2026

GEORGETOWN UNIVERSITY
Department of Human Resources
Office of Faculty & Staff Benefits

Legal Notices

Important Information About Medicare Prescription Drug Coverage

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 10-11 for more details.

This document contains the Legal Notices required for the Georgetown University health and welfare plans in effect on January 1, 2026. If you would like information on the plans, refer to the summary plan descriptions, evidence of coverage, insurance certificates and policies for complete terms, provisions, limitations and exclusions. Those documents are available on the Georgetown Benefits Website at **benefits.georgetown.edu**.

Legal Notices

Summary of benefits and coverage (SBC)

The Affordable Care Act requires that you have access to health plan SBCs so you can understand your choices. Georgetown medical plan SBCs are distributed electronically during Open Enrollment and are also available at **benefits.georgetown.edu**. For free paper copies of the SBCs, call the Department of Human Resources at 1-202-687-2500.

Notice of HIPAA privacy practices

Effective 02/16/2026, or such later date when this notice is first published.

PLEASE REVIEW THIS NOTICE CAREFULLY AS IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.
THIS NOTICE ALSO DIRECTS YOU TO HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION.

Georgetown University (the "Company") is providing you with this privacy notice so you understand how we use your health information and when we need to disclose your health information to others. For each obligation and right listed within this notice, the term "we" refers to both the Plan Administrator and the claims administrators for the self-insured coverage options beginning 02/16/2026, under the Georgetown University Welfare and Fringe Benefits Plan (the "Plan").

The Company is the Plan Administrator for the Plan. The claims administrators for the Plan are listed in the "Claims administrators" section on the last page of this notice.

This notice is subject to change. You may contact the Company's Privacy Official to request a copy of this notice. In addition, you may request a copy via mail at hipaaprivacy@georgetown.edu.

University Privacy Official
Georgetown University
2115 Wisconsin Ave, NW, Ste. 601
Washington, D.C. 20007

The Plan is required by law to abide by the terms of this notice, which may be amended from time to time.

Summary of your privacy rights
We may use and give out your health information to:

- Help manage the health care treatment you receive
- Pay for your health services
- Administer the Plan
- Tell you about other health benefits and services
- Help your family and friends involved in your care
- Do research

We may also use and give out health information for:

- Health and safety reasons
- Organ and tissue donation requests
- Military purposes
- Workers' compensation requests
- Lawsuits
- Law enforcement requests
- National security reasons
- Coroner, medical examiner, or funeral director use

Such other disclosures as may be required by law or further addressed herein You have the right to:

- Get a copy of your medical record.
- Request a change to your medical record if you think it's wrong.
- Ask for an accounting of certain disclosures of your health information.
- Ask us to limit the information we share.
- Ask for a copy of our privacy notice.
- Write a letter of complaint to us if you believe your privacy rights have been violated.

The purpose of this document is to outline and inform you about your privacy rights enacted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This privacy notice describes the privacy practices of the self-insured components under the Plan, which include group secondary medical and health flexible spending account benefits. If you are enrolled on a fully insured group health plan, the insurer for that option may also provide a Notice of HIPAA Privacy Rights specifically relating to the coverage under that option.

The Company, as the sponsor and administrator of the Plan, and each of the claims administrators that have been hired to administer the Plan's group health plans are required by law to protect the privacy of your health information.

"Protected health information," as used in this privacy notice, means any individually identifiable health information that is created or received by a health care provider or the Plan relating to:

- Your physical or mental health or condition
- The provision of health care to you
- The payment for health care

"Protected health information" does not include, among other things, any information maintained on the Company's payroll system or records related to an individual's enrollment in or coverage level under a Company group health plan. It also does not include any other information that the Company holds in its capacity as "employer" or in connection with plans other than the Company's group health plans.

The Company reserves the right to change or amend this privacy notice and our privacy practices and to make such changes effective for all protected health information that we maintain, but if we do, we will communicate any material changes to you in a revised privacy notice by the effective date of the material change. We will provide you with the revised notice, or information about the change and how to obtain the revised notice, in the next annual mailing to you. You may request a copy by contacting the Company's Privacy Official or you may also request a copy via mail at the address listed at the beginning of this notice.

How we may use or disclose your protected health information

We must use and disclose your protected health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative)
- To the Department of Health and Human Services, if necessary, to make sure your privacy is protected
- When it's required by law

We have the right to use and disclose your protected health information to pay for your health care and to operate and administer the Plan. Some examples of when we may use your protected health information are:

- For payment of claims for services received by you and processed by the claims administrators for the Plan in which you are enrolled.
- For treatment, so that doctors, hospitals, or both can provide you medical care.
- For coordination of benefits with other covered health plans.
- For health care operations, to operate and administer the plan and to help manage your health care coverage. For example, the Plan may use your protected health information in connection with:
  - A disease management or wellness program to improve your health
  - Underwriting, including, but not limited to, soliciting bids from potential insurance carriers (genetic information shall not be used for underwriting purposes)
  - Merger and acquisition activities
  - Determining participant contributions
  - Submitting claims to the plans' stop-loss (or excess loss) carrier (if any)
  - Conducting or arranging for medical review
  - Legal services
  - Audit services
  - Fraud and abuse detection programs

The Plan also may use your protected health information for other administrative activities, such as cost management and conducting quality assessment and improvement activities.

- To provide information on health-related programs or products. For example, the claims administrator might talk to your doctor about health-related products and services, or to suggest an alternative medical treatment or program

Under limited circumstances, we may have to use or disclose your protected health information:

- To persons involved with your care, such as a family member, if you are incapacitated, in an emergency, or when permitted by law.
- For public health activities, such as reporting disease outbreaks.
- For reporting victims of abuse, neglect, or domestic violence to government authorities, including a social service or protective service agency.
- For health oversight activities such as governmental audits, fraud, and abuse investigations.
- For judicial or administrative proceedings, such as responding to a court order, search warrant, or subpoena.
- For law enforcement purposes, such as providing limited information to locate a missing person.
- To avoid a serious threat to health or safety, such as disclosing information to public health agencies.
- For specialized government functions, such as military and veteran activities, national security, and intelligence activities.
- For workers' compensation, including disclosures required by state workers' compensation laws for job-related injuries.
- For research purposes, such as research related to the prevention of disease or disability, but only if the research study meets all privacy law requirements.
- To provide information regarding decedents, such as providing protected health information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law, or to funeral directors as necessary to carry out their duties.
- For organ procurement purposes, such as banking or transplantation of organs, eyes, or tissue.

The Plan also may use your protected health information for other administrative activities, such as cost management and conducting quality assessment and improvement activities.

Substance Use Disorder. You have certain additional protections available to you related to substance use disorder treatment records to the extent we receive substance use disorder treatment records from any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States. We will not use or disclose any of these records without first obtaining your written authorization to disclose such records or without a court order requiring these records to be used or disclosed. We will require that any court order be accompanied by a subpoena or other legal document compelling disclosure before the records will be disclosed. Please note, however, that your written authorization is not required if the records are being provided to public health authorities if the records are de-identified pursuant to the requirements under the Privacy Rule.

If none of the above reasons applies, then your written authorization is needed to use or disclose your protected health information. Specifically, your written authorization is required to use or disclose any psychotherapy notes, if applicable, and to use or disclose any protected health information for marketing purposes or for which the group health plans receive compensation. If applicable, the group health plans also may contact you to raise funds, but you may elect not to receive any such fundraising communications in the future. If a use or disclosure of protected health information is prohibited or materially limited by other applicable laws, then it is our intent to meet the requirements of the more stringent law to protect your privacy.

After we receive authorization from you to release your protected health information, we cannot guarantee that the person to whom the information is provided will not disclose your information. You may revoke your written authorization unless we have already acted based on your authorization. To revoke an authorization, contact the claims administrator for the Plan in which you are enrolled.

Note, any required or permitted disclosures described in this Notice may be subject to redisclosure by the recipient of the disclosure and, at that time, would no longer be protected by the rights and obligations described in this Notice. Further, the Plan does not use or disclose PHI, including substance use disorder information, for purposes of fundraising.

What are your rights to your protected health information?
You have the right to:

- Ask for restrictions on uses or disclosures of your protected health information for treatment, payment, or health care operations. You also can ask to restrict disclosures to family members or to others who are involved in or make payments for your health care. We may also have policies on dependent access that may authorize certain restrictions. We ask you to understand that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.

  A covered entity (such as a health care provider) must comply with a requested restriction if the disclosure is to a health plan for purposes of payment or health care operations and the protected health information relates to a health care item or service for which an individual paid in full, out of pocket. For example, if you receive medical care and choose to pay the provider for the entire amount of care in full, out of pocket, you can request that the provider not disclose such information to the Plan, and the provider must agree to such request.
- Choose how we contact you. You have the right to ask that we communicate with you about medical matters in a certain way or even at a certain location. An example of this could be that we only contact you at work or by mail. If you have a preference regarding how we communicate with you, please let us know in writing. We are not required to agree to your request, but, if we do agree to it, we will comply with it.
- See and obtain a copy of your protected health information that may be used to make decisions about you, such as claims and cases or medical management records. You may receive a summary of this health information. If your protected health information is maintained electronically in one or more designated record sets, then you have the right to get a copy of this health information in an electronic format. A written request will be needed to inspect and copy your protected health information. In certain limited circumstances, your request to inspect and copy your protected health information may be denied. An access request should be made to the applicable claims administrators as listed within this privacy notice.
- Ask to amend the protected health information we maintain about you if you believe it is wrong or incomplete. The amendment must be submitted in writing to the claims administrator for the Plan in which you are enrolled, along with a reason that supports your request. If your request is denied, you may have a statement of your disagreement added to your protected health information.

- Appoint a personal representative You may request that the Plan disclose your protected health information to your personal representative. A "personal representative" is an individual you designate to act on your behalf and make decisions about your medical care. If you want the Plan to disclose your protected health information to your personal representative, submit a written statement giving the Plan permission to release your protected health information to your personal representative and documentation that this individual qualifies as your personal representative under state law, such as a power of attorney authorizing this individual to make health care decisions for you. Submit this request in writing to the applicable claims administrator.
- Receive an accounting of disclosures of your protected health information made by the Plan during the six years before your request. This accounting will not include disclosures of protected health information made:
  1. For treatment, payment, and health care operations purposes;
  2. To you or pursuant to your authorization;
  3. To correctional institutions or law enforcement officials; and
  4. In connection with other disclosures for which federal law does not require us to provide an accounting

  Your request should indicate in what format you want the list (for example, on paper or electronically). Submit this request in writing to the applicable claims administrator. The first list that you request in a 12-month period will be free and we may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You may also request a copy via mail at the address listed at the beginning of this notice.

How to exercise your rights
Contact the claims administrators
If you have any questions about this privacy notice or want to exercise any of your rights, call the claims administrator for the Plan coverage option in which you are enrolled. Contact information is listed in the "Claims administrators" section on the last page of this notice.

Filing a complaint
If you believe your privacy rights have been violated, you may contact the Plan's HIPAA Privacy Official in writing at the following address:

University Privacy Official
Georgetown University
2115 Wisconsin Ave, NW, Ste. 601
Washington, D.C. 20007

You may also file a complaint with the Secretary of the United States Department of Health and Human Services Office of Civil Rights at: 200 Independence Avenue, SW, Room 509-F HHH Building, Washington, DC 20201, or at the applicable regional office of the HHS Office of Civil Rights, the contact information for which is available at: **http://www.hhs.gov/ocr/about-us/contact-us/index.html**

We will not take any action against you for filing a complaint
The Company's group health plans have policies and procedures in place designed to address breaches of unsecured protected health information. The Company's group health plans are obligated to, consistent with HIPAA, notify you if your unsecured protected health information is breached. If your complaint relates to breach notification procedures of the Company's group health plans or compliance with the policies and procedures of the Company's group health plans in general, send the complaint to the Privacy Official at the address listed above.

Restrictions on protected health information
The Company may not use or disclose protected health information for employment-related actions or decisions. The Company may only use or further disclose protected health information as permitted or required by law and will report any use or disclosure of protected health information that is inconsistent with the permitted uses and disclosures.

Plan Administrator and health plan separation
The Company's team members, classes of team members, or other workforce members listed as "authorized employees" in the Plan's HIPAA policies and procedures will have access to protected health information only to perform the plan administrative functions required of the Plan Administrator to administer the Company's group health plans.

This list includes every team member, class of team member, or other workforce member under the control of the individual who may receive protected health information relating to the ordinary course of business.
The team members, classes of team members, or other workforce members identified above (and any individual under the control of these team members) may be subject to disciplinary action and sanctions for any use or disclosure of protected health information that is in violation of these provisions.

Claims Administrators
To reach the claims administrator for the Company's self-insured group medical and health care flexible spending account benefits in which you are enrolled, please call the applicable number listed below:

CareFirst BlueCross BlueShield **1-800-628-8549**
United Healthcare **1-888-332-8885**
Optum Financial **1-877-292-4040**

Primary care physicians (PCPs) and OB/GYN care

To the extent that any of the medical plan options allow for the designation of a primary care provider, you have the right to designate any primary care provider who is available to accept you or your family members and who participates in the applicable medical plan option's network of providers. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical plan option may designate one for you.

Furthermore, you do not need prior authorization from your medical plan carrier or from anyone else (including a primary care provider) to access obstetrical or gynecological care from a health care professional in the applicable medical plan's network (as applicable) who specializes in obstetrics or gynecology. The health care professional, however, 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, contact the applicable medical plan carrier.

For information on how to select a primary care provider, and for a list of participating primary care providers, contact your medical plan carrier.

Women's Health and Cancer Rights Act

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.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

Michelle's Law

Public law 110-381, also known as "Michelle's Law," allows dependent college students insured under their parent's policy to remain covered if they are required to take a medical leave of absence from school or make any other enrollment changes that might cause them to lose dependent student eligibility. To qualify for this continued coverage, the dependent must be suffering from a serious illness or injury and the leave of absence or other enrollment changes must be medically necessary, as determined by the treating physician. Such dependents may remain covered up to the earlier of: one year after the first day of the medically necessary leave of absence; or the date on which such coverage would otherwise terminate under the terms of the plan/coverage. Following the medical leave, dependent students will once again be required to provide student certification (as may be required under the applicable plan) to remain eligible for dependent coverage.

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 to 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 **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, dial 1-877-KIDS-NOW (1-877-543-7669) or visit **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 **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 July 31, 2025. Contact your state for more information on eligibility.

Alabama Medicaid	**http://myalhipp.com** 1-855-692-5447
Alaska Medicaid	The AK Health Insurance Premium Payment Program: **http://myakhipp.com** 1-866-251-4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**
Arkansas Medicaid	**http://myarhipp.com** 1-855-MyARHIPP (1-855-692-7447)
California Medicaid	Health Insurance Premium Payment (HIPP) Program: **http://dhcs.ca.gov/hipp** 1-916-445-8322 (fax: 1-916-440-5676) hipp@dhcs.ca.gov
Colorado Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado: **www.healthfirstcolorado.com** Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: **https://hcpf.colorado.gov/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): **www.mycohibi.com** HIBI Customer Service: 1-855-692-6442
Florida Medicaid	**www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** 1-877-357-3268
Georgia Medicaid	GA HIPP: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** 1-678-564-1162, press 1 GA CHIPRA: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra** 1-678-564-1162, press 2
Indiana Medicaid	Health Insurance Premium Payment Program All other Medicaid **www.in.gov/medicaid** Family and Social Services Administration: **www.in.gov/fssa/dfr** 1-800-403-0864 Member Services: 1-800-457-4584
Iowa Medicaid and CHIP (Hawki)	Medicaid: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid** 1-800-338-8366 Hawki: **https://hhs.iowa.gov/medicaid/plans-programs/hawki** 1-800-257-8563 HIPP: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid/plans-programs/fee-service/health-insurance-premium-payment-program** 1-888-346-9562
Kansas Medicaid	**www.kancare.ks.gov** 1-800-792-4884 HIPP: 1-800-967-4660
Kentucky Medicaid	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** 1-855-459-6328 KIHIPP.PROGRAM@ky.gov KCHIP: **https://kynect.ky.gov** 1-877-524-4718 Kentucky Medicaid: **https://chfs.ky.gov/agencies/dms**
Louisiana Medicaid	**www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Medicaid Hotline: 1-888-342-6207 LaHIPP: 1-855-618-5488

Legal Notices

Maine Medicaid	Enrollment: **www.mymaineconnection.gov/benefits/s** 1-800-442-6003 TTY: Maine Relay 711 Private Health Insurance Premium: **www.maine.gov/dhhs/ofi/applications-forms** 1-800-977-6740 TTY: Maine Relay 711
Massachusetts Medicaid and CHIP	**www.mass.gov/masshealth/pa** 1-800-862-4840 TTY: 711 masspremassistance@accenture.com
Minnesota Medicaid	**https://mn.gov/dhs/health-care-coverage** 1-800-657-3672
Missouri Medicaid	**www.dss.mo.gov/mhd/participants/pages/hipp.htm** 1-573-751-2005
Montana Medicaid	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** 1-800-694-3084 HHSHIPPProgram@mt.gov
Nebraska Medicaid	**www.ACCESSNebraska.ne.gov** 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
Nevada Medicaid	**http://dhcfp.nv.gov** 1-800-992-0900
New Hampshire Medicaid	**www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program** 1-603-271-5218 HIPP program: 1-800-852-3345, ext. 15218 DHHS.ThirdPartyLiabi@dhhs.nh.gov
New Jersey Medicaid and CHIP	Medicaid: **www.state.nj.us/humanservices/dmahs/clients/medicaid** 1-800-356-1561 CHIP: **www.njfamilycare.org/index.html** 1-800-701-0710 (TTY: 711) CHIP Premium Assistance: 1-609-631-2392
New York Medicaid	**www.health.ny.gov/health_care/medicaid** 1-800-541-2831
North Carolina Medicaid	**https://medicaid.ncdhhs.gov** 1-919-855-4100
North Dakota Medicaid	**www.hhs.nd.gov/healthcare** 1-844-854-4825
Oklahoma Medicaid and CHIP	**www.insureoklahoma.org** 1-888-365-3742
Oregon Medicaid	**http://healthcare.oregon.gov/Pages/index.aspx** 1-800-699-9075
Pennsylvania Medicaid and CHIP	**www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html** 1-800-692-7462 CHIP: **www.pa.gov/agencies/dhs/resources/chip** 1-800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	**www.eohhs.ri.gov** 1-855-697-4347 Direct RIte Share Line: 1-401-462-0311
South Carolina Medicaid	**www.scdhhs.gov** 1-888-549-0820
South Dakota Medicaid	**https://dss.sd.gov** 1-888-828-0059
Texas Medicaid	**www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program** 1-800-440-0493
Utah Medicaid and CHIP	Utah's Premium Partnership for Health Insurance (UPP): **https://medicaid.utah.gov/upp** upp@utah.gov 1-888-222-2542 Adult Expansion: **https://medicaid.utah.gov/expansion** Utah Medicaid Buyout Program: **https://medicaid.utah.gov/buyout-program** CHIP: **https://chip.utah.gov**
Vermont Medicaid	**https://dvha.vermont.gov/members/medicaid/hipp-program** 1-800-250-8427
Virginia Medicaid and CHIP	**https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid/CHIP: 1-800-432-5924
Washington Medicaid	**www.hca.wa.gov** 1-800-562-3022
West Virginia Medicaid and CHIP	**https://dhhr.wv.gov/bms** **http://mywvhipp.com** Medicaid: 1-304-558-1700 CHIP: 1-855-MyWVHIPP (699-8447)
Wisconsin Medicaid and CHIP	**www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** 1-800-362-3002
Wyoming Medicaid	**https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility** 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, menu option 4, ext. 61565

Legal Notices

HIPAA special enrollment rights

If you decline enrollment in Georgetown University health care coverage for yourself or your eligible dependents (including your legal spouse/LDA) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in Georgetown University health care coverage if you or your dependents lose eligibility for that other coverage (or if an 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 an 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 in Georgetown University health care coverage. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment in Georgetown University health care coverage for yourself or for an eligible dependent (including your legal spouse/LDA) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in Georgetown University health care coverage if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' (including your legal spouse/LDA) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

For more information on making changes during the year, refer to the Qualifying Events Matrix at **benefits.georgetown.edu/enrolling/benefitschanges** or contact the Department of Human Resources at 1-202-687-2500 or benefitshelp@georgetown.edu.

Summary Annual Reports (SARs)

The SARs for Georgetown University's benefit plans are available online and include an explanation of plan expenses, employee and employer contribution information, and details on how you can obtain additional information about the plan. Since you were enrolled in, or eligible for, one or more of the University's benefits plans, it is your legal right as a participant to know this information about your benefits.

Each December 15, you may view copies of the prior plan year's SARs on our website at **benefits.georgetown.edu/legal**. You may not be enrolled in all of the plans that are referenced, so please disregard any reports that do not apply to you. You can order a paper copy of the SARs from the Department of Human Resources at benefitshelp@georgetown.edu or 1-202-687-2500.

Notice for highly compensated employees with a dependent care FSA

The Internal Revenue Code (IRC) allows pretax contributions to FSAs as long as the benefit does not favor highly compensated employees (HCEs). You are considered "highly compensated" if your gross earnings are above the annual amount set by the Internal Revenue Service (see the IRS website for details).

In accordance with IRC regulations, Georgetown University's Department of Human Resources examines Dependent Care FSA elections each year to ensure that the benefit does not disproportionately benefit HCEs and that the Plan remains compliant. If the benefit is found to "discriminate" against non-highly compensated employees, Georgetown University will reduce contributions made by HCEs to a level that enables compliance with the IRC. If the Dependent Care FSA fails the test for the year, HCEs will be taxed on the pretax deductions contributed to their Dependent Care FSA during that calendar year. Non-highly compensated employees are not affected by this rule.

Required workplace postings

The University has reviewed and established a list of states that are approved for telework. Go to **hr.georgetown.edu/emp-postings** to find the state where your workplace is located to view the required postings.

Important notice from Georgetown University about your prescription drug coverage and Medicare

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

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

1. 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.

2. Georgetown University has determined that the prescription drug coverage offered by the Georgetown University Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Read this notice carefully – it explains your options.

When can I join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. This applies to all Georgetown University Health and Welfare Plans.

What happens to my current coverage if I decide to join a Medicare drug plan?

If you are an active employee (or a covered legal spouse or dependent of an active employee), your current Georgetown University active employee medical plan pays for other medical expenses in addition to prescription drug benefits. If you decide to join a Medicare drug plan, your current Georgetown University coverage will not be affected. Specifically, you and your eligible dependents will still be eligible to receive all of your current medical and prescription drug benefits under Georgetown University's active employee medical and prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Georgetown University active employee medical and prescription drug plan, be aware that you and your dependents may be able to enroll back into Georgetown University's active employee medical and prescription drug plan at a later time, such as during an Open Enrollment period.

When will I pay a higher premium (penalty) to join a Medicare drug plan?

For plans with creditable coverage (all Georgetown University Health and Welfare Plans), you should also know that if you drop or lose your current coverage with Georgetown University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the Department of Human Resources at 1-202-687-2500 or benefitshelp@georgetown.edu.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Georgetown University changes. You also may request a copy of this notice at any time.

Legal Notices

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security website at **ssa.gov**, or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: 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 whether or not you are required to pay a higher premium (a penalty).

Date:	October 15, 2025
Name of entity/sender:	Georgetown University
Contact-position/office:	Department of Human Resources Associate Vice President for Benefits
Address:	2115 Wisconsin Avenue, N.W. Suite 601 Washington, D.C. 20007
Phone number:	1-202-687-2500
Email:	benefitshelp@georgetown.edu

Genetic Information Nondiscrimination Act

Congress passed the Genetic Information Nondiscrimination Act (GINA) establishing a national and uniform standard to protect workers from genetic discrimination. In addition to prohibitions on discrimination in employment practices, GINA prohibits group health insurers and group health plans from adjusting premiums or contributions based on genetic information. Also, GINA amended the HIPAA privacy rules to include genetic information in the definition of protected health information.

Transparency in coverage rule

In accordance with rules issued by the Centers for Medicaid and Medicare Services (CMS) in an effort designed to help patients know how much their healthcare will cost in advance of treatment, each of the Georgetown University medical plan claim administrators will disclose in-network provider negotiated service rates and historical out-of-network allowed amounts between health plans and healthcare providers in a "machine-readable file." The goal of this rule is to allow public access to health coverage information to aid in the understanding of health care pricing and mitigate the rise in health care spending. The machine-readable files are formatted to allow researchers, regulators, and application developers to access and analyze data more easily.

Here are the links containing the data for each the medical plans offered by Georgetown University which may need particular software capable of opening these machine-readable files:

- **CareFirst**
  individual.carefirst.com/individuals-families/mandates-policies/machine-readable-data.page
- **Kaiser**
  healthy.kaiserpermanente.org/maryland-virginia-washington-dc/front-door/machine-readable
- **UnitedHealthcare**
  transparency-in-coverage.uhc.com
  Enter **georgetown-university** in the search bar

If you have any questions or encounter technical issues, contact the respective Member Services.

Legal Notices

Health Insurance Marketplace

You can buy Health Insurance through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and the health coverage offered by Georgetown University.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace generally begins in November for coverage starting the following January 1.

Can I save money on my health insurance premiums in the Marketplace?

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

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from Georgetown University that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in Georgetown University's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if Georgetown University does not offer coverage to you at all, or does not offer coverage that meets certain standards.

Does the health coverage offered by Georgetown University satisfy the standards set by the Affordable Care Act?

The Georgetown University health plans offered satisfy the minimum value standard and the costs of the plan are intended to be affordable, based on wages. Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by Georgetown University, then you will lose the contribution provided by Georgetown University. Also, Georgetown University's contribution – as well as your contribution to Georgetown-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

Questions?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its costs. Please visit **healthcare.gov** for more information, including an online application for health insurance coverage.

Surprise billing notice

The Consolidated Appropriations Act, 2021 (CAA) requires health plans to provide protections against Surprise Medical Bills for services received on or after January 1, 2022. When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

If you believe you've been wrongly billed, contact the U.S. Department of Health & Human Services at 1-877-696-6775 or your State Insurance Commissioner. You can find more information specific to your Georgetown University coverage at **benefits.georgetown.edu**.

Pregnant Workers Fairness Act

Pursuant to Title IX of the Education Amendments of 1972 and the Pregnant Workers Fairness Act (PWFA), Georgetown University is committed to creating an accessible and inclusive environment for pregnant and parenting students, faculty, and staff. For more information on requesting adjustments and accommodations, visit **ideaa.georgetown.edu/ada/pregnancy-accommodations**.

Legal Notices

Newborns' and Mothers' Health Protection Act

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

Mental Health Parity and Addiction Equity Act

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), many health plans and insurers must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

If you have questions about MHPAEA or the mental health or substance use disorder benefits under your plan, contact the Department of Labor at **askebsa.dol.gov** or 1-866-444-3272.

Continuing health coverage during a military leave (USERRA rights)

Your right to continue enrollment in the Medical, Dental, and Vision Programs during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). You may continue your enrollment during a USERRA leave as long as you continue to make the required contributions. Generally, you may continue your enrollment through the 24-month period beginning on the date on which your USERRA leave begins or through the period ending on the day after the date on you fail to return to a position of employment with the University, as determined in accordance with USERRA, whichever ends earlier. If your USERRA leave is 31 days or longer, you may be required to pay up to 102% of the required contributions. If the USERRA leave is for less than 31 days, your required contributions will remain the same as similarly situated active employees. Note that coverage provided under USERRA will run concurrently with any right to continue coverage under COBRA.

To be eligible for USERRA benefits, you are generally required to give advance notice of your military service to the Department of Human Resources. For more information about continuing coverage under USERRA, contact the Department of Human Resources.

Summary Plan Description (SPD)

The Georgetown University Welfare and Fringe Benefits Summary Plan Description (SPD) contains important information regarding the benefits provided to you (and if applicable, your family) under the Plan. This document also outlines your rights and responsibilities under the Plan, including claims and appeals procedures. Please note that this document incorporates and/or references any current applicable Certificates of Coverage and/or benefit summaries that you have or will receive from Georgetown University. You can find a copy of the SPD at **benefits.georgetown.edu**. You also have the right to request and obtain at no charge a paper version of the Georgetown University Welfare and Fringe Benefits SPD. To do so, contact the Department of Human Resources at **1-202-687-2500** or **benefitshelp@georgetown.edu**.

Legal Notices

Nondiscrimination and accessibility requirements and nondiscrimination statement: discrimination is against the law

Georgetown University complies with applicable Federal and District of Columbia civil rights laws. The University provides equal opportunity in employment for all persons and does not discriminate on the basis of race, color, national origin, age, disability, sex, or any other factor prohibited by law.

Georgetown University provides:

- Accommodation assistance to people with disabilities, including applicants for employment and current employees, to communicate effectively with the University. Such reasonable accommodations may include:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Office of Institutional Diversity, Equity, and Affirmative Action (IDEAA). IDEAA is responsible for coordinating the University's response to various accommodation requests in accordance with federal and District of Columbia laws, as well as University policies.

If you believe that Georgetown University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or other factor prohibited by federal or District of Columbia law, you can file a grievance with IDEAA in person or by mail, fax, or email. If you need help filing a grievance, an IDEAA staff member is available to help you:

Office of Institutional Diversity, Equity, and Affirmative Action
M-36 Darnall Hall
37th & O Streets, N.W.
Washington, D.C. 20057

Main number: 1-202-687-4798
Fax: 1-202-687-7778
Email: ideaa@georgetown.edu

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

ATTENTION: If you speak limited English, language assistance services, free of charge, are available to you. Call 1-202-687-4798.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-202-687-4798.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-202-687-4798。
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-202-687-4798.
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-202-687-4798.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-202-687-4798.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-202-687-4798.
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-202-687-4798.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-202-687-4798.
Dè dɛ nià kɛ dyédé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nií, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá 1-202-687-4798
Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-202-687-4798.
AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-202-687-4798.
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-202-687-4798
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-202-687-4798 まで、お電話にてご連絡ください。
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-202-687-4798 번으로 전화해 주십시오.
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-202-687-4798.
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-202-687-4798.

Notice to all employees of Georgetown University: 2026 403(b) Universal Availability Notice for Georgetown University Voluntary Contribution Retirement Plan

This notice is to inform you that as an employee of Georgetown University you are eligible to participate in the Voluntary Contribution Retirement Plan.

The Georgetown University Voluntary Contribution Retirement Plan (the "Voluntary Plan") is a retirement workplace 403(b) savings plan. The Voluntary Plan, distinct from GURP and the Defined Contribution Retirement Plan, allows employees to make pre-tax contributions or additional pre-tax contributions to a 403(b) savings account to help save for retirement. The University does not contribute to the Voluntary Plan; all employee contributions are made through salary reduction. Employees are always 100% vested in the Voluntary Plan. Plan contributions as well as any investment earnings are tax-deferred – and are not taxable until distributed.

Eligibility

If you are an employee of the University, you are eligible to enroll in the Voluntary Plan.

Enrollment

You may enroll in the Voluntary Plan or discontinue or change your enrollment at any time. For more information, visit **benefits.georgetown.edu/retirement/voluntary** or call the Department of Human Resources at 1-202-687-2500.

Contribution and investment elections

To enroll, you must elect your contribution amount and designate the investment company to which you want your contributions deposited. To do so, log on to **gms.georgetown.edu** with your NetID and password. New employees will be prompted to enroll as part of the New Hire benefit event in their GMS inbox. All other employees should follow the instructions at **benefits.georgetown.edu/retirement/voluntary**. Annual contribution limits do apply. Once you submit your choices in GMS, you'll be automatically enrolled in a target date retirement fund by the investment company(ies) you have selected. You can change your investment allocations at any time after your first contribution has been made by contacting your investment company. You will receive further information and instructions from your chosen investment company(ies) soon after you enroll.

Investment companies

You may obtain further information about the Voluntary Plan by contacting the investment companies directly. You may do so by visiting their websites or calling their toll-free numbers to talk to a representative.

Fidelity Investments	TIAA	Vanguard
netbenefits.com/georgetown	tiaa.org/georgetown	ownyourfuture.vanguard.com/content/en/ekit/georgetown-university/index.html
1-800-343-0860	1-800-842-2888	1-800-523-1188

We look forward to serving you in 2026 and beyond.

Sincerely,

Vivek Kumar
Retirement Benefits Analyst
Department of Human Resources

Notice to Employees
Information on Paid Family Leave in the District of Columbia

Georgetown University is subject to the District of Columbia's Paid Family Leave law, which provides covered employees paid time off from work for qualifying parental, family, medical and prenatal events. For more information about the Paid Family Leave program, visit the Office of Paid Family Leave's website at **dcpaidfamilyleave.dc.gov**.

Covered workers

To receive benefits under the Paid Family Leave program, you must work for a covered employer in DC. To find out if you are a covered worker, speak with Georgetown University's Department of Human Resources or contact the Office of Paid Family Leave (see contact information at end of this page). Georgetown University is required to tell you if you are covered by the Paid Family Leave program. Additionally, Georgetown University is required to provide you information about the Paid Family Leave program at these three (3) times:

1. At the time you were hired;
2. At least once a year; and
3. If you ever ask Georgetown University for leave that could qualify for benefits under the Paid Family Leave program.

Covered events

There are four (4) kinds of Paid Family Leave benefits:

1. Parental leave - receive benefits to bond with a new child for up to 12 weeks in a year;
2. Family leave - receive benefits to care for a family member for up to 12 weeks in a year;
3. Medical leave - receive benefits for your own serious health condition for up to 12 weeks in a year; and
4. Prenatal leave - receive benefits for prenatal medical care for up to 2 weeks in a year.

Maximum leave entitlement

Each kind of leave has its own eligibility rules and its own limit on the length of time you can receive benefits in a year. The maximum amount of leave for any combination of parental, family, and medical leave is 12 weeks. However, there is an exception for pregnant women who take prenatal leave. Pregnant women are eligible for 2 weeks of prenatal leave while pregnant and 12 weeks of parental leave after giving birth, for a maximum of 14 weeks.

Applying for benefits

If you have experienced an event that may qualify for benefits, be sure to apply no more than 30 days after your event. You can learn more about applying for benefits with the Office of Paid Family Leave at **dcpaidfamilyleave.dc.gov**.

Benefit amounts

Paid Family Leave benefits are based on the wages Georgetown University paid to you and reported to the Department of Employment Services. If you believe your wages were reported incorrectly, you have the right to provide proof of your correct wages. The current maximum weekly benefit amount is $1,190.

Employee protection

The Office of Paid Family Leave does not administer any job protections for District workers who take leave from work. However, some job protections may be available under laws and regulations administered by the District's Office of Human Rights (OHR).

Under the Universal Paid Leave Act, the Office of Paid Family Leave is required to provide notice of the following:

1. That retaliation by a covered employer against a covered employee for requesting, applying for, or using paid-leave benefits is prohibited;
2. That an employee who works for a covered employer with under 20 employees shall not be entitled to job protection if he or she decides to take paid leave pursuant to this act; and
3. That employees have a right to file a complaint with OHR if they feel they have been retaliated against for requesting, applying for, or using paid leave.

For more information on OHR and job protections, please visit **ohr.dc.gov**.

If you have questions

For more information about Paid Family Leave, please visit the Office of Paid Family Leave's website at **dcpaidfamilyleave.dc.gov**, call 202-899-3700, or email does.opfl@dc.gov.

Continuation coverage rights under COBRA

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You and your spouse divorce or legally separate.

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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- 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).

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

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

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

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

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

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

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

For more information, visit **medicare.gov/medicare-and-you**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **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 **healthcare.gov**.

Keep your plan informed of address changes

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

Georgetown reserves the right to modify, terminate or amend its plans/provisions, or any part thereof, at its discretion at any time or for any reason. Details of the benefits or the limitations and exclusions of the plans are contained in the official plan documents and agreements between the insurance companies and Georgetown University. It is these documents that legally govern the operation of the plans and which will control in the event of any omission or other differences arising elsewhere. Copies of the summary plan description (SPD) for each plan can be found at **benefits.georgetown.edu** or can be obtained by contacting the Department of Human Resources at 1-202-687-2500.

GEORGETOWN UNIVERSITY
Department of Human Resources
Office of Faculty & Staff Benefits