



COLUMBIA UNIVERSITY

HR Benefits

Federal regulations require employers to provide employees with specific information (“notices”) concerning their rights and responsibilities under a benefits program on an annual basis. These notices cover a variety of topics and may not apply to everyone.

Please review the following information carefully and keep for future reference. If you have any questions on this material, please contact the Columbia Benefits Service Center:

615 West 131st Street, 4th floor, MC 8703, New York, NY 10027
Phone at 212-851-7000
Or email at hrbenefits@columbia.edu.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage.

Please see page 23 for more details.

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under the Columbia University Group Benefits Plan (the Plan). This notice contains important information about your right to continue your healthcare coverage in the Columbia University Group Medical Benefits, as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.healthcare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice before you make your decision. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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, the Health and Welfare Administrative Committee. You can reach the Plan Administrator at Benefits Service Center | 615 W. 131st Street, 4th Floor, MC 8703, New York, NY 10027. Notwithstanding the foregoing, the COBRA Administrator, BenefitConnect, is responsible for COBRA questions and administration.

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 coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or same-sex domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse or same-sex domestic partner dies;
- Your spouse's or same-sex domestic partner's hours of employment are reduced;
- Your spouse's or same-sex domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse or same-sex domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); **or**
- You become divorced or legally separated from your spouse, or your domestic partnership ends.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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."

Please note, a parent or legal guardian (regardless of whether they are a qualified beneficiary) may elect COBRA continuation coverage on behalf of a minor child, as applicable. Furthermore, because COBRA gives each qualifying beneficiary the right to elect coverage independently, an employee, a spouse or a dependent child(ren), if any, may elect single coverage and not include those individuals who do not wish to continue coverage. However, an employee may not decline coverage on behalf of a spouse or non-minor 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 under title 11 of the United States Code with respect to Columbia University, 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 and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA 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; or
- Death of the employee.

For retiree coverage, the employer must also notify the Plan Administrator of the following qualifying events:

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), 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. You can learn more about many of these options at www.healthcare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

You Must Give Notice of Some Qualifying Events

For the 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 60 days after the qualifying event occurs. You must provide this notice to the COBRA Administrator:

BenefitConnect | COBRA
DEPT: COBRA
PO BOX 981915
EL PASO, TX 79998
877-292-6272

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

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. You must provide written proof of the disability to BenefitConnect, DEPT: COBRA, PO BOX 981915, EL PASO, TX 79998, within 60 days of receiving a Social Security disability determination, and before the end of the 18-month period of 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. The extension due to a second qualifying event is available only if you provide notice to BenefitConnect, DEPT: COBRA, PO BOX 981915, EL PASO, TX 79998 within 60 days after the date of the second qualifying event.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. **Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.**

For more information visit www.medicare.gov/medicare-and-you.

You May Be Able to Get Coverage Through the Health Insurance Marketplace That Costs Less Than COBRA Continuation Coverage.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-costs coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

¹ www.medicare.gov/sign-up-change.plans/how-do-i-get-parts-a-b/part-b-sign-up-periods.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” Be careful, though — if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be able to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

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.

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

Plan Contact Information

This Notice does not fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available from the Plan Administrator.

Contact the Plan's COBRA Administrator using the below contact information if you have any questions regarding COBRA continuation coverage or your Plan.

BenefitConnect | COBRA
DEPT: COBRA
PO BOX 981915
EL PASO, TX 79998
877-292-6272

NOTICE REGARDING WELLNESS PROGRAM

The Columbia University wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be given the opportunity to complete a voluntary biometric screening, which will include a finger prick blood test for glucose, cholesterol, BMI, and blood pressure. You are not required to participate in the blood test or other medical examinations.

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Columbia University may use aggregate information it collects to design a program based on identified health risks in the workplace, neither the wellness program or its partners will disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives

your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is United Healthcare and its partners in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the plan administrator by calling the Columbia Benefit Service Center at 212-851-7000.

HIPAA PRIVACY NOTICE TO EMPLOYEES

OVERVIEW

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.

Columbia University (“Columbia”) is committed to maintaining the confidentiality of your private medical information. This notice is provided to you in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Recovery and Reinvestment Act of 2009 and accompanying regulations (the “Privacy Rule”). It describes the legal obligations of the group health plans maintained by Columbia under the Columbia University Group Benefits Plan regarding your health information. (The health plan is referred to in this notice as “we,” “our,” “us” or the “Covered Entity”.) The Privacy Rule requires that the Plan use and disclose your health information only as described in this notice. This notice only applies to health-related information received by or on behalf of the Covered Entity benefit programs listed below.

This notice applies to Columbia employees, former employees, and dependents who participate in any of the following benefit programs under the Covered Entity:

- Medical benefits
- Dental benefits
- Vision benefits
- Health care spending account program
- Employee Assistance Program

The Covered Entity’s actions and obligations are undertaken by Columbia employees as well as the third parties who perform services for the Covered Entity. However, Columbia employees perform only limited Covered Entity functions – most Covered Entity administrative functions are performed by third party service providers.

Protected Information

Federal law requires us to have a special policy for safeguarding certain of medical information called “protected health information.” Protected Health Information (PHI) is health information (including genetic information)

received or created in the course of administering the Covered Entity, that can be used to identify you and that relates to:

- your physical or mental health condition,
- the provision of health care to you, or
- payment for your health care.

Your medical and dental records, your claims for medical and dental benefits, and the explanation of benefits (EOB) sent in connection with payment of your claims are all examples of PHI.

If Columbia obtains your health information in another way – for example, if you are hurt in a work accident or if you provide medical records with your request for Family and Medical Leave Act (FMLA) absence--then Columbia will safeguard that information in accordance with other applicable laws, but such information is not considered PHI subject to this notice. Similarly, health information obtained by a non-health-related benefits program, such as the long-term disability program or accidental death and dismemberment program, is not protected under this notice. This notice does not apply in those situations because the health information is not received or created in connection with the Covered Entity.

Notice Regarding Substance Use Disorder (SUD) Records Confidentiality

If Columbia receives or maintains records related to diagnosis, treatment, or referral for treatment of a substance use disorder from a federally assisted program, those records are protected under federal law (42 CFR Part 2). These regulations impose strict limitations on the use and disclosure of such information. The Plan will not disclose any SUD-related information without your written consent, except as expressly permitted by law. Additional restrictions and rights apply under these rules, which are separate from HIPAA. For more information, contact the Plan's Privacy Officer.

The remainder of this notice generally describes our rules with respect to your PHI received or created by the Covered Entity.

Your Rights

When it comes to your PHI, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or obtain a copy of your health and claims records and other PHI we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain PHI for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we have shared PHI

- You can ask for a list of the times we’ve shared your PHI for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one report of this information each year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical or general power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint or use your PHI for employment purposes without your authorization.

Your Choices

For certain PHI, you can tell us your choices about what we share. If you have a clear preference for how we share your PHI in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share PHI with your family, close friends, or others involved in payment for your care
- Share PHI in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your PHI if we believe it is in your best interest. We may also share your PHI when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your PHI unless you give us written permission:

- Marketing purposes
- Sale of your PHI

Our Uses and Disclosures

We typically use or share your PHI in the following ways.

Help manage the health care treatment you receive

We may use your PHI and share it with professionals who are treating you.

Example: We might disclose PHI about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

Operate the Covered Entity

- We may use and disclose your PHI for Covered Entity operations. These uses and disclosures are necessary to run the Covered Entity.
- We may use medical information in connection with conducting quality assessment and improvement activities; enrollment, premium rating, and other activities relating to Covered Entity coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Covered Entity administrative activities.
- In no event will we use or disclose PHI that is genetic information for underwriting purposes. In addition to rating and pricing a group insurance policy, this means the Covered Entity may not use genetic information (including information requested or collected in a health risk assessment or wellness program) for setting deductibles or other cost sharing mechanisms, determining premiums or other contribution amounts, or applying preexisting condition exclusions.

Example: We may use your claims data to alert you to an available case management program if you become pregnant or are diagnosed with diabetes or liver failure. We may also disclose your PHI to another health plan or health care provider who has a relationship with you for their operations activities if the disclosure is for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.

Pay for your health services

We may use and disclose your PHI as we pay for your health services.

Example: We may exchange your PHI with your spouse's health plan for coordination of benefits purposes.

Administer your plan

We may disclose your PHI to Columbia, as the Covered Entity sponsor, for plan administration.

Example: If you elect to pay for your health coverage through salary reduction, we may disclose your enrollment information to Columbia, the Covered Entity sponsor, so that Columbia knows the amount to withhold from your paycheck.

Other ways we may use or share your PHI

We are allowed or required to share your PHI in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your PHI for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share PHI about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share a “limited data set” of your PHI for certain health research.

Comply with the law

We will share PHI about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share PHI about you with organ procurement organizations.
- We can share PHI with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

We can use or share PHI about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share PHI about you in response to a court or administrative order, or in response to a subpoena.

Communicate with service providers

We may enter into agreements with entities or individuals to provide services (for example, claims processing services) to the Covered Entity. These service providers, called “business associates,” may create, receive, have access to, use, and/or disclose (including to other business associates) PHI in conjunction with the services they provide to the Covered Entity, provided that we have obtained satisfactory written assurances that the business associates will comply with all applicable Privacy Rules.

Our Responsibilities

- We are required by law to maintain the privacy and security of your PHI.
- The Covered Entity must notify you within 60 days of discovery of a breach. A breach occurs if unsecured PHI is acquired, used or disclosed in a manner that is impermissible under the Privacy Rules, unless there is a low probability that the PHI has been compromised.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your PHI other than as described here unless you provide written authorization. If you authorize use or sharing, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will provide a copy to you.

No Guarantee of Employment

For purposes of Columbia employees, this notice does not create any right to employment for any individual, nor does it change Columbia’s right to discharge any of its employees at any time, with or without cause.

No Change to Covered Entity Benefits

This notice explains your privacy rights as a current or former participant in the Covered Entity. The

Covered Entity is bound by the terms of this notice as they relate to the privacy of your PHI. However, this notice does not change any other rights or obligations you may have under the terms of the governing documents. You should refer to the governing documents for additional information regarding your benefits.

Compliance with State Privacy Laws

State law may further limit the permissible ways the Covered Entity uses or discloses your PHI. If an applicable state law imposes stricter restrictions on the Covered Entity, we will comply with that state law.

Revised Date: January 1, 2025

Privacy Officer Contact Information:

Studebaker 4th Floor
615 West 131st Street, MC 8703
New York, NY 10027
(212) 851-7026
hrprivoff@columbla.edu

Women’s Health and Cancer Rights Act (WHCRA)

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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator at Columbia Benefit Service Center at 212-851-7000 or UHC Member Services at 800-232-9357.

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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid

<p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442</p>	<p>Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/df/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP

<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid

Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP

Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services

Employee Benefits Security Administration Centers for Medicare & Medicaid Services

www.dol.gov/agencies/ebsa www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Limited Changes During the Year — Qualified Life Status Changes

The IRS restricts when you can add coverage for a dependent or make changes to your healthcare benefits and Flexible Spending Account (FSA) elections during the year.

After new hire initial enrollment, or after annual Benefits Open Enrollment, you will only be able to change most benefits for the remainder of the calendar year if you experience a Qualified Life Status Change.

Examples of a Qualified Life Status Change include:

- Marriage, divorce or the beginning or end of a same-sex domestic partnership;
- Birth, adoption or placement for adoption or foster care;
- Death of a dependent (spouse, same-sex domestic partner, child);
- A dependent losing eligibility for coverage, such as a child reaching maximum age; or losing coverage under another plan, such as a spouse/partner losing coverage from his or her employer;
- A spouse or eligible dependent being called to military duty in the U.S. Armed Forces;
- Job promotions and/or transfers that change the benefit offerings.

If you experience a Qualified Life Status Change, you must go to www.hr.columbia.edu/benefits and make your changes within 31 days of the event.

If you need assistance, please contact the Columbia Benefits Service Center at **212-851-7000** and a specialist will help you with your changes. Please remember that, because these benefits must comply with IRS regulations, you must provide proper documentation for your change, such as a birth certificate, marriage certificate or divorce decree. Your benefit changes must be consistent with the nature of your Qualified Life Status Change. If you have Qualified Life Status Changes after mid-November, you may not be able to make changes to certain benefits for the remainder of the current calendar year. For more information and a list of the qualified life status change events that will allow you to make election changes to the group health plan is included in Columbia University Summary Plan Descriptions.

Federal regulations also provide for HIPAA special enrollment rights that allow an employee to enroll in coverage under the group health plan if an employee experiences certain life events. Please see the HIPAA Special Enrollment section below.

HIPAA Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for

adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 31-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact the Columbia Benefits Service Center at 212-851-7000.

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act prohibits health coverage discrimination and employment discrimination against employees based on their (or their family members') genetic information.

Genetic information includes:

- Your family medical history
- The results of your or your family member's genetic tests;
- The request for, or receipt of, genetic counseling or other genetic services by you or your family members
- The manifestation of a disease or disorder in an individual's family member; and
- The genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

The availability of genetic testing and results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, genetic information collected about family history, such as through a Health Risk evaluation, will be treated as confidential, as required by HIPAA and GINA.

The Columbia University in the City of New York Group Benefits Plan ("Plan") will not discriminate on the basis of genetic information. This means that the Plan will not adjust premiums for an employer or any group of similarly situated individuals under the Plan, on the basis of genetic information.

The Plan will not request or require you or your family member to undergo a genetic test. However, your Physician may obtain and use information about the results of a genetic test. The Plan may also obtain such information to the extent required in making a determination regarding payment (e.g., where payment is made only as to Medically Necessary treatment and the results of a genetic test are necessary to determine the Medical Necessity of the

services provided). In some circumstances the Plan may obtain or request genetic information for research purposes (if required by a state for the protection of individuals) or as part of your or your family member's voluntary participation in a research study.

The Plan will not collect genetic information for underwriting purposes, which includes (A) determination of, eligibility (including enrollment and continued eligibility) for benefits under the Plan or coverage (including changes in Deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); (B) the computation of premiums under the Plan or coverage (including discounts in return for activities such as completing a health risk assessment or participating in a wellness program); (C) the application of any preexisting condition exclusion under the Plan or coverage; and (D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. However, if the Plan conditions the benefit based on its medical appropriateness, which depends on the genetic information, the Plan is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness.

The Plan will not collect genetic information with respect to any individual prior to that individual's effective date of coverage under that plan, nor in connection with the rules for eligibility that apply to that individual. For more information on genetic information protection and nondiscrimination, contact the Plan Administrator at:

Columbia Benefits Service Center
615 W. 131st Street, 4th Floor, MC
8703 New York, NY 10027
Telephone: 212-851 7000
email: hrbenefits@columbia.edu

Creditable Coverage Disclosure Notice

Medicare Prescription Drug Coverage for Medicare-Eligible Active Employees and Medicare-Eligible Retirees (or Covered Medicare-Eligible Dependents) of Columbia University

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Columbia University and your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription 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.

What This Means to You as an Employee or Retiree of Columbia University

As an employee or retiree of Columbia University (or covered dependent) eligible for Medicare, you should keep the following points in mind as you consider whether to enroll in a Medicare Prescription Drug Plan:

Medicare prescription drug coverage was designed primarily for those who do not have access to employer-sponsored 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.

If you are enrolled in a Columbia University medical plan, you are already covered by prescription drug coverage that 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 Prescription Drug Plan.

Should You Have Columbia University Prescription Drug Coverage and Medicare Prescription Drug Coverage?

In most circumstances, there is no advantage to “doubling up” on coverage. If you join a Medicare Prescription Drug Plan, you will continue to receive your medical and prescription benefits through Columbia University. However, the amount you pay for your Columbia University coverage, where applicable, will not be reduced, and you may pay a separate premium for Medicare prescription drug coverage.

Since your benefits under the Columbia University active medical plan will be primary, it is unlikely you will receive much benefit, if any, from Medicare. In addition, your benefits under the Columbia University retiree medical plan will be secondary to Medicare, and your Columbia University medical plan prescription drug benefits will be reduced by benefits paid under the Medicare Prescription Drug Plan.

When Can You Join a Medicare Prescription Drug Coverage Plan?

You can join a Medicare Prescription Drug Plan when you first become eligible for Medicare and each year from October 15-December 7. You may also enroll when you first become Medicare eligible or after separating employment with the University if you are age 65 or older.

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

What Happens If You Terminate Your Columbia University Health Coverage or Employment?

If you drop or lose your Columbia University health coverage (for example, you do not pay a required premium) and you do not join a Medicare Prescription Drug Plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan in the future.

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.

If you choose to drop your coverage as an active employee under the Columbia University in The City of New York Group Benefits Plan in order to enroll in a Medicare prescription drug plan, you will not be able to re-enroll in a Columbia University medical plan until the next Open Enrollment period unless you have a Qualified Life Status Change. If you choose to drop your coverage as a retiree under the Columbia University Retiree Medical and Life Insurance Benefits Plan, you will not be able to re-enroll in the retiree plan.

For More Information about Medicare's 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.

- Visit www.medicare.gov for personalized help
- Call 800-MEDICARE (800-633-4227; TTY users should call 877-486-2048)
- 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.

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

About This Notice

This notice, as required by Law, contains important details about how your prescription drug coverage through the Columbia University in The City of New York Group Benefits Plan and the Columbia University Retiree Medical and Life Insurance Benefits Plan compares to Medicare prescription drug coverage available in 2025.

Please read this notice carefully and keep it for future reference. You'll receive this notice each year.

You may need to refer to this information in the future. If you enrolled in a Medicare Prescription Drug Plan after May 15, 2006, you may need to provide a copy of this notice to show that you do not have to pay a higher premium for Medicare prescription drug coverage. You are not required to pay more since you have had Creditable Coverage (or coverage that is at least as good as the standard Medicare prescription drug benefit) through a Columbia University medical plan.

You may receive information about creditable coverage through Columbia University at other times in the future, such as the next period you can enroll in Medicare prescription drug coverage and/or if your Columbia University prescription drug coverage changes. You may also request another copy of this information by calling the Columbia Benefits Service Center at **212-851-7000** or via email at hrbenefits@columbia.edu.

Columbia University reserves the right to change, amend, or terminate any benefit plan as it deems appropriate. This notice in no way guarantees or implies that Columbia University's retiree medical plans will continue into the future, nor does it guarantee or imply that the coverage and/or costs will remain the same.