



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 at 212-851-7000 or hrbenefits@columbia.edu.

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.

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 or same-sex domestic partner, 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."

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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation there may be other more affordable 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.

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 loss of 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:

BenefitConnect | COBRA
P. O. Box 919501
San Diego, CA 92191-9863
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 two ways in which this 18-month period of COBRA continuation coverage can be extended.

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-cost 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.

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.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. You must provide written proof of the disability to BenefitConnect | COBRA at P.O. Box 919501, San Diego, CA 92191-9863, 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 while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving 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, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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
P. O. Box 919501
San Diego, CA 92191-9863
877-292-6272

For more information about health insurance options available through the Health Insurance Marketplace, and to locate an Employee Benefits Security Administrator in your area who can talk to you about the different options, visit www.healthcare.gov.

Health Insurance Portability & Accountability Act (HIPAA)

Notice of Privacy Practices for Protected Health Information

With the growth of information technology, the protection of private medical information has become a national concern. Congress addressed these concerns with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), whose privacy provisions, applicable to all health plan providers, went into effect on April 14, 2003.

Disclosure Limitations

The Federal Health Insurance Portability and Accountability Act and related privacy rules require Columbia University in The City of New York to keep your health information private. The Columbia University Health Plan, which includes UnitedHealthcare Health Savings Plan (HSP), with its Health Savings Account (HSA), UnitedHealthcare Choice Plus, Cigna International, Express Scripts Rx, the Aetna Columbia Dental Plan and the UnitedHealthcare Flexible Spending Account – has always maintained the strictest privacy and confidentiality standards in the use and handling of your health insurance information.

Under HIPAA, health plan providers and designated Columbia University Human Resources employees can only disclose your protected health information for a limited number of purposes:

- To make or obtain payments
- To conduct healthcare operations
- To recommend treatment alternatives
- To provide information about health-related benefits and services
- To communicate with an individual—that is, a friend or family member—involved in your care or the payment for your care (if authorized by you)
- To comply with a federal, state or local requirement
- To comply with a court order or administrative proceeding
- To conduct health oversight activities
- To counter serious threats to your health or safety
- For law-enforcement purposes
- For specified government functions
- For worker's compensation
- To disclose your information to you
- To third party non-Columbia business associates that perform services for us or on our behalf, such as vendors
- To a medical examiner for the purpose of identifying a deceased person, determining the cause of death or other duties
- authorized by law
- To use or disclose your private health information to assist entities engaged in the procurement, or transplantation of cadaver organs, eyes or tissue

Otherwise, neither the health plan providers nor Columbia University Human Resources can disclose information about your or your dependents' health insurance, dental insurance, prescription drug coverage, healthcare FSA, HSA or medical plan enrollment with anyone other than the covered individual. This includes:

- Other offices of the University, as well as employees in Columbia Human Resources not involved in health plan administration
- Spouses or other family members not directly involved in your care or the payment for your care (unless authorized by you)

Your rights regarding your health information include:

- The right to request restrictions beyond those outlined above
- The right to receive confidential communications (for example) at only a specified phone number or email address
- The right to inspect and copy your private health information
- The right to be notified in the event the plan (or a business associate) discovered a breach of unsecured protected health information
- The right to prohibit the use of genetic information for underwriting purposes, except for underwriting for long-term care policies
- The right to a paper copy of the Notice of Columbia University Health Plan's Privacy Practices, sent to all Columbia employees on April 14, 2003, distributed to all subsequent new hires and available on the web at **www.hr.columbia.edu/benefits**.

Privacy Officer

To exercise your HIPAA rights under Columbia Health plans, please contact Columbia's designated Privacy Officer at:

Privacy Officer
Columbia Benefits
Studebaker 4th Floor, MC 8705
615 West 131st Street
New York, NY 10027
Email: **hrprivoff@columbia.edu**
Secure Fax: **212-851-7025**

OR

The Federal Secretary of the Department of
Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW (South West)
Washington, DC 20201

Authorization Forms

For HIPAA authorization forms, please visit the HR website at **<http://hr.columbia.edu/forms-docs/forms>**.

If You Have Questions

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) 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 the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Women's Health and Cancer Rights Act (WHCRA)

As required by the Women's Health and Cancer Rights Act of 1998, Columbia's medical plans provide benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Call UHC Member Services at 800-232-9357card for more information.

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, 2015. Contact your state for more information on eligibility:

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	INDIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	KANSAS – Medicaid
Website: https://www.flmedicaidprecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid

Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	OREGON – Medicaid
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP

Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
OMB Control Number 1210-0137
(expires 10/31/2016)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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 benefits 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 benefits 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.

Creditable Coverage Disclosure Notice

Medicare Prescription Drug Coverage for Active Employees over Age 65 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 active Columbia 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 19 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 November to join.

If you choose to drop your University-sponsored health coverage 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.

For More Information about Medicare's Prescription Drug Coverage:

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

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 Retiree Medical and Life Insurance Benefits Plan compares to Medicare prescription drug coverage available in 2015. Please read this notice carefully and keep it for future reference.

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 in the future.

Notices Required Under the Patient Protection and Affordable Care Act of 2010

Lifetime Limits Repealed

The lifetime limit on the dollar value of benefits under the Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to enroll in the Plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Plan Administrator at 212-851-7000.

Annual Dollar Limits

In accordance with applicable law, the annual dollar limits (except to the extent they exceed \$750,000 in 2011) set forth in this booklet shall not apply to “essential health benefits,” as such term is defined under Section 1302(b) of the Patient Protection and Affordable Care Act of 2010 or any regulations related thereto. For this purpose, a determination as to whether a benefit constitutes an “essential health benefit” shall be based on a good faith interpretation by the Plan Administrator of the applicable guidance available as of the date on which the determination is made.

Dependent Coverage to Age 26

Effective January 1, 2011, you may enroll your child who has not attained age 26 in the Plan without regard to your child’s financial dependency, residency or student status.

Prohibition on Pre-Existing Condition Exclusion

Beginning on September 23, 2010, children under the age of 19 cannot be denied from coverage based on pre-existing conditions, and for all other individuals beginning with the first plan year on or after January 1, 2014.

Administrative Legal Notices

Subject to the eligibility requirements of the applicable benefits options, an individual whose coverage ended, or who was denied coverage (or was not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 is eligible to be enrolled or reenrolled in the Plan if currently under the age of 26, unless the individual is eligible to enroll in other employer-provided group health coverage (other than coverage through a plan of the other parent’s employer). However, you must request the enrollment or reenrollment of your child who meets these criteria within 30 days of this notice. Enrollment will be effective January 1, 2011. For more information contact the Plan Administrator at 212-851-7000.

Over The Counter (OTC) Notice

Effective January 1, 2011, expenses for non-prescription drugs that constitute “medical care” under Section 213 of the Code (i.e., over-the-counter drugs) are not eligible for reimbursement from your flexible savings account.

Prohibition on Rescission of Coverage

Rescission is cancellation or discontinuance of coverage that applies retroactively. For plan years starting on or after September 23, 2010, once an enrollee is covered under a group health plan, rescinding the enrollee’s

coverage is prohibited unless the enrollee (or a person seeking coverage on the enrollee's behalf) has engaged in fraud or made an intentional misrepresentation of material fact.

Healthcare Flexible Spending Accounts

Effective for plan years beginning after Dec. 31, 2012, ACA limits the amount of salary reduction contributions to healthcare FSAs to \$2,500 per year, indexed by CPI for subsequent years.

Women's Health Coverage

ACA has expanded the benefits that must be covered at 100% to women who use in-network health care, including:

- Screening for gestational diabetes.
- Counseling and screening for Human Immunodeficiency Virus (HIV).
- Contraceptive methods: all FDA-approved implantable medical devices, female sterilization procedures and patient education and counseling for women with reproductive capacity.
- Breastfeeding support, supplies and counseling.
- W-2 Reporting: the cost of your healthcare coverage will now be included on your W-2 for the 2012 tax year and each year, thereafter. It is for reporting purposes only.

Health Plan Administration

Uniform Summary of Benefits and Coverage. All non-grandfathered and grandfathered health plans must provide a uniform summary of the Plan's benefits and coverage to participants. The summary must be written in easily understood language and is limited to four double-sided pages. Any mid-year changes to the information contained in the summary must be provided to participants 60 days in advance. ACA indicated that plans would be required to start providing the summary by March 23, 2012, but this deadline was pushed back.

Plans and issuers must start providing the summary by the following deadlines:

- Issuers must provide the summary to health plans effective Sept. 23, 2012;

Plans and issuers must provide the summary to participants and beneficiaries who enroll or re-enroll during an Open Enrollment period starting with the first day of the first Open Enrollment period that begins on or after September 23, 2012;

- Plans and issuers must provide the summary to participants who enroll for coverage other than through an Open Enrollment period (for example, newly eligible individuals and special enrollees) starting with the first day of the first plan year that begins on or after September 23, 2012.
- Reporting Health Coverage Costs on Form W-2. ACA requires employers to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2. This requirement was effective, but optional, for the 2011 tax year and is mandatory for later years for most employers. This requirement is optional for small employers (those filing fewer than 250 Form W-2s) at least for the 2012 tax year and will remain optional until further guidance is issued. Employers that file at least 250 Forms W-2 must comply with this reporting requirement for 2012 (for W-2 Forms that must be issued by the end of January 2013) and future years.

- **Medical Loss Ratio Rebates.** Sponsors of fully insured plans will receive rebates by August 1, 2012 if they qualify for a rebate from their health insurance issuers due to the medical loss ratio (MLR) rules. The MLR rules require insurance companies to spend a certain percentage of premium dollars on medical care and health care quality improvement, rather than administrative costs. Any portion of a rebate that is a plan asset must be used for the exclusive benefit of the plan's participants and beneficiaries. This may include, for example, reducing participants' premium payments.
- **Employee Notice of Exchanges.** By March 1, 2013, employers must provide a notice to employees regarding the availability of the health care reform insurance exchanges. HHS has indicated that it plans on issuing model exchange notices in the future for employers to use.

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:

- You 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; and
- The manifestation of a disease or disorder in an individual's family member.

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 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:

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