WELCOME TO THE 2021 BENEFITS OPEN ENROLLMENT PROCESS

The Institute’s annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to eligible faculty and staff. Our goal is to provide access to quality benefit plans, limiting the associated financial risk for you, while also being good financial stewards for the Institute. We offer multiple options to meet your and your dependents needs.

NOT SURE HOW TO GET STARTED? DON’T WORRY!

Prior to open enrollment, you will receive step-by-step enrollment instructions by email from Yuchao Wang in Human Resources.

Until then, now is the perfect time to prepare by doing the following:

Check that your personal information is accurate at synchr.com

✓ Review the benefits in which you are currently enrolled,

✓ Take a look at the changes for 2021, and;

✓ Check out the plans being offered for the coming year.

In this booklet, you’ll find easy-to-understand instructions to help you make your benefit decisions.

ENROLL ONLINE AT SYNCHR.COM

AS ALWAYS, WE VALUE YOU AS A MEMBER OF THE INSTITUTE FOR ADVANCED STUDY COMMUNITY AND LOOK FORWARD TO A HEALTHY AND SAFE 2021.

TIP

REMEMBER! Open enrollment is the one time of year you can make any adjustments you’d like for the upcoming plan year.

2021 CHANGES AT A GLANCE

- Both Option 1 and Option 2 cover all the same benefits.

- Both Option 1 and Option 2 have a $20 Primary Care Visit Copay and a $30 Specialist Visit Copay.

- Both options have a $250 Emergency Room Copay.

- Option 1 includes a coinsurance charge for Laboratory and Radiology services.

- Option 2 contributions are higher than Option 1. Option 1 contributions remain the same as the former Base Plan.

- Our new Life and Long Term Disability Insurance Carrier is Guardian Life. Benefits remain the same and there is no impact on employees.

- This is an open enrollment for any employee that has not elected supplemental Life/ADD benefits in the past.

- You will contact Guardian directly for all leave requests.
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Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

This is a general summary, detailed Plan Summaries, Plan Documents and other pertinent information is available by contacting the HR department.

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If you have any questions regarding your benefits, please contact Yuchao Wang in Human Resources or the claim representative listed below.

### HEALTH BENEFITS

Aetna  
Group Number: 658955  
www.Aetna.com  
800.962.6842

### PRESCRIPTION BENEFITS

RxBenefits—CVS/caremark  
Group Number: 2169IFAS  
www.caremark.com  
800.334.8134  
CVS Specialty  
800.318.6108

### DENTAL BENEFITS

MetLife  
Group Number: 05912858  
www.MetLife.com  
DMO—800.880.1800  
PPO—800.942.0854

### VISION BENEFITS—VSP

Group Number: 30043794  
www.VSP.com  
800.875.7175

### FLEXIBLE SPENDING/HEALTH SAVINGS ACCOUNTS

CBIZ Flex  
Group Number F1755  
https://myplans.cbiz.com  
800.815.3023  Option 4

### YOUR BENEFITS TEAM

Yuchao Wang  
ywang@ias.edu  
609-734-8243

### BROAD REACH BENEFITS REPRESENTATIVE

Angela Malgeri  
Senior Client Service Manager  
angela.malgeri@aleragroup.com  
973-377-3362
MEDICAL INSURANCE

YOUR HEALTH COVERAGE

As a full-time employee you have the choice between payment plan options with the same comprehensive coverage: Aetna Option 1 or Aetna Option 2 include the same coverage. Both come with Prescription coverage through Caremark/CVS. The only difference between options are the copays, deductibles, coinsurance and contributions.

While both give you the choice of using out-of-network providers, you can save money by using in-network providers because Aetna has negotiated significant discounts with them. If you choose to go out-of-network, you’ll be responsible for the difference between the actual charge and the Usual, Customary and Reasonable (UCR) charge, plus your out-of-network deductible and coinsurance.

Payment Option 1 offers you significantly lower premiums than the Payment Option 2 while covering the same benefits. Both plans include Prescription and Vision coverage.

FREQUENTLY ASKED QUESTIONS

How many hours do I need to work to be eligible for insurance benefits?
You must be a full-time employee working a minimum of 25 hours per week on a regular basis.

Will I receive a new Medical ID card?
You will receive two ID cards in the mail if you are electing medical coverage. The Aetna card is your Medical Card, all employees will receive new Aetna medical ID Card this year. The CVS/Caremark card is for your prescription drug coverage. If you are currently enrolled, you will not receive a new pharmacy card this year.

Does the deductible run on a calendar year or policy year basis?
A calendar year basis.

How long can I cover my dependent children?
Dependent children are eligible until the end of the month in which they turn age 26.

I just got hired. When will my benefits become effective?
Your medical insurance benefit will begin on your date of hire. Other benefits begin on the first day following your date of hire.

HOW TO GET STARTED

1. SELECT YOUR PAYMENT OPTION

- OPTION 1
- OPTION 2

OPTION 1
OFFERS SEVERAL BENEFITS:
- Routine preventive exams are covered at 100%.
- The same $20 Primary Care Visit Copay / $30 Specialist Visit Copay as Option 2.
- Same Covered Services, Same Network as Option 2.
- All enrollees will receive a new Aetna ID card this year.

OPTION 2
MAY BE FOR YOU IF THE FOLLOWING IS TRUE:
- You do not use In Network Providers.
- You would rather pay more in monthly premiums to spend less on medical expenses if they occur.
- Same Covered Services, Same Network as Option 1.
- All enrollees will receive a new Aetna ID card this year.
AETNA PAYMENT OPTIONS

With a POS plan, you have the option of receiving care from in-network or out-of-network providers. When you receive care from an in-network provider, your level of coverage is higher and you pay less out-of-pocket. You can, however, access out-of-network providers. When you do, you will be subject to deductibles and coinsurance and any amount above what Aetna normally pays for those services according to the plan. Benefits are identical for both plans, only the payment options are different.

<table>
<thead>
<tr>
<th>Aetna</th>
<th>CVS/caremark</th>
<th>Payment Option 1 Employee Monthly Cost</th>
<th>Payment Option 2 Employee Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible - Individual / Family</td>
<td>Deductible - Individual / Family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$250 / $500</td>
<td>$250 / $500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coinsurance (Member Pays)</td>
<td>Coinsurance (Member Pays)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maximum Out of Pocket - Individual / Family</td>
<td>Maximum Out of Pocket - Individual / Family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$2,000 / $4,000</td>
<td>$1,000 / $2,000</td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Primary Care Physician / Specialist Copay</td>
<td></td>
<td>$20 / $30</td>
<td>$20 / $30</td>
</tr>
<tr>
<td>Diagnostic Lab / X-Ray</td>
<td></td>
<td>Deductible then 20%</td>
<td>Deductible then 0%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td>$50 Copay</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Hospital Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Care (Facility / Physician)</td>
<td></td>
<td>Deductible then 20%</td>
<td>Deductible then 0%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td></td>
<td>Deductible then 20%</td>
<td>Deductible then 0%</td>
</tr>
<tr>
<td>Major Diagnostics &amp; Imaging</td>
<td></td>
<td>Deductible then 20%</td>
<td>Deductible then 0%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td></td>
<td>$250 Copay</td>
<td>$250 Copay</td>
</tr>
<tr>
<td>Prescription Drug</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Tier 1 / 2 / 3 Copay</td>
<td></td>
<td>$15 / $25 / $40</td>
<td>$10 / $20 / $35</td>
</tr>
<tr>
<td>Mail Order (90-day supply)</td>
<td></td>
<td>2x Retail Copay</td>
<td>2x Retail Copay</td>
</tr>
<tr>
<td>Out-of-Network (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual / Family</td>
<td></td>
<td>$2,000 / $4,000</td>
<td>$500 / $1,000</td>
</tr>
<tr>
<td>Coinsurance (Member Pays)</td>
<td></td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual / Family</td>
<td></td>
<td>$3,000 / $6,000</td>
<td>$2,500 / $5,000</td>
</tr>
</tbody>
</table>

(1) Family deductible/maximums are cumulative, an individual covered in a family will not exceed the individual deductible /maximum out of pocket limit.
(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays
(3) All Out-of-Network services subject to deductible, coinsurance and balance billing

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Both options are detailed in Aetna’s 2021 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.
PHARMACY BENEFITS

PRESCRIPTION DRUG COVERAGE

Medical Plan enrollees have CVS/Caremark as their Pharmacy benefit manager. This means, there are two ID Cards, one for your Aetna Option and one for the associated CVS/caremark benefit. Please be sure to keep them both. Employees currently enrolled, will not receive a new ID card this year.

There are more than 68,000 pharmacies in the CVS/caremark network, including most national chains and many independent stores. Specialty Medications must be purchased through CVS Specialty Pharmacy.

Mail Ordering for maintenance medications saves you time and money. Ninety day supply of Maintenance medications may be purchased at CVS Pharmacies only.

You can access a copy of the most current Performance Drug List at www.caremark.com

Need Assistance?
Call RxBenefits Member Services
800.334.8134
Monday through Friday
8:00 a.m. – 7:00 p.m. EST
Or via Email
customercare@rxbenefits.com

For Specialty Medications
You Must Call
CVS Specialty Pharmacy
800.318.6108

Did you know the CVS/caremark mobile app allows you to:

- Refill all your mail order and specialty prescriptions in one place?
- Manage and Track your orders in one easy to manage list?
- Set up Flexible Pick Up and Delivery at a CVS Pharmacy?
- Available on all Apple and Android devices.
SELECTING PAYMENT OPTIONS

Get the most out of your healthcare dollars, utilize in-network providers and ask yourself:

1. How much do I spend on healthcare per year including copays, deductibles, coinsurance and contributions?

2. What is the dollar difference in annual contributions between Option 1 and Option 2?

3. What is the Maximum Out of Pocket difference between the two options?

The following table illustrates the in-network difference if moving from Option 2 to Option 1:

<table>
<thead>
<tr>
<th></th>
<th>Employee Option 1</th>
<th>Employee Option 2</th>
<th>Annual Savings Opt 2 to Opt 1</th>
<th>INN MOOP Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monthly</td>
<td>Annual</td>
<td>Monthly</td>
<td>Annual</td>
</tr>
<tr>
<td>Employee</td>
<td>$127.86</td>
<td>$1,534</td>
<td>$211.19</td>
<td>$2,534</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$263.70</td>
<td>$3,164</td>
<td>$430.37</td>
<td>$5,164</td>
</tr>
<tr>
<td>Family</td>
<td>$363.14</td>
<td>$4,358</td>
<td>$529.81</td>
<td>$6,358</td>
</tr>
</tbody>
</table>

INN MOOP or In Network Maximum Out of Pocket is the worst case scenario difference between payment options. For more information on key terms, click the link below.

- Benefits Key Terms Explained
- Primary Care vs. Urgent Care vs. ER
The Institute offers your choice of the MetLife DMO or the Dental PPO. Both include comprehensive dental coverage with the PPO offering coverage both in and out-of-network. The DMO requires you to select a Primary Care Dentist and receive referrals from your PCD for specialty care, you are not covered out of network. On the PPO it is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding MetLife’s negotiated fees, plus any deductible and coinsurance associated with your procedure.

**MetLife DMO Employee Monthly Cost**
- Employee: $8.08
- Employee + Spouse: $15.36
- Employee + Child(ren): $16.14
- Employee + Family: $23.02

**MetLife Dental PPO Employee Monthly Cost**
- Employee: $25.46
- Employee + Spouse: $51.70
- Employee + Child(ren): $59.32
- Employee + Family: $90.74

**Deductible**
- Individual / Family (Basic & major)
- N/A

**Annual Maximum**
- $1,000

**Carrier Pays**
- Diagnostic / Preventive Services
  - Oral Evaluations / Cleanings / X-Rays: $5 Copay for Office Visit
  - Emergency Treatment (for temporary pain relief): Most Services Covered 100%
- Basic Services
  - Fillings / Endodontics / Periodontics: Fee Schedule
  - Simple & Surgical Extractions
- Major Services
  - Single Crowns | Inlays/Onlays: Fee Schedule
  - Bridges & Dentures | Prosthodontics
- Orthodontia Services
  - Diagnostics & Treatment (Adult & Child/Age 23): $1,850 lifetime maximum

**Find a Dental Provider**
To find a MetLife Dental Provider in your area, visit the website at www.metlife.com.
- Select “Find a Dentist” next to “What would you like to do today?”
- Select Dental HMO/Managed Care for DMO or, PDP Plus for PPO
- Enter Zip, City or State and select the “Find a Dentist” button. You will then be prompted to select your plan from the list.
- DMO is Met 245, PPO is PDP Plus Network

*This is a brief summary only. For exact terms and conditions, please refer to your certificate.*
3. REVIEW YOUR VISION PLAN

VSP REMAINS OUR VISION CARRIER FOR 2021

The vision plan is provided at no cost to all employees enrolled in the Institute Medical Plan. VSP offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

To find a participating provider, go to www.vsp.com/eye-doctor

<table>
<thead>
<tr>
<th>Vision Service Plan (VSP)</th>
<th>Frequency of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Lenses / Contacts</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Frames</td>
<td>Every other calendar year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam Copay</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Prescription Glasses</td>
<td>25 Copayment</td>
</tr>
<tr>
<td>Lenses (Single Vision, Bifocal, Trifocal)</td>
<td>Included in prescription glasses</td>
</tr>
<tr>
<td>Standard Progressive</td>
<td>55 Copayment</td>
</tr>
<tr>
<td>Premium Progressive</td>
<td>$95 - $105 Copayment</td>
</tr>
<tr>
<td>Custom Progressive</td>
<td>$150 - $175 Copayment</td>
</tr>
<tr>
<td>Average 20-25% off other lens options</td>
<td>N/A</td>
</tr>
<tr>
<td>Frames</td>
<td>$130 allowance - wide selection of frames</td>
</tr>
<tr>
<td>Contacts (Instead of Glasses)</td>
<td>Up to $60 Copayment. $130 Allowance for contacts; copay does not apply. Exam, fitting &amp; evaluation</td>
</tr>
</tbody>
</table>

To find a VSP Vision Provider in your area, visit the website at www.vsp.com/eye-doctor or call, 800.877.7195

This is a brief summary only. For exact terms and conditions, please refer to your certificate.
FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse’s) with pre-tax dollars. By contributing to a Flexible Spending Account, you can plan for out of pocket expenses you may incur if you elect Option 1. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. Be aware — any unused portion of the account at the end of the plan year is forfeited.

Click here for the full list of Healthcare FSA Eligible Expenses

What Is A Flexible Spending Account?

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, “Credit for Child and Dependent Care Expenses.” Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

How the Health Care Flexible Spending Account Works

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to CBIZ Flex.

2020 Maximum Contributions (2021 not yet updated by IRS)

<table>
<thead>
<tr>
<th>Account</th>
<th>Maximum Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Flexible Spending</td>
<td>$2,750 max</td>
</tr>
<tr>
<td>Dependent Care Expense Account</td>
<td>$5,000 max</td>
</tr>
</tbody>
</table>

PARKING & TRANSIT

Commuter Benefits allow you to conveniently pay for eligible work-related transit and parking commuting costs with pre-tax dollars deducted from your paycheck.

Transit Accounts can be used for train and bus passes up to $270 a month on a pre-tax benefit.

Parking Accounts can be used for parking at or near your work location or mass transportation up to $270 a month on a pre-tax benefit.

You may participate in one or both accounts. The accounts are separate. Per IRS regulations, you cannot use money in your Transit Account to pay for parking expenses, or vice versa. Transit dollars are no longer available as of the date of termination.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 800.815.3023, Option 4, or log on to myplans.cbiz.com to review your balances.

AT MYPLANS.CBIZ.COM YOU CAN:

- View account information and activity
- File claims
- Manage your profile
- View notifications

Claim Form may be mailed, faxed, or emailed Fax (800) 584-4185. If you are mailing your claim form, please keep a copy of the claim form and supporting documents for your records; CBIZ will not return.

Download the Mobile App through the AppStore or Google Play and search for “My Plans by CBIZ.”
LIFE INSURANCE AND AD&D

**What Is Life And AD&D Insurance?**

**BASIC LIFE AND AD&D**
The Institute for Advanced Study provides 1½x your annual earnings to a maximum of $1,000,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance. Amounts over $600,000 require evidence of insurability.

This coverage is offered through Guardian Life at no cost to you.

**VOLUNTARY LIFE AND AD&D**
You can purchase additional Life and AD&D Coverage beyond what the Institute provides. Guardian Life guarantee issues coverage during your initial enrollment period — which means you can’t be turned down for coverage based on medical history.

- **Voluntary Employee Life & AD&D:** minimum $25,000 to a maximum of 2x your annual salary, or $750,000, in $1,000 increments. Guarantee issue up to $250,000 for employees under age 65.
- **This is an open enrollment for any employee that has not elected supplemental Life/ADD benefits in the past.**
- **All current enrollees, will have the same benefit and rates as previously elected and can increase amounts up to the Guarantee issue amount without evidence of insurability.**

If you don’t enroll in the Voluntary Life and AD&D plan during this initial enrollment period, you’ll be required to complete an Evidence of Insurability form and be approved by Guardian Life before you’re able to get coverage in the future.

**Please note:** If you elect Voluntary Life, Voluntary AD&D is an automatic election based on the voluntary life insurance amount.

**GUARDIAN LIFE**
Rates per $1,000 of coverage

<table>
<thead>
<tr>
<th>Age</th>
<th>Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;29</td>
<td>$0.06</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.06</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.08</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.12</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.19</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.29</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.48</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.55</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.08</td>
</tr>
<tr>
<td>70-74</td>
<td>$1.85</td>
</tr>
<tr>
<td>75+</td>
<td>$6.11</td>
</tr>
</tbody>
</table>

**AD&D**

$0.02

**DID YOU KNOW? The Institute provides you Basic Life and AD&D AT NO COST.**
DISABILITY INSURANCE

SHORT-TERM DISABILITY INSURANCE
Benefits-eligible staff are covered under a private Short-Term Disability Plan that provides up to six months of benefits when an illness lasts more than seven consecutive days. The State disability rate is enhanced to full pay for a period equal to two times your number of years of service.

LONG-TERM DISABILITY INSURANCE
Long-Term Disability insurance is offered through Guardian Life. The Institute pays 100% of the premium cost. The plan benefit is 60% of basic monthly earnings up to a maximum of $20,000 per month.

The benefits begin after a 180 day waiting period during which you would be covered under Short Term Disability. Benefits can continue up to the Social Security Normal Retirement Age.

WHAT’S MORE LIKELY?
Many workers think these events are more likely than becoming disabled during their careers. But here are the actual odds:

<table>
<thead>
<tr>
<th>Event</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winning Mega Millions</td>
<td>.0000004%</td>
</tr>
<tr>
<td>Being struck by lightning</td>
<td>.02%</td>
</tr>
<tr>
<td>IRS Audit</td>
<td>1%</td>
</tr>
<tr>
<td>Having Twins</td>
<td>3%</td>
</tr>
<tr>
<td>Becoming Disabled</td>
<td>25%</td>
</tr>
</tbody>
</table>

In fact, nearly **40 million** American adults live with a disability.

What Is Disability Insurance?
LEAVE ADMINISTRATION

IF YOU ARE REQUESTING

- Family Medical Leave
- New Jersey Paid Family leave
- New York Paid Family Leave
- Or any other

Notify Yuchao Wang in Human Resources that you may have a situation that requires you to be out of the office, then call:

GUARDIAN ABSENCEWORKS
888.889.2953

The Family and Medical Leave Act (FMLA)

Entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons. You must be employed for one full year and have worked 1250 hours. You are eligible for up to 12 work weeks of leave in a 12-month period for one of more of the following reasons:

- Birth of a child or placement of a child for adoption or foster care;
- To care for a spouse, child or parent who has a serious health condition;
- For a serious health condition that makes you unable to perform the essential functions of your job; or
- For any qualifying exigency arising from a spouse, child or parent in the military on covered active duty or call to covered active duty status. A 26 work week benefit during a single 12 month period is also available to care for a covered service family member with a serious injury or illness

New Jersey Family Leave Insurance

Provides New Jersey employees cash benefits for up to twelve weeks to bond with a newborn or newly placed adoptive, or foster child, or to provide care for a seriously ill (including COVID-19) or injured loved one. More information on NJ Family Leave is available on SyncHR or www.myleavebenefits.nj.gov/help/faq/fli.shtml

New York Family Paid Leave

Provides New York employees up to twelve weeks of job protected Paid Family Leave where employees can receive a percentage of your average weekly to a set maximum per week. Benefits are available to bond with a newly born, adopted or fostered child. Care for a family member with a serious health condition or, assist loved ones when a spouse, domestic partner, child or parent is deployed abroad on active duty. More information on NJ Family Leave is available on SyncHR or www.paidfamilyleave.ny.gov/2021

7. LEAVE REQUESTS

- LEAVE REQUESTS ARE NOW BEING ADMINISTERED BY THE GUARDIAN
- KEEP THIS INFORMATION FOR WHEN YOU REQUEST LEAVE

FOR ALL LEAVE REQUESTS REMEMBER TO CALL

GUARDIAN ABSENCEWORKS
Dial 888.889.2953
Our Group Number is 546167

When calling, please provide:

- Your Group Number - 546167
- Your Name
- Your Social Security Number (your 9 digit ID number)
- Your Date of Birth
- Your Address & Telephone number.
- Your Physician’s Name
- Your Physician’s Address
- Your Physician’s Telephone and Fax numbers
WHO TO CALL FOR HELP?

QUESTIONS ON BENEFITS? NEED HELP WITH CLAIMS?

PLEASE CONTACT

Angela Malgeri
angela.malgeri@aleragroup.com
973-377-3362
VIDEO RESOURCES

MEDICAL PLANS
- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview

INSURANCE 101
- Benefits Key Terms Explained
- How To Read An EOB
- What Is A Qualifying Event?

TAX ADVANTAGE SAVINGS ACCOUNTS
- What Is A Flexible Spending Account?

ANCILLARY BENEFITS
- What Is Dental Insurance?
- What Is Vision Insurance?
- What Is Life And AD&D Insurance?

OTHER INFORMATION
- Primary Care vs. Urgent Care vs. ER

OPEN ENROLLMENT RUNS
11/9/20 — 11/20/20
MEDICARE PART D CREDITABLE COVERAGE

Important Notice from The Institute for Advanced Study About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CVS/caremark and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current IAS coverage may be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the IAS medical plan, be aware that you and your dependents may not be able to get this coverage back.

This notice is a summary. For a full description of all of Institute for Advanced Study Benefit plans, please refer to the Summary Plan Descriptions, located at: https://clients.synchr.com
When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with IAS and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through IAS changes. You also may request a copy of this notice at any time.

If you have any questions Contact: Yuchao Wang 609.734.8243

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Date: October 10, 2020
Name of Entity/Sender: Institute for Advanced Study
Contact--Position/Office: Yuchao Wang, Benefits Manager/HR
Address: One Einstein Drive, Princeton NJ
Phone Number: 609-734-8243
MEDICAID CHIP NOTICE

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility—

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td>Medicaid</td>
<td><a href="http://www.myalhipp.com">www.myalhipp.com</a></td>
<td>855-692-5447</td>
</tr>
<tr>
<td>ALASKA</td>
<td>Medicaid</td>
<td><a href="http://www.myakhipp.com">www.myakhipp.com</a> <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td>866-251-4861</td>
</tr>
<tr>
<td>ARKANSAS</td>
<td>Medicaid</td>
<td><a href="http://www.myarhipp.com">www.myarhipp.com</a></td>
<td>855-692-7447</td>
</tr>
<tr>
<td>FLORIDA</td>
<td>Medicaid</td>
<td><a href="http://www.flmedicaidtplrecovery.com/hipp/">www.flmedicaidtplrecovery.com/hipp/</a></td>
<td>877-357-3268</td>
</tr>
<tr>
<td>GEORGIA</td>
<td>Medicaid</td>
<td><a href="http://www.medicaid.georgia.gov">www.medicaid.georgia.gov</a></td>
<td>404-656-4507</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Click on Health Insurance Premium Payment (HIPP)</td>
<td></td>
</tr>
<tr>
<td>INDIANA</td>
<td>HIP Plan</td>
<td><a href="http://www.in.gov/fssa/hip">www.in.gov/fssa/hip</a></td>
<td>877-438-4479</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Healthy Indiana Plan for low-income adults aged 19 to 64</td>
<td></td>
</tr>
<tr>
<td>IOWA</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.iowa.gov/hawk-i">www.dhs.iowa.gov/hawk-i</a></td>
<td>800-257-8563</td>
</tr>
<tr>
<td>KANSAS</td>
<td>Medicaid</td>
<td><a href="http://www.kdheks.gov/hcf">www.kdheks.gov/hcf</a></td>
<td>785-296-3512</td>
</tr>
<tr>
<td>State</td>
<td>Medicaid/CHIP Website</td>
<td>Contact Number</td>
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<tr>
<td>Kentucky - Medicaid</td>
<td><a href="http://www.chfs.ky.gov">www.chfs.ky.gov</a></td>
<td>800-635-2570</td>
<td></td>
</tr>
<tr>
<td>Louisiana - Medicaid</td>
<td><a href="http://www.dhh.louisiana.gov/index.cfm/subhome/1/n/331">www.dhh.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td>888-695-2447</td>
<td></td>
</tr>
<tr>
<td>Massachusetts - Medicaid &amp; CHIP</td>
<td><a href="http://www.mass.gov/eohhs/gov/departments/masshealth">www.mass.gov/eohhs/gov/departments/masshealth</a></td>
<td>800-862-4840</td>
<td></td>
</tr>
<tr>
<td>Missouri - Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>573-751-2005</td>
<td></td>
</tr>
<tr>
<td>Montana - Medicaid</td>
<td><a href="http://www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
<td>800-694-3084</td>
<td></td>
</tr>
<tr>
<td>Nebraska - Medicaid</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a></td>
<td>855-632-7633</td>
<td></td>
</tr>
<tr>
<td>Nebraska - Medicaid (Lincoln)</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a></td>
<td>402-473-7000</td>
<td></td>
</tr>
<tr>
<td>Nebraska - Medicaid (Omaha)</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a></td>
<td>402-595-1178</td>
<td></td>
</tr>
<tr>
<td>Nevada - Medicaid</td>
<td><a href="http://www.dhcfp.nv.gov">www.dhcfp.nv.gov</a></td>
<td>800-992-0900</td>
<td></td>
</tr>
<tr>
<td>New Hampshire - Medicaid</td>
<td><a href="http://www.dhhs.nh.gov/oii/hipp.htm">www.dhhs.nh.gov/oii/hipp.htm</a></td>
<td>603-271-5218 or 800-852-3345, ext. 5218</td>
<td></td>
</tr>
<tr>
<td>New Jersey - Medicaid</td>
<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td>609-631-2392</td>
<td></td>
</tr>
<tr>
<td>New Jersey - CHIP</td>
<td><a href="http://www.njfamilycare.org/index.html">www.njfamilycare.org/index.html</a></td>
<td>800-701-0710</td>
<td></td>
</tr>
</tbody>
</table>
### IMPORTANT NOTICES

<table>
<thead>
<tr>
<th>State</th>
<th>Website Information</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORTH DAKOTA - Medicaid</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid">www.nd.gov/dhs/services/medicalserv/medicaid</a></td>
<td>844-854-4824</td>
</tr>
<tr>
<td>OKLAHOMA - Medicaid &amp; CHIP</td>
<td><a href="http://www.insureoklahoma.org">www.insureoklahoma.org</a></td>
<td>888-365-3742</td>
</tr>
<tr>
<td>RHODE ISLAND - Medicaid</td>
<td><a href="http://www.eohhs.ri.gov">www.eohhs.ri.gov</a></td>
<td>855-697-4347</td>
</tr>
<tr>
<td>SOUTH CAROLINA - Medicaid</td>
<td><a href="http://www.scdhhs.gov">www.scdhhs.gov</a></td>
<td>888-549-0820</td>
</tr>
<tr>
<td>SOUTH DAKOTA - Medicaid</td>
<td><a href="http://www.dss.sd.gov">www.dss.sd.gov</a></td>
<td>888-828-0059</td>
</tr>
<tr>
<td>TEXAS - Medicaid</td>
<td><a href="http://www.gethipptexas.com">www.gethipptexas.com</a></td>
<td>800-400-0493</td>
</tr>
<tr>
<td>VERMONT - Medicaid</td>
<td><a href="http://www.greenmountaincare.org">www.greenmountaincare.org</a></td>
<td>800-250-8427</td>
</tr>
<tr>
<td>VIRGINIA - Medicaid</td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>800-432-5924</td>
</tr>
<tr>
<td>VIRGINIA - CHIP</td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>855-242-8282</td>
</tr>
<tr>
<td>WASHINGTON - Medicaid</td>
<td><a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
<td>800-562-3022, ext. 15473</td>
</tr>
<tr>
<td>WEST VIRGINIA - Medicaid</td>
<td><a href="http://www.mywvhipp.com">www.mywvhipp.com</a></td>
<td>855-699-8447</td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

**WOMEN’S HEALTH & CANCER RIGHTS ACT OF 1998**

If you have had, or are going to have, a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: a $250 Individual Deductible and either 0% or 20% coinsurance depending on which payment option is selected. If you would like more information on WHCRA benefits, contact Yuchao Wang 609.734.8243.

**IMPORTANT INFORMATION REGARDING 1095 FORMS**

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether he/she was covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2021. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

**SPECIAL ENROLLMENT NOTICE**

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent’s or spouse’s employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

**NOTICE OF MATERIAL CHANGE**

The Institute for Advanced Study has amended the medical benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you would like a copy, please submit your request to Human Resources.

**NOTICE OF PRIVACY PRACTICES**

The Institute for Advanced Study is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.
**Expanded Women’s Preventative Care**

In plan years starting with June 1, 2013, the following preventive services will be covered at no cost-sharing under Preventive Services for Women as per the Affordable Care Act.

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well-woman visits</strong></td>
<td>Well-woman preventative care visit annually for adult women to obtain the recommended preventative services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care. This well-woman visit should, where appropriate, include other preventative services listed in this set of guidelines, as well as others referenced in section 2713.</td>
<td>Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventative services, depending on a woman’s health status, health needs, and other risk factors.</td>
</tr>
<tr>
<td><strong>Screening for gestational diabetes</strong></td>
<td>Screening for gestational diabetes</td>
<td>In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.</td>
</tr>
<tr>
<td><strong>Human papillomavirus testing</strong></td>
<td>High-risk human papillomavirus DNA testing in women with normal cytology results</td>
<td>Screening should begin at 30 years of age and should occur no more frequently than every 3 years.</td>
</tr>
<tr>
<td><strong>Counseling for sexually transmitted infections</strong></td>
<td>Counseling on sexually transmitted infections for all sexually active women</td>
<td>Annual.</td>
</tr>
<tr>
<td><strong>Counseling and screening for human immune-deficiency virus</strong></td>
<td>Counseling and screening for human immune-deficiency virus infection for all sexually active women</td>
<td>Annual.</td>
</tr>
<tr>
<td><strong>Contraceptive methods and counseling</strong></td>
<td>All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity</td>
<td>As prescribed.</td>
</tr>
<tr>
<td><strong>Breastfeeding support, supplies, and Counseling</strong></td>
<td>Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment</td>
<td>In conjunction with each birth.</td>
</tr>
<tr>
<td><strong>Screening and counseling for interpersonal and domestic violence</strong></td>
<td>Screening and counseling for interpersonal and domestic violence</td>
<td></td>
</tr>
</tbody>
</table>
INITIAL COBRA NOTICE

Introduction
You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your hours of employment are reduced, or
• Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your spouse dies;
• Your spouse’s hours of employment are reduced;
• Your spouse’s employment ends for any reason other than his or her gross misconduct;
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
• The parent-employee dies;
• The parent-employee’s hours of employment are reduced;
• The parent-employee’s employment ends for any reason other than his or her gross misconduct;
• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the Plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Institute for Advanced Study and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
• The end of employment or reduction of hours of employment;
• Death of the employee;
IMPORTANT NOTICES

- Commencement of a proceeding in bankruptcy with respect to the employer;
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: Yuchao Wang, 609.734.8243.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event.

This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage.

If you have questions -

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes -

To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information -

Yuchao Wang
609.734.8243
ywang@ias.edu

This notice is intended as a brief outline; please see HR for more information.
SAMPLE STATEMENT REGARDING INSTITUTE FOR ADVANCED STUDY GROUP HEALTH & WELFARE PLAN
ELECTRONIC DISCLOSURES

As an individual entitled to receive benefits under the Institute for Advanced Study Group Health & Welfare Plan (the “Plan”), you also have the right to be provided with specific documents required by ERISA. We intend to provide the following documents to you via electronic delivery as described below:

- Summary Benefits of Coverage
- Summary Plan Description
- Summary Annual Report

any documents required to be furnished under ERISA Section 104(b)(4) on request by a participant or beneficiary of the Plan or made available under ERISA Section 104(b)(2)

Description of Electronic Delivery Method

We will provide these required documents to you as attachments to an e-mail which we will send to the e-mail address you specify. The attachment will be in Microsoft Word. In order to access the email and attachment you must have:

- A computer with internet access
- A program installed on that computer which allows you receive and send e-mails (such as Google Chrome, Internet Explorer, etc.)
- If you have regular access to a computer as part of your job and have been issued a company email address we will send the information to your company email address as the default.
- The application program Microsoft Word 2016 or higher (or a Microsoft Word reader application) that allows you to open and review the attached document

In order to keep a copy of the email and attached document you must be able to either print a copy on a printer attached to your computer or save a copy in electronic form to your computer hard drive or on a backup system external to your computer (for example, a flash drive).

If any of these requirements change in a way that creates a meaningful possibility that you may no longer be able to access and save electronically transmitted documents, we will provide you with notice and you will be required to provide another consent to receive documents electronically.

What You Must Do: To receive documents electronically, you must do the following:

- Return the enclosed consent form by sending an email to ywang@ias.edu with a subject line that says Consent for Electronic Disclosure and includes the full text of the consent language included below.
- Provide us with your preferred email address for receiving electronic documents. It is your responsibility to keep your preferred email address up to date. Please note that if you use a spam filter that blocks or re-routes emails from senders not listed in your email address book, you must add the Company to your email address book so that you will be able to receive the communications we send to you. If your preferred email address changes, you must notify us by sending an email to ywang@ias.edu with a subject line that says Change in Email for Electronic Disclosure.
Withdrawing Your Consent

You can withdraw your consent at any time by sending an email to ywang@ias.edu with a subject line that says Withdrawal of Consent for Electronic Disclosure and includes your full name, address, and phone number.

You Have a Right to Receive a Paper Copy

You have the right to request and receive a paper version of any of the electronically transmitted required documents at no charge. To make this request, please contact Yuchao Wang at 609.734.8243, ywang@ias.edu to request a paper copy.

Consent to Receive Electronic Plan Disclosures

I have read and understood the Statement Regarding Institute for Advanced Study Group Health & Welfare Plan Electronic Disclosures and consent to receive the types of documents described in that statement electronically, at the following email address:

[EMPLOYEE SHOULD INSERT PREFERRED EMAIL ADDRESS HERE]

I understand that if my email address changes, it is my responsibility to notify Yuchao Wang by sending a message to ywang@ias.edu.

I am confirming that I am able to receive, open, and print or download a copy of any of the disclosures referenced in the statement and that I understand I will receive these documents only in electronic form unless I specifically request a paper copy or withdraw my consent.

I understand that I can withdraw my consent at any time by sending an email message to ywang@ias.edu with a subject line that says Withdrawal of Consent for Electronic Disclosure and includes my full name, address, and phone number.
MARKETPLACE COVERAGE OPTIONS

PART A: General Information

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

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

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

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Institute for Advanced Study HR department.

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

1 An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit cost covered by the plan is no less than 60% of such costs.
MARKETPLACE COVERAGE OPTIONS (CONT.)

PART B: Information About Health Coverage Offered By Your Employer

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

<table>
<thead>
<tr>
<th>Employer Name:</th>
<th>Employer Identification Number (EIN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institute for Advanced Study</td>
<td>21-0634988</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer Address:</th>
<th>Employer Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Einstein Drive, Princeton, NJ</td>
<td>609.734.8000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who can we contact about employee health coverage at this job?</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yuchao Wang</td>
<td>609.734.8243</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Email Address:</th>
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</thead>
<tbody>
<tr>
<td><a href="mailto:ywang@ias.edu">ywang@ias.edu</a></td>
</tr>
</tbody>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  
  All employees. Eligible employees are:
  
  - Full time employees, working a minimum 25 per week on a regular basis. Employees will be effective the Date of Hire.
  
  - Some employees. Eligible employees are:

- With respect to dependents:
  
  - We do offer coverage. Eligible dependents are: Spouses, Domestic Partners and Dependent Children
  
  - We do not offer coverage.

  - If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Above is the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
IMPORTANT NOTICES

PAPERWORK REDUCTION ACT STATEMENT

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

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