This communication is intended to be a *Summary of Material Modifications (SMM)* for the healthcare and other benefits plans and programs. It briefly describes your benefits plans including any changes effective January 1, 2019. Although Princeton intends to continue these benefits, the University reserves the right to amend or terminate these plans at any time. You can find full details regarding coverage, eligibility, and limitations in the *Summary Plan Descriptions (SPDs)* available on our website. You may also request to receive a paper copy of an *SPD* or any administrative notice by contacting the Benefits Team.

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

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

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

**CONTACT US**

*Human Resources Benefits Team*

(609) 258-3302
benefits@princeton.edu
www.princeton.edu/hr/benefits

*Human Resources Service Center*

4 New South
Princeton, NJ 08544
Monday–Friday
9:00 a.m.–4:00 p.m.

*Benefits Services available by appointment or during walk-in hours:*

Monday, Wednesday, and Friday
9:00 a.m.–1:00 p.m.
Tuesday and Thursday
12:30–4:00 p.m.

**PROVIDER INFORMATION**

<table>
<thead>
<tr>
<th>Healthcare Plans</th>
<th>Provider</th>
<th>Group Number/Plan ID</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Directed Health Plan</td>
<td>Aetna</td>
<td>468619</td>
<td>(800) 535-6689</td>
<td>aetna.com/dse/princeton</td>
</tr>
<tr>
<td>Telemedicine and Telemental Health</td>
<td>Teladoc</td>
<td>NA</td>
<td>(855) 835-2362</td>
<td>teladoc.com/princeton</td>
</tr>
<tr>
<td>Prescription Drug Plan</td>
<td>OptumRx</td>
<td>PURPRNCEM</td>
<td>(877) 629-3117</td>
<td>optumrx.com</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Retirement Plans</th>
<th>Provider</th>
<th>Group Number/Plan ID</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement Savings Plan</td>
<td>TIAA &amp; Vanguard (Main)</td>
<td>102862</td>
<td>(800) 842-2776</td>
<td>tiaa.org</td>
</tr>
<tr>
<td></td>
<td>TIAA &amp; Vanguard (PPPL)</td>
<td>102866</td>
<td>(800) 842-2776</td>
<td>tiaa.org</td>
</tr>
</tbody>
</table>
DEPENDENT ELIGIBILITY AND VERIFICATION

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

INELIGIBLE DEPENDENTS

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

DEPENDENT VERIFICATION PROCESS

For each dependent you are enrolling in one or more of Princeton’s healthcare plans, you must provide the required dependent verification documentation within 31 days from the effective date of your coverage. Otherwise, your dependent(s) will be removed and not have coverage. As soon as you have the documentation available, submit copies by fax to (609) 258-5920, email to benefits@princeton.edu, or campus mail to the Office of Human Resources, 4 New South. You can also call the Benefits Team at (609) 258-3302 to make arrangements. All documentation received is handled confidentially.

DEPENDENT VERIFICATION DOCUMENTATION

<table>
<thead>
<tr>
<th>Dependent Type</th>
<th>Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Marriage certificate¹ and most recently filed tax return with Social Security numbers and all financial information redacted, i.e., blacked out, by the employee</td>
</tr>
<tr>
<td>Biological child who is under age 26²</td>
<td>Birth certificate³</td>
</tr>
<tr>
<td>Adopted child</td>
<td>Legal adoption papers</td>
</tr>
<tr>
<td>Stepchild</td>
<td>Birth certificate including names of biological parents and employee’s marriage certificate</td>
</tr>
<tr>
<td>Legal ward</td>
<td>Legal guardianship papers showing full financial support and custody responsibilities</td>
</tr>
<tr>
<td>Foster child</td>
<td>Official placement papers</td>
</tr>
</tbody>
</table>

¹ Foreign nationals can provide current visa documentation showing marriage in lieu of a marriage certificate.
² Coverage can continue through the calendar year in which the child turns 26.
³ Foreign nationals can provide current visa documentation listing dependent child(ren) in lieu of a birth certificate(s).
The Internal Revenue Service (IRS) limits when you can add coverage for dependents or make changes to your healthcare, flexible spending account, and life insurance elections during the year. You have the following opportunities to elect or make changes to your benefits:

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

For more information, review the Notice of Special Enrollment Rights on page 14 or visit our website.

**QUALIFYING STATUS EVENT CHANGES**

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

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

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

Preventive services in the CDHP e.g., annual exams, colonoscopies, and mammographies, are covered at 100% in-network before deductible.

**URGENT CARE CENTERS**

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

**CENTERS OF EXCELLENCE AND INSTITUTES OF QUALITY**

Aetna offers Institutes of Quality (IOQs) for CHD, behavioral health, transplant services, bariatric surgery, orthopedic procedures for joints and spine, and infertility services. For information, contact Aetna.

**MEDICAL PLAN ID CARDS**

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

**PRECERTIFICATION**

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

**TELEMEDICINE**

Telemedicine is included in all our medical plans through Teladoc. It is a convenient and affordable option that allows you to talk to a U.S. Board Certified doctor 24 hours a day, 7 days a week, who can diagnose, recommend treatment, and prescribe medication (when appropriate), for many of your medical issues.

**Conditions commonly treated through Telemedicine**

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

Individuals enrolled in the CDHP will pay approximately $40 per visit until the annual deductible is met at which point visits will be covered at 80% until the out-of-pocket maximum (OPM) is reached. Once you reach the OPM, visits will be covered at 100%.

To register for this service, go to www.teladoc.com/princeton, call (855) TELADOC (835-2362), or download the Teladoc app from the Apple App Store or Google Play.

**TELEMENTAL HEALTH**

Teladoc Behavioral Health is a convenient option that allows participants age 18 and older to video conference with a licensed health provider—including psychiatrists, psychologists, and counselors—who can provide both therapy and medication management.

**Conditions commonly treated through Telemental Health**

- Depression
- Bipolar disorder
- Anxiety
- Substance abuse

Visits are covered at the same cost as in-network in-person mental health visits. Individuals enrolled in the CDHP will pay the coinsurance after the annual deductible is met.

To register for this service, go to www.teladoc.com/princeton or download the Teladoc app from the Apple App Store or Google Play.

In addition, Aetna offers their own telemental health service. To schedule an appointment for this service with Aetna (referred to as Televideo), call their in-network provider Inpathy at (800) 442-8938. If you reside outside of NJ, NY, or PA, go to www.aetna.com/dse/princeton or call Aetna at (800) 535-6689.
**Consumer Directed Health Plan (CDHP)**

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

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

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

All out-of-network costs are subject to reasonable and customary limits. In- and out-of-network coverages have independent deductibles and out-of-pocket maximums (OPMs).

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**UTILIZING PREFERRED SPECIALISTS AND LABS**

**Tiered Specialists**

When utilizing specialists, first check to see if they are in a category that identifies in-network preferred specialist providers. Since a provider’s status can change, confirm the provider’s status prior to your appointment. Aetna preferred providers are listed as Aexcel with a blue star. Listed in the table are the categories and locations, as of the printing of this book. For the most current list of categories and locations, contact Aetna, or visit our website.

**Labs**

Quest Diagnostics and LabCorp are the preferred labs for Aetna. These labs charge less and perform a wide variety of services. There is no coverage for out-of-network lab services.

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**Aetna (Aexcel)**

**Categories with In-Network Preferred Specialists**

- Cardiology
- Cardiothoracic Surgery
- Gastroenterology
- General Surgery
- Neurology
- Neurosurgery
- Obstetrics and Gynecology (OB/GYN)
- Orthopedics
- Otolaryngology—Ear, Nose, and Throat (ENT)
- Plastic Surgery
- Urology
- Vascular Surgery

**Locations with Limited or No Access to Preferred Specialists**

- MI; NC; NH; OR; SD; WA; and Southeastern, Central, and Western PA

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AETNA  
www.aetna.com/dse/princeton  
(800) 535-6689  
CDHP/PHP Group #: 486819

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www.princeton.edu/hr/benefits  
Benefits 2019 | 5
MEDICAL PLAN BENEFITS COMPARISON

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

<table>
<thead>
<tr>
<th>Consumer Directed Health Plan (CDHP)</th>
<th>In-Network Preferred</th>
<th>In-Network Non-Preferred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible (Individual / Family)</strong></td>
<td>$1,500 / $3,000</td>
<td>$3,000 / $6,000</td>
<td>$3,000 / $6,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (OPM) (Individual / Family)</strong></td>
<td>$3,000 / $6,000</td>
<td>$6,000 / $12,000</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Visits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telemedicine</td>
<td>$40 until deductible is met, then 20%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Standard Specialists</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Tiered Specialists</td>
<td>10% after deductible&lt;sup&gt;2,3&lt;/sup&gt; 20% after deductible&lt;sup&gt;2,3&lt;/sup&gt; 50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$0 after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Emergency Room (no coverage for nonemergencies)</td>
<td>$0 after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and Surgical Procedures&lt;sup&gt;4&lt;/sup&gt;</td>
<td>10% after deductible&lt;sup&gt;2,3&lt;/sup&gt; 20% after deductible&lt;sup&gt;2,3&lt;/sup&gt; 50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health&lt;sup&gt;4&lt;/sup&gt;</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Procedures&lt;sup&gt;4&lt;/sup&gt; (Independent Facility / Hospital)</td>
<td>10% after deductible&lt;sup&gt;2,3&lt;/sup&gt; 20% after deductible&lt;sup&gt;2,3&lt;/sup&gt; 50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>$0 after deductible</td>
<td>40% after deductible&lt;sup&gt;2&lt;/sup&gt; Not covered</td>
<td></td>
</tr>
<tr>
<td>Radiology (X-Ray) (Independent Facility / Hospital)</td>
<td>$0 after deductible / 20% after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Hi-Tech Radiology (MRI, CAT, etc.,&lt;sup&gt;4&lt;/sup&gt; Independent Facility / Hospital)</td>
<td>$0 after deductible / 20% after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Preventive Care and Immunizations&lt;sup&gt;5&lt;/sup&gt;</td>
<td>$0</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>20% after deductible</td>
<td>25% after deductible</td>
<td></td>
</tr>
<tr>
<td>Annual Eye Exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Prescription Eyeglasses and/or Contact Lenses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy (100 visits per CY)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care (20 visits per CY)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Acupuncture (20 visits per CY)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> Costs above reasonable and customary (R&C) are your responsibility. Refer to the Summary Plan Description (SPD) for more information.

<sup>2</sup> For a list of specialists or labs covered under the tiered plan design, refer to page 11.

<sup>3</sup> Patient costs for tiered specialists fees will correspond to the tier of the specialist utilized to perform the medical or surgical procedure under the CDHP.

<sup>4</sup> Coverage requires precertification.

<sup>5</sup> Includes seven well baby visits in the first year of a child’s life.
Prescription coverage is through OptumRx. For more detail, refer to the Summary Plan Description ( SPD) on our website.

**IF YOU CHOOSE:**

<table>
<thead>
<tr>
<th>THEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Directed Health Plan (CDHP)</td>
</tr>
</tbody>
</table>

**THREE-TIER FORMULARY**

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

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

**APPEALS**

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

**SPECIALTY MEDICATIONS**

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

**HOME DELIVERY (MAIL ORDER)**

If you take certain prescriptions on a monthly basis, you can purchase a three-month supply through mail order at the same cost as a two-month supply at retail. Contact OptumRx to make arrangements or complete the mail order form available on the HR website. If you continue to fill your maintenance medication through a retail pharmacy for more than three months, subsequent refills will cost twice the retail pharmacy copayment. You should use retail pharmacies for short-term prescriptions, such as antibiotics.

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

**PATIENT SAFETY, EFFICIENCY, AND EFFECTIVENESS**

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

**PREVENTIVE ITEMS AND SERVICES**

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

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

<table>
<thead>
<tr>
<th>Member Pays the Difference</th>
<th>Lipitor Gross Cost</th>
<th>$220</th>
<th>minus (-)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic Gross Cost</td>
<td>$20</td>
<td>plus (+)</td>
</tr>
<tr>
<td></td>
<td>Generic Copayment</td>
<td>$5</td>
<td></td>
</tr>
</tbody>
</table>

equals (=)

Member Pays the Difference $205

OUT-OF-POCKET MAXIMUM (OPM)

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

If you are enrolled under the Consumer Directed Health Plan (CDHP), your OPM is integrated with your medical plan coverage. Therefore, your OPM will combine your eligible prescription plan expenses plus your eligible medical plan expenses. Once you have reached your annual OPM, your eligible medical and prescription plan expenses will be covered at 100% through the end of the calendar year.

GENETIC TESTING

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

OPTUMRX APP

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

PRESCRIPTION PLAN ID CARD

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

PRESCRIPTION COVERAGE UNDER THE CDHP

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

Drugs that Bypass the Deductible

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

Cancer
- Breast Cancer
Cardiovascular/Heart Disease
- Anti-Anginal Agents
- Anticoagulants
- Cardiac Glycosides
- Cholesterol Lowering Agents
- High Blood Pressure
Central Nervous System
- Antipsychotics
- Smoking Deterrents
Diabetes
- Insulin
- Non-insulin
Gastrointestinal
- Acid Suppression (Ulcer)
HIV/AIDS
Musculoskeletal
- Osteoporosis
Respiratory
- Asthma/COPD
Transplant
- Anti-Rejection
Vitamins and Electrolytes
- Pediatric Vitamins with Fluoride
- Prenatal Vitamins
Women’s Health
- Birth Control
- Estrogens
RETIREMENT SAVINGS PLAN

In addition to the contributions provided through the Princeton University Retirement Plan (PURP), it is important that you also save for your future. As a 403(b) plan, the Retirement Savings Plan allows you to save additional monies for your retirement on a pretax or after-tax basis. If you save pretax and are a resident of New Jersey or Pennsylvania, these contributions are not exempt from state tax when they are deducted from your pay. For additional information about the Plan, refer to the Summary Plan Description on our website.

PARTICIPATION AND VESTING

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

CONTRIBUTIONS

Contributions may be made pretax or after-tax and are subject to limits set by the Internal Revenue Code. In 2018, the limit was $18,500 for the calendar year. If you are age 50 or older during the calendar year, you may contribute an additional amount, equal to $6,000 in 2018. The contribution limits for 2019 were not released as of the printing of this booklet. Once new limits are announced, they will be updated online in HR Self Service and on our website.

Contributions may be as little as $25 per pay or the maximum permitted by the Internal Revenue Service in the calendar year and will begin in the immediate pay period following your online election. You can start, stop, increase, or decrease your contributions at any time.

After-Tax Contributions (Roth)

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

ROLLOVERS

You may roll over your retirement plan account from your previous employer to Princeton’s Retirement Savings Plan, which accepts rollovers from qualified employer plans; however, IRAs including Roth IRAs and SEP IRAs, are not eligible for rollover.

INVESTMENT ALLOCATIONS

You can choose allocations from among TIAA and/or Vanguard investments. If you do not choose investments, your contributions will default into the Vanguard Target to Retirement Fund closest to the year you reach age 65.

LOANS AND DISTRIBUTIONS

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

Loan

The loan program is administered by TIAA. The minimum loan is $1,000. The maximum number of loans allowed from your account, at any one time, is five. If you have more than five loans outstanding, you will not be eligible for additional loans until you have less than five outstanding. The total of your outstanding loans cannot exceed $50,000 or 45% of your account, whichever is less.

Hardship Withdrawal

Should you have a financial hardship due to certain qualified reasons, you may be able to take a hardship withdrawal from your account to meet that need. Qualified reasons include buying your primary residence, preventing eviction, paying medical expenses or educational expenses for you or your immediate family, or paying funeral expenses for your immediate family. If you take a hardship withdrawal, you are required to stop deferring into the plan for a period of six months.

In-Service Distribution

You may take an in-service distribution from your account at any time after you reach age 59½.

Qualified Domestic Relations Order (QDRO) Distribution

If you are involved in a court proceeding that results in a QDRO, your account will be split in accordance with the order, establishing a separate account for the alternate payee. The alternate payee account will not be available for distribution until you, the employee, are eligible for a plan distribution.

Termination of Employment

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

TIAA AND VANGUARD

We encourage you to register online with TIAA, our recordkeeper for both TIAA and Vanguard funds, to:

• Establish your account;
• Name your beneficiaries; and
• Select your allocations.

Call to speak with a counselor or schedule an on-campus appointment.

<table>
<thead>
<tr>
<th>TIAA</th>
<th><a href="http://www.tiaa.org/princeton">www.tiaa.org/princeton</a></th>
<th>(800) 842-2776</th>
</tr>
</thead>
<tbody>
<tr>
<td>VANGUARD</td>
<td><a href="http://www.meetvanguard.com">www.meetvanguard.com</a></td>
<td>(800) 662-0106 x 14500</td>
</tr>
</tbody>
</table>

Plan ID: 102862 or 102866 (PPPL)
Princeton University provides coverage under the Workers' Compensation Plan at no cost to you. The plan provides coverage for medical treatment and wage replacement for an approved absence from work if you suffer a work-related injury, illness, or disability.

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

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

**AMOUNT OF BENEFIT**

The University’s Workers’ Compensation Plan provides benefits-eligible faculty and staff with income replacement at 70% of base pay in effect at the time of the injury or illness for up to 26 weeks. Casual hourly and short-term professional employees are paid at the lesser of the State weekly maximum for the New Jersey Workers’ Compensation Law or 70% of weekly wages. Union employees should refer to their collective bargaining agreement.

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

**PAYMENT OF BENEFITS PREMIUMS**

While you are on workers’ compensation, the University will be unable to deduct your regular benefits contributions from your paycheck. Therefore, to maintain coverage, you must pay the monthly bill you receive from ECSI, our third party administrator, to pay for your contributions. If you are enrolled in a supplemental health plan, the Legal Services Plan, or the LTD Buy-up Plan, you will be billed directly by Winston Benefits. Once you return to work, payroll deductions will resume.

**TAXATION OF BENEFITS**

The amount of the statutory benefit, up to the State weekly maximum, is not taxable. For 2019, the weekly maximum is $921.

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**DISABILITY COVERAGE**

**Short Term Disability Plan**

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

**BENEFITS AND APPLICATION**

Approved short term disability provides continued income to benefits-eligible employees according to a formula. You must apply within the first two weeks you are absent from work, and your medical provider must submit the necessary medical documentation. Employees who are not eligible for benefits, i.e., temporary workers, are eligible to apply for the New Jersey statutory benefit.

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

**TAXATION OF BENEFITS**

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

New Jersey Family Leave Insurance

The New Jersey Family Leave Insurance (NJFLI) law allows eligible employees up to six weeks of paid leave to be with a child after birth or adoption, or to care for a family member with a serious health condition. Under State law, the University withholds a state tax of 0.09% of the taxable wage base from employees’ paychecks to finance this program. The taxable wage base changes each year and was $33,700 in 2018; the maximum yearly deduction was $30.33. NJFLI may provide up to two-thirds of your base salary, up to a weekly maximum, that will be payable through the State. For 2018, the weekly maximum was $637. The amounts for 2019 were not released as of the printing of this booklet.

A detailed notice issued by the New Jersey Department of Labor and Workforce Development is on page 54. If you have questions about NJFLI provisions or would like to obtain an application form, contact the Benefits Team. For information on the Family and Medical Leave Act (FMLA) or the New Jersey Family Leave Act (NJFLA), visit our website.
TAXATION OF YOUR BENEFITS

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

FORM 1095-C

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

If you were a full-time employee for at least one month in 2018, or if you were a part-time employee who elected healthcare coverage through Princeton in 2018, you will receive your 1095-C from Princeton University on or about February 1, 2019.

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

NEW JERSEY INDIVIDUAL HEALTH INSURANCE MANDATE

The New Jersey Individual Health Insurance Mandate requires New Jersey residents without health coverage to pay a tax penalty. This mandate mirrors the federal mandate that was part of the Affordable Care Act, which concluded on December 31, 2018. Under the law, New Jersey residents who are subject to the mandate (and their dependents) must have minimum essential coverage during each month of the year. As of the printing of this booklet, the penalty is $695 for adults, $247.50 per child, or 2.5% of a taxpayer’s income, whichever is greater (the maximum household penalty will be $2,085).

DEFINITIONS OF “DEPENDENT” FOR TAX PURPOSES

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

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

We suggest that you consult a tax advisor to determine whether you may claim a dependent for tax purposes before you certify that you can. For additional information, see page 2.

IMPUTED INCOME

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

MEDICAL PLANS

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

RETIREMENT SAVINGS PLAN

The current limits for calendar year 2018 are $18,500 if you are under age 50 and $24,500 if you are over age 50. These amounts may be indexed for calendar year 2019. If you split your contributions between pre- and after-tax the maximums are aggregated for the annual limits.

Pretax Savings

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

After-tax Savings

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

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

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

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

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

Continued healthcare coverage will be available to your eligible dependents for up to 36 months from the date you became eligible for Medicare if:

- You become eligible for Medicare and are no longer an active employee but your spouse is under 65.

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

For more information about COBRA, visit our website.

**ACA Section 1557 Notice**

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

**Health Insurance Marketplace Notice**

As a requirement of the Patient Protection and Affordable Care Act (PPACA), Princeton University must provide the Health Insurance Marketplace, formerly known as the Exchanges, notice to all employees, found on pages 50 and 51. For benefits-eligible employees, Princeton University offers options for healthcare coverage that meet the minimum value standards of the PPACA and are intended to be affordable. In addition, Princeton makes a significant contribution toward the cost of healthcare premiums, and your contributions are deducted pretax from your pay. If you have any questions on the healthcare coverage offered by Princeton University or on the notice, contact the Benefits Team at benefits@princeton.edu or (609) 258-3302.
**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.

**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.
Health Insurance Portability and Accountability Act (HIPAA)

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

Notice of Privacy Practices for Employees, Retirees and Eligible Dependents Participating in the Princeton University Health Care Plans
If you have any questions about this notice or our privacy practices, contact the Privacy Officer at (609) 258-2169.

EFFECTIVE SEPTEMBER 2018

DISCLOSURE LIMITATIONS OF YOUR HEALTH INFORMATION

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

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

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

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

¹ To the extent you have questions about the privacy practices of the Vision Benefits Plan or the Dental Benefits Plan, we direct you to MetLife and Aetna (contact information on page 46).
• To law enforcement under certain circumstances, such as to identify or locate a suspect, fugitive, material witness or missing person.

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

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

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

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

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

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

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

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

• To assist in disaster relief efforts.

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

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

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

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

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

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

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

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

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

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

• To assist in disaster relief efforts.

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

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

USES AND DISCLOSURES REQUIRING AUTHORIZATION

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

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

ADDITIONAL RESTRICTIONS

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

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Your rights regarding your health information include:

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

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

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

• The right to request an amendment to your health information. You may ask us to correct or amend your health information contained in your medical/billing record. Such a request must be in writing and directed to the Privacy Officer and must specify the reason for the request. We may deny your request, but you may respond by filing a written statement of disagreement and ask that the statement be included with your record.

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

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

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

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

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

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

**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 www.princeton.edu/hr/benefits/hipaa 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.

Megan Adams  
701 Carnegie Center, Suite 439  
Princeton, NJ 08544  
adamsm@princeton.edu  
(609) 258-2169  
(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
Medicaid and the Children’s Health Insurance Program (CHIP)

**Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)**

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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<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>
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</tr>
<tr>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a></td>
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<tr>
<td>Phone: 1-877-357-3268</td>
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<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<tbody>
<tr>
<td>The AK Health Insurance Premium Payment Program</td>
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<tr>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td></td>
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<tr>
<td>Phone: 1-866-251-4861</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
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</tr>
<tr>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> – Click on Health Insurance Premium Payment (HIPP)</td>
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<tr>
<td>Phone: 404-656-4507</td>
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<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
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<tr>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
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<tr>
<td>Phone: 1-855-MyARHIP (855-692-7447)</td>
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<tr>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
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<tr>
<td>Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a></td>
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<tr>
<td>Phone: 1-877-438-4479</td>
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<tr>
<td>All other Medicaid</td>
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<tr>
<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
<td></td>
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<tr>
<td>Phone 1-800-403-0864</td>
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<tr>
<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
<th>IOWA – Medicaid</th>
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</thead>
<tbody>
<tr>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
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<tr>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</td>
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<tr>
<td>CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus</td>
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<tr>
<td>Website: <a href="http://dhs.iowa.gov/hawk-i">http://dhs.iowa.gov/hawk-i</a></td>
<td></td>
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<tr>
<td>Phone: 1-800-257-8563</td>
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<tr>
<td>State</td>
<td>Medicaid/CHIP Website</td>
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<tr>
<td>KANSAS – Medicaid</td>
<td><a href="http://www.kdheks.gov/hcf/">Website</a></td>
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<tr>
<td>KENTUCKY – Medicaid</td>
<td><a href="https://chfs.ky.gov">Website</a></td>
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<tr>
<td>LOUISIANA – Medicaid</td>
<td><a href="http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331">Website</a></td>
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<tr>
<td>MAINE – Medicaid</td>
<td><a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">Website</a></td>
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<tr>
<td>MASSACHUSETTS – Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/eohhs/departments/masshealth/">Website</a></td>
</tr>
<tr>
<td>MINNESOTA – Medicaid</td>
<td><a href="https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp">Website</a></td>
</tr>
<tr>
<td>MISSOURI – Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">Website</a></td>
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<tr>
<td>MONTANA – Medicaid</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP">Website</a></td>
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<tr>
<td>NEBRASKA – Medicaid</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">Website</a></td>
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<tr>
<td>NEVADA – Medicaid</td>
<td><a href="https://dhcfp.nv.gov">Website</a></td>
</tr>
<tr>
<td>NEW HAMPSHIRE – Medicaid</td>
<td><a href="https://www.dhhs.nh.gov/ombp/nhhpp/">Website</a></td>
</tr>
<tr>
<td>NEW JERSEY – Medicaid and CHIP</td>
<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">Website</a></td>
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<tr>
<td>NEW YORK – Medicaid</td>
<td><a href="https://www.health.ny.gov/health_care/medicaid/">Website</a></td>
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<tr>
<td>NORTH CAROLINA – Medicaid</td>
<td><a href="https://dma.ncdhhs.gov/">Website</a></td>
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<tr>
<td>NORTH DAKOTA – Medicaid</td>
<td><a href="http://www.insureoklahoma.org">Website</a></td>
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<tr>
<td>OREGON – Medicaid</td>
<td><a href="http://healthcare.oregon.gov/Pages/index.aspx">Website</a></td>
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<tr>
<td>PENNSYLVANIA – Medicaid</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Website</a></td>
</tr>
<tr>
<td>RHODE ISLAND – Medicaid</td>
<td><a href="http://www.eohhs.ri.gov/">Website</a></td>
</tr>
<tr>
<td>SOUTH CAROLINA – Medicaid</td>
<td><a href="https://www.scdhhs.gov">Website</a></td>
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To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)
PART A: General Information

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

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

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

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

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

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

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

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

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

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

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.
New Jersey Earned Sick Leave Notice

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: __________ End of Benefit Year: __________

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 120 days after you begin employment.

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)
• Grandparent
• Grandchild
• Sibling
• Spouse
• 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, and
- Informing another person of that person’s potential rights under the law.

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

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

Keep a copy of this notice and all documents that show your amount of sick leave accrual and usage.
You have a right to be given this notice in English and, if available, your primary language.

For more information visit the website of the Department of Labor and Workforce Development: nj.gov/labor.
Beginning July 1, 2009, New Jersey law will provide up to six (6) weeks of Family Leave Insurance benefits. Benefits are payable to covered employees from either the New Jersey State Plan or an approved employer-provided private plan to:

- **Bond with a child** during the first 12 months after the child’s birth, if the covered individual or the domestic partner or civil union partner of the covered individual, is a biological parent of the child, or the first 12 months after the placement of the child for adoption with the covered individual.

- **Care for a family member with a serious health condition** supported by a certification provided by a health care provider. Claims may be filed for six consecutive weeks, for intermittent weeks or for 42 intermittent days during a 12 month period beginning with the first date of the claim.

Family member means a child, spouse, domestic partner, civil union partner or parent of a covered individual.

Child means a biological, adopted, or foster child, stepchild or legal ward of a covered individual, child of a domestic partner of the covered individual, or child of a civil union partner of the covered individual, who is less than 19 years of age or is 19 years of age or older but incapable of self-care because of mental or physical impairment.

**New Jersey State Plan**

Employees covered under the New Jersey State Plan can obtain information pertaining to the program and an application for Family Leave Insurance benefits (Form FL-1), after June 1, 2009, by visiting the Department of Labor and Workforce Development’s web site at www.nj.gov/labor, by telephoning the Division of Temporary Disability Insurance’s Customer Service Section at (609) 292-7060, or by writing to the Division of Temporary Disability Insurance, PO Box 387, Trenton, NJ 08625-0387.

If an employee is receiving State Plan temporary disability benefits for pregnancy, after the child is born, the Division will mail the employee information on how to file a claim for Family Leave Insurance benefits to bond with the newborn child.

If a claim is filed to have Family Leave Insurance benefits begin immediately after the employee recovers from her pregnancy-related disability, she will be paid at the same weekly benefit amount as she was paid for her pregnancy-related disability claim and no waiting period will be required.

**Private Plan**

An employer can elect to provide workers with Family Leave Insurance benefits coverage under a private plan approved by the Division of Temporary Disability Insurance. The Division will not approve a private plan requiring employee contributions unless a majority of the employees, covered by the private plan, have agreed to private plan coverage by written election. Employers will provide information regarding the private plan and the proper forms to claim benefits to employees covered under the private plan.

**Financing of the Program**

This program is financed by employee contributions. Beginning January 1, 2009, employers are authorized to deduct the contributions from employee wages for all employees covered under the State Plan. These deductions must be noted on the employee’s pay envelope, paycheck or on some other form of notice. The taxable wage base for Family Leave Insurance benefits is the same as the taxable wage base for Unemployment and Temporary Disability Insurance.

Employees covered under an approved private plan will not have contributions deducted from wages for Family Leave Insurance benefits coverage unless a majority of the workers consent to contribute to the approved private plan. If employees consent to contribute to the private plan, the contributions cannot exceed those paid by workers covered under the State Plan.