my healthcare and retirement

BENEFITS

2017

at Princeton

under the affordable care act
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, 2017. 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 Description (SPD)* located online at [www.princeton.edu/hr/benefits](http://www.princeton.edu/hr/benefits). You may also request to receive a paper copy of an *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. The *SBC* is available on the HR website at [www.princeton.edu/hr/benefits/sbc](http://www.princeton.edu/hr/benefits/sbc). You may request to receive a paper copy of the *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](http://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
- 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(^1) and most recently filed tax return with Social Security numbers and all financial information blacked out, i.e., redacted, by the employee</td>
</tr>
<tr>
<td>Biological child</td>
<td>Birth certificate(^2)</td>
</tr>
<tr>
<td>Adopted child</td>
<td>Legal adoption papers</td>
</tr>
<tr>
<td>Stepcild</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 must also provide current visa documentation showing marriage.

\(^2\) Coverage will exist through the calendar year in which the child turns 26.

\(^3\) Foreign nationals must provide current visa documentation showing date of birth of child.
MAKING CHANGES TO YOUR BENEFITS

The Internal Revenue Service (IRS) limits when you can add coverage for dependents or make changes to your healthcare election 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.

Visit our website at www.princeton.edu/hr/benefits for further information.

QUALIFYING STATUS EVENT CHANGES

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

If you experience a Qualifying Status Event, you must contact the Benefits Team at benefits@princeton.edu or (609) 258-3302 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.

CHANGES PERMITTED DURING THE YEAR WITHOUT A QUALIFYING STATUS EVENT

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

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.

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). 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).

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

IN-NETWORK PREFERRED SPECIALISTS

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

You will be charged a higher amount for utilizing an in-network non-preferred or out-of-network provider in these specialist categories.

You will be charged the in-network preferred cost share when you utilize in-network providers in other specialist categories not listed or in locations where no preferred providers are identified or available. Refer to Utilizing Specialists for more details.

For information on costs for services, refer to the Medical Plan Benefits chart. Contact Aetna before you seek care from a specialist.

IN-NETWORK PREFERRED LABS

Quest Diagnostics is the preferred in-network lab for Aetna. These labs charge less and perform a wide variety of services. If you use any other in-network lab, you will be charged more.

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.

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 from your provider’s website at www.aetna.com/dse/princeton. You will receive a separate ID card for the OptumRx prescription drug plan.

Aetna (Aexcel)

Categories with In-Network Preferred Specialists

Cardiology, Cardiothoracic Surgery, Gastroenterology, General Surgery, Neurology, Neurosurgery, Obstetrics and Gynecology (OB/GYN), Orthopedics, Otolaryngology, Plastic Surgery, Urology, and Vascular Surgery

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

### MEDICAL PLAN BENEFITS

This is intended to provide an overview of the plan benefits. Details are available online at [www.princeton.edu/hr/benefits](http://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>Tier 1 In-Network Preferred</th>
<th>Tier 2 In-Network Non-Preferred</th>
<th>Tier 3 Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$1,500 / $3,000</td>
<td>$3,000 / $6,000</td>
<td>$3,000 / $6,000</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (OPM)</td>
<td>$3,000 / $6,000</td>
<td>$6,000 / $12,000</td>
<td></td>
</tr>
</tbody>
</table>

### Physician Visits

- **Telemedicine**: $40 until deductible is met, then 20%
- **Primary Care Physician (PCP)**: 20% after deductible, 50% after deductible
- **Standard Specialists**: 20% after deductible, 50% after deductible
- **Tiered Specialists**: 10% after deductible, 20% after deductible, 50% after deductible

### Emergency Services

- **Urgent Care Center**: $0 after deductible, 50% after deductible
- **Emergency Room (no coverage for nonemergencies)**: $0 after deductible

### Inpatient Hospital Services

- **Medical and Surgical Procedures**: 10% after deductible³, 20% after deductible³, 50% after deductible³
- **Mental Health**: 20% after deductible³, 50% after deductible³

### Outpatient Services

- **Surgical Procedures**: 10% after deductible³, 20% after deductible³, 50% after deductible³
- **Laboratory**: $0 after deductible, 20% after deductible³, 50% after deductible³
- **Radiology (X-Ray)**: 20% after deductible
- **Hi-Tech Radiology (MRI, CAT, and PET Scans)**: 20% after deductible, Not covered
- **Preventive Care and Immunizations**: $0, 50% after deductible
- **Mental Health**: 20% after deductible, 25% after deductible
- **Annual Eye Exam**: Not covered, Not covered
- **Physical Therapy (50 visits per calendar year)**: 20% after deductible, 50% after deductible
- **Chiropractic Care (20 visits per calendar year)**: 20% after deductible, 50% after deductible

---

1. For a list of specialists covered under the tiered plan design, refer to [www.princeton.edu/hr/benefits](http://www.princeton.edu/hr/benefits).
2. Patient costs for tiered specialists fees will correspond to the tier of the specialist utilized to perform the medical or surgical procedure.
3. No coverage without precertification.
4. Includes seven well baby visits in the first year of a child’s life.

### TELEMEDICINE

We are pleased to offer telemedicine as part of our 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 infection/urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache
- 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](http://www.teladoc.com/princeton) or call (855) 835-2362 (TELADOC).
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 OptumRx directly 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 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.

PATIENT SAFETY, EFFICIENCY, AND EFFECTIVENESS
Princeton University participates in prior authorization, step therapy, quantity duration, and compound medication 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.

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.

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 the HR website at www.princeton.edu/hr/benefits.
www.princeton.edu/hr/benefits/pdf/preventiveitems.pdf. This list 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.

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.

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/mycatamaranrx.

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
As a 403(b) plan, the Retirement Savings Plan allows you to save additional monies for your retirement on a pretax basis. If you 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 are subject to limits set by the Internal Revenue Code. In 2016, 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 2016. The contribution limits for 2017 were not released as of the printing of this booklet. 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.

**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 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 50% of your account, whichever is less.

**Hardship Withdrawal**

Should you have a financial hardship due to certain qualified reasons, you may be able to take a hardship withdrawal from your account to meet that need. Qualified reasons include buying your primary residence, preventing eviction, paying medical expenses or educational expenses for you or your immediate family, or paying funeral expenses for your immediate family. 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 59 1/2.

**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 59 1/2, 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.

My Benefits Under the ACA 2017 | 8
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.

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.

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 2016, or if you were a part-time employee who elected healthcare coverage through Princeton in 2016, you will receive your 1095-C from Princeton University by February 1, 2017.

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

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. The current limits for calendar year 2015 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 2016.
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, refer to [www.princeton.edu/hr/benefits/hlth/cobra](http://www.princeton.edu/hr/benefits/hlth/cobra).

**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.
**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

**EFFECTIVE SEPTEMBER 2016**

**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 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.

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).

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.

• 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 specifying the reason for such request. Any denial by us 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 in the event of a breach of your unsecured Protected Health Information.

• an accounting of instances when your Protected Health Information has been disclosed. 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.

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 at (609) 258-3302.

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.

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 Office of Human Resources at (609) 258-3302.

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. 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
Email: adamsm@princeton.edu
Campus Phone: (609) 258-2169
Campus Fax: (609) 258-3448

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 provided below.

HIPAA CONTACTS

Aetna
(Consumer Directed Health Plan)
Member Services
(800) 535-6689

OptumRx
(Prescription Drug Plan)
Attn: Member Services
P.O. Box 3410
Lisle, IL 60532-8410
Member Services
(877) 629-3117

Office of Human Resources
2 New South
Princeton, NJ 08544
(609) 258-3302
Email: benefits@princeton.edu
Fax: (609) 258-5920
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.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a></td>
</tr>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Phone: 1-877-357-3268</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>The AK Health Insurance Premium Payment Program</td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a></td>
</tr>
<tr>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>- Click on Health Insurance Premium Payment (HIPP)</td>
</tr>
<tr>
<td>Phone: 1-866-251-4861</td>
<td>Phone: 404-656-4507</td>
</tr>
<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td></td>
</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>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
</tr>
<tr>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td>Website: <a href="http://www.hip.in.gov">http://www.hip.in.gov</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-877-438-4479</td>
</tr>
<tr>
<td></td>
<td>All other Medicaid</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
</tr>
<tr>
<td></td>
<td>Phone 1-800-403-0864</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLORADO – Medicaid</th>
<th>IOWA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a></td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">http://www.dhs.state.ia.us/hipp/</a></td>
</tr>
<tr>
<td>Medicaid Customer Contact Center: 1-800-221-3943</td>
<td>Phone: 1-888-346-9562</td>
</tr>
<tr>
<td>State</td>
<td>Medicaid/CHIP Website</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Kansas</td>
<td><a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a></td>
</tr>
<tr>
<td>Nevada</td>
<td><a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a></td>
</tr>
<tr>
<td>Kentucky</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
</tr>
<tr>
<td>New York</td>
<td><a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a></td>
</tr>
<tr>
<td>Massachusetts</td>
<td><a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
</tr>
<tr>
<td>North Carolina</td>
<td><a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a></td>
</tr>
<tr>
<td>Minnesota</td>
<td><a href="http://mn.gov/dhs/ma/">http://mn.gov/dhs/ma/</a></td>
</tr>
<tr>
<td>North Dakota</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
</tr>
<tr>
<td>Missouri</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
</tr>
<tr>
<td>Oklahoma</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
</tr>
<tr>
<td>Nebraska</td>
<td><a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td><a href="http://www.dhs.pa.gov/hipp">http://www.dhs.pa.gov/hipp</a></td>
</tr>
</tbody>
</table>

Website: [http://www.kdheks.gov/hcf/](http://www.kdheks.gov/hcf/)  
Phone: 1-785-296-3512  
Website: [http://dwss.nv.gov/](http://dwss.nv.gov/)  
Phone: 1-800-992-0900  
Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
Phone: 1-800-635-2570  
Phone: 603-271-5218  
Website: [http://dhh.louisiana.gov/index.cfm/subhome/1/n/331](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331)  
Phone: 1-888-695-2447  
Website: [http://www.state.nj.us/humanservices/dmhs/clients/medicaid/](http://www.state.nj.us/humanservices/dmhs/clients/medicaid/)  
Phone: 609-631-2392  
Website: [http://www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)  
Phone: 1-800-462-1120  
Website: [http://www.nyhealth.gov/health_care/medicaid/](http://www.nyhealth.gov/health_care/medicaid/)  
Phone: 1-800-541-2831  
Phone: 1-800-442-6003  
TTY: Maine relay 711  
Website: [http://www.ncdhhs.gov/dma](http://www.ncdhhs.gov/dma)  
Phone: 919-855-4100  
Website: [http://mn.gov/dhs/ma/](http://mn.gov/dhs/ma/)  
Phone: 1-800-657-3739  
Website: [http://www.nd.gov/dhs/services/medicalserv/medicaid/](http://www.nd.gov/dhs/services/medicalserv/medicaid/)  
Phone: 1-844-854-4825  
Website: [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005  
Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org)  
Phone: 1-888-365-3742  
Website: [http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP](http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP)  
Phone: 1-800-694-3084  
Website: [http://www.oregonhealthykids.gov](http://www.oregonhealthykids.gov)  
Website: [http://www.hijossaludablesoregon.gov](http://www.hijossaludablesoregon.gov)  
Phone: 1-800-699-9075  
Website: [http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx](http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx)  
Phone: 1-855-632-7633  
Website: [http://www.dhs.pa.gov/hipp](http://www.dhs.pa.gov/hipp)  
Phone: 1-800-692-7462
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Medicaid Phone</th>
<th>CHIP Website</th>
<th>CHIP Phone</th>
</tr>
</thead>
</table>

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565
**Women’s Health and Cancer Rights Act**

The Women’s Health and Cancer Rights Act of 1998 requires all group health plans that provide medical and surgical benefits for mastectomy to provide coverage for reconstruction of the breast on which the mastectomy was performed; surgery reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema. These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles and coinsurance provisions applicable to other such medical and surgical benefits provided under the plan. Please refer to your Summary Plan Description for deductibles and coinsurance information applicable to the plan in which you choose to enroll.

**Newborns’ and Mothers’ Health Protection Act**

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours.

**Health Insurance Marketplace Notice**

As a requirement of the Patient Protection and Affordable Care Act (PPACA), Princeton University must provide the Health Insurance Marketplace, formerly known as the Exchanges, notice to all employees, found on pages 42 and 43. 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 (609) 258-3302 or benefits@princeton.edu.

**Notice of Creditable Coverage**

If you are enrolled in the Aetna HMO Plan, the Aetna J-1 Visa Plan, or the Aetna or UnitedHealthcare Princeton Health Plan (PHP), the prescription drug coverage under these plans is at least as good as what is offered under Medicare Part D. Medicare calls this “Creditable Coverage.” As long as you are covered under a plan that has Creditable Coverage then you will not be penalized for enrolling at a later date as long as you enroll in Medicare Part D within 63 days of no longer having Creditable Coverage. The Notice of Creditable Coverage, found on pages 44 and 45, applies to benefits-eligible employees and their dependents who are Medicare eligible. No action is required on your part.

**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 healthcare 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.
PART A: General Information

As a result of the healthcare law, there is 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 new 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 new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2016 for coverage starting as early as January 1, 2017.

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.¹

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 of the Office of Human Resources at 609-258-3302 or benefits@princeton.edu

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

¹ 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, 2 New South
6. Employer phone number: (609) 258-3302
7. City Princeton
8. State NJ
9. Zip code 08544
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.
Important Notice from Princeton University About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it with your other important papers. This notice has information about your current prescription drug coverage with Princeton University and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Princeton University has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can you Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Part D drug plan.

What Happens to your Current Coverage if you Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your Princeton University coverage will not be affected. As a benefits-eligible employee you and your eligible dependents can keep your prescription plan coverage if you elect Medicare Part D and this plan will coordinate with the Part D coverage.

Please remember that your prescription drug plan through Princeton University is part of your medical plan coverage. If you decide to enroll in a Medicare prescription drug plan and request to drop your Princeton University prescription drug coverage, be aware that you may also be dropping your medical plan coverage. If you do drop your medical and prescription plan coverage, you are your dependents will be able to re-enroll in a Princeton University medical plan at a later date.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will you Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your coverage with Princeton University and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current Princeton University prescription drug coverage, please contact the Benefits Team in the Office of Human Resources at (609) 258-3302 or via e-mail at benefits@princeton.edu.

NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if Princeton University changes its prescription drug plan coverage. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:

• Visit [www.medicare.gov](http://www.medicare.gov).
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

[Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).]

Date: October 2016
Name of Entity/Sender: Princeton University
Contact--Position/Office: Linda Nilsen, Assistant Vice President, Human Resources
Address: Office of Human Resources, 2 New South, Princeton, NJ 08544
Phone Number: (609) 258-3302
New Jersey Department of Labor and Workforce Development

NEW JERSEY DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
(To be posted in a conspicuous place)
This employer is subject to the
Family Leave Insurance provisions of the New Jersey Temporary Disability Benefits Law.

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.

Enforced by:
New Jersey Department of Labor and Workforce Development
Division of Temporary Disability Insurance
PO Box 387
Trenton, New Jersey 08625-0387

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.

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

<table>
<thead>
<tr>
<th>Medical and Prescription</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>486819</td>
<td>(800) 535-6689</td>
<td><a href="http://www.aetna.com/dse/princeton">www.aetna.com/dse/princeton</a></td>
</tr>
<tr>
<td>Telemedicine (Aetna)</td>
<td>Teladoc</td>
<td>NA</td>
<td>(855) 835-2362</td>
<td><a href="http://www.teladoc.com/princeton">www.teladoc.com/princeton</a></td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>OptumRx</td>
<td>PURPRNCEM</td>
<td>(877) 629-3117</td>
<td><a href="http://www.optumrx.com/mycatamaranrx">www.optumrx.com/mycatamaranrx</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Retirement</th>
<th>TIAA and Vanguard (Main)</th>
<th>102862</th>
<th>(800) 842-2776</th>
<th><a href="http://www.tiaa.org">www.tiaa.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement Savings Plan</td>
<td>TIAA and Vanguard (PPPL)</td>
<td>102866</td>
<td>(800) 842-2776</td>
<td><a href="http://www.tiaa.org">www.tiaa.org</a></td>
</tr>
</tbody>
</table>