The Plan Sponsor reserves the right to amend this Plan at any time or from time to time without the consent of any Employee or Participant. Although the Plan Sponsor expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan feature or component at any time without liability.
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COLUMBIA UNIVERSITY
GROUP BENEFIT PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Restated effective as of January 1, 2016

This document, together with the provider contracts identified in Schedule A, and their respective policies, Benefit Summaries and other materials (either written or electronic) (collectively, “Welfare Benefit Documents”), constitute the written plan and the summary plan description as required by Section 102 of the Employee Retirement Income Security Act of 1974 (ERISA) and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Columbia University Group Benefit Plan (the “Plan”). The Plan was first effective January 1, 1987, and has been amended and restated as of January 1, 2016.

The Welfare Benefit Documents for each underlying Plan feature govern the benefits to be provided and include more details on how the Plan features operate. If there is any conflict between this plan document and such Welfare Benefit Document, then such Welfare Benefit Document will control. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan will always govern.

A. GENERAL INFORMATION ABOUT THE PLAN

This section contains general information that you¹ may need to know about the Plan.

1. General Plan Information

The name of the Plan is the Columbia University Group Benefits Plan.

The Plan Sponsor has assigned Plan Number 515 to the Plan.

The Plan Year is the twelve-month period ending each December 31st.

The Plan includes the following Plan features:

• Group Medical Benefits (the “Group Medical Feature”)
• Group Dental Benefits (the “Group Dental Feature”)
• Group Life/AD&D Benefits (the “Group Life/AD&D Feature”)
• Group Salary Continuation Benefits (the “Group Salary Continuation Feature”)
• Group Long Term Disability Benefits (the “Group LTD Feature”)

¹ The terms “you” and “your” as used in this Plan Document and Summary Plan Description refer to an employee of the University who is otherwise eligible to participate in the Plan and is actually participating in the Plan pursuant to its terms. Your receipt of this Plan Document and Summary Plan Description is not an indication that you are in fact a participant in the Plan.
• Group Long Term Care Benefits (the “Group LTC Feature”)
• Flexible Benefits Plan (the “Healthcare and Dependent Care FSA Features”)
• Group Travel Insurance Benefits (the “Group Travel Feature”)

2. **Plan Sponsor Information**

The Plan Sponsor’s name, address, and employer identification number are:

Columbia University in the City of New York  
Attn: The Trustees of Columbia University in the City of New York  
Studebaker Bldg., MC 8703  
615 West 131st Street  
New York, NY 10027-7922  
Telephone Number: (212) 851-7000  
EIN: 13-5598093

3. **Plan Administrator Information**

The Plan Administrator’s name and telephone number is:

The Trustees of Columbia University in the City of New York  
Studebaker Bldg., MC 8703  
615 West 131st Street  
New York, NY 10027-7922  
Telephone Number: (212) 851-7000

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan.

4. **Service of Legal Process**

The name and address of the Plan’s agent for service of legal process is:

Columbia University  
Attention: Director, Benefits  
Studebaker Bldg., MC 8703  
615 West 131st Street  
New York, NY 10027-7922  
Service of legal process may also be made upon the Plan Administrator.

5. **Type of Plan**

The Plan is intended to be an “employee welfare benefit plan” within the meaning of ERISA Section 301. The Salary Continuation Feature and the Dependent Care FSA Feature are
not employee benefit plans under ERISA and the benefits under the Salary Continuation Feature and the Dependent Care FSA Feature are not covered by ERISA. As such, any provisions herein that provide for special benefits, rights or features pursuant to ERISA shall not apply to the benefits provided under the Salary Continuation Feature or the Dependent Care FSA Feature.

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the applicable requirements of the Patient Protection and Affordable Care Act of 2010, as amended, ("Affordable Care Act") as such requirements become effective from time to time with respect to the Group Medical Feature, and the Group Medical Feature is to be administered and interpreted in a manner consistent therewith.

6. **Hybrid Entity Status.**

The Plan is considered a "hybrid entity" as defined by 45 C.F.R. Part 164.504(a) of the Standards for the Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 (the "Privacy Rule"), promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The following Plan features constitute the covered components of the hybrid entity and are subject to the requirements of the Privacy Rule:

(a) Group Medical Feature;
(b) Group Dental Feature; and
(c) Healthcare FSA Feature.

7. **Type of Administration**

Benefits furnished under the Plan are administered by the providers from which benefits are purchased, or in the case of certain self-funded benefits, by the Plan Administrator (or a third-party administrator, as may be designated in writing by the Plan Administrator from time to time). The name of each provider is set out in Schedule A. Unless otherwise indicated, all benefits furnished under the Plan are provided under the insurance policies, administrative contracts and/or plan documents identified in Schedule A, and the respective providers identified therein provide all necessary administrative services.

8. **Amendment and Termination**

(a) Amendment.

The University reserves the right to amend any one or more of the underlying Plan features or component benefits of the Plan at any time without the consent of any employee or participant; except that any amount which became payable under the Plan, or any Plan Feature available under the Plan, prior to the date an amendment is effective will be paid or payable in accordance with the terms of the Plan or an applicable Welfare Benefit Document as in effect immediately prior to the effective date of the amendment.
(b) Termination

The University expressly reserves the right to terminate the Plan, in whole or in part, at any time. No Plan participant or covered dependent will have a vested right to any benefit under this Plan. On termination of the Plan, any amounts that became payable under the terms of the Plan, or any feature available under the Plan, prior to the date of termination will be paid in accordance with the terms of the Plan or an applicable Welfare Benefit Document as in effect immediately prior to the date of such termination. Upon the termination of the Plan or a Plan feature, as the case may be, all elections and reductions in compensation relating to the Plan or the applicable Plan feature will terminate.

(c) Notice of Amendment or Termination.

Plan participants will be notified of any amendment or termination of a Plan feature or of the Plan within a reasonable time; provided, however, that, with respect to mid-year changes, notice of a material reduction in benefits under the Group Medical Feature of the Plan will be provided to Plan participants enrolled in the affected benefit at least 60 days prior to the effective date of the amendment. Upon the termination of a Plan feature or of the Plan, your benefit rights, if any, as well as those of your covered dependents affected thereby shall become payable as the Plan Administrator may direct.

B. ELIGIBILITY AND BENEFITS

1. Eligibility Requirements

(a) General Rules.

As an employee of the University, you and your dependents will be eligible to participate in any of the Plan features available under the Plan to the extent you meet the classification, age, service, and other requirements specified in the Welfare Benefit Documents for any such Plan feature. Participation will continue only in accordance with the provisions of the Welfare Benefit Documents and terms and conditions set forth herein. If you and your dependents meet the eligibility requirements for a particular Plan feature, you will begin coverage only after your completion of the necessary enrollment forms in accordance with the procedures set forth by the Plan Administrator.

(b) Determination of Eligibility.

Subject to the eligibility provisions of the Welfare Benefit Documents, the Plan Administrator may determine, under uniformly applicable rules, the eligibility of any individual to participate in this Plan. The Plan Administrator, in its sole discretion, shall determine whether an order or notice qualifies as a QMCSO in accordance with the procedures established for such purpose subject to ERISA Section 609.

(c) Initial Enrollment.

Eligible employees who meet the eligibility requirements set forth in Subsection (a) shall enroll in a Plan feature in accordance with the provisions of the Welfare Benefit Documents.
Newly-hired eligible employees shall enroll themselves and eligible dependents within 31 days following the first day the employee is eligible to do so, subject to enrollment instructions specified by the Plan Administrator or Claims Administrator. COBRA beneficiaries shall enroll pursuant to the administrative rules established by the Plan Administrator, and shall pay the COBRA premium for continued coverage. COBRA coverage will be effective as of the first day of the month following the month in which the participant terminates employment.

(d) Annual Enrollment Period.

In addition to the initial enrollment period described above, to the extent you otherwise meet the eligibility requirements for a given Plan feature, you may enroll yourself and eligible Dependents in such Plan feature during the annual enrollment period designated by the Plan Administrator and occurring during the last quarter of the Plan Year, subject to enrollment instructions specified by the Plan Administrator or Claims Administrator. Elections made during the annual enrollment period shall be effective the January 1 following the date you make the election.

(e) You Are Responsible for Covering Only Eligible Dependents.

You are responsible for ensuring that only your eligible dependents are enrolled in the Group Medical and Dental Features. An employee who covers an individual whom he or she knows does not meet the definition of an eligible dependent will be subject to disciplinary action up to and including dismissal and may be liable for other punishment under the law. If the University learns that you have enrolled an ineligible dependent (such as a former spouse or a child over the age limit), the dependent will not be covered by the Plan for any medical and/or dental expenses incurred while he or she was ineligible, to the extent permitted by the Affordable Care Act. You will be required to repay all costs to the University and/or Plan of providing coverage and any benefits paid to you. Also, if you don’t notify the Plan Administrator when a dependent has become ineligible, the dependent could lose his or her ability to continue coverage under COBRA health care continuation rules.

(f) Report Changes in Dependent Eligibility

When a dependent is no longer eligible, it is your responsibility to report any changes in the status of your dependents within 31 days of the change. Examples of changes include, but are not limited to, divorce, child reaching the limiting age under the Plan, etc. Go to the CU Benefits Enrollment System at www.M.columbia.edu/benefits and update any changes in the status of your dependents online. If you need assistance, call the Columbia Benefits Service Center at 212-851-7000.

(g) Proof of Eligibility.

The Plan Administrator, its delegate or the Provider of a particular Plan feature, as the case may be, has a responsibility to ensure that only eligible expenses are paid from the Plan. This is a requirement of the Internal Revenue Service (IRS) regulations that govern tax-qualified benefit plans as well as U.S. Department of Labor (DOL) regulations that limit the use of Plan assets to paying benefits due under the terms of the Plan and to defraying the costs of administering the Plan.
You must be prepared to provide satisfactory proof that your enrolled dependents meet the eligibility requirements. Audits are conducted periodically each year to ensure that all dependents continue to meet the eligibility requirements of the benefit plans. If you are selected for an audit, you will receive a letter detailing the audit process. Examples of proof of dependent eligibility include, but are not limited to, birth certificates for each covered child, a marriage certificate, etc. If you cannot provide proof that your dependent is eligible for coverage, his or her coverage will be terminated.

(h) You Choose Who to Cover Under Your Benefits.

You must select from one of the following coverage options to ensure your dependents have medical and dental benefits:

- Yourself and your legal spouse or yourself and your same-sex domestic partner;
- Yourself and a child or children; or
- Family.

(i) Qualified Medical Child Support Order (QMCSO).

Federal law requires the Plan to honor a QMCSO issued by a state court as part of a judgment or decree under state domestic relations law or under a law relating to medical child support. A QMCSO relates to and must specify that it arises from medical child support. The Plan Administrator will comply with the terms of any QMCSO it receives, and will:

- Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under ERISA Section 609;
- Promptly notify you and any alternate recipient (as defined in ERISA Section 609(a)(2)(C)) of the receipt of any medical child support order, and the Plan’s procedures for determining whether medical child support orders are qualified medical child support orders; and
- Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify you and each alternate recipient of such determination.

If a QMCSO is issued for your child, that child will be eligible for coverage as required by the order and pursuant to the Plan’s terms. You will not be considered a Late Entrant for Dependent Insurance.

You must notify the Plan Administrator and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

(j) Definition of Qualified Medical Child Support Order
A Qualified Medical Child Support Order is a judgment, decree or order (including court approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the Plan, and satisfies all of the following:

- The order recognizes or creates a child’s right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child’s name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child’s mailing address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to the child, the child’s custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

(k) If You and Your Spouse or Same-Sex Domestic Partner Work for the University

If you and your spouse or same-sex domestic partner work for the University and are eligible for medical coverage, you may choose your coverage in either of the following ways:

- One spouse or same-sex domestic partner makes the medical choice for the entire family, including eligible dependent children, if any. In this case, the other spouse or same-sex domestic partner must select “No Coverage.”
- Each spouse or same-sex domestic partner can make his or her own medical choice. In this case, all eligible dependent children must be covered by employee or the other spouse or same-sex domestic partner.
2. Special Enrollment Rights

(a) HIPAA. If you do not enroll yourself and your dependents in group health coverage offered under the Group Medical Feature after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under HIPAA that apply when an individual declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you declined coverage because you had other health care coverage that you have now lost through no fault of your own (or employer contributions to your other health care coverage terminate); or (ii) you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in group health coverage offered under the Group Medical Feature if you provide notice to the Plan Administrator within 31 days after you lose your alternative coverage (or employer contributions to your alternative coverage cease) or the date of your marriage or the birth, adoption, or placement for adoption of your child.

(b) CHIP. You may also enroll yourself and your dependents in a Group Health Feature if your or one of your eligible dependent’s coverage under Medicaid or the state Children’s Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, or if you or one of your eligible dependents become eligible for premium assistance under a Medicaid or CHIP plan. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/CHIP coverage or of the determination of eligibility for premium assistance under Medicaid/CHIP. The Group Health Features offered under the Plan are the: (i) Group Medical Feature, (ii) Group Dental Feature and (iii) Healthcare FSA Feature.

(c) Affordable Care Act. You may revoke your previous Group Medical Feature election for the remainder of the Plan Year if:

(i) Reduction in Hours of Service. You had been reasonably expected to average at least 30 hours of service per week and you experience a change in your employment status such that you are reasonably expected to average less than 30 hours of service per week after the change, even if that reduction does not result in your ceasing to be eligible under the applicable Group Medical Feature; provided that revocation of the election of coverage under the Group Medical Feature corresponds to your (and any related Dependents who also cease coverage due to the revocation) intended enrollment in another plan that provides Minimum Essential Coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the coverage under the Group Medical Feature is revoked.

(ii) Enrollment in Qualified Health Plan. You are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace’s annual open enrollment period; provided that revocation of the election of coverage under the Group Medical Feature corresponds to your (and any related Dependents who also cease coverage due to the revocation) intended enrollment in a Qualified Health Plan through a Marketplace for new coverage
that is effective beginning no later than the day immediately following the last day of coverage under the Group Medical Feature. Your election changes pursuant to this Section will be effective as of the date immediately before the first date of your coverage under the Qualified Health Plan.

(iii) Election changes under this Paragraph (c) shall only be permitted to the extent such changes are consistent with IRS Notice 2014-55 and any subsequent regulations. Capitalized terms used in this Paragraph but not otherwise not defined shall have the same meaning as in IRS Notice 2014-55.

See the Plan Administrator if you have questions about special enrollment.

3. **Special Rule for Maternity and Infant Coverage**

   Under the Newborns’ and Mothers’ Health Protection Act of 1996, as the same may be amended from time to time, (“NMHPA”) group health plans and health insurance issuers generally may not, 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, the NMHPA generally does not prohibit the attending provider or physician, 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 the NMHPA, 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). This rule applies to the Group Medical Feature under the Plan.

4. **Special Rule for Women’s Health Coverage**

   The Women’s Health and Cancer Rights Act of 1998 (“WHCRA”) requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Group Medical Feature. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits. This rule applies to the Group Medical Feature under the Plan.

5. **Mental Health Parity**

   The Plan will comply with the Mental Health Parity Act of 1996, as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), to the extent MHPAEA is applicable to the Plan. Nothing in the Plan will be construed to require any Plan feature to provide mental health and/or substance use disorder benefits. This subsection will not create any rights in excess of the minimum required by law.
6. **Loss of Benefits**

As noted above, the Plan Sponsor reserves the right to change or eliminate any Plan feature under the Plan and may amend or terminate the Plan at any time. Except in the case of certain health care continuation rights under Federal law, all benefits terminate when your active employment terminates or when you are no longer eligible for benefits or when the group insurance policy terminates, whichever occurs first.

7. **Plan Costs**

The Plan Sponsor pays a portion of the cost of the Group Life Feature, Group LTD Feature, Group Medical Feature and Group Dental Feature. Participants pay the balance of the cost of the Plan for these features. Participant contributions for the Group Life Plan, Group LTD Plan, Group Medical Plan and Group Dental Plan will be communicated to you when you first enroll in a Plan, and during each open and special enrollment period. Upon the terms and conditions set forth in the Plan Sponsor’s Flexible Benefits Feature, your contributions will be made on a pre-tax basis. Participants may also elect to contribute to their Healthcare and Dependent Care FSAs. Notwithstanding anything to the contrary, if your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for your group health coverage under the Group Medical Feature instead of for Medicaid coverage, if it is cost effective. This includes premiums for continuation coverage under the Group Medical Feature as required by federal law.

8. **Notice Regarding Lifetime and Annual Dollar Limits**

In accordance with applicable law, none of the lifetime dollar limits and annual dollar limits set forth in the Plan shall apply to “essential health benefits” (as defined under Section 1302(b) of the Affordable Care Act and applicable state law) offered under the Group Medical Feature. The Affordable Care Act defines “essential health benefits” to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services, but currently provides little further information. Regulations issued under the Affordable Care Act permit the Plan Administrator to select what state law it will use to further define what is considered an “essential health benefit” under the Plan for purposes of administering the various rules under the Affordable Care Act that apply to the Plan. The Plan Administrator has selected New York state law for this purpose. Accordingly, a determination as to whether a benefit under the Group Medical Feature constitutes an “essential health benefit” will be based on a good faith interpretation by the Plan Administrator of guidance issued under the Affordable Care Act and New York state law that is available as of the date on which the determination is made.

9. **Tax Notes**

(a) **Same-sex Spouses.** Some States, such as New York, recognize same-sex spouses. Federal law also recognizes same-sex spouses who are legally married pursuant to state law. As such, the tax treatment of your same-sex spouse’s benefit will be the same as that of an opposite-
sex spouse to the extent you and your same-sex spouse are married pursuant to state law (i.e., the benefit will generally not be taxable to you). If you are not legally married to your same-sex partner, then the tax treatment of your partner’s benefits will be as described below with respect to domestic partners.

(b) **Domestic Partners.** Neither federal nor some state law recognizes “domestic partners” for specialized tax treatment under employer-sponsored group health plans. Unless your domestic partner and domestic partner’s child(ren) are your federal tax dependents for group health plan purposes, you will be subject to federal and state tax (as applicable) on the imputed value of the coverage provided to the domestic partner and the domestic partner’s child(ren). You must notify the Plan Administrator if you believe your spouse meets the requirements for a federal tax dependent for group health plan purposes.

It is important that you understand the tax and legal issues set out above. Therefore, if the situations described above apply to you, you may want to consult your tax and legal advisors to determine the impact on you.

C. **RESPONSIBILITIES FOR PLAN ADMINISTRATION**

1. **Plan Administrator**

The Plan Administrator has (i) the power and authority in its sole, absolute and uncontrolled discretion to control and manage the operation and administration of the Plan and (ii) all powers necessary to accomplish these purposes.

The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA and other applicable laws. With respect to the Plan, the Plan Administrator has discretion (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, (iv) to determine the conditions under which benefits become payable under the Plan and (v) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Subject to any applicable claims procedure, any determination made by the Plan Administrator will be final, conclusive and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity.

**DESPITE ANY PLAN PROVISION TO THE CONTRARY, THE WELFARE BENEFIT DOCUMENTS FOR EACH UNDERLYING PLAN FEATURE GOVERN THE BENEFITS TO BE PROVIDED UNDER THAT FEATURE, AND THE PROVIDERS FOR EACH PLAN FEATURE ARE RESPONSIBLE FOR MAKING BENEFIT DETERMINATIONS UNDER EACH SUCH PLAN FEATURE, NOT THE PLAN ADMINISTRATOR. IF THERE IS ANY CONFLICT BETWEEN THIS PLAN DOCUMENT AND SUCH WELFARE BENEFIT DOCUMENTS, THEN SUCH OTHER DOCUMENTS WILL CONTROL.**
2. **Duties of the Plan Administrator**

The Plan Administrator will (i) administer the Plan in accordance with its terms, (ii) decide disputes which may arise relative to a Plan participant's rights, (iii) keep and maintain the Plan documents and all other records pertaining to the Plan, (iv) pay or arrange for the payment of claims, (v) with respect to each Group Health Feature covered under the Plan, establish and communicate procedures to determine whether a medical child support order is qualified under Section 609 of ERISA, and (vi) perform all necessary reporting as required by ERISA.

3. **Plan Administrator Compensation**

While the Plan Administrator serves without compensation, all expenses for administration, including compensation for hired services, will be paid by the Plan unless paid by the Plan Sponsor.

4. **Claims and Appeals Administrators**

   (a) The Plan Administrator has full power and discretion to resolve all issues concerning eligibility, status, entitlement to benefits, and any other interpretations under the Plan. Such interpretations or rulings will be binding on all parties. The Plan Administrator has the right to delegate some of these duties to third party providers, such as the Claims Administrators and Appeals Administrators for the Plan features. As the Plan Administrator’s delegates, the Claims and Appeals Administrators have the authority to make decisions relating to benefit claims.

   (b) The Plan Administrator has delegated the claim fiduciary responsibilities of the Plan to various Claims and Appeals Administrators as indicated in the Welfare Benefit Documents. As such, the Claims and Appeals Administrators named in the Welfare Benefit Documents have the discretion to:

   (i) interpret the terms of the applicable Welfare Benefit Document and benefits defined thereunder;

   (ii) interpret the other terms, conditions, limitations and exclusions of the Plan feature, including this SPD and any Riders and/or Amendments; and

   (iii) make factual determinations related to the Plan feature and its Benefits.

5. **Fiduciary Duties**

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the participants and their dependents and defraying reasonable expenses of plan administration. These duties must be carried out with the care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in accordance with Plan documents to the extent that they are consistent with ERISA.
6. **The Named Fiduciary**

The Plan Administrator is a “named fiduciary” with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing to monitor the fiduciary or (ii) the named fiduciary breached its fiduciary responsibility under ERISA Section 405(a).

7. **Liability and Indemnification**

The University and any person to whom it may delegate any duty or power in connection with administering the Plan and the officers and trustees of the University, will be entitled to rely conclusively upon, and will be fully protected in any action taken or suffered by them in good faith in the reliance upon, any accountant, counsel, other specialist, or other person selected by the Plan Administrator or in reliance upon any tables, valuations, certificates, opinions, or reports which will be furnished by any of them. Employees acting on behalf of the University in its role as Plan Administrator will be indemnified by the University against any and all liabilities arising by reason of any act or failure to act made in good faith in accordance with the Plan, including expenses reasonably incurred in the defense of any related claim. A Plan fiduciary that is a third party service provider or an insurer will be entitled to indemnification only to the extent provided in a written agreement with such service provider.

D. **UNIFORMED SERVICES REEMPLOYMENT RIGHTS**

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under a group health plan by paying premiums in the manner specified by the Plan Sponsor.

If you do not elect to continue to participate in a group health plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect continuation coverage under a group health plan for up to the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds, subject to the rules that are set out in the applicable Plan features.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.
E. LEAVE UNDER FAMILY MEDICAL LEAVE ACT

If you take a leave of absence for your own serious health condition or to care for family members with a serious health condition or to care for a newborn or adopted child, you may be able to continue your health coverage under the Plan. If you drop your health coverage during the leave, you can also have your health coverage reinstated on the date you return to work—assuming you pay any contributions required for the coverage. See the Plan Administrator for more information about your rights.

F. COBRA

1. Introduction

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. The following 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. For more information about your COBRA rights and obligations under the Plan and under Federal law, you should ask the Plan Administrator.

The Plan Administrator is responsible for administering COBRA continuation coverage, but the Plan Administrator may delegate its administrative duties to a third party administrator from time to time. The Plan Administrator has delegated authority for administering COBRA continuation coverage to the following COBRA Administrator:

COBRA Administrator
Willis Towers Watson
1000 Midlantic Drive, Suite #200
Mt. Laurel, NJ 08054

2. COBRA Continuation Coverage

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” COBRA applies to each Group Health Feature under the Plan. The Group Health Features offered under the Plan are the: (i) Group Medical Feature, (ii) Group Dental Feature and (iii) Healthcare FSA Feature. Specific qualifying events are listed later. 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. 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 a group health plan because either one of the following qualifying events happens:
- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

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

- 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;
- You become divorced or legally separated from your spouse.

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

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under the plan as a “dependent child.”

Each Group Health Feature under 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 or death of the employee, the Plan Sponsor must notify the Plan Administrator (or third-party COBRA administrator, as applicable) of the qualifying event within 30 days of the date the event occurs or the date you would otherwise lose coverage under the group health plan due to a qualifying event, whichever is later.

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. Each Group Health Feature covered under the Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs or the date you would otherwise lose coverage under the group health plan due to a qualifying event, whichever is later.

Within 14 days of the Plan Administrator (or third-party COBRA administrator, as applicable) receiving notice (in accordance with the procedures set forth below under “Furnishing Notice to Administrator”) that a qualifying event has occurred, the Plan
Administrator (or third-party COBRA administrator, as applicable) will send out an election notice, offering COBRA continuation coverage to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage under the Group Health Feature would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to 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 a Group Health Feature is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator (or third-party COBRA administrator, as applicable) in a 60 days, 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 (or third-party COBRA administrator, as applicable) is notified of the Social Security Administration’s determination within 60 days of the latest of the date of the determination, the date of the qualifying event or the date you would otherwise lose coverage under the Group Health Feature due to a qualifying event, and before 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 while receiving COBRA continuation coverage, and such event would result in loss of health coverage if the first qualifying event had not already occurred, 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 is available to the spouse and dependent children if the former employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible for coverage under the Group Health Feature as a dependent child. 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 or the date you would otherwise lose coverage under the Group Health Feature due to a qualifying event, whichever is later.

**Furnishing Notice to Administrator**

Unless the Plan has a third-party COBRA administrator, in which case qualified beneficiaries should follow the notice procedures established by the third-party COBRA administrator, 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 Columbia Benefits 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.

If you have questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest regional or district office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA’s website at www.dol.gov/ebsa.

Keep your plan informed of address changes

In order to protect your family’s rights, you should keep the Plan Administrator (and third-party COBRA administrator, if applicable) 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 (or third-party COBRA administrator, as applicable).

Events Causing Termination of COBRA

Notwithstanding the foregoing, continuation of coverage pursuant to the provisions of this section as to any covered persons (whether or not a qualified beneficiary) shall terminate upon the first to occur of the following events:

- Failure to make timely payment of any required contribution, as set forth herein or in the applicable COBRA election notice.

- The date the Plan and all Group Health Features are terminated by the Plan Sponsor.

- After the qualified beneficiary makes an election for continuation coverage, the covered person becomes covered under another group health plan that does not exclude or limit coverage with respect to any pre-existing conditions of the covered person. If the exclusions or limitations for pre-existing conditions in the other group health plan would not apply to the covered person (or would be satisfied by the covered persons due to the requirements enacted by HIPAA or the Affordable Care Act), then the Plan may terminate continuation coverage under this provision.

- After the qualified beneficiary makes an election for continuation coverage, the covered person becomes entitled to Medicare benefits under Title XVIII of the federal Social Security Act.
If continuation coverage is extended due to a disability, the earlier of (i) the first day of the month that begins more than thirty (30) days after the date of a final determination that the qualified beneficiary is no longer disabled under Title II or XVI of the federal Social Security Act, or (ii) the end of twenty-nine (29) calendar months; provided that, in such case coverage shall not terminate before the end of the applicable coverage duration described above (without regard to the extension of coverage for disability).

Cause, which shall include acts of fraud, misrepresentation or deceit by a covered person or a covered person’s omission of a material fact in seeking continuation of coverage or related benefits under the Plan. In addition, continuation of coverage with respect to a dependent of an eligible employee may terminate for cause to the same extent the eligible employee loses coverage for cause under the terms of the Plan.

G. FUNDING POLICY

1. Benefits furnished hereunder are provided through the purchase of insurance policies and other provider contracts, unless otherwise indicated in Schedule A. The Plan Sponsor will collect the applicable employee premiums and will pay when due all premiums required to keep such policies and contracts in force. Funding is derived from the funds of the Plan Sponsor and contributions made by covered employees. The level of any employee contributions is set by the Plan Sponsor, which will be communicated to you when you first enroll in the Plan, and during each open and special enrollment period. The Plan Sponsor reserves the right to modify employee contribution amounts. Employee contributions will be used to fund, or reimburse the Plan Sponsor for funding, the cost of the Plan benefits as soon as practicable after they have been received from the employee or withheld from the employee’s pay through payroll deduction. No employee will have a right to or interest in any assets of the Plan Sponsor, except as specifically provided in this Plan.

2. The Plan Sponsor will have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type which may become payable under any such insurance contract will not be assets of the Plan but will be the property of, and will be retained by, the Plan Sponsor to the extent permitted by law. In the event that amounts are attributable to employee contributions or are required to be treated as Plan assets by law, the Plan Administrator will make a reasonable determination as to how to apply such refunds. The Plan Sponsor will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan, including, but not be limited to, losses or obligations which pertain to the following:

a. Once insurance is applied for or obtained, the Plan Sponsor will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Plan Sponsor.

b. To the extent premium notices are received by the Plan Sponsor, the Plan Sponsor’s liability for the payment of such premiums will be limited to such
premiums and will not include liability for any other loss which results from such failure.

c. The Plan Sponsor will not be liable for the payment of any insurance premium or any loss which may result from the failure to pay an insurance premium if employee contributions (if any) are not enough to provide for such premium cost at the time it is due. In such circumstances, the employee will be responsible for and see to the payment of such premiums.

d. When employment ends, the Plan Sponsor will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan, and the Plan Sponsor will not be liable for or responsible to see to the payment of any premium after employment ends.

H. SUBROGATION AND RIGHTS OF RECOVERY

The Plan is designed to only pay covered expenses under each Plan feature for which payment is not available from anyone else, including any insurance company or any other health or welfare plan. However, at times the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, you and your dependents are subject to, and agree to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan.

1. Assignment of Rights (Subrogation)

You and your dependents automatically assign to the Plan any rights (or causes of action) you and/or your dependents may have to recover all or part of the same covered expenses from any party, including an insurer or any other group health or welfare program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to (or causes of action for) any funds paid by a third party to you and/or any of your dependents or paid to another for your benefit (or the benefit of one of your dependents). This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) you and/or one of your dependents constitute a full or a partial recovery, and even applies to funds paid for non-medical or non-disability charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that you and/or any of your dependents may have, whether or not you or such dependent chooses to pursue that claim. By this assignment, the Plan’s right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
2. **Equitable Liens/Equitable Remedies**

   The Plan shall also have an equitable lien against any rights (or causes of action) you and/or your dependents may have to recover the same covered expenses from any party, including an insurer or any other group health or welfare program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anyone (including, but not limited to, you or your dependent, your or your dependent's attorney, and/or a trust) as a result of an exercise of your and/or your dependent's rights of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the Plan may reduce any future covered expenses otherwise available to you and/or your dependents under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

3. **Assisting Reimbursement Activities**

   You and your covered dependents have an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on your behalf (and on behalf of your dependents), and to provide the Plan with any information concerning your and/or your dependent's other insurance coverage (whether through automobile insurance, other group health or welfare program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits on your behalf (or on behalf of one of your dependents). You and/or your dependents are required to: (a) cooperate fully in the Plan's exercise of its right to subrogation and reimbursement; (b) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan); (c) sign any document deemed by the Plan Administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights; and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator to enforce the Plan's rights.

   Failure by you or your dependents to follow the above terms and conditions may result, at the discretion of the Plan Administrator, in a reduction from future benefit payments available to you or your dependents under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.

   The Plan's rights hereunder shall not be construed to interfere or conflict in any way with the provisions of any insurance policies or other provider contracts that are made part of the Plan. Rather, the Plan's rights under this Section I shall run concurrent with any such similar right provided to any such insurer, vendor or provider under the Plan, but in no event shall you,
or any of your dependents, as the case may be, be obligated to make payments to the Plan in excess of the Reimbursable Payments.

I. COORDINATION OF BENEFITS

Welfare Benefits available under the Plan shall be subject to the coordination of benefits provisions described in the Welfare Benefit Documents, if any. The following provisions of this Section I shall only apply in coordination of benefits determinations if not specifically provided otherwise in the applicable Welfare Benefit Document:

1. **Purpose.** The coordination of benefits provisions are intended to ensure that, when you or your eligible dependent is covered both by this Plan and by another group health plan or Medicare, you or your dependent shall receive reimbursement at not less than if you or your eligible dependent had coverage only under this Plan. The Plan Administrator shall administer these provisions in accordance with this intended purpose.

2. **Definitions.** The meaning of key terms used in this Section I are shown below.

   (a) "Allowable Expense" is any necessary, reasonable and customary item of expense that is at least partially covered by at least one Other Plan. For the purposes of determining the Plan’s payment, the total value of Allowable Expense as provided under this Plan and all Other Plans will not exceed the greater of: (1) the amount this Plan would determine to be eligible expense if the individual incurring the expense were covered under this Plan only; or (2) the amount any Other Plan would determine to be eligible expense in the absence of other coverage.

   (b) "Other Plan" is any of the following:

   (i) Group, blanket or franchise insurance coverage;

   (ii) Group service plan contract, group practice, group individual practice and other group prepayment coverages; or

   (iii) Group coverage under labor-management trusted plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

   The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

   (c) "Principal Plan" is the plan which will have its benefits determined first.

   (d) "This Plan" is that portion of the Plan that provides benefits subject to this Section
3. **Effect on Benefit**

(a) If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

(b) If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

(c) The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if the individual were covered under This Plan only.

4. **Order of Benefits Determination.** The following rules determine the order in which benefits are payable:

(a) A plan that has no coordination of benefits provision pays before a plan that has a coordination of benefits provision.

(b) A plan that covers the individual as an employee pays before a plan that covers the individual as a dependent. However, if the individual is eligible for Medicare, and Medicare pays (i) after the plan which covers the individual as a dependent, but (ii) before the plan which covers the individual as an employee, then the plan which covers the individual as a dependent pays before the plan which covers the individual as an employee.

(c) For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. However, if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits. Notwithstanding the foregoing, for a dependent child of parents who are divorced or separated, the following rules will be used in place of Subsection 5.2(d)(iii):

(i) If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

(ii) If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

a. The plan that covers that child as a dependent of the parent with custody.

b. The plan that covers that child as a dependent of the stepparent (married to the parent with custody).

c. The plan that covers that child as a dependent of the parent without custody.

d. The plan that covers that child as a dependent of the stepparent (married to the parent without custody).
(iii) Regardless of the above, if there is a court decree which establishes a parent’s financial responsibility for that child’s health care coverage, a plan which covers that child as a dependent of that parent pays first.

(d) The plan covering the individual as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering the individual as other than a laid-off or retired employee or the dependent of such an individual.

(e) The plan covering the individual under a continuation of coverage provision in accordance with state or federal law pays after a plan covering the individual as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

(f) When the above rules do not establish the order of payment, the plan under which the individual has been enrolled the longest pays first unless the individual’s effective date of coverage under both plans is the same. In this case, Allowable Expense is split equally between the two plans.

5. **Rights of Claims Administrators.**

(a) Responsibility for Timely Notice. The Plan is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this Section I.

(b) Reasonable Cash Value. If any Other Plan provides the benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and This Plan’s liability will be reduced accordingly.

(c) Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, the Claims Administrator has the right to pay that Other Plan any amount it determines to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy the requirements of this Section I.

(d) Right of Recovery. If payments made under This Plan exceed the maximum payment necessary under this Section I, This Plan has the right to recover that excess amount from any individuals or organizations to or for whom those payments were made, or from any insurance company or service plan.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://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](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums.** The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility:

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Medicaid</th>
</tr>
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<tbody>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Medicaid Website: <a href="http://www.colorado.gov">http://www.colorado.gov</a>/Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943</td>
</tr>
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</table>

**ALASKA – Medicaid**

Website: [http://health.hss.state.ak.us/dpa/programs/medicaid](http://health.hss.state.ak.us/dpa/programs/medicaid)

Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

**ARIZONA – CHIP**

Website: [http://www.azahcccs.gov/applicants](http://www.azahcccs.gov/applicants)
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

**FLORIDA – Medicaid**

Website: [https://www.flmedicaidplrecovery.com](https://www.flmedicaidplrecovery.com)
Phone: 1-877-357-3268

**GEORGIA – Medicaid**


<table>
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<th>State</th>
<th>Medicaid Website/Phone</th>
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<th>Medicaid Website/Phone</th>
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<tbody>
<tr>
<td>Idaho</td>
<td>Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150</td>
<td>Montana</td>
<td>Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a> Phone: 1-800-694-3084</td>
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<td>Nebraska</td>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a> Phone: 1-800-383-4278</td>
</tr>
<tr>
<td>Iowa</td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562</td>
<td>Nevada</td>
<td>Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900</td>
</tr>
<tr>
<td>Kansas</td>
<td>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a> Phone: 1-800-792-4884</td>
<td>Kentucky</td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a> Phone: 1-888-695-2447</td>
<td>New Jersey</td>
<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710</td>
</tr>
<tr>
<td>Maine</td>
<td>Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Medicaid and CHIP Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------</td>
<td></td>
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</tr>
</tbody>
</table>
| **MASSACHUSETTS**     | Website: [http://www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)  
Phone: 1-800-462-1120 |
| **MINNESOTA**         | Website: [http://www.dhs.state.mn.us/](http://www.dhs.state.mn.us/) Click on Health Care, then Medical Assistance  
Phone: 1-800-657-3629 |
| **MISSOURI**          | Website: [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005 |
| **OKLAHOMA**          | Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org)  
Phone: 1-888-365-3742 |
| **OREGON**            | Website: [http://www.oregonhealthykids.gov](http://www.oregonhealthykids.gov)  
Phone: 1-800-699-9075 |
| **PENNSYLVANIA**      | Website: [http://www.dpw.state.pa.us/hipp](http://www.dpw.state.pa.us/hipp)  
Phone: 1-800-692-7462 |
| **RHODE ISLAND**      | Medicaid Website: [http://www.dmas.virginia.gov/rcp-HIPP.htm](http://www.dmas.virginia.gov/rcp-HIPP.htm)  
Medicaid Phone: 1-800-432-5924  
CHIP Website: [http://www.famis.org/](http://www.famis.org/)  
CHIP Phone: 1-866-873-2647 |
| **NEW YORK**          | Website: [http://www.nyhealth.gov/health_care/medicaid/](http://www.nyhealth.gov/health_care/medicaid/)  
Phone: 1-800-541-2831 |
| **NORTH CAROLINA**    | Website: [http://www.ncdhhs.gov/dma](http://www.ncdhhs.gov/dma)  
Phone: 919-855-4100 |
| **NORTH DAKOTA**      | Website: [http://www.nd.gov/dhs/services/medicalserv/medicaid/](http://www.nd.gov/dhs/services/medicalserv/medicaid/)  
Phone: 1-800-755-2604 |
| **UTAH**              | Website: [http://health.utah.gov/upp](http://health.utah.gov/upp)  
Phone: 1-866-435-7414 |
| **VERMONT**           | Website: [http://www.greenmountaincare.org/](http://www.greenmountaincare.org/)  
Phone: 1-800-250-8427 |
| **WASHINGTON**        | Medicaid Website: [http://www.dmas.virginia.gov/rcp-HIPP.htm](http://www.dmas.virginia.gov/rcp-HIPP.htm)  
Medicaid Phone: 1-800-432-5924  
CHIP Website: [http://www.famis.org/](http://www.famis.org/)  
CHIP Phone: 1-866-873-2647 |
<table>
<thead>
<tr>
<th>SOUTH CAROLINA – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
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</thead>
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<tr>
<td>Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a></td>
</tr>
<tr>
<td>Phone: 1-888-549-0820</td>
<td>Phone: 1-877-598-5820, HMS Third Party Liability</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>SOUTH DAKOTA - Medicaid</th>
<th>WISCONSIN – Medicaid</th>
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<tbody>
<tr>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a></td>
</tr>
<tr>
<td>Phone: 1-888-828-0059</td>
<td>Phone: 1-800-362-3002</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TEXAS – Medicaid</th>
<th>WYOMING – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a></td>
<td>Website: <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a></td>
</tr>
<tr>
<td>Phone: 1-800-440-0493</td>
<td>Phone: 307-777-7531</td>
</tr>
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</table>

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

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

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

K. COMPLIANCE WITH APPLICABLE FEDERAL LAWS

Notwithstanding the provisions of this SPD, Benefits Summaries, insurance policies, contracts or certificates of coverage to the contrary, all Plan benefits shall be administered in accordance with the applicable provisions of ERISA, ACA, COBRA, HIPAA, FMLA, USERRA, the Newborns’ and Mothers’ Health Protection Act, the Women’s Health and Cancer Rights Act, the HEART Act, the Genetic Information Nondiscrimination Act of 2008 ("GINA"), the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Michelle’s law, and
all other federal law as applicable, if at all, to the particular Plan feature under which the benefit is offered.

L. NONDISCRIMINATION

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex in the provision of group health benefits under the Plan. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

The Plan provides 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 Executive Director, Benefits of Columbia University at (212) 851-7000.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a claim under the Plan.

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:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,

or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW., Room 509F  
HHH Building  
Washington, DC 20201  
1-800-868-1019, 800-537-7697 (TDD).

M. PLAN IS NOT AN EMPLOYMENT CONTRACT

The establishment, maintenance and provision of the Plan will not be considered or construed: (i) as giving you any right to continue in the employment of the University; (ii) as limiting the right of the University to discipline or discharge you; (iii) as creating any contract of employment between you and the University; or (iv) as conferring any legal or equitable right against the Plan Administrator or the University.

N. HIPAA PRIVACY AND SECURITY PROVISIONS

1. Disclosure of Information

(a) The Plan Sponsor may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. §160.103) as permitted by the "Standards for Privacy of Individually Identifiable Health Information" under the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, and applicable guidance (the "Privacy Rule").

(b) The Plan will disclose Protected Health Information to the Plan Sponsor only upon its receipt of a certification by the Plan Sponsor that the Plan Sponsor agrees to:

(i) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(ii) Ensure that any agents, including subcontractors, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(iii) Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(iv) Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Privacy Rule of which it becomes aware;

(v) Make available Protected Health Information based on HIPAA’s access requirements in accordance with 45 C.F.R. §164.524;

(vi) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;

(vii) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;
(viii) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule;

(ix) If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) Ensure that adequate separation of the Plan and the Plan Sponsor is established as required by 45 C.F.R. 164.504(f)(2)(iii) as described below.

2. Certification of the Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan, if applicable) will disclose Protected Health Information to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section .1. The Plan will not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 C.F.R. §164.520(b)(1)(iii)(C) is included in the appropriate notice.

3. Separation of Plan and the Plan Sponsor

(a) Only designated employees in the human resources department of the Plan Sponsor ("Permitted Employees") will be given access to the Protected Health Information. Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business, will also be included in the definition above of Permitted Employees.

(b) The Permitted Employees may only use the Protected Health Information for Plan administrative functions that the Plan Sponsor performs for the Plan.

4. Security of Electronic Protected Health Information

In accordance with 45 C.F.R. §164.314(b)(2), to the extent as may be required by law, the Plan Sponsor agrees to:

(a) Implement administrative, physical, and technical safeguards that reasonably and, appropriately protect the confidentiality, integrity, and availability of the
electronic Protected Health Information that the Plan Sponsor may create, receive, maintain, or transmit on behalf of the Plan;

(b) Ensure that the adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) Ensure that any agents, including subcontractors, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware with respect to electronic Protected Health Information.

5. **Contact Person / Privacy Officer**

You may write to the Privacy Officer that the Health Plan has dedicated as its Contact Person for all issues regarding your privacy rights:

HIPAA Privacy Officer  
Associate Director, HR Vendor Relations  
615 West 131st Street, MC 8703  
Studebaker 4th Floor  
New York, NY 10027  
(212) 851-7026  
hprivoff@columbia.edu

O. **ADDITIONAL PLAN INFORMATION**

1. **Your Rights Under ERISA**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to —

- examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
• receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

• continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

• a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Notwithstanding the foregoing, no preexisting condition exclusion or limitation under the Plan will apply to any enrollee under age 19.

2. **Prudent Actions by Plan Fiduciaries**

   In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

3. **Enforce Your Rights**

   If your claim for a benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain schedules.

   Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. **Assistance with Your Questions**

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also visit their website at www.dol.gov/ebsa.

**P. CLAIMS PROCEDURE FOR THE PLAN**

If the Plan Administrator, Claims Administrator or Appeals Fiduciary determines that your or your eligible dependent’s claim for benefits should be denied, the claim will be handled in accordance with the claim procedures described in the applicable Welfare Benefit Document and in accordance with Section 503 of ERISA and any applicable regulations. Benefits will be paid under the Plan only if the Plan Administrator, or the Claims Administrator if so delegated under the Welfare Benefit Documents, determines in its discretion that you or your eligible dependent is entitled to them.

**Q. COURT ACTIONS & EXHAUSTION OF ADMINISTRATIVE REMEDIES**

1. No action at law or in equity shall be brought to recover under this Plan until the mandatory appeal rights herein provided have been exercised and the benefits requested in such appeal have been denied on final appeal in whole or in part. If you have complied with and exhausted the appropriate claims procedures and intend to exercise your right to bring civil action under Section 502(a) of ERISA, you must bring such action within 12 months following the date on which you submitted the last required appeal (or voluntary appeal, if offered and you file a voluntary appeal) under such procedures. If you do not bring such action within such 12-month period, you will be barred from bringing an action under ERISA related to your claim.

2. If you bring an timely action pursuant to Section M.1., evidence presented in such action shall be limited to the administrative record reviewed by the Plan Administrator, Claims Fiduciary or Appeals Fiduciary, whichever the case may be, in connection with its determination of your claim for benefits. The administrative record shall include evidence timely presented to the Plan Administrator, Claims Fiduciary or Appeals Fiduciary, whichever the case may be, by you, or your duly authorized representative during the claims process pursuant to Section L.
R. RECOVERY OF OVERPAYMENTS.

Whenever the Plan pays benefits in excess of the maximum amount of payment required under an applicable Welfare Benefit Document, the Plan Administrator, its delegate(s) or a Claims Administrator will have the right to recover any such excess payments and associated earnings from any person who received the excess payments.

S. CONTROLLING LAW

To the extent not preempted by ERISA, New York shall be controlling in all matters relating to the Plan.

T. NO ASSIGNMENT

Except in the case of an assignment running in favor of the Plan pursuant to Section H or as specifically permitted under the terms of particular Plan feature’s Welfare Benefit Document, your right to receive benefits under the Plan (including the right to file a lawsuit against the Plan, any Plan feature, the University, the Plan Administrator, or any Plan fiduciary with respect to the Plan) will not be alienable by assignment. Your right to receive any benefits under the Plan will not be subject to any claims by any creditor of or claimant against you; and any attempt to reach such amounts by any such creditor or claimant, or any attempt by you to confer on any such creditor or claimant any right or interest with respect to such amounts, will be null and void, except as provided in Section 609 of ERISA with respect to QMCSO. The payment of benefits may be made directly to a service provider who has provided medical care to you or to any other third-party to whom such person is indebted as a convenience to such person, provided that such person shall remain primarily liable at all times with respect to payment for such medical care or other indebtedness and such payment shall not imply an enforceable assignment of benefits or the right to receive such benefits. No compensation reduction elections or other contributions under this Plan will cause the University to be liable for, or subject to, any manner of debt or liability of yours.

U. NO GUARANTEE OF TAX CONSEQUENCES

The University makes no commitment or guarantee that any amounts paid to or for the benefit of a participant under this Plan will be excludible from the participant’s gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any participant. Each participant is obligated to determine whether each payment under this Plan is excludible from the participant’s gross income for federal and state income tax purposes, and to notify the University if the participant has reason to believe that any such payment is not so excludible.

V. INCOMPETENCY.

If any person entitled to payments under the Plan is a minor or under other legal disability or otherwise incapacitated so as to be unable to manage his or her financial affairs, or is otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. If the payment is to be made by an insurance provider, such payment shall be made in accordance with the terms of the contract under which such benefit is payable.
If the payment is to be otherwise made, the Plan Administrator, in its discretion, may direct that all or any portion of such payment be made:

(a) to such person;

(b) to such person's legal guardian or conservator; or

(c) to such person's Spouse or to any other person,

in any manner the Plan Administrator considers advisable, to be expended for his or her benefit. The decision of the Plan Administrator (or, where applicable, that of the Insurance Company) shall, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations of the Plan, the University, the Plan Administrator and any insurance provider, with respect to such payment.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan to be executed in its name and on its behalf this 5 day of October, 2016 by a duly authorized officer of the Plan Sponsor.

Trustees of Columbia University

By: [Signature]

Name: DIANNE KENNEY

Title: VP, HUMAN RESOURCES
# COLUMBIA UNIVERSITY GROUP BENEFIT PLAN

## SCHEDULE A

As of January 1, 2016

### I. Group Medical Feature

<table>
<thead>
<tr>
<th>Claims Administrator</th>
<th>Contract/Group No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Healthcare Services, Inc.</td>
<td>POS: 80, 90, 100: 712790</td>
</tr>
<tr>
<td>One Penn Plaza</td>
<td>Group Medicare</td>
</tr>
<tr>
<td>New York, NY 10119</td>
<td>Advantage (HMO):</td>
</tr>
<tr>
<td></td>
<td>40512/NJ, 66013/NY</td>
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### II. Group Dental Feature

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<th>Claims Administrator</th>
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</thead>
<tbody>
<tr>
<td>Aetna Life Insurance Company</td>
<td>619362</td>
</tr>
<tr>
<td>151 Farmington Avenue</td>
<td></td>
</tr>
<tr>
<td>Hartford, CT 06156</td>
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### III. Group Life/AD&D Feature

<table>
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<tr>
<th>Carrier</th>
<th>Contract/Group No.</th>
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<tbody>
<tr>
<td>Cigna Corporation</td>
<td>3205616</td>
</tr>
<tr>
<td>900 Cottage Grove Road</td>
<td></td>
</tr>
<tr>
<td>Harford, CT 0612</td>
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### IV. Group Salary Continuation Feature

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V. Group LTD Feature

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<tbody>
<tr>
<td>Cigna Corporation</td>
<td>3205616</td>
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<tr>
<td>900 Cottage Grove Road</td>
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<tr>
<td>Harford, CT 0612</td>
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VI. Group LTC Feature

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<td>Genworth Life Insurance Company</td>
<td>13010</td>
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<tr>
<td>Long Term Care Claims</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 40007 Lynchburg, VA</td>
<td></td>
</tr>
<tr>
<td>24506-9939</td>
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</table>

VII. Flexible Benefits Feature

A. Healthcare and Dependent Care Flexible Spending Account

<table>
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<tr>
<th>Administrator</th>
<th>Contract/Group No.</th>
</tr>
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<tbody>
<tr>
<td>United Healthcare Services, Inc. One Penn Plaza</td>
<td>40512/NJ, 66013/NY</td>
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<tr>
<td>New York, NY 10119</td>
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B. Health Savings Account

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<th>Contract/Group No.</th>
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<tr>
<td>United Healthcare Services, Inc. One Penn Plaza</td>
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<td>New York, NY 10119</td>
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VII. Business Travel Insurance

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<tr>
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</thead>
<tbody>
<tr>
<td>Cigna Health and Life Insurance Company</td>
<td>02202D</td>
</tr>
<tr>
<td>P.O. Box 15111, Wilmington, DE 19850</td>
<td></td>
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