2024

Administrative Notices

Federal and state regulations require Princeton University to provide you with certain information concerning your rights and responsibilities regarding benefits on an annual basis. This information, referred to as "administrative notices," are contained in this document. These notices are also available on our website at hr.princeton.edu/benefits-administrative-notices. In addition, the Patient Protection and Affordable Care Act (PPACA), requires Princeton to provide a Summary of Benefits Coverage (SBC) to all participants and their dependents. The SBCs are included in this document and are also available on our website at hr.princeton.edu/summary-benefits-coverage.

Please review the following information carefully and keep for future reference. If you have any questions about these materials, contact the Human Resources Benefits Team at (609) 258-3302 or benefits@princeton.edu.
**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**

Continued 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/ehsa/healthreform](http://dol.gov/ehsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.
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.

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/dsepublic/#/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 and/or after-tax monies directly from your paycheck and invest in a variety of investment funds. You are responsible for choosing your investment funds from those offered under the plan. Information about the investment options is available at tiaa.org/princeton. If you 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 are a benefits eligible employee, you are automatically enrolled in the Retirement Savings Plan at a 5% contribution. If you are not benefits eligible, but you are receiving pay directly from the University, you can send an email to benefits@princeton.edu and request enrollment information. You can change your deferral election at any time during the year.

If you have questions, contact the Benefits Team at 609-258-3302 or benefits@princeton.edu.
Health Information as your “health information” in this Notice.

You receive, or payment for your care. We refer to your Protected

To your physical or mental health or condition, the health care

received or created by the PLAN that identifies you and relates

protected Health Information generally includes information

in effect.

To comply with the terms of the notice currently

maintain the privacy of your “Protected Health Information”

We refer to these duties and privacy practices with respect to your Protected Health Information, and to comply with the terms of the notice currently in effect.

The Princeton University health plans listed above (hereinafter referred to collectively as “the PLAN”) are required by law 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.

The Princeton University health plans listed above (hereinafter referred to collectively as “the PLAN”) are required by law to

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.

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 at the number on your ID card.
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 if you believe it is inaccurate or incomplete. Your right to request an amendment is subject to certain conditions. For example, we may deny your request if it would result in a violation of federal and state laws. 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.
• 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 on 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

hr.princeton.edu/thrive
New Jersey Department of Labor and Workforce Development

New Jersey Earned Sick Leave

Notice of Employee Rights

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

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

YOU HAVE A RIGHT TO EARNED SICK LEAVE.

Amount of Earned Sick Leave
Your employer must provide up to a total of 40 hours of earned sick leave every benefit year. Your employer’s benefit year is:
- Start of Benefit Year: July 1
- End of Benefit Year: June 30

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

Date Accrual Begins
You begin to accrue earned sick leave on October 29, 2018, or on your first day of employment, whichever is later.

Exception: If you are covered by a collective bargaining agreement that was in effect on October 29, 2018, you begin to accrue earned sick leave under this law beginning on the date that the agreement expires.

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

Acceptable Reasons to Use Earned Sick Leave
You can use earned sick leave to take time off from work when:
- You need diagnosis, care, treatment, or recovery for a mental or physical illness, injury, or health condition; or you need preventive medical care.
- You need to care for a family member during diagnosis, care, treatment, or recovery for a mental or physical illness, injury, or health condition; or your family member needs preventive medical care.
- You or a family member have been the victim of domestic violence or sexual violence and need time for treatment, counseling, or to prepare for legal proceedings.
- You need to attend school-related conferences, meetings, or events regarding your child’s education; or to attend a school-related meeting regarding your child’s health.
- Your employer’s business closes due to a public health emergency or you need to care for a child whose school or child care provider closed due to a public health emergency.

Family Members
The law recognizes the following individuals as “family members:”
- Child (biological, adopted, or foster child; stepchild; legal ward; child of a domestic partner or civil union partner)
- Grandchild • Sibling • Spouse • Parent • Grandparent
- Domestic partner or civil union partner
- 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
- 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/complaint/files/wage_claim.html or by calling 609-292-2305 between 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.

Display this poster in a conspicuous place

MW-565 (12/21)
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 reduces 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% 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.

---

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>
</tr>
</thead>
<tbody>
<tr>
<td>Princeton University</td>
<td>21-0634501</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address:</th>
<th>6. Employer phone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of Human Resources, 100 Overlook Center</td>
<td>(609) 258-3302</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Princeton</td>
<td>NJ</td>
<td>08540</td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?

The Benefits Team in the Office of Human Resources.

<table>
<thead>
<tr>
<th>11. Phone number (if different from above):</th>
<th>12. Email address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="mailto:benefits@princeton.edu">benefits@princeton.edu</a></td>
</tr>
</tbody>
</table>

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.
Notice of Creditable Coverage

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 2023
Name of Entity/Sender: Princeton University
Contact--Position/Office: Linda Nilsen, Assistant Vice President, Human Resources
Address: Office of Human Resources, 100 Overlook Center, Princeton, NJ 08540
Phone Number: (609) 258-3302
New Jersey law provides up to 6 weeks of family leave insurance benefits. Beginning July 1, 2020, the law will allow up to 12 weeks of continuous family leave or 56 days of intermittent leave. Employees who are covered by family leave insurance can apply for benefits to:

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

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

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

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

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

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

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

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

**Who pays for Family Leave Insurance?**

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

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 Retirement Trust I. If you did not make an investment election, you would default into the Vanguard Target Retirement Trust I which is chosen by using the date-specific fund nearest your expected year of retirement (i.e., the year you reach age 65). Enclosed is the fund fact sheet for the Vanguard Target Retirement Trust I, which includes information about your default fund, such as the investment objective, fees and expenses, and risk and return characteristics.

Investments in Vanguard Target Retirement Trust I 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 Retirement Trust I 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 within 30 days.

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 (Main) 102865 (PPPL).
• By phone. Call 800-842-2776 weekdays 8 a.m. to 10 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.
Qualified Default Investment Alternative (QDIA) Annual Notice for the Princeton University Retirement Savings Plan

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

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

Your plan's default fund
Your plan also designates a default fund, where your contributions will be invested if you have not made an affirmative investment election. The plan's default fund is the Vanguard Target Retirement Fund. If you did not make an investment election, you would default into the Vanguard Target 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 is the fund fact sheet for the Vanguard Target 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 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 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 within 30 days.

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 Savings Plan: 102862 (Main) 102866 (PPPL).
• By phone. Call 800-842-2776 weekdays 8 a.m. to 10 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.
ACA Section 1557 Notice

Notice of Nondiscrimination
Required Under Section 1557 of the
Patient Protection and Affordable Care Act of 2010, as amended

The Princeton University Retiree Healthcare Benefits 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 in the provision of group health benefits under the Plan. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Human Resources Benefits Team at (609) 258-3302 or benefits@princeton.edu.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a claim under the Plan. (Refer to your summary plan description for information as to how to file a claim for a benefit.)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building
Washington, DC 20201
1-800-868-1019, 800-537-7697 (TDD).

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, 2023. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>ALASKA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-855-692-5447</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARKANSAS – Medicaid</th>
<th>CALIFORNIA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
<th>FLORIDA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td></td>
</tr>
<tr>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711</td>
<td></td>
</tr>
<tr>
<td>CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a></td>
<td></td>
</tr>
<tr>
<td>Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a></td>
<td></td>
</tr>
<tr>
<td>HIBI Customer Service: 1-855-692-6442</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Website: <a href="https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html">https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html</a>  |
| Phone: 1-877-357-3268 |  |</p>
<table>
<thead>
<tr>
<th>GEORGIA – Medicaid</th>
<th>INDIANA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a></td>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
</tr>
<tr>
<td>Phone: 678-564-1162, Press 1</td>
<td>Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a></td>
</tr>
<tr>
<td>Phone: 678-564-1162, Press 2</td>
<td>All other Medicaid</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-457-4584</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IOWA – Medicaid and CHIP (Hawki)</th>
<th>KANSAS – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a></td>
<td>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a></td>
</tr>
<tr>
<td>Medicaid Phone: 1-800-338-8366</td>
<td>Phone: 1-800-792-4884</td>
</tr>
<tr>
<td>Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a></td>
<td>HIPP Phone: 1-800-967-4660</td>
</tr>
<tr>
<td>Hawki Phone: 1-800-257-8563</td>
<td></td>
</tr>
<tr>
<td>HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
<td></td>
</tr>
<tr>
<td>HIPP Phone: 1-888-346-9562</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KENTUCKY – Medicaid</th>
<th>LOUISIANA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a></td>
<td>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a></td>
</tr>
<tr>
<td>Phone: 1-855-459-6328</td>
<td>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</td>
</tr>
<tr>
<td>Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a></td>
<td></td>
</tr>
<tr>
<td>KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-877-524-4718</td>
<td></td>
</tr>
<tr>
<td>Kentucky Medicaid Website: <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAINE – Medicaid</th>
<th>MASSACHUSETTS – Medicaid and CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1-800-442-6003</td>
<td>Phone: 1-800-862-4840</td>
</tr>
<tr>
<td>TTY: Maine relay 711</td>
<td>TTY: 711</td>
</tr>
<tr>
<td>Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a></td>
<td>Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a></td>
</tr>
<tr>
<td>Phone: 1-800-977-6740</td>
<td></td>
</tr>
<tr>
<td>TTY: Maine relay 711</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MINNESOTA – Medicaid</th>
<th>MISSOURI – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1-800-657-3739</td>
<td>Phone: 573-751-2005</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MONTANA – Medicaid</th>
<th>NEBRASKA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1-800-694-3084</td>
<td>Phone: 1-855-632-7633</td>
</tr>
<tr>
<td>Email: <a href="mailto:HHSHIPPPProgram@mt.gov">HHSHIPPPProgram@mt.gov</a></td>
<td>Lincoln: 402-473-7000</td>
</tr>
<tr>
<td></td>
<td>Omaha: 402-595-1178</td>
</tr>
<tr>
<td>State</td>
<td>Medicaid and CHIP Information</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| NEVADA – Medicaid   | Medicaid Website: [http://dhcfp.nv.gov](http://dhcfp.nv.gov)  
Medicaid Phone: 1-800-992-0900 |
| NEW HAMPSHIRE – Medicaid | Website: [https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program](https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program)  
Phone: 603-271-5218  
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| NEW JERSEY – Medicaid and CHIP | Medicaid Website: [http://www.state.nj.us/humanservices/dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)  
Medicaid Phone: 609-631-2392  
CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-701-0710 |
| NORTH CAROLINA – Medicaid | Website: [https://medicaid.ncdhhs.gov/](https://medicaid.ncdhhs.gov/)  
Phone: 919-855-4100 |
| NORTH DAKOTA – Medicaid | Website: [https://www.hhs.nd.gov/healthcare](https://www.hhs.nd.gov/healthcare)  
Phone: 1-844-854-4825 |
| OKLAHOMA – Medicaid and CHIP | Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org)  
Phone: 1-888-365-3742 |
| OREGON – Medicaid | Website: [http://healthcare.oregon.gov/Pages/index.aspx](http://healthcare.oregon.gov/Pages/index.aspx)  
Phone: 1-800-699-9075 |
| PENNSYLVANIA – Medicaid and CHIP | Website: [https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx](https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx)  
Phone: 1-800-692-7462  
CHIP Website: [Children's Health Insurance Program (CHIP)](http://pa.gov)  
CHIP Phone: 1-800-986-KIDS (5437) |
| RHODE ISLAND – Medicaid and CHIP | Website: [http://www.eohhs.ri.gov/](http://www.eohhs.ri.gov/)  
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line) |
| SOUTH CAROLINA – Medicaid | Website: [https://www.scdhhs.gov](https://www.scdhhs.gov)  
Phone: 1-888-549-0820 |
| SOUTH DAKOTA - Medicaid | Website: [http://dss.sd.gov](http://dss.sd.gov)  
Phone: 1-888-828-0059 |
| TEXAS – Medicaid | Website: [Health Insurance Premium Payment (HIPP) Program](https://www.health.utah.gov/chip)  
Texas Health and Human Services  
Phone: 1-800-440-0493 |
| UTAH – Medicaid and CHIP | Medicaid Website: [https://medicaid.utah.gov/](https://medicaid.utah.gov/)  
CHIP Website: [http://health.utah.gov/chip](http://health.utah.gov/chip)  
Phone: 1-877-543-7669 |
| VERMONT– Medicaid | Website: [Health Insurance Premium Payment (HIPP) Program](https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select)  
Department of Vermont Health Access  
Phone: 1-800-250-8427 |
| VIRGINIA – Medicaid and CHIP | Medicaid Website: [https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs](https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs)  
CHIP/CHIP Phone: 1-800-432-5924 |
| WASHINGTON – Medicaid | Website: [https://www.hca.wa.gov/](https://www.hca.wa.gov/)  
Phone: 1-800-562-3022 |
| WEST VIRGINIA – Medicaid and CHIP | Medicaid Website: [https://dhhr.wv.gov/bms/](https://dhhr.wv.gov/bms/)  
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>WISCONSIN</td>
<td>Medicaid and CHIP</td>
<td><a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a></td>
<td>1-800-362-3002</td>
</tr>
</tbody>
</table>

**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 1/31/2026)
Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can’t balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.
When balance billing isn’t allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed, you may contact Aetna or UnitedHealthcare member services at the phone number on your ID card.

The New Jersey Family Leave Act (NJFLA) entitles certain employees to take up to 12 weeks of family leave in a 24-month period without losing their jobs.

Employers generally must provide NJFLA leave if:

- The EMPLOYER has at least 30 employees worldwide OR is a government entity, regardless of size;
- The EMPLOYEE has worked for that employer for at least 1 year, AND has worked at least 1,000 hours in the past 12 months; and
- The LEAVE is being taken to:

  - Care for or bond with a child within 1 year of the child’s birth or placement for adoption or foster care;
  - Care for a family member, or someone who is equivalent of family, who has a serious health condition, or who has been isolated or quarantined because of suspected exposure to a communicable disease (including COVID-19) during a state of emergency; or
  - Provide required care or treatment for a child during a state of emergency if their school or place of care is closed due to an epidemic of a communicable disease (including COVID-19) or other public health emergency.

Certain employees may be eligible for additional leave under the federal Family and Medical Leave Act. Note that the NJ Family Leave Act does not provide leave for the employee’s own health condition.

Remedies may include money damages, an order to stop violating the Act, adoption of new policies and procedures, attorney’s fees, and more.

To get more information or file a complaint, contact the Division on Civil Rights.

1-833-NJDCR4U | NJCivilRights.gov | #CivilRightsNJ

No one can retaliate against you for attempting to take or taking NJFLA leave, reporting NJFLA violations, or exercising other rights under the NJFLA.
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the Benefits Team at 609-258-3302. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 609-258-3302 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Calendar Year In-Network: Individual $1,600/Family $3,200. Out of Network: Individual $3,200/Family $6,400</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. In-network preventive services are covered before the deductible is met.</td>
<td>For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For each Calendar Year In-Network: Individual $3,200/Family $6,400; Out of Network: Individual $6,400/Family $12,800.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, penalties for prescriptions, failure to obtain pre-authorization for services, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/dse/princeton">www.aetna.com/dse/princeton</a> or call 800-535-6689 for a list of network providers.</td>
<td>You pay the least if you use a provider in the plan’s Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
</tbody>
</table>

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

⚠️ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least) 20% coinsurance after deductible. Out-of-Network Provider (You will pay the most) 50% coinsurance after deductible.</td>
<td>Applies to Internal Medicine, Pediatrics, Family Practice, and General Medicine.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Network Provider (You will pay the least) 20% coinsurance after deductible. Out-of-Network Provider (You will pay the most) 50% coinsurance after deductible.</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Network Provider (You will pay the least) No charge. Out-of-Network Provider (You will pay the most) 50% coinsurance after deductible.</td>
<td>Age and frequency schedules may apply. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Network Provider (You will pay the least) $0 after deductible at Quest or LabCorp; 40% after deductible for other in-network lab. Out-of-Network Provider (You will pay the most) Not covered.</td>
<td>X-rays/Radiology covered $0 after deductible at independent facility. 20% after deductible at hospital. No coverage out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Network Provider (You will pay the least) $0 after deductible at in-network independent facility; 20% after deductible at in-network hospital. Out-of-Network Provider (You will pay the most) Not covered.</td>
<td>Precertification required, or services will not be covered. In-Network provider will obtain necessary precertification. No coverage out-of-network.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Network Provider (You will pay the least) Per Prescription $5 copay (retail) $10 copay (mail order) Out-of-Network Provider (You will pay the most) Per Prescription $5 copay (retail).</td>
<td>Covers up to a 30-day supply (retail); 90 day supply (mail order). If maintenance medication is purchased at a retail for more than 3 months, subsequent refills will cost twice the retail copayment rate. Some scripts require Prior Authorization, Step Therapy and Quantity Duration Programs. If there is a generic equivalent for a brand-name drug, Member pays the generic copay plus the difference between the Plan’s cost of the brand drug and the Plan’s cost of the generic</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Network Provider (You will pay the least) Per Prescription $25 copay (retail) $50 copay (mail order) Out-of-Network Provider (You will pay the most) Per Prescription $25 copay (retail).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Network Provider (You will pay the least) Per Prescription $40 copay (retail) $80 copay (mail order) If a generic equivalent. Out-of-Network Provider (You will pay the most) Per Prescription $40 copay (retail).</td>
<td></td>
</tr>
</tbody>
</table>

[* For more information about limitations and exceptions, see the plan or policy document at https://hr.princeton.edu/summary-plan-descriptions-spds]
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>exists, see &quot;Limitations &amp; Exceptions&quot; for cost</td>
<td>exists, see &quot;Limitations &amp; Exceptions&quot; for cost</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Costs are the same as the categories above</td>
<td>Costs are the same as the categories above</td>
<td>Most Specialty drugs must be purchased through Optum Rx Specialty Pharmacy.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$0 after deductible</td>
<td>Not covered for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$0 after deductible</td>
<td>$0 after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$0 after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance, after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% after deductible</td>
<td>25% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
</tbody>
</table>

[* For more information about limitations and exceptions, see the plan or policy document athttps://hr.princeton.edu/summary-plan-descriptions-spds]
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance after deductible</td>
<td>Coverage limited to 60 visits per calendar year. Precertification same as described for outpatient surgery on page 3.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance after deductible</td>
<td>Chiropractic care 20 visits per calendar year limit. Subject to medical necessity review.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance after deductible</td>
<td>Subject to medical necessity review.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance after deductible</td>
<td>Coverage limited to 60 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance after deductible</td>
<td>Coverage limited to 180 days lifetime maximum.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered under this plan; covered under Aetna or MetLife Dental Plans if elected.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs
- Non-emergency care when traveling outside of the US (covered at the out-of-network level)
- Private-duty nursing (precertification required; 60 visit limit per year)

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- Acupuncture (20 visit limit per year)
- Bariatric surgery (precertification required)
- Chiropractor care (20 visit limit per year)
- Hearing aids (up to $1,500 every 3 years)
- Infertility coverage – Diagnosis and treatment of underlying medical condition covered with no lifetime maximum. Other fertility treatment provided through Kindbody; four (4) cycles covered per member per lifetime. In-network only coverage through Kindbody. No out-of-network coverage.
- Non-emergency care when traveling outside of the US (covered at the out-of-network level)
- Private-duty nursing (precertification required; 60 visit limit per year)

[* For more information about limitations and exceptions, see the plan or policy document at https://hr.princeton.edu/summary-plan-descriptions-spds]
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Benefits Team at 609-258-3302 or Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-535-6689
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-535-6689
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-535-6689
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-535-6689

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $1,600
- Specialist [cost sharing]: 20%
- Hospital (facility) [cost sharing]: 20%
- Other [cost sharing]: 20%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1,600</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Copayments</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn’t covered**

Limits or exclusions: $

**The total Peg would pay is** $1,800

---

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $1,600
- Specialist [cost sharing]: 20%
- Hospital (facility) [cost sharing]: 20%
- Other [cost sharing]: 20%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$5,600</th>
</tr>
</thead>
</table>

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1,600</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>$50</td>
</tr>
</tbody>
</table>

**What isn’t covered**

Limits or exclusions: $20

**The total Joe would pay is** $1,870

---

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $1,600
- Specialist [cost sharing]: 20%
- Hospital (facility) [cost sharing]: 20%
- Other [cost sharing]: 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$2,800</th>
</tr>
</thead>
</table>

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1,600</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Copayments</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn’t covered**

Limits or exclusions: $

**The total Mia would pay is** $1,800

---

Note: *These numbers assume the patient is not participating in the condition management incentive program. If you participate in this program, you may reduce your costs. For more information, contact the Benefits Team at 609-258-3302.

The plan would be responsible for the other costs of these EXAMPLE covered services.