



Compliance Notices

Colgate University

Effective Date:

January 1, 2021



General Notice of COBRA Continuation Coverage Rights

Group Health Benefits Plan

Plan Administrator: Colgate University

Street Address: 13 Oak Drive

City, ST Zip: Hamilton, New York 13346

NOTE: All notifications should be sent to the Plan Administrator at the address noted above.

Date: January 1, 2021

Introduction

You are receiving this notice because you became eligible or are covered under one or more of the plan sponsored health plans (the "Plan").

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **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.** This notice gives only a summary of your COBRA continuation coverage rights. Please note that the Plan Administrator maintains procedures for administering COBRA. For more information about the rights, obligations and procedures under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan document from the Plan Administrator.

You may have other options available to you when you lose group health coverage

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premium 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. Some of these options may cost less than COBRA. You can learn more about these options at **www.HealthCare.gov**.

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. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. 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 will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because of any of the qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

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

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

A child who is born or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Plan Administrator of the birth or adoption.

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, or entitlement of the employee to Medicare benefits (under Part A, Part B, or both), the employer (Plan Administrator) will notify the COBRA Administrator within 30 days following the date coverage ends.

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. The Plan requires you to notify the Plan Administrator within 60 days after the latter of; (1) the date the qualifying event occurs or; (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the qualifying event.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either; (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost.

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.

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 (the "SSA") to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the SSA's determination within 60 days of the later of: (a) the date of the SSA determination; (b) the date of the qualifying event; or (c) the date you would otherwise lose coverage under the Plan. In addition, such notice must be given before the end of the 18-month period of COBRA continuation coverage.

Note that you must make sure that the Plan Administrator is notified within 30 days of the date of the SSA's determination that any such member of your family is no longer disabled, and disability extension coverage will terminate upon such determination.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or the former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if a 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. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

Furnishing Notice To Plan Administrator

You should follow these procedures when notifying the plan administrator of a qualifying event or a disability determination. Failure to follow these procedures may cause loss of coverage.

When furnishing a notice to the Plan Administrator with respect to the occurrence of a qualifying event or with respect to a disability determination by the Social Security Administration, such notices will be delivered to the Human Resources department of the Plan Administrator (i) by hand-delivery, (ii) via facsimile, followed by written confirmation by first class mail, or (iii) by registered or certified mail, return receipt requested. Such notices will include the name(s) of the covered employee and/or qualified beneficiaries, as applicable, a general description of, and circumstances surrounding, the qualifying event or disability determination, and the date of such qualifying event or disability determination. Once the Plan Administrator receives such notice, it reserves the right to make further inquiry to verify the circumstances surrounding such qualifying event or disability determination.

Early Termination of COBRA Coverage

COBRA continuation coverage may terminate early if:

The required premium payment is not paid when due;

You and your spouse or dependent child(ren), if any, become covered under another group health plan after the date COBRA coverage is elected that does not contain any exclusion or limitation for any of your preexisting conditions;

You, your spouse or dependent child(ren), if any, become entitled to Medicare benefits (under Part A, Part B or both) after the date COBRA coverage is elected;

All of Plan Administrator's group health plans are terminated; or

If coverage is extended to 29-months due to disability, a determination that the individual is no longer disabled.

Note: Federal law requires that the individual inform the Plan Administrator of any final determination that he or she is no longer disabled within 30 days of such a determination.

Note: If the qualifying event or subsequent qualifying event is a disability and the individual is later determined not to be disabled. COBRA continuation coverage will not continue notwithstanding the 36-month extension under New York law described previously.

Note: Continuation coverage under COBRA is provided subject to your eligibility. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. HIPAA coordinates COBRA's other coverage cut-off rules with these new limits as follows. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the plan's pre-existing condition rule does not apply to you by reason of HIPAA's restriction on pre-existing condition clauses, the Plan may terminate your COBRA coverage. HIPAA allows individuals to pay for their COBRA premiums from withdrawals from an Individual Retirement Account (IRA). Withdrawals may be made penalty free (usually 10%) for medical insurance if the individual has received unemployment compensation under federal or state law for at least twelve (12) weeks. This provision only eliminates the 10% penalty fee and not the standard income tax.

How can you elect continuation coverage?

Each qualified beneficiary has 60-days from either (1) the date coverage is lost under the Plan or (2) the date they are notified of their right to elect continuation coverage, whichever is later, to respond informing the Plan Administrator that they want to elect continuation coverage. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the election notice. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. **There is no extension of the election period.**

If an employee, spouse or dependent chooses continuation coverage and pays the applicable premium within the time period specified in the qualifying event notice, the Plan Administrator is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated active employees or family members. If Plan Administrator changes or ends group health coverage for similarly situated active employees, your coverage will also change or end.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Qualified beneficiaries do not have to show that they are insurable in order to choose continuation coverage. But a qualified beneficiary must have been actually covered by the Plan the day before the qualifying event in order to elect COBRA coverage.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

Furnishing Notice To Plan Administrator

You should follow these procedures when notifying the plan administrator of a qualifying event or a disability determination. Failure to follow these procedures may cause loss of coverage.

When furnishing a notice to the Plan Administrator with respect to the occurrence of a qualifying event or with respect to a disability determination by the Social Security Administration, such notices will be delivered to the Human Resources department of the Plan Administrator (i) by hand-delivery, (ii) via facsimile, followed by written confirmation by first class mail, or (iii) by registered or certified mail, return receipt requested. Such notices will include the name(s) of the covered employee and/or qualified beneficiaries, as applicable, a general description of, and circumstances surrounding, the qualifying event or disability determination, and the date of such qualifying event or disability determination. Once the Plan Administrator receives such notice, it reserves the right to make further inquiry to verify the circumstances surrounding such qualifying event or disability determination.

Note: The foregoing description of notice obligations are required to be included in this notice under federal law.

Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage.

If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act of 2002 is also available at www.doleta.gov/tradeact/2002act_index.asp.

[When and how must payment for continuation coverage be made?](#)

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage at the time of your election. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date your election notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the plan administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for periodic payments

Although periodic payments are due on the first day of the month, you will be given a grace period of 30-days to make each periodic payment. Only in the case of mental incapacity is any further extension permitted. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

[Conversion Privileges](#)

At the end of the continuation coverage period, qualified beneficiaries will be allowed the option to enroll in an individual conversion health plan provided under the Plan **if such conversion plan is available**.

[If You Have Questions](#)

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, 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.) For more information about the Marketplace, visit www.HealthCare.gov

Note that the Plan Administrator and its representatives do not have authority to modify the terms of the Plan. Therefore, if the terms of the Plan and a response given to you by the Plan Administrator or its representatives conflict, the Plan document will control.

[Keep Your Plan Informed of Address Changes](#)

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

Notice to The Employee

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes some provisions that may affect the decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The provisions are as follows:

Under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18-months after the qualifying event, subject to various requirements (or any state applicable mandates). Before HIPAA, this 18-month period could be extended for up to 11-months (for a total COBRA coverage of up to 29-months from the initial qualifying event) if an individual was determined by the Social Security Administration, under the Social Security Act, to have been disabled at the time of the qualifying event and if the Plan Administrator was notified of that disability determination within 60-days of the determination and before the end of the original 18-month period.

Note: The foregoing description of the disability extension required to be included in this notice under federal law. However, because the plan is subject to the New York law described in the box above, in all cases under New York law COBRA continuation coverage has been automatically extended to 36 months.

1. Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60-days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements in a timely fashion.
2. A child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan(s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.
3. HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations.
4. If you were covered by a group health plan(s) prior to your employment with us, your previous employer's insurance carrier should have provided you with a Certificate of Creditable Coverage, a form required by the HIPAA law that describes the health coverage you and your dependents, if any, have or had, and the dates you were covered. **If you have not received a Certificate of Creditable Coverage and are entitled to one, please contact your former employer.** Once you deliver the Certificate of Creditable Coverage to us, you are exempt from any pre-existing condition exclusions in our group health plan(s), provided you had 12- months of creditable coverage (18-months, if late enrollment) and have not had more than a 63-day gap in coverage.
5. HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be immediately terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plan(s) may terminate your COBRA coverage.

If you have any questions about COBRA, or if you have changed marital status, or you, or your spouse have changed addresses, please contact the plan administrator.

Important Notice from Colgate University About Your Prescription Drug Coverage and Medicare

Effective Date: January 1, 2021

If you and/or your dependent(s) have Medicare or will become eligible for Medicare in the next 12-months, please take special care in reviewing this notice.

You should keep this notice where you can find it!

This notice has information about your current prescription drug coverage and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **Colgate University**
has determined that the prescription drug coverage offered is on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered **Creditable Coverage**.

Because the coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

3. **Colgate University**
has determined that the prescription drug coverage is on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered **Non-Creditable Coverage**.
☒ Not Applicable ☐ Applicable

This is important because for most people enrolled in the above NON-CREDITABLE plans, enrolling in Medicare prescription drug coverage means you will get more assistance with drug costs than if you had prescription drug coverage exclusively through the above NON-CREDITABLE plans.

Consider enrolling in Medicare prescription drug coverage. You can keep your **Non-Creditable coverage** from **Colgate University**

You can keep the coverage regardless of whether it is as good as a Medicare drug plan. However, because **Non-Creditable Coverage** is, on average, NOT at least as good as standard Medicare drug coverage, you may pay a higher premium (a penalty) if you decide later to join a Medicare drug plan.

4. **You have decisions to make about Medicare prescription drug coverage** that may affect how much you pay for that coverage, depending on if and when you enroll. Read this notice carefully—it explains your options.

- **Why is your decision so important?**

You should also know that if you drop or lose your coverage with

Colgate University

and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the 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.

- **When to enroll?**

You can join a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. This may mean that you have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. Additionally, if you decide to leave your employer sponsored plan, you will be eligible to join a Part D plan at that time using an employer group Special Enrollment Period.

If you do decide to enroll in a Medicare prescription drug plan and drop your current prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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

- **You need to make a decision!**

When you make your decision, you should also compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

For more information about this notice or your current prescription drug coverage—

Contact our office for further information at 315-228-7565

Note: You will receive this notice annually and at other times in the future such before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook from Medicare. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. For more information about Medicare prescription drug plans:

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

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778)

Remember! Keep this Creditable/Non-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 whether or not you are required to pay a higher premium (a penalty).

Annual Notices

Plan Administrator: Colgate University
Street Address: 13 Oak Drive
City, ST Zip: Hamilton, New York 13346
Effective Date: January 1, 2021

Health Insurance Portability & Accountability Act (HIPAA) Special Enrollment Rights Notice

Loss of Other Coverage

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 and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 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 a 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 30 days after the marriage, birth, adoption, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60-days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information contact your Plan Administrator, noted above.

Michelle's Law Notice

When a dependent child over the age of 26 loses student status under the eligibility policy of the Plan Administrator's group health plan coverage, as a result of a medically necessary leave of absence from a post-secondary educational institution, the Plan Administrator group health plan will continue to provide coverage during the leave of absence for the earlier end date of up to one year, or until coverage would otherwise terminate under the Plan Administrator's group health plan.

To maintain eligibility, continue coverage as a dependent during such leave of absence:

- The Plan Administrator group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary

To obtain additional information, please contact your Plan Administrator, noted above.

Newborns' and Mother's Health Protection Act (NMHPA) Notice

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

Annual Notices — continued

Patient Protection Disclosure

The Plan generally allows the designation of a primary care provider. You have the right to designate any participating primary care provider who is available to accept you or your family members.

For information on how to select a primary care provider and for a list of participating primary care providers, visit the Plan on-line at the website: www.excellusbcbs.com

For more information, contact the Plan Administrator at the phone number listed above. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional; however, you may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit the Plan on-line at the web address or contact your Plan Administrator, noted previously, for more information.

Women's Health & Cancer Rights Act Enrollment Notice

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, contact your Plan Administrator, noted above.

Premium Assistance Under Medicaid & 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 that 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 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 1, 2020. Contact your State for more information on eligibility—

ALABAMA — Medicaid	COLORADO –Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhcpp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711
ALASKA — Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhcpp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/mcicaid/default.aspx	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS — Medicaid	GEORGIA – Medicaid
Website: http://myarhcpp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaidand CHIP (Hawki)	NEBRASKA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	NEVADA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY — Medicaid	NEW HAMPSHIRE – Medicaid
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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA — Medicaid	NEW JERSEY – Medicaid and CHIP
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS — Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA — Medicaid	NORTH DAKOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other health insurance?”] Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
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://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA –Medicaid	RHODE ISLAND — Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

Premium Assistance Under Medicaid & the Children's Health Insurance Program (CHIP) — Continued

SOUTH CAROLINA –Medicaid	VIRGINIA –Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA – Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT – Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 1, 2020, or for more information on special enrollment rights, contact either:

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

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

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 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 1/31/2023)

HIPAA Notice of Privacy Practices

Plan Administrator: **Colgate University**
Street Address: **13 Oak Drive**
City, ST Zip: **Hamilton, New York 13346**
Effective Date: **January 1, 2021**

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.

If you have any questions about this notice, please contact:

Human Resources Department

Phone: 315-228-7565

Who Will Follow This Notice

During the course of providing you with Health Coverage, we have access to information about you that is deemed to be “protected health information,” or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. The procedures outlined in this section have been added to the Plan to ensure that your PHI is treated with the level of protection required by HIPAA. This notice describes the medical information practices of your Health FSA plan (the “Plan”) and that of any third party that assists in the administration of Plan claims.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the PHI records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor’s use and disclosure of your medical information created in the doctor’s office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of notice this is currently in effect.

Your PHI will be disclosed to certain employees of the Plan Sponsor: Members of the Human Resources Department.

These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of the Plan Sponsor who violates the rules for handling PHI established herein will be subject to adverse disciplinary action.

The Plan Sponsor has certified that it will comply with the privacy procedures set forth herein. The Plan Sponsor may not use or disclose your PHI other than as provided herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by the Plan Sponsor for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. The Plan Sponsor must report to the Plan any uses or disclosures of your PHI of which the Employer becomes aware that are inconsistent with the provisions set forth herein.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information for purposes of health plan administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment (as described in applicable regulations). If needed, we may use medical information about you to facilitate medical treatment or services.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operation (as described in applicable regulations). We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; conducting or arranging for medical review, legal services, audit services; and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Reviewing and improving the quality, efficiency and cost of care that we provide.

- Improving health care and lowering costs for groups of people who have similar health problems and helping to manage and coordinate the care for these groups or people.
- Reviewing and evaluating the skills, qualifications, and performance of health care providers.
- Participating in training programs for students, trainees, health care providers, or non-health care professionals.
- Cooperating with outside organizations that assess the benefits that we provide and that evaluate/design strategies for improvement.
- Managing the business and general administrative activities, including our activities related to complying with the HIPAA Privacy Rule and other legal requirements.
- Creating “de-identified” information that is not identifiable to any individual.

Research. We may utilize de-identified images and information for research purposes. We must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.

Marketing. We may provide your name and address and telephone number to our health insurance carrier and/or Relph Benefit Advisors, its affiliates and subsidiaries, so that they may contact you about their services.

Fundraising Activities. We may use your information (name, address, telephone number, age, date of birth, gender, health insurance status or dates of service) to contact you for the purpose of raising money. Money raised by such fundraising efforts will be used to expand and improve the service and programs we provide to the community. If you do not wish to receive these communications, you may opt out by contacting:

ATT: **Human Resources Department**
Colgate University
13 Oak Drive
Hamilton, New York 13346

Genetic Information. Use of genetic information for underwriting purposes is prohibited, including genetic tests and manifested diseases/disorders of family members.

Prohibition of Sale of PHI. Sale of PHI would require the authorization of the individual except in instances of research, mergers, acquisitions and due diligence.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special Situations

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan maintained by the Plan Sponsor for the purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to the Plan Sponsor personnel solely for purposes of administering benefits under the Plan

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities (e.g., to prevent or control disease, injury or disability).

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities, include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in a dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to:

ATT: **Human Resources Department**
Colgate University
13 Oak Drive
Hamilton, New York 13346

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding. The Plan Sponsor will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to:

ATT: **Human Resources Department**
Colgate University
13 Oak Drive
Hamilton, New York 13346

In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

The Plan Sponsor must act on your request for an amendment of your PHI no later than 60-days after receipt of your request. The Plan Sponsor may extend the time for making a decision for no more than 30-days, but it must provide you with a written explanation for the delay. If the Employer denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures” (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations. In addition, only to the extent required by the Health Information Technology for Economic and Clinical Health Act (the “HiTech Act”), you may have the right to request an accounting of all electronic disclosures of PHI, including those made with respect to treatment, payment or health care operations; provided that, the foregoing shall apply only as and when rules regarding such accountings become effective and then only in accordance with such rules.

To request this list or accounting of disclosures, you must submit your request in writing to:

ATT: Human Resources Department
Colgate University
13 Oak Drive
Hamilton, New York 13346

Your request must state a time period which may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

Note: that HIPAA provides several important exceptions to your right to an accounting of the disclosure of your PHI. The Plan Sponsor will not include in your accounting any of the disclosure for which there is an exception under HIPAA. The Plan Sponsor must act on your request for an accounting of the disclosure of your PHI no later than 60-days from receipt of the request. The Plan Sponsor may extend the time for providing you an accounting by no more than 30-days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. The Plan Sponsor will impose a fee for each subsequent request within the 12-month period.

Restriction Request. In accordance with, and only to the extent the following restriction requests apply as a result of, the HiTech Act, you may request a restriction on disclosures of PHI to only those involving payment or health care operations (and is not for treatment purposes), therefore excluding from any PHI disclosure PHI that pertains solely to a health care item or service for which the health care provider involved was paid out of pocket in full by you. For information on this restriction, please contact:

ATT: Human Resources Department
Colgate University
13 Oak Drive
Hamilton, New York 13346

Right to an Electronic Copy of Record. You have the right to request an electronic copy of record in a readable form. The Plan Sponsor may impose a fee for the cost of materials.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a paper copy of this notice be mailed to you by contacting:

ATT: Human Resources Department
Colgate University
13 Oak Drive
Hamilton, New York 13346

The Plan Sponsor must make its internal practices, books and records related to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with these privacy protections.

When the Plan Sponsor no longer needs PHI disclosed to it by the Plan, for the purposes for which the PHI was disclosed, the Plan Sponsor must, if feasible, return or destroy the PHI that is no longer needed. If it is not feasible to return or destroy the PHI, the Employer must limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

Special Rules for Electronic Breach of Unsecured PHI

In the event of a "breach" of unsecured PHI (as defined in Section 13400(1) of the American Recovery and Reinvestment Act of 2009 ("ARRA"), except as otherwise not required by law, we will report any breach of unsecured PHI (as defined in 45 C.F.R. § 164.402) which notice will include (i) a list of all individuals whose unsecured PHI has been, or is reasonably believed by us to have been, accessed, acquired, used, or disclosed during such breach, and (ii) any other available information that the we are required to provide under applicable law. As necessary, we will provide notice as required by applicable law, including to the extent applicable 45 C.F.R. § 164.406, if the legal requirements for media notification are triggered by the circumstances of such breach. The foregoing will not apply if PHI has been rendered unreadable, unusable and indecipherable in accordance with federal rules.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the further. We will post a copy of the current notice on the Plan website. The notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Plan official listed on page 1 of this notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us (including most disclosures of psychotherapy notes, disclosures for marketing, and the sale of Personal Health Information) will be made only with your written permission.

The Plan is also prohibited by law from using or disclosing Personal Health Information that is genetic information for underwriting purposes.

If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Group Name: Colgate University
Address: 13 Oak Drive
City, State & Zip Code: Hamilton, New York 13346
Phone Number: 315-228-7565
Website: www.colgate.edu



800 Parker Hill Drive | Suite 100 | Rochester, NY
14625 | 800-836-0026 | www.aleragroup.com