit flexible spending account (HFSA), Health Savings Account (HSA) and dependent care flexible spending account (DFSA))
- Total Disability Insurance Program – Long Term Disability
- Short Term Disability
- Business Travel Accident Plan
- Group Life Insurance Program – Basic
- Group Life Insurance Program – Supplemental
- Vision Care Plan

This document describes general provisions that apply to all of the benefit plans offered by Princeton University. Details regarding each benefit plan are described online in the Summary Plan Descriptions for each plan and should be used in conjunction with this document for a full understanding of these benefit programs.

Although the University intends to continue each of the current benefit plans, it reserves the right to terminate or amend any plan, at any time, and for any reason.

Eligibility

This section describes employee and dependent eligibility for Princeton University's benefit plans.

Employee 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% of more of the normal workweek schedule (36 ¼ or 40 hours, depending on the position) for 4.5 months or more and receive pay directly from the University.
- Casual, (biweekly and hourly paid) and short-term professional employees, temporary contract employees, and those who are full-time students are not eligible to participate in the University's benefit plans, unless a review of their hours worked, or anticipated hours worked meets the requirements of the Employer Mandate of the Affordable Care Act, in which case they will be offered an option for medical plan coverage.
- Visiting faculty and staff may only be eligible for some of the following benefits.
 - Medical Benefits
 - Dental Benefits
 - Vision Benefits
 - Retirement Savings Plan

- Healthcare and Dependent Care Flexible Spending Accounts, Health Savings Account
- Faculty and Staff Assistance and Work/Life Programs
- Princeton University Retirement Plan eligibility only via written approval by the Office of the Dean of the Faculty
- All J-1 visa holders are eligible for certain benefits based on job title or staff group. J-1 visa holders may be eligible for the same benefits as Visiting Faculty and staff listed above with the following exception:
 - Health Care – the only medical plan options are the J-1 visa health plan option administered by Aetna or the Aetna HMO health plan.

Dependent Eligibility

If you are an eligible employee, you may enroll certain family members in the Medical, Dental, and Vision Care Plans. Your eligible dependents include your legal spouse, and eligible children to December 31st in which they turn 26. Children must be under the age of 26 at the time of enrollment. Once enrolled, coverage can continue through the end of the calendar year in which the child turns 26.

Coverage may be available to your eligible child regardless of student, residential, or marital status; however, if your child is married, the spouse and/or children of your eligible child are not eligible for coverage under our Plans. "Child" includes your biological, step, adopted, and foster children.

Eligible dependents may also include:

- dependent, unmarried children of any age who are physically or mentally challenged and became disabled before the end of the calendar year in which they turn 26. Contact the Benefits Team for more information.

Enrollment Procedures

Enrollment in most benefit plans is not automatic. If you are eligible for coverage, you must enroll yourself and your dependents in order to receive coverage.

Initial Enrollment

When you are hired into a benefits-eligible position, you will receive enrollment information and an email notifying you to complete your online enrollment via HR Self Service. You have 31 days from the date of hire to complete and submit your enrollment via our online system. For most benefits, if you do not enroll, you will not be covered, and will not be able to enroll until the next annual benefits open enrollment period. The table below describes the status of your enrollment and in relevant cases, the default coverage you receive if you do not enroll:

You must complete your online enrollment to enroll in the following plans	Within...	Or...
Medical Plan (includes Prescription coverage)	31 days of your date of hire or appointment	You will not have health insurance coverage for the remainder of that calendar year. You will be unable to enroll in health insurance coverage until the next open enrollment period (with an effective date of January 1 of the following year), unless you experience a <u>Qualifying Status Event</u> .
Dental Care Plan	31 days of your date of hire or appointment	You will not have dental care coverage for the remainder of that calendar year. You will be unable to enroll in coverage until the next open enrollment period (with an effective date of January 1 of the following year), unless you experience a <u>Qualifying Status Event</u> .
Vision Care Plan	31 days of your date of hire or appointment	You will not have vision care coverage for the remainder of that calendar year. You will be unable to enroll in coverage until the next open enrollment period (with an effective date of January 1 of the following year), unless you experience a <u>Qualifying Status Event</u> .
Supplemental Life Insurance Plan	31 days of your date of hire or appointment	You are required to complete an Evidence of Insurability (EOI) form.

Healthcare Flexible Spending Account (HFSA)	31 days of your date of hire or appointment	You will not have HFSA coverage for the remainder of that calendar year. You will be unable to enroll in coverage until the next open enrollment period (with an effective date of January 1 of the following year), unless you experience a Qualifying Status Event.
Dependent Care Flexible Spending Account (DFSA)	31 days of your date of hire or appointment	You will not have DFSA coverage for the remainder of that calendar year. You will be unable to enroll in coverage until the next open enrollment period (with an effective date of January 1 of the following year), unless you experience a Qualifying Status Event.
Health Savings Account (HSA)	Any time throughout the year while enrolled in the Consumer Directed Health Plan	
Princeton University Retirement Plan	31 days of your date of hire or appointment	Your investment selection for University contributions will be defaulted to the Vanguard Target Retirement Funds.
Princeton University Retirement Savings Plan	31 days of your date of hire or appointment	You are defaulted to contribute 5% of pay, pre-tax towards your account. Your investment selection will be defaulted to the Vanguard Target Retirement Funds.
Basic Life Insurance	Automatically enrolled and coverage effective on your first day of hire or appointment	The Hartford will name your beneficiaries per their Preferential Beneficiary Arrangement, which provides that your life insurance will be paid to the first of the following: Your (a) surviving spouse; (b) surviving child(ren) in equal shares; (c) your surviving parents in equal shares; (d) surviving siblings in equal shares; (e) your estate.
Accidental Death and Dismemberment	Automatically enrolled and coverage effective on your first day of hire or appointment	

Business Travel Accident Insurance	Automatically enrolled and coverage effective on your first day of hire or appointment	
Short Term Disability	Automatically enrolled and coverage effective on your first day of hire or appointment	
Long Term Disability	Automatically enrolled first of the month coincident with or next following one year of benefits eligible service	The waiting period may be waived if you participated in a Long Term Disability Plan with your prior employer; contact the Benefits team for additional information
Employee Assistance Program (EAP)	Automatically enrolled first of the month coincident with or next following your date of hire	

Open Enrollment

Current eligible employees can enroll in or change coverage elections during the annual benefits open enrollment period, which is held in the fall of each year. The benefit choices you make during each year's open enrollment period take effect on the following January 1 and will remain in effect until the following December 31.

In general, you may not make changes to your open enrollment elections until the following open enrollment period unless you experience a mid-year change as described below.

If you do not enroll during the annual benefit open enrollment period, your coverage under most plans defaults to your current election. However, you must actively make an election to enroll in the HFSA and DFSA for the next year. If you are contributing to the HSA, your election will automatically carry over to the following year.

Shortly after the open enrollment period ends, you will be able to review your enrollment for each plan in HR Self Service showing the coverage you have elected (and/or any default elections) for the next year.

Mid-Year Changes

Ordinarily, you cannot change your benefit elections until the next annual benefit open enrollment period. However, you may be permitted to make a change during the course of the year if you experience a Qualifying Status Event. Such events which are described in detail below.

There are some benefit elections you may change during the year without a Qualifying Status Event. These are: Commuter benefits, Health Savings Account, Supplemental Life Insurance, Retirement Savings, and investment allocations in any applicable benefit plan.

Qualified Status Events

- a change in your legal marital status, including marriage, divorce, death of your spouse, legal separation, or annulment (example below);
- a change in the number of your tax dependents through birth, adoption, or death;
- termination or commencement of employment by you, your spouse, or child(ren);
- entitlement to governmental benefits, such as Medicare (detail below);
- taking or returning from an approved leave (detail below) (detail below);
- judgments, decrees, or court orders, such as QMCSOs (detail below);
- a significant change in cost or coverage (detail below); a change in work schedule, such as reduction or increase in hours by you, your spouse, or your child(ren) that would make you ineligible or eligible for benefits;
- your dependent's ability or inability to satisfy dependent eligibility requirements; or
- a change in residence or work site by you, your spouse, or dependents that causes you to lose access to providers in your medical plan's network.

Any change you make in your benefits must be consistent with the qualified status event. For example, if you marry during the year, you are permitted to change the level of health care plan coverage from employee only to employee and dependents. You may also waive coverage to join your spouse's health care plan. You are not permitted to change plans, e.g., you may not move from the Princeton Health Plan to the HMO.

You must notify the Office of Human Resources of a qualified status event within 31 days of the event to change your benefit coverage. In the case of the birth, adoption, or placement for adoption of a child, you have 90 days to notify the Office of Human Resources of the birth, adoption, or placement for adoption to change your coverage.

If you do not notify the Office of Human Resources within the time specified, you will not be able to add a dependent or make any other coverage changes until the next open enrollment period, with benefits coverage effective the following January 1.

Coverage and Cost Events

In some instances, you may be able to make changes to your benefit coverage for certain other reasons, as described below.

Cost Changes

If there is a significant increase or decrease in the cost of coverage, you may be permitted to:

- in the case of a significant decrease in cost, revoke your election and elect coverage under the less expensive option, or elect such less expensive option for the first time if you previously declined coverage, or
- in the case of a significant increase in cost, revoke your existing election and elect coverage under another option providing similar coverage (if no alternative similar coverage is available, you may revoke your election with respect to such coverage).

Coverage Changes

- **Curtailment or Loss of Coverage.** If your benefit coverage is significantly curtailed or ceases entirely, you may revoke your elections and elect coverage under another option providing similar coverage, if one is available. Coverage is significantly curtailed if there is an overall reduction in coverage generally. If the curtailment is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election for coverage.
- **Addition to or Improvement in Coverage.** If the University adds or significantly improves a coverage option during the year and you had elected an option providing similar coverage, you may revoke your existing election and instead elect the newly added or newly improved option.
- **Changes in Coverage under Another Employer Plan.** If the plan provided by the employer of your spouse or dependent allows for a change in your family member's coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change. For example, if your spouse elects family medical coverage during his or her employer's open enrollment period, you may drop your University health plan coverage.

Entitlement to Governmental Benefits

If you, your spouse or dependent becomes entitled to, or loses entitlement to, Medicare, Medicaid or certain other governmental group medical programs, you may make a corresponding change to your coverage elections.

Approved Leave

If you return to service after taking an approved leave and are otherwise eligible to participate in the benefit programs, you will be reinstated on the same terms that applied prior to taking such approved leave. For more information, see Continuation of Coverage.

Judgment, Decree, or Order (including QMCSOs)

If a judgment, decree or order (including a qualified medical child support order (QMCSO) requires the plan to provide coverage to your child or foster child, then the plan automatically may change your election under the plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of such judgment, decree or order, if you desire.

If the judgment, decree or order requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child if you provide proof to the plan administrator that such other person actually provides the coverage for the child.

When Coverage Begins

The effective date of coverage depends on the provisions of the specific benefit plan. For some plans, the initial effective date of coverage is the date of your hire or appointment. For other plans, the initial effective date of coverage is the first day of the month coincident with or next following your hire or appointment date, or job and family status change. Please refer to the specific benefit plan summary for additional information about the effective date of coverage.

For new hires, medical, dental and vision coverage will be effective as of your date of hire. 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.

Rehires

If you are rehired into a benefits-eligible position within six months of terminating from a benefits-eligible position, your elections can be reinstated into the benefits you were previously enrolled in by contacting the benefits team. Enrollment in the HFSA, DFSA, and HSA always requires a new election.

You must complete the enrollment process no later than 31 days after the date the previous coverage ends. See “When Coverage Begins” section above for details on when your coverage will be effective.

You can make a change during the year by contacting your Office of Human Resources within 31 days of the event.

Paying for Coverage

The University provides Basic Life Insurance (including Accidental Death and Dismemberment Insurance), Business Travel and Accident Insurance, Short and Long Term Disability Insurance coverage, Employee Assistance Program, and Work/Life Programs to you free of charge. In addition, the University makes a contribution to the Princeton University Retirement Plan on your behalf.

If you elect coverage in any one of the health care plans, you and the University both contribute toward the cost of coverage. Your contribution will be deducted on a pretax basis from your paycheck. Some plans are employee pay all plans. These plans include: flexible spending account(s), vision, supplemental life, and the retirement savings plan. The full amount for these plans is deducted from your pay.

Pre-tax Contributions

For most benefits-eligible faculty or staff members, when you complete your benefit election process, you authorize the University to deduct from your paycheck any contributions needed to pay your portion of the cost for your benefit elections. Under federal law, some of your contributions are taken from your earnings before taxes are deducted. As a result, you pay less in federal income and Social Security taxes. Depending on your state of residence, pretax contributions may also reduce your state and local income taxes. The following premiums or contributions may be made on a pretax basis:

- Health care plan coverage,
- Dental care plan coverage,
- Vision care plan coverage,
- Flexible spending account plans,
- Health savings account
- Retirement Savings Plan election.

Contributions to your supplemental life insurance coverage are made on an after-tax basis which means the cost of these benefits is deducted after federal, state, and local income and Social Security taxes have been withheld.

Coordination of Benefits

The coordination of benefits feature applies when you or a covered dependent are covered under a Princeton University benefit plan that provides health benefits and another plan that provides health benefits such as Medicare, a plan provided by your spouse's employer, or a no-fault insurance plan. This feature determines which plan or plans has primary responsibility for paying benefits and which plan has secondary responsibility. Keep in mind that whenever there is more than one plan, the total amount of benefits paid in a calendar year under all plans cannot exceed the amount that would have been paid if there had been no other coverage.

How Coordination Works

When you or a covered dependent are covered under more than one health care plan and your Princeton University health care plan is primary, the University plan pays a benefit first without regard to any coverage you may have under the other, secondary, plan. When your Princeton University benefit plan is secondary, the following calculations are made:

1. Determine the amount of benefits that would be payable under the University plan in the absence of the coordination of benefits provision.
2. Subtract the amount of benefits paid by other plans from the amount of benefits payable under the University plan before you make your claim to your Princeton University Health Care Plan for the same services.
3. You are paid the difference. The University's Plan will never pay you more than the benefit you would have received if you were only covered under the Princeton University benefit plan.

Which Plan Pays First

The plan administrator has the right to secure information for the determination of coordination of benefits. Once the information is secured, the following rules determine which plan is primary and which is secondary:

- As a Princeton University employee, coverage for you under the Princeton University benefit plan is primary for covered expenses.
- When your spouse is covered under the Princeton University benefit plan as a dependent and under another group plan as an employee, then the plan covering your spouse is primary and the University plan is secondary.
- When your dependent child is covered under both the University plan and your spouse's plan, the "Birthday Rule" is in effect. The Birthday Rule provides that the parent whose birthday falls earlier in the calendar year (year of birth is not a consideration) is the parent whose coverage is primary. For example, a mother and father both cover a child under employer-sponsored plans. The mother's birthday is in May while the father's birthday is in October. Therefore, the mother's plan is primary and the father's plan is secondary. If both parents have the same birthday, the plan covering a parent for the longer period of time is primary.
 - When a dependent child of divorced or separated parents is covered under more than one health care plan, benefits for the child are determined in the following order:
 - Primary, the plan of the parent with custody of the child.
 - Secondary, the plan of the spouse of the parent with custody of the child, if applicable,
 - Finally, the plan of the parent not having custody of the child.

If a court order has been made, the above rules are disregarded. A plan with no coordination of benefits provision is primary to one that has a coordination of benefits provision.

Medicare

If you have coverage through Medicare, the Princeton University benefit plan is primary if:

- eligibility for Medicare is due to your reaching age 65 and you are currently employed as a benefits eligible employee at Princeton University, or
- eligibility for Medicare is based on End Stage Renal Disease (ESRD).

Medicare pays primary to the Princeton University benefit plan for you, if:

- eligibility for Medicare is due to disability and the employee is not actively at work or
- eligibility for Medicare is due to End Stage Renal Disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

Medicare Enrollment Requirements for Non-retired Employees

If you are age 65 and currently employed as a benefits-eligible employee, Medicare is secondary insurance. The Princeton University benefit plan is primary. This means you submit your health care claims first to the Princeton University benefit plan, then to Medicare.

When the Princeton University benefit plan pays benefits first and you would like Medicare to supplement this benefit, you must enroll for Medicare Parts A and B.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under the Princeton University benefit plan, whether or not you have enrolled for Medicare. For those who are retired or on long term disability, enrollment in Medicare Parts A and B are required before you can receive a benefit.

Other Government Plans

If you are covered under a plan which is established under the laws of any government, the Princeton University benefit plan does not cover any services or supplies available to you through that plan, unless the government plan requires by law the Princeton University benefit plan to pay primary.

Recovery Provisions

Right of the Plan to Recover Improperly Paid Benefits

Princeton University has the right to recover an amount paid in error. For example, if you receive benefits for a service under the Princeton University benefit plan in error, and you also receive benefits from another plan for the same service, Princeton University and the plan vendor have the right to recover the amount paid to you by the other plan. You are not permitted to receive total benefits above the cost of the service provided. The same is true if

payment is made in excess of what should have been paid under the Princeton University benefit plan.

Refund of Overpayments

If benefits are paid under the Princeton University benefit plan for expenses incurred, you or any other person or organization that was paid must make a refund to the Plan if:

- all or some of the expenses were not paid by you or did not legally have to be paid by you or
- all or some of the payment made under the Plan exceeded the benefits under the Plan.

The refund equals the amount paid in excess of the amount that should have been paid under the Plan.

If the refund is due from another person or organization, then you agree to assist Princeton University in obtaining the refund when requested.

If you, or any other person or organization that was paid, do not promptly refund the full amount, the amount owed will be deducted from any future claim reimbursements.

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to

make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq.*, to

share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

When Coverage Ends

Employee Coverage

Employee coverage ends on the earliest of the following dates:

- the benefit plan is terminated;
- you are no longer eligible for benefits;
- you fail to make the required contributions;
- medical, dental, vision, and EAP benefits terminate the last day of the month in which employment terminates; life, supplemental life, HFSA, or DFSA accounts terminate on the last day of employment;
- the last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due;
- you cancel your coverage, as applicable; or
- you die.

Dependent Coverage

Dependent coverage ends on the earliest of the following dates:

- the last day of the month in which the employee's coverage ends,
- the last day of a period for which contributions for the cost of dependent coverage have been made if the contributions for the next period are not made when due, or
- the end of the month in which the dependent stops being an eligible dependent (dependent children losing eligibility due to age will lose coverage at the end of the calendar year in which they turn 26).

Continuation of coverage for incapacitated children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as the child is considered to be a dependent and meet one of the following conditions:

- the child is incapacitated,
- the child is not capable of self-support, or
- the child depends mainly on the employee for support.

The employee must provide proof to the healthcare plan that the child meets one of these conditions when requested.

This proof is not required more often than once per year.

Continuation of Coverage

Princeton University provides continuation of coverage for health, dental, vision, and the Healthcare Flexible Spending Account (HFSA) while on an approved leave of absence. Coverage continues for up to 12 weeks during a Family and Medical Leave Act (FMLA) leave of absence, as well as during a disability/medical leave. In certain situations, you may be responsible for paying premiums during your leave. If you are on a paid leave, payroll deductions continue. If you are on an unpaid leave for less than one month, upon your return premiums will be deducted from your pay retroactively. If you are on an unpaid leave for more than one month, you will receive billing coupons from the University. You are required to pay premiums during your leave. Contact your Office of Human Resources for additional information.

Continuing Coverage during FMLA

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take up to 12 weeks of leave each year for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition. State laws may allow for longer leaves.

If you take a paid leave of absence during FMLA, the cost of coverage will continue to be deducted from your pay on a pretax basis.

If you take an unpaid leave of absence that qualifies under FMLA, all benefits other than compensation-based benefits continue for you and your dependents.

Note that your monthly contributions during an unpaid leave are made on an after-tax basis.

If you lose any coverage during an FMLA leave because you did not make the required contributions, you must wait for the next Open Enrollment to re-enroll when you return from your leave.

If you do not return to work at the end of your FMLA leave, or your employment is terminated while you are on an FMLA leave, you will be entitled to purchase COBRA continuation coverage for your health, dental, vision, and the HFSA.

Special Rules Regarding Your Expense Accounts: When you go on a leave of absence without pay, contributions to your Flexible Spending Account stop, but you can continue to file for eligible expenses for your HFSA or DFSA while you are on your leave without pay. The total amount you elected for the plan year is eligible for reimbursement from the HFSA. Reimbursements from the DFSA are limited; however, to the amount you have already contributed prior to the start of your leave.

When you return from leave during the same calendar year, your contributions to your account will resume. The monthly reductions for the remaining portion of the calendar year will be pro-rated based on the total amount you elected for the calendar year. Claims for eligible expenses may be filed through March 31 following the calendar year in which you took your leave.

Continuing Coverage during Military Leave

If you take a military leave, whether for active duty or for training, you are entitled to continue your health, dental, vision, and HFSA for up to 24 months. Your total leave, when added to any prior periods of military leave from Princeton University, cannot exceed five years. Please refer to the military leave policy on our website for additional information or contact the Benefits Team to request a printed copy of the policy.

If you take a military leave and your coverage under a benefit plan is terminated, you will need to re-enroll in benefits within 31 days of your return to active status. If you are on military leave and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage for the remaining months, up to a total of 18 months (see below).

Continuing Coverage during a Non-FMLA or Personal Leave

If you are on an unpaid leave of absence (LOA) that does not qualify for FMLA, health, dental, and vision coverage for you and your dependents and your participation in the HFSA may continue for up to twelve months and you are responsible for payment of elected benefits during the leave.

Continuing Coverage after Your Employment Ends

The section contains important information about your right to a temporary extension of coverage under the Princeton University-sponsored group health plan. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that Princeton University provide you and/or your covered dependents who are qualified beneficiaries under COBRA with the opportunity to continue coverage under the plan for a temporary period in certain instances where your coverage under the plan would otherwise end.

This SPD provides your initial COBRA notice. This SPD explains COBRA continuation coverage, your right to obtain it, and what you need to do to protect the right to receive it.

As a qualified beneficiary, you can elect to continue the health, dental, vision, or HFSA coverage in effect on the date your coverage would otherwise end. Qualified beneficiaries include you, your spouse, and dependent children who were covered under the plan immediately before coverage ends due to a qualifying event. A qualified beneficiary also includes a child born or placed for adoption with you while you are enrolled in COBRA continuation coverage, provided you notify the COBRA Administrator within 30 days of the event.

The Plan Administrator is Princeton University. The COBRA Administrator is:

PayFlex Systems
P.O. Box 3039
Omaha, NE 68103-3039
(800) 284-4885

Who is Covered

You should receive a letter from PayFlex Systems shortly after you become a benefits-eligible employee. If you are an employee who is covered by a Princeton University-sponsored health, dental, vision, or HFSA, you have a right to choose continuation coverage under the applicable benefit plan if you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee, or a covered dependent child of an employee, and are covered by a Princeton University-sponsored health, dental, vision, or HFSA on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose your coverage due to the reasons noted in the When Coverage Ends Section.

Your Duties

Under the law, the employee or a family member has the responsibility to inform Princeton University Office of Human Resources at (609) 258-3302 of a divorce or a child losing dependent status under a Princeton University-sponsored benefit plan that provides health, dental, vision, or HFSA benefits. You must notify the Office of Human Resources at (609) 258-3302 within 60 days from the date of the divorce or a child losing dependent status or, if later, the date coverage would normally be lost because of the event. If the employee or a family member fails to provide this notice to Princeton University during this notice period, any family member who loses coverage will not be offered the option to elect continuation coverage.

When Princeton University is notified that one of these events has happened, PayFlex in turn will notify you that you have the right to choose continuation coverage. If you or your family member fails to notify Princeton University and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce or a child losing dependent status, then the employee and family members will be required to reimburse the employer-sponsored group health plans for any claims mistakenly paid.

Princeton University's Duties

Qualified beneficiaries will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage. The employee's:

- death,
- termination (for reasons other than gross misconduct),
- reduction in hours of employment, or
- Medicare entitlement.

Electing COBRA

To inquire about COBRA coverage, contact the Office of Human Resources at (609) 258-3302. If you have questions regarding the election forms or process, contact PayFlex Systems at (800) 284-4885.

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage, or, 60 days after PayFlex Systems provides you notice of your right to elect continuation coverage if this is later. An employee or family member who does not choose coverage within the time period described above will lose the right to elect coverage.

If you choose continuation coverage, Princeton University is required to give you coverage that is identical to the coverage provided under the plan you are enrolled in at the time coverage stopped. Plan changes affect you the same as employees still in the plan.

If you elect continuation coverage and then have a child, either by birth, adoption, or placement for adoption, during the period of continuation coverage, the new child is eligible to be covered under COBRA as long as you notify PayFlex Systems within 90 days of the birth or adoption of the child in accordance with the terms our group health plan.

If you fail to notify PayFlex Systems as discussed above, you will not be offered the option to elect COBRA coverage for your child. Newly acquired dependents, other than children born to, adopted by, or placed for adoption with the employee, will not be considered qualified beneficiaries but may be added to your continuation coverage in accordance with the rules for changing coverage set forth above in Enrollment Procedures.

Separate Elections: Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, i.e., at Open

Enrollment, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect different coverage than the employee elects.

Duration of COBRA

The law requires that you be afforded the opportunity to maintain continuation coverage for 18 months if you or your covered dependents lose group health coverage because of a termination of employment or reduction in your hours of employment.

Additional qualifying events, such as a death, divorce, or Medicare entitlement, that occur while the continuation coverage is in effect can result in an extension of an 18-month continuation period to 36 months. However, in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. You should notify PayFlex Systems in writing if a second qualifying event occurs during your continuation coverage period. This notice must be provided within 60 days from the date of the second qualifying event or the date coverage would normally be lost because of the second qualifying event if later. When PayFlex Systems is notified that one of these events has happened, the covered family member will automatically be entitled to the extended period of continuation coverage. If an employee or covered family member fails to provide the appropriate notice and supporting documentation PayFlex Systems during this 60-day notice period, the covered family member will not be entitled to extended continuation coverage.

Special Rules for Disability: The 18 months may be extended to 29 months if you or a covered family member is determined by the Social Security Administration to be disabled at the time of the qualifying event or at any time during the first 60 days of continuation coverage. This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must inform PayFlex Systems in writing within 60 days of the Social Security determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must inform PayFlex Systems in writing of this re-determination within 30 days of the date it is made at which time the 11-month extension will end.

Medicare: If you experience a termination of employment or reduction in hours following Medicare enrollment, your covered family members may elect COBRA coverage for up to 36 months from the date you become covered by Medicare or 18 months from your termination or reduction in hours, whichever is longer.

Healthcare Flexible Spending Account (HFSA): Regardless of the type of qualifying event, you can elect to continue your HFSA until the end of the plan year.

Early Termination of COBRA

The law provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- Princeton University no longer provides coverage to any of its employees under that particular plan,
- the premium for continuation coverage is not paid on time (within the applicable grace period),
- the qualified beneficiary becomes covered after the date COBRA is elected under another health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any pre-existing condition of the individual,
- the qualified beneficiary becomes entitled to Medicare after the date COBRA is elected, or
- coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA coverage cannot be terminated unless in the exceptional case where the other plan's pre-existing condition rule is excluded from the HIPAA rules.

COBRA and FMLA

A leave that qualifies under the Family and Medical Leave Act (FMLA) does not make you eligible for COBRA coverage. If you are covered under our health benefit plans, you will be eligible for COBRA if you decide not to return to active employment. Your continuation coverage will begin on the earliest of the following to occur:

- when you definitively inform Princeton University that you are not returning to work, or
- the end of the FMLA leave, assuming you do not return to work.

Cost of Coverage

You will be required to pay 102% of the cost of coverage which is the employee contribution and the employer contribution plus a 2% administrative fee. If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the cost of covering an employee and any eligible dependents, if applicable. In such a case this increase begins with the 19th month of COBRA coverage, provided that the disabled individual is one of the individuals who elected the disability extension. The cost of group health coverage changes annually. If you elect COBRA coverage, you will be notified of these annual payment changes.

COBRA coverage is not effective until you elect it and make the required payment. You have an initial grace period, i.e., 45 days from the date of your initial election, to make your first premium payment. Thereafter, payments are due by the first day of each month to which the payments apply. Payments must be postmarked on or before the end of the 30-day grace period.

If you do not make timely payments, your COBRA coverage will be terminated as of the last day of the month for which you made timely payment.

CLAIMS REVIEW & APPEALS PROCESS:

Claims Review

The claims review begins by your filing a claim with the Plan Administrator. Any participant or beneficiary or his/her duly authorized representative (the “claimant”) has a right to file a written claim for benefits. If, after you have read the information set forth in the plan benefit booklet and below, you have any questions regarding how to file an initial claim, please contact the appropriate Claims Administrator as described in the Plan Administration and Legal Information section of this document.

Each benefit plan has a specific amount of time, by law, to evaluate and process claims for benefits covered by ERISA. The length of time the benefit plan has to evaluate and process a claim begins on the date the claim is first filed and are described below.

Four categories of health benefit claims review are recognized:

Urgent Care Claims. Claims for which the application of non-urgent care timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician with knowledge of the patient’s condition, would subject the patient to severe pain that cannot be adequately managed otherwise.

The Claims Administrator will notify you of the plan’s determination, whether adverse or not, as soon as possible, taking into account medical requirements but, not later than 72 hours after receipt of the claim unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally, unless the claimant requests written notification. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify you of the plan’s benefit determination as soon as possible, but no later than 48 hours after the earlier of the plan’s receipt of the specified information or the end of the period afforded you to provide the specified additional information.

Pre-service Claims. Claims must be decided before a patient will be afforded access to healthcare, e.g., preauthorization requests.

The Plan Administrator will notify you of the Claims Administrator's determination, whether adverse or not, within a reasonable period of time, but not later than 15 days after receipt of the claim. This period may be extended by 15 days, provided the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Claims Administrator and notifies you, within the initial period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information.

If the claim is improperly filed, the Claims Administrator will notify you as soon as possible, but not later than five days after receipt of the claim by the plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally unless you request written notification. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service Claims. Claims involving the payment or reimbursement of costs for medical care that has already been provided.

For non-urgent post-service health claims, the plan has up to 30 days following receipt of the claim to evaluate and respond to claims for benefits covered by ERISA. This period may be extended by 15 days provided the Claims Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the plan and notifies you, within the initial period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

If you file a claim for a prescription you obtained at a retail or mail-order pharmacy, that claim will be treated as a post-service claim.

Concurrent Care Claims. Claims where the plan has previously approved a course of treatment over a period of time or for a specific number of treatments and the plan later reduces or terminates coverage for those treatments.

Concurrent care claims may fall under any of the other three categories, depending on when the appeal is made. However, the plan must give you sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

If Your Healthcare Claim Is Denied

If your healthcare claim has been denied for any reason, you will receive a statement that will include:

- the specific reason for the claim denial;
- the specific provisions of the plan on which the determination is based;
- a description of any additional information needed to reconsider the claim and the reason this information is needed;
- a description of the plan's review procedures and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- if any internal rules, guidelines, protocols, or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocol, or other similar criteria, or a statement that a copy of such information will be made available free of charge upon request;
- for adverse determinations based on medical necessity, experimental treatment, or other similar exclusions or limits, either an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- for adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than three days after the oral notice.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You or an appointed representative may appeal and request a claim review within 180 days after receiving the denial notice. The request must be made in writing and should be filed with the Claims Administrator. The claimant is also entitled to reasonable access to and copies of all information that is relevant to the claim. This includes all information (i) relied on in making the benefit determination, (ii) submitted to, considered, or generated by the program in considering the claim, and (iii) that demonstrates the program's processes for ensuring proper, consistent decisions.

The request for review should include:

- the patient's name and the identification number from the ID card,
- the date(s) of medical service(s),
- the provider's name,
- the reason the covered person believes the claim should be paid, and
- any documentation or other written information to support the covered person's request for claim payment.

The review will be conducted by the Claims Administrator or other appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination which is the subject of the review, nor the subordinate of such individual, including any physicians involved in making the decision on appeal if medical judgment is involved. Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate healthcare professional. No deference will be afforded to the initial adverse benefit determination. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable U.S. Department of Labor regulations. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will notify you of the plan's determination on review within the following timeframes for:

- urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours after receipt of the request for review;
- pre-service claims, within a reasonable period of time given the medical situation, but no later than 30 days after receipt of the request for review; and
- post-service claims, within a reasonable period of time, but not later than 60 days after receipt of the request for review.

The Claims Administrator will provide you with written notification of the plan's determination on review. In the case of an adverse benefit determination, such notice will indicate:

- the specific reason for the adverse determination on review;
- reference to the specific provisions of the plan on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a description of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on review;
- if any internal rules, guidelines, protocols, or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- for adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and

- a description of your right to obtain additional information upon request about any voluntary appeals procedures under the plan.

The notice will also include the following information: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

If Your Long Term Disability Claim Is Denied

Coverage for Long Term Disability is provided through The Hartford. If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from The Hartford of your denial. Information on the Long Term Disability plan, as well as the determination of benefits notification and the appeals process is located in the “Princeton University Long Term Disability” Certificate of Coverage located on our website at: <https://hr.princeton.edu/summary-plan-descriptions-spds> You may also request to receive a paper copy of the Certificate of Coverage by contacting the Benefits Team at (609) 258-3302 or benefits@princeton.edu.

If Your Life Insurance or Business Travel Accident Claim Is Denied

If the claimant receives a denial notice and disagrees, the claimant is entitled to apply for a full and fair review of the claim and the denial. The claimant or an appointed representative can appeal and request a claim review within 60 days after receiving the denial notice. The request must be made in writing and should be filed with the Claims Administrator.

The claimant is also entitled to reasonable access to and copies of all information that is relevant to the claim. This includes all information (i) relied on in making the benefit determination; (ii) submitted to, considered, or generated by the program in considering the claim; and (iii) that demonstrates the program’s processes for ensuring proper, consistent decisions. The claimant should include in the claimant’s appeal the reasons the claimant believes the claim was improperly denied and all additional information the claimant considers relevant in support of the claimant’s claim.

The reviewer will reconsider the claimant’s claim, and the claimant will receive a written notice of the decision within 60 days after the claimant files the appeal. If more time is needed, the reviewer may be permitted to have a 60-day extension, so long as the claimant is notified in advance of the need and reasons for the delay.

If the claimant’s appeal is denied, the claimant will receive notice of a denial, which will include:

- the specific reasons for the denial;
- the specific program provisions on which the denial is based;

- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
- a statement of your right to bring a civil action under ERISA following a denial on review.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Plan Administration and Legal Information

Plan Administrator

The Plan Administrator is responsible for the administration of the Princeton University benefit plans. The Princeton University Benefits Committee (the Committee) is the administrator for all of its plans. As such, the Committee has discretionary authority to interpret plan provisions, construe terms, determine eligibility for benefits and otherwise make all decisions and determinations regarding plan administration. By participating in any Princeton University benefit plan, you accept the Plan Administrator's authority. You may contact the Committee by sending a letter to the Princeton University Benefits Committee, Manager of Benefits, Office of Human Resources, 100 Overlook Center, Suite 400, Princeton University, Princeton, NJ 08540.

Claims Administrator

For some of the plans, the University, as plan administrator, has delegated authority to a third party to act as the Claims Administrator. The claims administrator for each Princeton University benefit is the company identified in the following chart unless a company is not identified. Princeton University delegates its authority to the Claims Administrator to apply the plan's provisions for benefit claims determinations.

The following chart includes the names, addresses, and phone numbers of the companies responsible for administering claims under the Plans. Use this chart as a reference when you need to contact a Claims Administrator regarding a claim. Detailed information about filing a claim under a particular plan may be found in the appropriate section of this book or the applicable benefit booklet.

Plan	Address	Phone
Princeton Health Plan (PHP) UnitedHealthcare	Claims Department UnitedHealthcare Insurance Company PO Box 740800 Atlanta, GA 30374-0800	(877) 609-2273

Princeton Health Plan (PHP) Aetna	Claims Department Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106	(800) 535-6689
HMO Aetna	Claims Department Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106	(800) 535-6689
Consumer Directed Health Plan (CDHP) Aetna	Claims Department Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106	(800) 535-6689
J-1 Visa Plan Aetna	Claims Department Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106	(800) 535-6689
Prescription Drug Plan OptumRx	OptumRx PO Box 968022 Schaumburg, IL 60196-8022	(877) 629-3117
DMO Dental Plan Aetna	Aetna Dental P. O. Box 14094 Lexington, KY 40512-4094	(877) 238-6200
Basic and High Option Dental Plan Metlife	Metlife Dental Claims PO Box 981282 El Paso, TX 79998-1282	(866) 832-5756
Vision Care Plan Metlife	MetLife Vision PO Box 385018 Birmingham, AL 35238-5018	(855) 638-3931
Healthcare Flexible Spending Account and Health Savings Account PayFlex Systems	PayFlex Systems USA, Inc. PO Box 981158 El Paso, TX 79998-1158	(800) 284-4885
Dependent Care Flexible Spending PayFlex Systems	PayFlex Systems USA, Inc. PO Box 981158 El Paso, TX 79998-1158	(800) 284-4885
Long Term Disability Plan The Hartford	The Hartford Life and Accident Insurance Company One Hartford Plaza Hartford, CT 06155	(877) 778-1383
Basic and Supplemental Life Insurance Plan (and AD&D) The Hartford	The Hartford Life and Accident Insurance Company One Hartford Plaza Hartford, CT 06155	(877) 778-1383
Employee Assistance Programs Carebridge Corporation	Carebridge Corporation The Greentree Plaza	(800) 437-0911

	40 Lloyd Avenue Malvern, PA 19355	
Business Travel Accident Plan Federal Insurance Company	Federal Insurance Company 2028 Hall's Mill Road Whitehouse Station, NJ	(800) 252-4670

Limitations on Rights

Participation in a plan does not give you the right to remain employed by the University. Also, you may not sell, transfer or assign either voluntarily or involuntarily the value of your benefit under any plan except that you may assign your basic life and supplemental life.

Plan Amendment or Termination

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

Participant Rights/ERISA Requirements

As a participant in an employee welfare benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to certain rights. They include your right to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may assess a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65), and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to earn a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve months. The plan must provide the statement free of charge.
- Continue healthcare coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Continuation of Coverage section of this summary plan description and the documents governing the plan for the rules governing your Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage rights.

- To receive a creditable coverage statement from this plan, which may reduce or eliminate exclusionary periods of coverage due to preexisting conditions under another group health plan. You will be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after you enroll in another group health plan.

Fiduciary Duties

In addition to creating rights for plan participants above, ERISA imposes duties upon the people responsible for the operation of employee benefit plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA. If your claim for a plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Enforcement of Your Rights

If your claim for a health or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a court of competent jurisdiction. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Mental Health Parity

Notwithstanding anything in this SPD to the contrary, the plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance

coverage offered in connection with the plan, as required by Code Section 9812 and ERISA Section 712, and the regulations thereunder. Specifically:

Lifetime or Annual Dollar Limits. The plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

Financial Requirement or Treatment Limitations. The plan will not apply any financial requirement or treatment limitation (whether quantitative or non-quantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Criteria for medical necessity determinations. The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You can also obtain certain procedures about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800) 998-7542.

If you have any specific questions about any of the plans discussed in this summary plan description, contact the Office of Human Resources at (609) 258-3302.

Employer Identification Number

The Internal Revenue Service has assigned the Employer Identification Number (EIN) 21-0634501 to Princeton University. If you need to correspond with a government agency about a benefit plan, use this number along with the plan name and the University's name.

Additional Notices

Qualified Medical Child Support Order (QMCSO)

You may enroll your dependents in a health care plan if you are required by a qualified medical child support order (QMCSO), as legally defined to provide coverage for your dependents. If you are not enrolled in a plan at the time you receive such an order, you must enroll in a plan. Coverage is effective on the date specified in the QMCSO. You may obtain a copy of Princeton University's procedures governing QMCSO determinations, free of charge, by contacting Human Resources Benefits, Princeton University, 100 Overlook Center, Suite 400 Princeton, NJ 08540.

Personal Injury Protection (PIP)

In New Jersey, motor vehicle insurance policies sold in the state are required by law to provide primary personal injury protection coverage ("PIP"), which pays for medical expenses resulting from a motor vehicle accident. In addition to this protection, most motorists carry additional health insurance through an employer. Because Princeton University offers its employees self-insured health care plans, if you are covered under one of the Princeton University health plans, you may not elect the plan as your primary insurance coverage in the event of a motor vehicle accident. You should have selected your motor vehicle insurance policy's "PIP" coverage as your primary coverage.

Women's Health and Cancer Act

Federal law requires group health care plans to cover certain reconstruction surgery following a mastectomy. Group health care plans must include under Covered Expenses, expenses associated with reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; and the cost of prostheses and the costs for treatment of physical complications in all stages of the mastectomy, including lymphedemas (swelling associated with the removal of the lymph nodes.) These services are required to be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these medical services is subject to the applicable deductible and coinsurance amounts.

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).

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act prohibits health coverage discrimination and employment discrimination against employees based on their (or their family members') genetic information.

Genetic information includes:

- You or your family member's genetic tests;
- The request for, or receipt of, genetic counseling or other genetic services by you or your family members; and
- The manifestation of a disease or disorder in an individual's family member.

The availability of genetic testing and results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, genetic information collected about family history, such as through a Health Risk evaluation, will be treated as confidential, as required by HIPAA and GINA.

The Plan will not discriminate on the basis of genetic information. This means that the Plan will not adjust premiums for an employer or any group of similarly situated individuals under the Plan, on the basis of genetic information.

The Plan will not request or require you or your family member to undergo a genetic test. However, your Physician may obtain and use information about the results of a genetic test. The Plan may also obtain such information to the extent required in making a determination regarding payment (e.g., where payment is made only as to Medically Necessary treatment and the results of a genetic test are necessary to determine the Medical Necessity of the services provided). In some circumstances the Plan may obtain or request genetic information for research purposes (if required by a state for the protection of individuals) or as part of your or your family member's voluntary participation in a research study.

The Plan will not collect genetic information for underwriting purposes, which includes (A) determination of, eligibility (including enrollment and continued eligibility) for benefits under the Plan or coverage (including changes in Deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); (B) the computation of premiums under the Plan or coverage (including discounts in return for activities such as completing a health risk assessment or participating in a wellness program); (C) the application of any preexisting condition exclusion under the Plan or coverage; and (D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. However, if the Plan conditions the benefit based on its medical appropriateness, which depends on the genetic information, the Plan is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness.

The Plan will not collect genetic information with respect to any individual prior to that individual's effective date of coverage under that plan, nor in connection with the rules for eligibility that apply to that individual.

For more information on genetic information protection and nondiscrimination, contact:

Office of Human Resources
100 Overlook Center, Suite 400
Princeton, NJ 08540
Telephone: 609-258-3302
email: benefits@princeton.edu

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. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

General Contact Information

Several resources are available to you whenever you have questions about any of the information in this document:

Office of Human Resources
Phone: (609) 258-3302
Email: benefits@princeton.edu

Web site:
www.princeton.edu/hr/benefits

Glossary

After-tax – Deductions taken after Federal, State and local income and Social Security taxes have been withheld.

Calendar Year – The 12- month period commencing on January 1 and ending December 31.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) –This legislation mandates employer-provided health care plans to permit continued coverage under the employer’s group plan upon certain job and family status changes.

Coordination of Benefits (COB) – A group health plan provision designed to eliminate duplicate payments and provide the sequence in which coverage will apply (primary and secondary) when a person is covered under two plans.

Covered Expenses – Hospital, medical and related costs that qualify for reimbursement according to the provisions of the health care plan.

Evidence of Insurability Form –A form required in certain circumstances in order to apply for additional life insurance coverage; the form provides documented proof of good health.

Open Enrollment Period – The Annual Open Enrollment Period is held each fall and provides you the opportunity to add or delete eligible dependents to your health plan(s). You may also choose new plans and terminate coverage in others. Certain benefits require an annual election, others will roll forward from year to year.

Pre-tax – Deductions taken before Federal, State and local income and Social Security taxes have been withheld. Some states do not recognize pre-tax deductions.

Qualifying Event, Life Event, or Status Event– An occurrence entitling a person to make health care plan elections other than at hire or at Open Enrollment.

Subrogation – The right of the employer or plan administrator to recoup benefits paid to participants through a legal suit, if the action causing the disability and subsequent medical expenses was the fault of another individual.