my healthcare and retirement

BENEFITS

2018

at Princeton

under the affordable care act
My Benefits 2018 provides highlights and brief descriptions of the benefits programs that are available to benefits-eligible faculty and staff of Princeton University.

This communication is intended to be a Summary of Material Modifications (SMM) for the healthcare and retirement plans and programs. It briefly describes your benefits plans including any changes effective January 1, 2018. 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) located online at www.princeton.edu/hr/benefits. You may also request to receive a paper copy of any SPD by contacting the Benefits Team at (609) 258-3302 or benefits@princeton.edu.

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 the HR website at www.princeton.edu/hr/benefits/sbc. You may request to receive a paper copy of any SBC by contacting the Benefits Team at (609) 258-3302 or benefits@princeton.edu.

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 online at www.princeton.edu/hr/benefits.
Dependent Eligibility and Verification

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

**Ineligible Dependents**

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

**Dependent Verification Process**

For each dependent you are enrolling in one or more of Princeton’s healthcare plans, you must provide the required dependent verification documentation within 31 days from the effective date of your coverage. Otherwise, your 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, 2 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 certificate&lt;sup&gt;1&lt;/sup&gt; 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 26&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Birth certificate&lt;sup&gt;3&lt;/sup&gt;</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>

<sup>1</sup> Foreign nationals can provide current visa documentation showing marriage in lieu of a marriage certificate.

<sup>2</sup> Coverage can continue through the calendar year in which the child turns 26.

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

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

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

For more information, review the Notice of Special Enrollment Rights on page 38 or visit our website at www.princeton.edu/hr/benefits.

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

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

CHANGES PERMITTED DURING THE YEAR WITHOUT A QUALIFYING STATUS EVENT

• Elect, change, or terminate participation in the Retirement Savings Plan
MEDICAL PLANS

HOW TO FIND IN-NETWORK PROVIDERS
To find an in-network provider or laboratory, independent radiology center, or urgent care center follow the steps below for your medical plan provider.

Aetna (CDHP)
2. Select the Provider Type that you are looking for.
3. Enter the zip code for the area you wish to search.
4. Select your medical plan from the list provided.

URGENT CARE CENTERS
When you have an emergency that is not life-threatening, e.g., a sprain, broken bone, or 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.

LABORATORY SERVICES
Quest Diagnostics is the preferred lab for Aetna. If you go to any other in-network lab with Aetna, you will be charged more.

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

PRECERTIFICATION
Certain 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.

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 at www.aetna.com/dse/princeton. You will receive a separate ID card for the OptumRx prescription drug plan.

TELEMEDICINE
Telemedicine is offered as part of the medical plan. 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
- Fever
- Bronchitis
- Migraine/ headaches
- Cold/flu
- 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% for the CDHP.

To register for this service with Aetna (referred to as Teladoc), go to www.teladoc.com/princeton or call (855) TELADOC (835-2362).

TELEMENTAL HEALTH
Telemental Health is included in our medical plan. It is a convenient option that allows you to video conference with a licensed health provider—including psychiatrists, psychologists, and counselors—who can provide both therapy and medication management.

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 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, call Aetna at (800) 535-6689 or go to www.aetna.com/dse/princeton.

Did You Know?
MEDICAL NECESSITY REQUIRED
All services or supplies must be medically necessary or they will not be covered. For example, physical therapy will need to result in significant improvement in the member’s condition to be covered. Refer to the Summary Plan Descriptions to determine if medical services are covered, excluded, or limited. Alternatively, contact Aetna or UnitedHealthcare for more detail.
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. Refer to pages 7 and 8 for details.

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. 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).

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).

The CDHP in-network preferred and non-preferred coverage is similar to the PHP. Refer to the description below and the Medical Plan Benefits Comparison Chart on page 6.

For details about the CDHP, visit www.princeton.edu/hr/benefits. For a current physician directory, visit Aetna’s website at www.aetna.com/dse/Princeton.

**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.

<table>
<thead>
<tr>
<th>Aetna (Aexcel)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Categories with In-Network Preferred Specialists</strong></td>
</tr>
<tr>
<td>Cardiology; Cardiothoracic Surgery; Gastroenterology; General Surgery; Neurology; Neurosurgery; Obstetrics and Gynecology (OB/GYN); Orthopedics; Otolaryngology—Ear, Nose, and Throat (ENT); Plastic Surgery; Urology; and Vascular Surgery</td>
</tr>
</tbody>
</table>

| Locations with Limited or No Access to Preferred Specialists |
| Mt; NC; NH; OR; SD; WA; and Southeastern, Central, and Western PA |

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

This is intended to provide an overview of the plan benefits. Details about the plans, including the Summary Plan Description (SPD) and Summary of Benefits Coverage (SBC) are available online at www.princeton.edu/hr/benefits. 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-Network¹</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 / $6,000 / $12,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (OPM) (Individual / Family)</strong></td>
<td>$3,000 / $6,000</td>
<td>$6,000 / $12,000</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Visits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teledicine</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 deductible²,³</td>
<td>20% after deductible²,³</td>
<td>50% after deductible</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 Procedures⁴</td>
<td>10% after deductible²,³</td>
<td>20% after deductible²,³</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Mental Health⁴</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 Procedures⁴ (Independent Facility / Hospital)</td>
<td>10% after deductible²,³</td>
<td>20% after deductible²,³</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$0 after deductible²</td>
<td>20% after deductible²</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Radiology (X-Ray)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Hi-Tech Radiology (MRI, CAT, etc.)⁴ (Independent Facility / Hospital)</td>
<td>20% after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Preventive Care and Immunizations⁵</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 (50 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>

¹ Costs above reasonable and customary (R&C) are your responsibility. Refer to the Summary Plan Description (SPD) for more information.
² For a list of specialists or labs covered under the tiered plan design, refer to page 5.
³ 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.
⁴ Coverage requires precertification.
⁵ Includes seven well baby visits in the first year of a child’s life.
Prescription Drug Plan

Prescription coverage is through OptumRx. For more detail, refer to the Summary Plan Description (SPD).

IF YOU CHOOSE:  
Consumer Directed Health Plan (CDHP)  
THEN:  
Coverage is provided after the medical plan’s annual deductible(s) are met. Exceptions for immediate coverage are preventive drugs and IRS-designated drugs for chronic conditions. For details see Prescription Coverage Under the CDHP.

**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 www.princeton.edu/hr/benefits 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 an appeal on your behalf with OptumRx. If approved, you will pay the 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 (855) 427-4682 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 of a two-month supply at retail. Contact OptumRx to make arrangements or complete the mail order form available on the HR website.

**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 at www.princeton.edu/hr/benefits/pdf/preventiveitems.pdf. 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 an appeal for a clinical exception on your behalf with OptumRx.

OUT-OF-POCKET MAXIMUM (OPM)
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.

OUT-OF-POCKET MAXIMUM (OPM)

+ Lipitor
  - Gross Cost $220
  - minus (-) Generic Gross Cost $20
  + Generic Copayment $5
  = Member Pays the Difference $205

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.

OPTUMRX APP
The OptumRx mobile app provides easy, on-the-go access to your personalized health information and prescriptions. Get the app by searching for OptumRx in the Apple App Store or on Google Play.

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:

- Anticoagulants
- Antihypertensive agents (high blood pressure)
- Asthma/COPD
- Cholesterol lowering agents
- Diabetes
- Heart disease
- Hepatitis C
- Immunosuppressant agents
- Mental health and substance abuse agents
- Prenatal vitamins
- Thyroid disease
- Osteoporosis
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 Princeton University Retirement Savings Plan, refer to the Summary Plan Description at www.princeton.edu/hr/benefits/spd.

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 account.

CONTRIBUTIONS
Contributions may be made pretax or after-tax and are subject to limits set by the Internal Revenue Code. In 2017, the limit was $18,000 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 2017. The contribution limits for 2018 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 at www.princeton.edu/hr/benefits.

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 through HR Self Service.

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 59¼ 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 at www.princeton.edu/hr/benefits/retire.

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 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 anytime after you reach age 59¼.

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 59¼, 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, login, and password;
• name your beneficiaries; and
• select your allocations with TIAA and/or Vanguard.

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

Speak with a counselor or schedule an on-campus appointment.

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

Schedule an on-campus appointment.
WORKERS’ COMPENSATION PLAN

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

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

For more information about workers’ compensation benefits and procedures, contact the Benefits Team at (609) 258-3302 or refer to www.princeton.edu/hr/benefits/disability/workcomp.

AMOUNT OF BENEFIT
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.

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. 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 2018, the weekly maximum is $903.

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.

PRINCETON FORMULA
For more detailed information about the Short Term Disability Plan, eligibility, benefit, and application process, refer to www.princeton.edu/hr/benefits/disability/std.

TAXATION OF BENEFITS
The short term disability benefit is taxable for federal and FICA purposes and is not subject to state income tax.
NEW JERSEY PAID FAMILY LEAVE

The New Jersey Paid Family Leave 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 0.1% of the taxable wage base from employees' paychecks to finance this program. The taxable wage base changes each year and was $33,500 in 2017; the maximum yearly deduction was $33.50. New Jersey Paid Family Leave may provide up to two-thirds of your base salary, up to a weekly maximum, that will be payable through the State. For 2017, the weekly maximum was $633. The amounts for 2018 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 49.

If you have questions about the New Jersey Paid Family Leave Insurance provisions or would like to obtain an application form, contact a member of the Benefits Team at (609) 258-3302 or benefits@princeton.edu.

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.

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.

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.

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 2017, or if you were a part-time employee who elected healthcare coverage through Princeton in 2017, you will receive your 1095-C from Princeton University on or about February 1, 2018.

RETIREMENT SAVINGS PLAN

The current limits for calendar year 2017 are $18,000 if you are under age 50 and $24,000 if you are over age 50. These amounts may be indexed for calendar year 2018. 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, your 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 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 or call (800) 318-2596. For more information about COBRA, refer to www.princeton.edu/hr/benefits/hlth/cobra.

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.

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 at benefits@princeton.edu or (609) 258-3302.
**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 at [www.princeton.edu/hr/policies/notices/federal](http://www.princeton.edu/hr/policies/notices/federal). You may request to receive a paper copy of the notice by contacting the Benefits Team at (609) 258-3302 or benefits@princeton.edu.

**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 45 and 46. 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, please contact the Benefits Team at benefits@princeton.edu or (609) 258-3302.

**FAIR Act**

The FAIR Act of 1990 revised the rules governing personal injury protection provided through motor vehicle insurance policies issued or renewed in the State of New Jersey on or after January 1, 1991.

In New Jersey, motor vehicle insurance policies sold in the state are required by law to provide primary personal injury protection coverage (PIP), which pays for medical expenses resulting from a motor vehicle accident. In addition to this protection, most motorists carry additional health insurance through an employer. Under the FAIR Act, New Jersey state residents may choose whether primary medical coverage will be provided by their motor vehicle insurance policy’s PIP coverage or by their employer’s medical plan. However, the FAIR Act does not apply to self-insured health care plans.

If you have healthcare insurance coverage under a Princeton medical plan, you should not elect your Princeton medical plan as your primary insurance coverage in the event of a motor vehicle accident. You should elect your motor vehicle PIP coverage as your primary coverage. Please note, in the event you do not elect PIP coverage as primary and you are in motor vehicle accident, your healthcare insurer has the right to subrogate and any monies they paid out for claims will be subject to reimbursement by you.

**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 result of marriage, birth, adoption, or placement for 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 a birth, adoption, or placement for 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, adoption, or placement for adoption, which allows for a 90-day period. To request special enrollment or obtain more information, contact the Benefits Team at benefits@princeton.edu or (609) 258-3302.
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 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 2017

DISCLOSURE LIMITATIONS OF YOUR PLAN INFORMATION

Princeton University sponsors various healthcare plans, including the Aetna Consumer Directed Health Plan, Aetna HMO Plan, Aetna J-1 Visa Plan, Aetna Princeton Health Plan, UnitedHealthcare Princeton Health Plan, PayFlex Healthcare Flexible Spending Account, and OptumRx Prescription Drug Plan.

The Princeton University healthcare plans listed above (hereinafter referred to collectively as “the PLAN”) are committed to both protecting the privacy of health information maintained by the PLAN and ensuring that outside vendors who perform services for the PLAN, such as the PLAN’s third-party administrators, also protect the privacy of such information. The PLAN is required by law to maintain the privacy of your “Protected Health Information” (as described below) and is committed to doing so. The PLAN also is required to provide you with this Notice of its legal duties and privacy practices with respect to your Protected Health Information and comply with the terms of this Notice.

Protected Health Information generally includes information that identifies plan participants, including you and your dependents, (such as name or unique identifying numbers or geographic information), and that relates to payment for plan participants’ health care, health condition (such as an illness a plan participant may have), or health services a plan participant has received or may receive in the future (such as an operation).

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The PLAN will generally obtain your written authorization before sharing your health information with others outside of the PLAN. However, the PLAN is permitted to use and disclose your health information without your authorization in the following circumstances:

• **For payment purposes.** We may use or disclose health information about you to determine eligibility for PLAN benefits, facilitate payment for the treatment and services you receive from healthcare providers, determine responsibility under the PLAN, or to coordinate PLAN coverage. For example, we may disclose information to another entity to assist with the adjudication or subrogation of claims or disclose information to a doctor to determine if a service is payable under the PLAN.

• **For healthcare operations.** We may use or disclose health information about you to conduct 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).

• **For treatment purposes.** We may use or disclose health information to health care providers to help them treat you or to recommend treatment alternatives. 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 information to send you information about health-related benefits and services, provided we do not receive financial remuneration from a third party for purposes of making such communications.

USES AND DISCLOSURES WITHOUT AN ACKNOWLEDGEMENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your Protected Health Information without your consent, authorization, or opportunity to verbally agree or object for the following purposes:

• We may disclose your Protected Health Information to comply with a court order or administrative proceeding or for law enforcement purposes or other specialized government functions, such as related to military missions, and to comply with a federal, state, or local legal requirement, for example workers’ compensation law.

• We may disclose information where a law requires that we report information about suspected abuse, neglect, or domestic violence or relating to suspected criminal activity. We may also disclose your Protected Health Information to authorities who monitor compliance with these privacy requirements.

• We may disclose Protected Health Information to a public health authority for public health activities, such as responding to public health investigations. We may also disclose Protected Health Information to a healthcare oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations, and inspections.

• We may disclose information about an individual’s death in certain circumstances to funeral directors, coroners, and medical examiners or to facilitate organ, eye, or tissue donation.

• We may allow business associates of the PLAN (such as third party administrators) to provide payment, treatment, or healthcare operation services.

• In certain circumstances, we may disclose Protected Health Information to assist medical/psychiatric research.
USES AND DISCLOSURES REQUIRING PARTICIPANT AUTHORIZATION

Other than as set forth above or as set forth in the laws applicable to the PLAN, the PLAN cannot disclose information about you or your dependents’ health insurance, prescription drug coverage, or medical plan enrollment with anyone without a written authorization from you or your dependents. If you authorize us to use and disclose Protected Health Information, you may revoke that authorization, in writing, at any time. You understand that we cannot take back any disclosure we have already made with your permission and that we are required to retain certain records that contain your Protected Health Information. The PLAN cannot retaliate against you or your dependents for refusing to sign an authorization or revoking an authorization previously given.

We must obtain your authorization to use or disclose your Protected Health Information for marketing activities, unless such activities involve face-to-face communications made by us to you or a promotional gift of nominal value provided by us to you. Communications that involve a drug or biologic that is being prescribed to you are not marketing activities that require your authorization, unless we receive remuneration for such communications that is not reasonably related to our cost in making such communications. Further, communications regarding case management or care coordination, or to direct or recommend alternative treatments, therapies, healthcare providers, or settings of care do not require your authorization, unless we receive financial remuneration in exchange for making the communication.

PROHIBITED USES OF PROTECTED HEALTH INFORMATION

Your health information cannot be used for employment-related purposes. This means that the PLAN cannot disclose your Protected Health Information with officers and other employees of Princeton University, other than those who are involved in PLAN administration. Further, if health information is used for medical underwriting purposes, genetic information will not be used or disclosed for any underwriting purposes, including determining eligibility for benefits or premiums, as prohibited by the Genetic Information Nondiscrimination Act of 2008 (GINA).

USES AND DISCLOSURES REQUIRING PATIENT OPPORTUNITY TO OBJECT

We are permitted to disclose your Protected Health Information without your written consent or authorization to a family member, other relative, close personal friend, or other person identified by you, if the information is directly relevant to that person’s involvement in your care or payment for your care. We may also use or disclose Protected Health Information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures to your family, relatives, friends, or others identified by you. If you are able and available to agree and object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to object, we will exercise our professional judgment in communications with your family and others.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Your rights regarding your health information include the right to:

• request restrictions beyond those outlined above by making such request in writing to the Privacy Officer as set forth below. The PLAN is not required to agree to a requested restriction, but in the event we do agree to such a restriction it is binding upon us.

• receive confidential communications at only a specified phone number or mail or email address. We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

• inspect and copy your Protected Health Information by making such request in writing to the Privacy Officer. We must respond to your request within 30 days. To the extent we maintain your health information in one or more designated record sets electronically, we must provide you access to the information in the electronic form and format requested by you, if it is readily producible in such electronic form and format or, if not, in a readable electronic form and format as agreed to by us. We may charge you a reasonable fee for a copy of your health information. You have the right to choose what portions of your information you want copied and to have prior information on the cost of copying.

• amend your Protected Health Information, by a written request to the Privacy Officer specifying the reason for such request. Any denial by us will be provided to you in writing within 60 days. It will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.

• be notified promptly in the event of a breach of your Protected Health Information.

• an accounting of instances when your Protected Health Information has been disclosed for up to six years prior to the date of your request. We will include all the disclosures except for those about treatment, payment, health care operations, and certain other disclosures (such as any you asked us to handle). You may request one such accounting free of charge each year. There may be a charge for more frequent requests.

• receive a paper copy of this Notice upon request at any time.

PERSONAL REPRESENTATIVE

You have the right to name a personal representative who may act on your behalf with regard to your Protected Health Information. If you wish to take advantage of this right, please contact the Office of Human Resources. We will make sure the person has the authority and can act for you before we take any action.

POLICY MODIFICATIONS

The PLAN may change its privacy practices from time to time. However, if a material change is made, the PLAN will revise this Notice and will notify you either by email or mail of the changes within 60 days.
COMPLAINTS
Federal law requires the PLAN to maintain the privacy of your PLAN records as set forth in this policy. If you believe your privacy rights have been violated, you can file a complaint with the Plan by contacting the Office of Human Resources or the Privacy Officer.

You may also file complaints with the secretary of the Department of Health and Human Services or with the third-party administrator for your particular plan. Contact information is listed below. No one will retaliate or take action against you for filing a complaint.

PRIVACY OFFICER
To exercise your HIPAA rights under the PLAN, 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)

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

HIPAA CONTACTS

Aetna
(Consumer Directed Health Plan, HMO, Princeton Health Plan, and J-1 Visa Plan)
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

PayFlex Systems USA, Inc.
(Healthcare Flexible Spending Account)
Member Services
(800) 284-4885

US Department of Health and Human Services
(877) 696-6775
www.hhs.gov/hipaa

Office of Human Resources
2 New South
Princeton, NJ 08544
benefits@princeton.edu
(609) 258-3302
(609) 258-5920 (fax)
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.askeba.dol.gov](http://www.askeba.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 August 10, 2017. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Program Details</th>
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<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com</a> Phone: 1-855-602-5447</td>
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<td>FLORIDA – Medicaid</td>
<td>Website: <a href="http://flmedicaidiplrecovery.com/hipp/">http://flmedicaidiplrecovery.com/hipp/</a> Phone: 1-877-357-3268</td>
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<tr>
<td>ALASKA – Medicaid</td>
<td>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com">http://myakhipp.com</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp">http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp</a></td>
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<tr>
<td>GEORGIA – Medicaid</td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</td>
</tr>
<tr>
<td>ARKANSAS – Medicaid</td>
<td>Website: <a href="http://myarhipp.com">http://myarhipp.com</a> Phone: 1-855-MyARHIPP (855-692-7447)</td>
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<tr>
<td>INDIANA – Medicaid</td>
<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip">http://www.in.gov/fssa/hip</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864</td>
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<td>New Jersey</td>
<td>Medicaid and CHIP</td>
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<td>North Carolina</td>
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<td>Missouri</td>
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<td>Oklahoma</td>
<td>Medicaid and CHIP</td>
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<tr>
<td>Rhode Island</td>
<td>Medicaid</td>
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<tr>
<td>South Carolina</td>
<td>Medicaid</td>
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</table>
To see if any other states have added a premium assistance program since August 10, 2017, 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

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**SOUTH DAKOTA - Medicaid**
Website: [http://dss.sd.gov](http://dss.sd.gov)
Phone: 1-888-828-0059

**WASHINGTON – Medicaid**
Website: [http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program](http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program)
Phone: 1-800-562-3022 ext. 15473

**TEXAS – Medicaid**
Website: [http://gethipptexas.com/](http://gethipptexas.com/)
Phone: 1-800-440-0493

**WASHINGTON – Medicaid**
Website: [http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program](http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program)
Phone: 1-800-562-3022 ext. 15473

**WEST VIRGINIA – Medicaid**
Website: [http://www.dhs.wisconsin.gov/publications/pi/pi0095.pdf](http://www.dhs.wisconsin.gov/publications/pi/pi0095.pdf)
Phone: 1-800-362-3002

**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

**WISCONSIN – Medicaid and CHIP**
Website: [https://www.dhs.wisconsin.gov/publications/pi/pi0095.pdf](https://www.dhs.wisconsin.gov/publications/pi/pi0095.pdf)
Phone: 1-800-362-3002

**VERMONT – Medicaid**
Website: [http://www.greenmountaincare.org/](http://www.greenmountaincare.org/)
Phone: 1-800-250-8427

**Wyoming – Medicaid**
Website: [https://wyequalitycare.acs-inc.com/](https://wyequalitycare.acs-inc.com/)
Phone: 307-777-7731

**VIRGINIA – Medicaid and CHIP**
Medicaid Website: [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)
Medicaid Phone: 1-800-432-5924
CHIP Website: [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)
CHIP Phone: 1-855-242-8282

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To see if any other states have added a premium assistance program since August 10, 2017, 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% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.2

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

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

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

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

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

<table>
<thead>
<tr>
<th>3. Employer name:</th>
<th>4. Employer Identification Number (EIN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Princeton University</td>
<td>21-0634501</td>
</tr>
<tr>
<td>5. Employer address:</td>
<td>6. Employer phone number:</td>
</tr>
<tr>
<td>Office of Human Resources, 2 New South</td>
<td>(609) 258-3302</td>
</tr>
<tr>
<td>Princeton</td>
<td>NJ</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.

11. Phone number (if different from above): 12. Email address:

benefits@princeton.edu

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

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

Additional copies of this poster or any other required posters may be obtained free of charge by contacting the New Jersey Department of Labor and Workforce Development, Office of Constituent Relations, PO Box 110, Trenton, New Jersey 08625-0110 - (609) 777-3200 or from our website: [www.nj.gov/labor](http://www.nj.gov/labor).

The New Jersey Department of Labor and Workforce Development is an equal opportunity employer with equal opportunity programs. Auxiliary aids and services are available upon request to individuals with disabilities.

If you need this document in Braille or large print, call (609) 292-2680. TTY users can contact this department through New Jersey Relay: 7-1-1.
## PROVIDER INFORMATION

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<thead>
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<th>Medical and Prescription</th>
<th>Provider</th>
<th>Group Number/Plan ID</th>
<th>Phone Number</th>
<th>Website</th>
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<tbody>
<tr>
<td>Consumer Directed Health Plan</td>
<td>Aetna</td>
<td>486819</td>
<td>(800) 535-6689</td>
<td>aetna.com/dse/princeton</td>
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<tr>
<td>Teledicine (Aetna)</td>
<td>Teladoc</td>
<td>NA</td>
<td>(855) 835-2362</td>
<td>teladoc.com/princeton</td>
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<td>Prescription Drug</td>
<td>OptumRx</td>
<td>PURPRNCEM</td>
<td>(877) 629-3117</td>
<td>optumrx.com</td>
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<td>Retirement</td>
<td>TIAA &amp; Vanguard (Main)</td>
<td>102862</td>
<td>(800) 842-2776</td>
<td>tiaa.org</td>
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<td></td>
<td>TIAA &amp; Vanguard (PPPL)</td>
<td>102866</td>
<td>(800) 842-2776</td>
<td>tiaa.org</td>
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