About Your Benefits
Summary Plan Description
Health, Welfare, and Education Plans
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Introduction

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

- Health Care Plan (which provides medical, dental, Employee Assistance Program (EAP), health benefit expense account (HBEA), and dependent care expense account (DCEA) benefits)
- Total Disability Insurance Program – Long Term Disability
- Business Travel Accident Plan
- Group Life Insurance Program – Basic
- Group Life Insurance Program – Supplemental
- Vision Care Plan
- Group Long Term Care Plan
- Parking and Transit Reimbursement Account Programs
- Staff and Children’s Educational Assistance Programs

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

This document is not intended to provide medical, legal, financial, tax or investment advice. Complete details of each benefit plan are found in the official plan documents and contracts that legally govern all aspects of the plans. The plan documents are available for review in the Office of Human Resources. If there is any discrepancy between the plan documents and the summaries in this handbook, the plan documents will prevail. The University’s benefit plans are intended to comply with all applicable federal and state laws. In the event of a conflict, the terms of the federal and state laws will govern. The benefits described in this document are based on federal and state laws.

Changes in the University benefit plans may occur as a result of future legislation or at the discretion of the University. If your benefits do change, you will receive updated information. Please contact your Office of Human Resources if you have questions or need additional information about your benefits.

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

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

Employee Eligibility

• Members of the faculty and staff whose work schedule is at least five months of the year at 50% duty time or greater are eligible to participate in the University’s benefit plans.

• Casual, (biweekly and hourly paid) and short-term professional employees, temporary contract employees, and those who are full-time students are not eligible to participate in the University’s benefit plans.

• Visiting faculty and staff, postdoctoral research fellows and visiting fellows may only be eligible for some of the following benefits.
  o Medical Benefits
  o Dental Benefits
  o Vision Benefits
  o Group Supplemental Retirement Annuity
  o Health and Dependent Care Expense Accounts
  o Faculty and Staff Assistance and Work/Life Programs
  o Princeton University Retirement Plan eligibility only via written approval by the Office of the Dean of the Faculty

• All J-1 visa holders are eligible for certain benefits based on job title or staff group. J-1 visa holders may be eligible for the same benefits as Visiting Faculty and staff listed above with the following exception:
  o Health Care – the only medical plan options are the J1 visa health plan option administered by Aetna or the Aetna HMO health plan.

Dependent Eligibility

If you are an eligible employee, you may enroll certain family members in the Medical, Dental, Vision Care Plans, and Long-Term Care. Your eligible dependents include your legal spouse, same-sex domestic partner or same-sex civil union partner, and eligible children to the December 31st in which they turn 26.

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

Eligible dependents also include:
• dependent, unmarried children of any age who are physically or mentally challenged and became disabled before the end of the calendar year in which they turn 26.

• Unmarried children of any age who are physically or mentally challenged who were covered dependents and became disabled before the end of the calendar year in which they turn 25 are also eligible dependents.

Same-Sex Domestic Partner
Your same-sex domestic partner (and his or her children, if any) qualifies as a dependent if:

• your partner is not related to you by blood,
• you and your partner have lived together in a committed personal relationship for at least six consecutive months, you agree to be jointly responsible for each other's common welfare, living expenses, and financial obligations, and you intend to live together indefinitely, and
• you must be able to present at least three forms of documentation showing your shared financial responsibilities.

There are two forms that must be completed in order for your same-sex domestic partner (and his or her children, if any) to be covered under the applicable benefit plans:

• Statement of Same Sex Domestic Partnership.
• Tax Certification of Dependency for Health Insurance Coverage. If your same-sex domestic partner and/or his/her children can be classified as tax dependents, you must complete this form in order to have benefits provided on a tax free basis. The form describes when your same sex domestic partner and/or his or her children are classified as tax dependents.

These forms are available via the Web at www.princeton.edu/hr/forms or you can contact your Office of Human Resources to request the appropriate forms.

Please Note: There may be important personal tax consequences that arise as a result of domestic partner coverage. For example, you may be subject to imputed income for tax purposes. For more information, contact your Office of Human Resources.
Enrollment Procedures

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

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

<table>
<thead>
<tr>
<th>You must complete your online enrollment via eBenefits to enroll in the following plans</th>
<th>Within…</th>
<th>Or…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plan</td>
<td>31 days of your date of hire or appointment</td>
<td>You will be defaulted into the High Deductible Plan with employee only coverage (no prescription plan and a $5,000 deductible). You will be unable to choose another health care plan until the next open enrollment period (with an effective date of January 1 of the following year).</td>
</tr>
<tr>
<td>Dental Care Plan</td>
<td>31 days of your date of hire or appointment</td>
<td>You are not eligible to participate in the calendar year of your hire.</td>
</tr>
<tr>
<td>Vision Care Plan</td>
<td>31 days of your date of hire or appointment</td>
<td>You are not eligible to participate in the calendar year of your hire.</td>
</tr>
<tr>
<td>Supplemental Life Insurance Plan</td>
<td>31 days of your date of hire or appointment</td>
<td>You are required to complete an Evidence of Insurability (EOI) form.</td>
</tr>
<tr>
<td>Health Benefit Expense Account Plan</td>
<td>31 days of your date of hire or appointment</td>
<td>You are not eligible to participate in the calendar year of your hire.</td>
</tr>
<tr>
<td>Plan</td>
<td>Eligibility</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dependent Care Expense Account Plan</td>
<td>31 days of your date of hire or appointment</td>
<td>You are not eligible to participate in the calendar year of your hire.</td>
</tr>
<tr>
<td>Parking and Transit Reimbursement Accounts</td>
<td>31 days or your date of hire or appointment</td>
<td>At any time using the appropriate enrollment/change form.</td>
</tr>
<tr>
<td>Princeton University Retirement Plan</td>
<td>31 days of your date of hire or appointment</td>
<td>Your investment selection for University contributions will be defaulted to the Vanguard Target Retirement Funds.</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>31 days of your date of hire or appointment</td>
<td></td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Automatically enrolled and coverage effective on your first day of hire or appointment</td>
<td>Prudential will name your beneficiaries per their Preferential Beneficiary Arrangement, which provides that your life insurance will be paid to the first of the following: Your (a) surviving spouse; (b) surviving child(ren) in equal shares; (c) your surviving parents in equal shares; (d) surviving siblings in equal shares; (e) your estate.</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment</td>
<td>Automatically enrolled and coverage effective on your first day of hire or appointment</td>
<td></td>
</tr>
<tr>
<td>Business Travel Accident Insurance</td>
<td>Automatically enrolled and coverage effective on your first day of hire or appointment</td>
<td></td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>Automatically enrolled and coverage effective on your first day of hire or</td>
<td></td>
</tr>
</tbody>
</table>
Special note regarding domestic partner coverage: The events qualifying you to make a mid-year election change described in this section also apply to events related to a domestic partner who is a tax dependent. If you make a mid-year change due to an event involving your domestic partner and your coverage for the domestic partner is on an after-tax basis these rules will not apply and you will be able to make a change at any time.

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

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

If you do not enroll during the annual benefit open enrollment period, your coverage under most plans defaults to your current election. However, you must actively make an election to enroll in the HBEA and DCEA for the next year.

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

Mid-Year Changes
Ordinarily, you cannot change your benefit elections until the next annual benefit open enrollment period. However, you may be permitted to make a change during
the course of the year if you experience a mid-year election change event. Such events which are described in detail below include:

- a special enrollment event, such as losing coverage under another plan or gaining a new dependent;
- a qualified life status change event, such as an event that changes your marital or employment status;
- a significant change in coverage under spouse/or same-sex domestic partners other plan;
- entitlement to governmental benefits, such as Medicare;
- taking or returning from an approved leave;
- judgments, decrees, or court orders, such as QMCSOs; or
- other coverage changes that cause the need for a change to your coverage under the University’s plans.

Special Enrollment Events

If you are rehired into a benefits-eligible position within six months of terminating from a benefits-eligible position, you will be reinstated into the benefits you were previously enrolled in. However, enrollment in the Health Benefits Expense Account and the Dependent Care Expense Account, if you are rehired in a new calendar year even if within the six months, requires a new election.

Loss of Other Health Plan Coverage

If you decline or waive coverage for yourself and your eligible dependents when you are originally eligible or during an open enrollment period because of other coverage and you subsequently lose that other coverage, then you may enroll yourself and your eligible dependents for coverage.

You must complete the enrollment process no later than 31 days after the date the previous coverage ends. Coverage for newly enrolled individuals will begin as of the first day of the month coincident or next following the last day of coverage under the previous plan.

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

New Dependents

If you gain an eligible dependent as a result of marriage, you may enroll your spouse, and any other eligible dependent for benefits coverage. However, if you are enrolled you may also waive medical coverage. You must complete the enrollment process no
later than 31 days after the date of such event. Coverage will be effective the first of the month coincident with or next following the date of marriage.

In the case of the birth or adoption of a child, you have 90 days to notify your Office of Human Resources of the birth, adoption, or placement for adoption to add your dependents. Coverage will be added retroactive to the date of birth, adoption or placement for adoption.

Qualified Life Status Change Events
A qualified life status change event means:

- a change in your legal marital status, including marriage, divorce, death of your spouse or same-sex domestic partner, legal separation, or annulment;
- a change in the number of your tax dependents through birth, adoption, or death;
- termination or commencement of employment by you, your spouse, same-sex domestic partner, or dependent;
- a change in work schedule, such as reduction or increase in hours by you, your spouse, same-sex domestic partner or your dependent that would make you ineligible or eligible for benefits;
- your dependent’s ability or inability to satisfy dependent eligibility requirements; or
- a change in residence or work site by you, your spouse, same-sex domestic partner, or dependents that causes you to lose access to providers in your medical plan’s network.

For purposes of the foregoing, a qualified life status change will only occur with regard to a domestic partner and his or her dependents who if the domestic partner and his or her dependents are your tax dependents as discussed above in the Eligibility section.

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

You must notify your Office of Human Resources of a qualified life status change event within 31 days of the event to change your benefit coverage. In the case of the birth, adoption, or placement for adoption of a child, you have 90 days to notify your Office of Human Resources of the birth, adoption, or placement for adoption to change your coverage.
If you do not notify your Office of Human Resources within the time specified, you will not be able to add a dependent or make any other coverage changes until the next open enrollment period, with benefits coverage effective the following January 1.

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

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

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

Coverage Changes
- Curtailment or Loss of Coverage. If your benefit coverage is significantly curtailed or ceases entirely, you may revoke your elections and elect coverage under another option providing similar coverage, if one is available. Coverage is significantly curtailed if there is an overall reduction in coverage generally. If the curtailment is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election for coverage.

- Addition to or Improvement in Coverage. If the University adds or significantly improves a coverage option during the year and you had elected an option providing similar coverage, you may revoke your existing election and instead elect the newly added or newly improved option.

- Changes in Coverage under Another Employer Plan. If the plan provided by the employer of your spouse, domestic partner who is a tax dependent, or dependent allows for a change in your family member’s coverage (either during that employer’s open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change. For example, if your spouse elects family medical coverage during his or her employer’s open enrollment period, you may drop your University health plan coverage.
Entitlement to Governmental Benefits
If you, your spouse, domestic partner who is a tax dependent, or dependent becomes entitled to, or loses entitlement to, Medicare, Medicaid or certain other governmental group medical programs, you may make a corresponding change to your coverage elections.

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

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

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

Change in Family Status
It is important that you notify your Office of Human Resources within 31 days of any change in your family status, such as marriage, divorce, birth, or adoption of a child (have 90 days for birth or adoption), legal guardianship, marriage of a dependent child, and death of a spouse or child.

In general, the plan administrator will determine whether a requested change qualifies as a result of a mid-year election change event. Princeton University requires written documentation of any dependent’s eligibility for plan benefits and/or the effective date of any mid-year election change event.

To change your election due to a mid-year election change event, you must notify your Office of Human Resources or Human Resources (main campus) at (609) 258-3302 and make the change within 31 days of the event—90 days for birth or adoption. The change will generally be effective the first of the month coincident or next following the date of the event that prompted the mid-year election change. In the event of a birth or adoption, the effective date will be retroactive to that date.
When Coverage Begins

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

Paying for Coverage

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

If you elect coverage in any one of the health care plans (with the exception of the High Deductible Plan), you and the University both contribute toward the cost of coverage. Your contribution will be deducted on a pretax basis from your paycheck. Some plans are employee pay all plans. These plans include: expense account(s), dental, vision, supplemental life, group long term care, the tax-deferred annuity, and parking and transit reimbursement accounts. The full amount for these plans is deducted from your paycheck.

Pretax Contributions

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

- Health care plan coverage,
- Dental care plan coverage,
- Vision care plan coverage,
- Expense account plan coverage,
- Parking and transit reimbursement accounts, and
- Tax-deferred annuity plan election.
Contributions to your supplemental life insurance coverage and group long term care are made on an after-tax basis which means the cost of these benefits is deducted after federal, state, and local income and Social Security taxes have been withheld.

Same-Sex Domestic Partners
The cost of coverage for a domestic partner is the same as the cost for a spouse. The cost of coverage for a domestic partner’s child(ren) is the same as the cost for a dependent child. If your domestic partner and his or her child(ren) qualify as your dependents under section 152 of the Tax Code, your contributions for domestic partner coverage will be taken before taxes are withheld and there will be no tax implications for you. To enroll a same-sex domestic partner and or his or her children as tax dependents, you must complete a Tax Certification of Dependency for Health Insurance Coverage. This form is available via the Web at www.princeton.edu/hr or from your Office of Human Resources.

However, if your same-sex domestic partner and his or her child(ren) do not qualify as dependents under section 152 of the Tax Code, you will pay your portion of the cost of the coverage provided to your domestic partner and his or her children on an after-tax basis and the value of the coverage for your domestic partner and/or his or her child(ren) paid for by Princeton University will be considered “imputed income.” The amount of imputed income will be shown on your pay statement and Form W-2 and you will pay taxes on the amount of imputed income. The value of the coverage paid for by Princeton University is calculated by determining the excess of the fair market value (FMV) of the coverage over the after-tax amount you paid for the coverage. Princeton University will not treat dependents of your same-sex domestic partner as your tax dependents under the Tax Code unless you notify the plan administrator that they are your tax dependents.

Since these tax requirements are complex, you should consult a tax professional for advice on your personal situation. To review the qualifications of a section 152 dependent, see IRS Publication 17, Your Federal Income Tax.
Coordination of Benefits

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

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

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

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

- As a Princeton University employee, coverage for you under the Princeton University benefit plan is primary for covered expenses.
- When your spouse or same-sex domestic partner is covered under the Princeton University benefit plan as a dependent and under another group plan as an employee, then the plan covering your spouse or same-sex domestic partner is primary and the University plan is secondary.
- When your dependent child is covered under both the University plan and your spouse’s plan, the “Birthday Rule” is in effect. The Birthday Rule provides that the parent whose birthday falls earlier in the calendar year (year of birth is not a consideration) is the parent whose coverage is primary. For example, a mother
and father both cover a child under employer-sponsored plans. The mother’s birthday is in May while the father’s birthday is in October. Therefore, the mother’s plan is primary and the father’s plan is secondary. If both parents have the same birthday, the plan covering a parent for the longer period of time is primary.

- When a dependent child of divorced or separated parents is covered under more than one health care plan, benefits for the child are determined in the following order:
  - Primary, the plan of the parent with custody of the child.
  - Secondary, the plan of the spouse of the parent with custody of the child, if applicable,
  - Finally, the plan of the parent not having custody of the child.

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

Medicare

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

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

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

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

Medicare Enrollment Requirements for Non-retired Employees

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

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

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

Recovery Provisions

Right of the Plan to Recover Improperly Paid Benefits
Princeton University has the right to recover an amount paid in error. For example, if you receive benefits for a service under the Princeton University benefit plan in error, and you also receive benefits from another plan for the same service, Princeton University and the plan vendor have the right to recover the amount paid to you by the other plan. You are not permitted to receive total benefits above the cost of the service provided. The same is true if payment is made in excess of what should have been paid under the Princeton University benefit plan.

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

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

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

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

If you, or any other person or organization that was paid, do not promptly refund the full amount, the amount owed will be deducted from any future claim reimbursements.
Subrogation
In the event that you suffer an injury or sickness as a result of an alleged negligent or wrongful act or omission of a third party, the Princeton University Health Care Plan has the right to pursue subrogation against any person or insurer.

The Princeton University Health Care Plan will be subrogated and succeed to your right of recovery against any person or insurer. The Princeton Plan may use this right to the extent of the benefits under the Plan. You must agree to help the Princeton University Health Care Plan use this right when requested.

When Coverage Ends

Employee Coverage
Employee coverage ends on the earliest of the following dates:

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

Dependent Coverage
Dependent coverage ends on the earliest of the following dates:

- the last day of the month in which the employee’s coverage ends,
- the last day of a period for which contributions for the cost of dependent coverage have been made if the contributions for the next period are not made when due, or
- the end of the calendar year in which the dependent stops being an eligible dependent.

Continuation of coverage for incapacitated children
A mentally or physically incapacitated child’s coverage will not end due to age. It will continue as long as the child is considered to be a dependent and meet one of the following conditions:
• the child is incapacitated,
• the child is not capable of self-support, or
• the child depends mainly on the employee for support.

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

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

Continuation of Coverage

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

Continuing Coverage during FMLA

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

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

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

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

If you lose any coverage during an FMLA leave because you did not make the required contributions, you must wait for the next Open Enrollment to re-enroll when you return from your leave.
If you do not return to work at the end of your FMLA leave, or your employment is terminated while you are on an FMLA leave, you will be entitled to purchase COBRA continuation coverage for your health, dental, vision, and the HBEA.

Special Rules Regarding Your Expense Accounts: If you’re on an approved FMLA leave, you’ll have the option of continuing your participation in the HBEA and DECA during the leave as long as you continue to contribute for the cost of the coverage during the leave.

When you take an unpaid FMLA leave, the entire amount you elected under your HBEA will be available to you during your leave period, less any prior reimbursement, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your coverage under the HBEA will terminate while you are on unpaid FMLA leave. In that case, you may not receive reimbursement for any healthcare expenses incurred after your coverage terminated.

If your coverage terminates during your leave, your HBEA elections may be reinstated if you return to work during the same year in which your leave began. You will have the choice of either resuming your contributions at the same level in effect before your FMLA leave, or you may elect to increase your contribution level to “make up” for the contributions you missed during your leave. If you simply resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave. If you elect to make up contributions, then the amount available for reimbursement will be the same amount you could receive immediately before the leave.

Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred after your coverage terminated are not eligible for reimbursement.

Continuing Coverage during Military Leave
If you take a military leave, whether for active duty or for training, you are entitled to continue your health, dental, vision, and HBEA for up to 24 months. Your total leave, when added to any prior periods of military leave from Princeton University, cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, your deductions will be taken retroactively. If the entire length of the leave is 31 days or longer, you will be required to pay up to 102% of the full amount necessary to cover an employee who is not on military leave. You will receive billing coupons from the Office of Finance and Treasury to pay for these benefit premiums. Unlike payroll deductions, amount paid by using the billing coupons will be paid on an after-tax basis.
If you take a military leave and your coverage under a benefit plan is terminated, you will need to re-enroll in benefits within 31 days of your return to active status. If you are on military leave and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage for the remaining months, up to a total of 18 months (see below).

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

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

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

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

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

PayFlex Systems
P.O. Box 3039
Omaha, NE 68103-3039
(800) 284-4885
Who is Covered
You should receive a letter from PayFlex Systems shortly after you become a benefits-eligible employee. If you are an employee who is covered by a Princeton University-sponsored health, dental, vision, or HBEA, you have a right to choose continuation coverage under the applicable benefit plan if you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

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

Special Rules for Domestic Partners: Although domestic partners and their eligible dependent children are generally not considered qualified beneficiaries for purposes of legal entitlement to COBRA continuation coverage, Princeton University does make COBRA coverage available to domestic partners and their eligible dependent children who meet the requirements for eligibility under the Plan. Accordingly, if you have enrolled your domestic partner and his or her eligible dependent children for coverage under the Plan and you terminate your domestic partnership, you must notify Princeton University within 31 days of the qualifying event. Your domestic partner and his or her eligible dependent children will be eligible to receive COBRA continuation coverage under the Plan as described in this section.

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

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

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

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

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

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

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

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

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

Separate Elections: Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, i.e., at Open Enrollment, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse/domestic partner or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse/domestic partner or dependent child may elect different coverage than the employee elects.

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

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

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

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

Health Benefit Expense Account (HBEA): Regardless of the type of qualifying event, you can elect to continue your HBEA until the end of the plan year.

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

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

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

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

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

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

If you do not make timely payments, your COBRA coverage will be terminated as of the last day of the month for which you made timely payment.
Health Insurance Portability & Accountability (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, 2013

Disclosure Limitations of Your Plan Information


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 health care 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 health care 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 health care 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, health care 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 e-mail 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
E-mail: 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:

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

Aetna
(Princeton Health Plan, J1 Visa, and High Deductible)
Member Services
(800) 535-6689

Aetna
(HMO Plan)
Member Services
(888) 287-4296
CLAIMS REVIEW & APPEALS PROCESS:

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

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

Four categories of health benefit claims review are recognized:

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

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

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

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

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

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

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

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

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

If Your Healthcare Claim Is Denied

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

- the specific reason for the claim denial;
- the specific provisions of the plan on which the determination is based;
- a description of any additional information needed to reconsider the claim and the reason this information is needed;
- a description of the plan’s review procedures and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- if any internal rules, guidelines, protocols, or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocol, or other similar criteria, or a statement that a copy of such information will be made available free of charge upon request;
- for adverse determinations based on medical necessity, experimental treatment, or other similar exclusions or limits, either an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- for adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than three days after the oral notice.
If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You or an appointed representative may appeal and request a claim review within 180 days after receiving the denial notice. The request must be made in writing and should be filed with the Claims Administrator. The claimant is also entitled to reasonable access to and copies of all information that is relevant to the claim. This includes all information (i) relied on in making the benefit determination, (ii) submitted to, considered, or generated by the program in considering the claim, and (iii) that demonstrates the program’s processes for ensuring proper, consistent decisions.

The request for review should include:

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

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

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

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

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

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

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

If Your Long Term Disability Claim Is Denied
Coverage for Long Term Disability is provided through Prudential. If your initial claim for long term disability benefits is denied, in whole or in part, the Claims Administrator will provide you with a written explanation or electronic notification of the reasons for the denial within 45 days from the date the claim is received. The notice will include:
If Your Life Insurance, Business Travel Accident, or Long-Term Care Benefits Claim Is Denied

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

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

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

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

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

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

Secondary Benefit Claim Appeal Process
Any benefits eligible faculty and staff hired through the Office of the Dean of the Faculty or the Office of Human Resources, whose claim for benefits under a University benefit plan has been totally or partially denied by the insurance carrier/administrator, may request a review by the University of the claim(s) that were denied. To do so, the faculty or staff member must first follow the steps outlined in the insurance carrier/administrator’s written explanation of how to appeal the denied claim(s). If the appeal is denied by the insurance carrier/administrator the faculty or staff member may follow the steps outlined below.

Application of General Benefit Claim Appeal Process
If the faculty or staff member believes that he or she has been adversely affected by a misinterpretation or misapplication of a University benefit plan, he or she may request a review of the denied claim(s) by the Office of Human Resources. All requests for a review of claims that have been denied by the insurance carrier/administrator should be submitted to the Executive Director of Benefits and Compensation, Office of Human Resources, 2 New South, within 30 business days from the final decision of the insurance carrier/administrator. The Executive Director of Benefits and Compensation will review the benefit plan and the specific claim and will advise the faculty or staff member of the decision, usually within 15 business days following receipt of the employee’s request.

If the decision reached by the Executive Director of Benefits and Compensation regarding the claim under question is unsatisfactory to the employee, the employee may request that the University’s Benefits Committee review the matter in dispute. A written request for formal review by the Committee should be submitted to the University Benefits Committee, Office of Human Resources within 15 business days from receipt of findings from the Executive Director of Benefits and Compensation. After receipt of the employee’s request for review, the Committee will consider the issues raised and will provide a written response to the employee, within 30 business days after completion of the review. The decision of the Benefits Committee is final.
You will have the opportunity to submit written comments, documents, records, and other information relating to the claim, and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable DOL regulations.

The review will take into account all comments, documents, records, and other information you submitted relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

In certain cases, the program may obtain a limited time extension if notice of the extension is provided to you before the end of the initial decision making period.

Plan Administration and Legal Information

Plan Administrator
The Plan Administrator is responsible for the administration of the Princeton University benefit plans. The Princeton University Benefits Committee (the Committee) is the administrator for all of its plans. As such, the Committee has discretionary authority to interpret plan provisions, construe terms, determine eligibility for benefits and otherwise make all decisions and determinations regarding plan administration. By participating in any Princeton University benefit plan, you accept the Plan Administrator's authority. You may contact the Committee by sending a letter to the Princeton University Benefits Committee, Manager of Benefits, Office of Human Resources, 2 New South, Princeton University, Princeton, NJ 08544.

Claims Administrator
For some of the plans, the University, as plan administrator, has delegated authority to a third party to act as the Claims Administrator. The claims administrator for each Princeton University benefit is the company identified in the following chart unless a company is not identified. Princeton University delegates its authority to the Claims Administrator to apply the plan’s provisions for benefit claims determinations. The following chart includes the names, addresses, and phone numbers of the companies responsible for administering claims under the Plans. Use this chart as a reference when you need to contact a Claims Administrator regarding a claim. Detailed information about filing a claim under a particular plan may be found in the appropriate section of this book or the applicable benefit booklet.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>
| Princeton Healthcare Plan UnitedHealthcare | Claims Department UnitedHealthcare Insurance Company  
PO Box 740800  
Atlanta, GA 30374-0800 | (877) 609-2273 |
| Princeton Healthcare Plan Aetna          | Claims Department Aetna Life Insurance Company  
P.O. Box 981106  
El Paso, TX 79998-1106 | (800) 535-6689 |
| HMO Aetna                                | Claims Department Aetna Life Insurance Company  
P.O. Box 981106  
El Paso, TX 79998-1106 | (888) 287-4296 |
| High Deductible Health Plan Aetna        | Claims Department Aetna Life Insurance Company  
P.O. Box 981106  
El Paso, TX 79998-1106 | (800) 535-6689 |
| Prescription Drug Plan Express Scripts   | Express Scripts  
P. O. Box 2187  
Lee's Summit, MO 64063-2187(?) | (800) 711-0917 |
| DMO Dental Plan Aetna                    | Aetna Dental  
P. O. Box 14094  
Lexington, KY 40512-4094 | (877) 238-6200 |
| Basic and High Dental Plan Metlife       | Metlife Dental Claims  
P.O. Box 981282  
El Paso, TX 79998-1282 | (800) 438-6388 |
| Vision Care Plan Vision Service Plan     | Vision Service Plan  
PO Box 2487  
Columbus, OH 43216-2487 | (800)-77-7195 |
| Health Benefit Expense Account PayFlex Systems | PayFlex Systems  
P.O. Box 3039  
Omaha, NE 68103-3039 | (800) 284-4885 |
| Dependent Care Expense Account PayFlex Systems | PayFlex Systems  
P.O. Box 3039  
Omaha, NE 68103-3039 | (800) 284-4885 |
| Parking and Transit Reimbursement Accounts PayFlex Systems | PayFlex Systems  
P.O. Box 3039  
Omaha, NE 68103-3039 | (800) 284-4885 |
Limitations on Rights
Participation in a plan does not give you the right to remain employed by the University. Also, you may not sell, transfer or assign either voluntarily or involuntarily the value of your benefit under any plan except that you may assign your basic life and supplemental life.

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

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

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and
an updated summary plan description. The administrator may assess a reasonable charge for the copies.

- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65), and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to earn a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve months. The plan must provide the statement free of charge.

- Continue healthcare coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Continuation of Coverage section of this summary plan description and the documents governing the plan for the rules governing your Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage rights.

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

Fiduciary Duties

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

Enforcement of Your Rights

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

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

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

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

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

Qualified Medical Child Support Order (QMCSO)
You may enroll your dependents in a health care plan if you are required by a
qualified medical child support order (QMCSO), as legally defined to provide
coverage for your dependents. If you are not enrolled in a plan at the time you receive such an order, you must enroll in a plan. Coverage is effective on the date specified in the QMCSO. You may obtain a copy of Princeton University’s procedures governing QMCSO determinations, free of charge, by contacting Human Resources Benefits, Princeton University, 2 New South.

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. Because Princeton University offers its employees self-insured health care plans, your options under the FAIR Act depend upon which health care plan option you elect.

If you are covered under the one of the Princeton University health plans, you may not elect the plan as your primary insurance coverage in the event of a motor vehicle accident. You should have selected your motor vehicle insurance policy’s “PIP” coverage as your primary coverage.

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

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

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

Main Campus HR Benefits   Princeton Plasma Physics Lab (PPPL)
Phone: (609) 258-3302      Phone: (609) 243-2101
E-mail: benefits@princeton.edu   E-mail: kmastrom@pppl.gov

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

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