COLUMBIA UNIVERSITY

RETIREE MEDICAL AND LIFE INSURANCE BENEFITS PLAN

Amended and Restated August 1, 2018
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APPENDIX A COMPONENT PLANS
SECTION I

PURPOSE AND EFFECTIVE DATE

1.1 Purpose. This document constitutes the Columbia University Retiree Medical and Life Insurance Benefits Plan (the “Plan”). Columbia University (the “Employer”) established this Plan to provide medical and life insurance benefits to eligible Retired Employees of the Employer and their Eligible Dependents.

The Plan is intended to be maintained for the exclusive benefit of Participants and their Eligible Dependents. The Plan is established and shall be maintained with the intention of meeting the requirements of ERISA with respect to those Component Plans covered under ERISA (which include all of the Component Plans identified in Appendix A). It is also intended that the Plan qualify as a health plan under Code Sections 105 and 106 and its terms are to be interpreted in a manner consistent with the requirements of such Code sections.

The Employer intends to maintain this Plan for the Participants and their Eligible Dependents but retains the right to amend or terminate, with or without advance notice, the Plan as provided in Section XI.

1.2 Effective Date. The effective date of this amended and restated Plan is May 1, 2018.

1.3 Insured Programs. It is intended that this document cover the insured and self-insured Component Plans offered under the Plan. However, to the extent conflict exists between the Plan document and an applicable Component Plan or Insurance Contract, such Component Plan or Insurance Contract shall supersede the provisions of this document. The following is a nonexclusive list of areas in which an applicable Component Plan or Insurance Contract may supersede this document:

   (a) definitions relating to dependents;
   (b) coordination of benefits;
   (c) claims procedures including appeals; and
   (d) subrogation and right to reimbursement.

The Plan terms including covered services and drugs, protocols, and networks, of any insured Component Plan are not described in this document but are described in the applicable Insurance Contracts and Summary Plan Description, which are hereby incorporated by reference.

1.4 Compliance with the Patient Protection and Affordable Care Act. This Plan is intended to constitute a plan covering “less than two participants who are current employees” for purposes of the Patient Protection and Affordable Care Act (“Affordable Care Act”), as such amends the applicable provisions of the Code and ERISA, and the applicable regulations promulgated from time to time pursuant thereto, as such requirements become
effective from time to time with respect to the Plan. As such, most of the provisions of the Affordable Care Act do not apply to the Plan. Notwithstanding the foregoing, to the extent any requirements of the Affordable Care Act still impact the Plan, the Plan is to be administered and interpreted in a manner consistent therewith. Notwithstanding any provision of the Plan to the contrary, in no event shall an employee of the Employer or any of its affiliates be eligible to be a participant in the Plan. If a participant in the Plan becomes an employee of the Employer or any of its affiliates, such person shall immediately become ineligible for the Plan and shall cease participation in the Plan in all respects.
SECTION II
DEFINITIONS

The following terms used in the Plan shall have the following meanings:

2.1 “Benefit” shall mean the benefits provided to a Participant under a Component Plan or the payment or reimbursement by the Plan to a Participant for an expense which is covered under a Component Plan.

2.2 “Benefit Plan Materials” means the summary plan description of each of the Component Plans identified in Appendix A and such other material which describes the provisions of the Component Plans such as Insurance Contracts or certificates, schedule of benefits and benefits booklet for each Component Plan.

2.3 “Board” or “Board of Trustees” shall mean the Board of Trustees of Columbia University and any other group, position or person authorized by the Board to make decisions concerning the Plan.

2.4 “COBRA” shall mean the provisions of Section 4980B of the Code and Sections 601 through 608 of ERISA, and the regulations issued thereunder, as in effect at the time with respect to which the term is used.

2.5 “Code” shall mean the Internal Revenue Code of 1986, and regulations and rulings issued thereunder as amended from time to time.

2.6 “Component Plan” shall mean any of the plans listed in Appendix A of this Plan.

2.7 “Domestic Partner” shall mean an Employee’s same-sex domestic partner as of the date the Employee first becomes a Retired Employee. An Employee’s domestic partnership status shall be determined in accordance with uniform procedures as adopted by the Plan Administrator. If a Participant enters into a domestic partnership or dissolves a domestic partnership after first becoming eligible for benefits under this Plan, the then current Domestic Partner and any former Domestic Partner of such Participant shall not be eligible for benefits hereunder.

2.8 “Eligible Dependent” shall mean the following:

(a) a Participant’s Spouse;

(b) a Participant’s Domestic Partner; and

(c) a Participant’s Spouse’s or Domestic Partner’s unmarried dependent children, including adopted children, foster children and stepchildren. They are eligible:

(i) until the end of the calendar year in which they turn 19;

(ii) until the end of the month in which they turn 26 if they are full-time students; or
at any age if they have a physical or mental disability, provided that when they were diagnosed they were covered dependents and it was prior to the end of the calendar year in which they turned age 19.

2.9 “Employee” shall mean an individual who is treated as a full-time or part-time employee of the Employer (a) who is paid a salary, wages or other compensation by the Employer; (b) who is considered by the Employer to be an employee at the time of the payment of such salary, wages, or other compensation; and (c) whose salary, wages or other compensation is treated by the Employer at the time of such payment as being subject to statutorily required payroll tax withholding, such as withholding of federal or state income or withholding of the employee’s share of social security tax.

All other individuals will not be included within the definition of “Employee”, even if one or more of such other individuals is determined by a court, the Internal Revenue Service or any other entity under any federal or state law, rule or regulation to be (or have been) a common law or statutory employee of an Employer for some or all of the period of time in question.

2.10 “Employer” shall mean Columbia University or any of its affiliates that are designated by the Board of Trustees of Columbia University for inclusion in this Plan.

2.11 “ERISA” shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

2.12 “HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and the regulations issued thereunder, as in effect at the time with respect to which the term is used, and, in particular, those portions of the Code and ERISA concerning group health plans inserted by such act.

2.13 “Insurance Contract” shall mean any viable contract of insurance between the Employer and an insurer authorized to sell insurance under applicable state law that provides insurance benefits to Participants and covered Eligible Dependents. Any such Insurance Contracts shall apply only during the periods agreed to in the written policy.

2.14 “Medicare” shall mean the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended from time to time.

2.15 “Officer” shall mean an Employee who is eligible to participate in the Columbia University Retirement Plan for Officers.

2.16 “Participant” shall mean any Retired Employee or Eligible Dependent who is eligible to receive a benefit under the terms of this Plan and who is enrolled in this Plan in accordance with Section III.

2.17 “Plan” shall mean the Columbia University Retiree Medical and Life Insurance Benefits Plan, as set forth in this document and as amended from time to time, together with all the Component Plans and all amendments and supplements thereto.
2.18 “Plan Administrator” shall mean the Health and Welfare Administrative Committee, other entity or individual designated from time to time by the Employer to supervise the administration of the Plan. The Plan Administrator will be the “named fiduciary” of the Plan, within the meaning of ERISA Section 402(a).

2.19 “Plan Year” shall mean the period from July 1 to the following June 30.

2.20 “Qualified Beneficiary” shall mean an individual who is a “qualified beneficiary” under Code section 4980B.

2.21 “Qualifying Event” shall mean any of the following events which would result in a loss of coverage for a Qualified Beneficiary: divorce or legal separation; failure to qualify as an Eligible Dependent under the provisions of this Plan; covered Employee’s entitlement to benefits under Medicare (under Part A, Part B, or both); death of a covered Employee; bankruptcy of the Employer (under certain conditions), or any other events which are Qualifying Events within the meaning of COBRA.

2.22 “Retired Employee” or “Retiree” shall mean any former Employee who meets the eligibility criteria set out in Section III.

2.23 “Retirement Plan” shall mean the retirement plan from the following list in which the Employee was an active participant immediately before retirement: the Columbia University Retirement Plan for members of Local 241 of the Transport Workers Union of America, the Columbia University Retirement Plan for Supporting Staff, the Columbia University Retirement Plan for Supporting Staff Association, the Columbia University Retirement Plan for Building and Maintenance Employees of the Columbia University Properties, or the Columbia University Retirement Plan for Officers.

2.24 “Spouse” shall mean the person to whom a Participant is legally married on the date of retirement. If a Participant marries or remarries after first becoming eligible for this Plan, the then current spouse and any former spouse of such Participant shall not be eligible for benefits hereunder. Spouse does not include an individual who is married under common law or who is legally separated from a Participant, unless recognized under the applicable Benefit Plan Materials or required by law.

2.25 “Summary Plan Description” shall mean any and all materials that, when provided to Participants and Covered Eligible Dependents, are collectively intended to meet the requirements of Section 102 of ERISA and the regulations promulgated thereunder.

2.26 “Support Staff” shall mean an Employee who is eligible to participate in the Columbia University Retirement Plan for members of Local 241 of the Transport Workers Union of America, the Columbia University Retirement Plan for Supporting Staff, the Columbia University Retirement Plan for Supporting Staff Association, or the Columbia University Retirement Plan for Building and Maintenance Employees of the Columbia University Properties.

2.27 “Years of Service” shall mean the ‘years of service’ credited to the Participant under the terms of the applicable Retirement Plan, as amended from time to time.
SECTION III

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility. The following Employees are considered “Retired Employees” or “Retirees” and eligible to enroll for benefits under this Plan as described hereunder:

(a) **Officers.** Employees who attain age 55 with 10 or more Years of Service after the age of 45 under the Columbia University Retirement Plan for Officers. Officers receiving benefits under the Columbia University Long Term Disability (“LTD”) program will be eligible to participate in this Plan when the LTD benefit period ends, provided that the Officer had 10 Years of Service when they first began to receive LTD benefits.

(b) **Transport Workers Union.** Employees who retire under the Columbia University Retirement Plan for Members of Local 241 of the Transport Workers Union of America after attainment of age 55 with at least 10 Years of Service; or Employees at age 60 or older plus five (5) Years of Service. If employee retirees under disability, the attainment of age 55 is waived.

(c) **Supporting Staff Association.** Employees who retire under the Columbia University Retirement Plan for Supporting Staff Association after attainment of age 55 with at least 10 Years of Service. If employee retirees under disability, the attainment of age 55 is waived.

(d) **Supporting Staff.** Employees who retire under the Columbia University Retirement Plan for Supporting Staff after attainment of age 55 with at least 10 Years of Service. If employee retirees under disability, the attainment of age 55 is waived.

(e) **Building and Maintenance.** Employees who retire under the Columbia University Retirement Plan for Building and Maintenance Employees of the Columbia University Properties with 10 Years of Service attained prior to July 1, 1991 and who are enrolled in a Columbia University health plan at the time of their retirement.

3.2 Enrollment and Participation.

(a) **Initial Eligibility.** Upon first becoming eligible to participate in this Plan, a Retired Employee and their Eligible Dependents may elect to participate for the remainder of the Plan Year by filing a properly completed election form in accordance with uniform and nondiscriminatory procedures as adopted by the Plan Administrator and as set forth in the Benefit Plan Materials and upon payment of Participant contributions, if any. For participation in the Support Staff Plan through Empire Health Plans, it is not necessary to complete an election form.
(b) **Annual and Special Enrollment Periods.** In addition, during any annual enrollment period, any Participant meeting the eligibility requirements in Section 3.1 above may elect to change Component Plans (as referred to in Section V) or to continue their participation effective as of the first day of any Plan Year by filing a properly completed election form in accordance with procedures adopted by the Plan Administrator on or before the applicable deadline specified in the enrollment provisions of the Benefit Plan Materials. A Participant may waive all medical and dental coverage under this Plan, however once coverage is waived, the Participant and their Spouse/Domestic Partner/Eligible Dependents will not be eligible for any future medical or dental coverage until a designated annual Open Enrollment period, or once per year if no election was made during the Open Enrollment period. If you waive coverage you can only elect coverage within a 5 year window from the date of retirement. Notwithstanding the foregoing, to the extent required under the special enrollment provisions of Code Section 9801(f), a Retired Employee who meets the eligibility requirements in Section 3.1 above and who has not enrolled for coverage under a group health Plan which is a Component Plan (or whose Spouse, Domestic Partner or Eligible Dependent is eligible but not enrolled in such plan) may elect to participate in this Plan if such Employee (Spouse, Domestic Partner or Eligible Dependent, as applicable) loses coverage, or the employer ceases contributions, under a group health plan covering the Spouse or Domestic Partner. In such event the Eligible Employee shall have 30 days from the date he or she loses coverage or employer contributions cease (as applicable) to elect to enroll under such Component Plan.

(c) **Waiver of Enrollment Deadline.** The Plan Administrator may, in its sole discretion, waive the above deadlines for a Retired Employee who is absent due to illness or injury of the retired employee which resulted in the employee being fully and totally medically incapacitated; which must be documented by a physician. This does not apply to Spouse/Domestic Partner/Eligible Dependents of retired employees. If a Retired Employee elects not to enroll in a Retiree Medical and/or Dental Plan upon retirement, he or she has a five year period from the date on which he or she retired to elect to enroll in the Medical and/or Dental Plan. If a Retired Employee does not enroll in the Medical and/or Dental Plan during such five year period, the Retired Employee will waive enrollment in the Medical and/or Dental Plan and will not be eligible to enroll in either of the Plans at any future date. No exceptions will be made.

3.3 **Revocation or Modification of Plan Election.** Plan elections may not be revoked or modified during a Plan Year with respect to all or a part of that same Plan Year except during an annual enrollment period, or, if no election is made during Open Enrollment, then once during each Plan Year, and following other certain situations as permitted under the Code and as set forth in the Benefit Plan Materials. Any revocation or modification of an election shall be made in accordance with uniform and nondiscriminatory procedures as adopted by the Plan Administrator. To the extent required under section 4980B of the Code and sections 601 through 608 of ERISA, the term “Retired Employee” as used in this Section shall also include individuals who elect,
pursuant to COBRA, continuation of their coverage under the Plan after such Retired Employee’s participation in the Plan would otherwise cease under this Section III.

3.4 **Enrollment Process.** Notwithstanding any other provision of this Plan, the Plan Administrator may elect to use an electronic enrollment process. In such cases, the Employer and the Plan Administrator can rely on the elections provided by Participants through such electronic process as if they were provided in written form.

3.5 **Termination of Participation.** A Participant’s participation in the Plan shall terminate upon the earliest of the following dates:

(a) the date the Participant fails to make the required Participant contributions, if any, to the Plan;

(b) the date the Plan is terminated;

(c) the date the Participant dies;

(d) the date the Participant voluntarily waives coverage; or

(e) the date the Participant commits fraud on the Plan.

If the Employer decides to discontinue a Component Plan, a Participant covered by such Component Plan may elect to be covered by another Component Plan then available provided the Participant has continued required contributions.

3.6 **Death of Participant with Covered Spouse or Domestic Partner.** If a Participant has covered a Spouse or Domestic Partner under this Plan at the time the Participant dies, such Spouse or Domestic Partner may continue benefits hereunder by making the requisite contributions for individual coverage. Such Spouse or Domestic Partner cannot cover any other individual under the Plan except a person who was an Eligible Dependent of the Participant immediately before the Participant’s death and in that case only if such individual was covered under the Plan immediately before the Participant’s death and is an Eligible Dependent of the Spouse or Domestic Partner after the Participant’s death.

The Spouse’s or Domestic Partner’s and any Eligible Dependents’ coverage shall terminate upon the earliest of the following dates:

(a) the date the Spouse/Domestic Partner/Eligible Dependent is no longer eligible to participate in the Plan;

(b) the date the Spouse/Domestic Partner/Eligible Dependent fails to make the required contributions, if any, to the Plan;

(c) the date the Plan is terminated;

(d) the date the Spouse/Domestic Partner/Eligible Dependent dies;
(e) the date the Spouse/Domestic Partner/Eligible Dependent waives coverage; or

(f) the date the Spouse/Domestic Partner/Eligible Dependent commits fraud on the Plan.
SECTION IV
PARTICIPANT CONTRIBUTIONS

4.1 Officers who retired before January 1, 1987: Officers who retired before January 1, 1987 are not required to contribute for health coverage hereunder. Notwithstanding the foregoing, Columbia University reserves the right to amend or modify Participant contributions at any time.

4.2 Officers who retired after 1986 and before July 1, 1994: Participants may be required to make contributions for certain Component Plans providing health care benefits. Contributions will be set at the discretion of Columbia University, at its sole discretion.

4.3 Officers who retired after June 30, 1994: The Plan will pay a fixed dollar amount (Columbia Dollar Commitment or “CDC”) toward the cost of a Participant’s medical coverage under the Component Plan. Plan Participants will be responsible for paying the difference between the cost of coverage under the Component Plan that they enroll in and the CDC. In no event will a Participant be entitled to any part of the CDC in cash if the cost of coverage under the Component Plan costs less than the CDC. The CDC may be adjusted by amendment to this Plan.

(a) For the period of July 1, 1994 through June 30, 1997, the CDC was:

(i) $88 per month for a Retired Employee who is age 65 or older and $88 per month for an Eligible Dependent who is age 65 or older;

(ii) $144 per month for a Retired Employee who is under age 65 and $172 per month for an Eligible Dependent who is under age 65;

(b) For the period from July 1, 1997 through June 30, 1999, the CDC was:

(i) $95 per month for a Retired Employee who is age 65 or older and $95 per month for an Eligible Dependent who is age 65 or older;

(ii) $177 per month for a Retired Employee who is under age 65 and $212 per month for an Eligible Dependent who is under age 65;

(c) For the period commencing July 1, 1999 and ending June 30, 2000 the CDC was:

(i) $115 per month for a Retired Employee who is age 65 or older and $115 per month for an Eligible Dependent who is age 65 or older;

(ii) $209 per month for a Retired Employee who is under age 65 and $251 per month for an Eligible Dependent who is under age 65;

(d) For the period commencing July 1, 2000 and the period ending June 30, 2002 the CDC was:
(i) $128 per month for a Retired Employee who is age 65 or older and $96 per month for an Eligible Dependent who is age 65 or older;

(ii) $232 per month for a Retired Employee who is under age 65 and $174 per month for an Eligible Dependent who is under age 65;

(e) For the period commencing July 1, 2002 and ending June 30, 2004 the CDC was:

(i) $144 per month for a Retired Employee who is age 65 or older and $108 per month for an Eligible Dependent who is age 65 or older;

(ii) $248 per month for a Retired Employee who is under age 65 and $186 per month for an Eligible Dependent who is under age 65;

(f) For the period commencing July 1, 2004 the CDC is:

(i) $144 per month for a Retired Employee who is age 65 or older and $72 per month for an Eligible Dependent who is age 65 or older;

(ii) $248 per month for a Retired Employee who is under age 65 and $124 per month for an Eligible Dependent who is under age 65; and

(g) For the period commencing December 31, 2011, the CDC is:

(i) $72 per month for a Retired Employee and $36 per month for an Eligible Dependent.

Columbia University is entitled to any and all refunds, credits, rebates or other payments credited to Columbia University by a Component Plan or government entity. The Plan Administrator may choose to share any of these credits in a manner it deems appropriate.

For purposes of this Section 4.3, if a Participant has more than one Eligible Dependent covered by the Plan, the oldest Eligible Dependent will be the basis for determining the CDC, and the monthly CDC amount shall include all Eligible Dependents. The Plan Administrator may choose the basis and frequency for Participant contributions. Notwithstanding any other provision to the contrary, Columbia University reserves the right to amend or revise the basis for determining contributions for Officers in accordance with Section 11.1.

4.4 Contributions for Support Staff. Participant contributions for Support Staff (other than Support Staff subject to a collective bargaining agreement specifically governing contributions) shall be set by Columbia University at its sole discretion. Participant contributions for Support Staff subject to a collective bargaining agreement specifically governing contributions shall be governed by the applicable collective bargaining agreement. Notwithstanding any other provision to the contrary, Columbia University reserves the right to amend or revise the basis for determining contributions for Support Staff in accordance with Section 11.1.
4.5 **Contributions for Life Insurance.** There are no contributions required for life insurance coverage. Notwithstanding the foregoing, Columbia University reserves the right to amend or modify Participant contributions at any time.
SECTION V

BENEFIT OPTIONS AND PAYMENT OF BENEFITS

5.1 Benefit Options. The benefits of each Component Plan listed in Appendix A are described in the plan document, summary plan description or Insurance Contract for each Component Plan. The Benefit Plan Materials for each of these Component Plans sets forth the substantive Plan provisions, are incorporated herein by reference, and are deemed a part of the Plan. The Plan Administrator will be responsible for selecting vendors and plan design provisions. Except as may be provided in a relevant collective bargaining agreement, the Employer is under no obligation to offer any specific Component Plan(s) or insurer hereunder and may change the Component Plans at any time through administrative action. No amendment to this Plan shall be required to remove or add a Component Plan.

5.2 Payment of Benefits.

(a) The Benefits under this Plan shall be payable according to the payment policy of each Component Plan.

(b) The life insurance benefit under this Plan for Officers is $5,000. Effective for Officers whose employment with the Employer terminated after December 31, 2002, life insurance coverage is eliminated.

(c) The life insurance benefit for Support Staff, if any, shall be governed by the applicable collective bargaining agreement. Unless specifically required by the collective bargaining agreement, Support Staff are not eligible for life insurance benefits under the Plan.
SECTION VI
COORDINATION OF BENEFITS

6.1 Other Plan Coverage. The Benefits of the Component Plans will be coordinated with the coverage under any other plan that provides such benefits or services to a Participant, Spouse, Domestic Partner or Eligible Dependent, which benefits or services are provided in any form, including the following:

(a) group, blanket or franchise insurance coverage;

(b) service plan contracts, group practice, individual practice or other prepayment coverage;

(c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

(d) any coverage under governmental programs, and any coverage required or provided by any statute;

(e) group or individual no-fault automobile contracts or group traditional automobile medical expense contracts; and

(f) student coverage obtained through an educational institution above the high school level.

6.2 Order of Benefit Determination. The order of Benefit determination shall be governed by the applicable Benefit Plan Materials of the Component Plan Except as may be provided otherwise in the applicable Benefit Plan Materials, the following rules will be used to establish the order of Benefit determination:

(a) the plan which covers the person as an employee will pay benefits before the plan which covers the person as a dependent;

(b) (i) except for cases in which a person for whom a claim is made as a dependent child whose parents are separated or divorced, with respect to the plan which covers the person as a dependent, benefits will be payable first from the plan of the parent whose birthday occurs earlier in a calendar year. In the event that such dates of birth are identical, the plan that has covered one of the individuals for the longest period of time shall be primary;

(ii) in the case of a person for whom a claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the plan which covers the child as a dependent of the parent with custody of the child will pay benefits before the plan which covers the child as a dependent of the parent without custody;
(iii) in the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the plan which covers the child as a dependent of the parent with custody shall pay benefits before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will pay benefits before the benefits of a plan which covers that child as a dependent of the parent without custody; and

(iv) in the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, then, notwithstanding Sections (ii) and (iii) above, the plan which covers the child as a dependent of the parent with such financial responsibility shall pay benefits before the benefits of a plan which covers the child as a dependent child;

(c) the plan which covers a person as an employee or a dependent of an employee will pay benefits before the benefits of a plan which covers the person as a retiree or as a dependent of a retiree;

(d) when rules (a), (b) and (c) do not establish an order of benefit determination, the plan which has covered the person on whose expenses claim is based for the longer period of time will pay benefits before the plan which has covered the person the shorter period of time; and

(e) when a plan does not contain a provision coordinating its benefits, that plan is always primary and always pays first.

6.3 Calculation of Benefits. The benefits of another plan will be ignored for the purposes of determining Benefits under this Plan if:

(a) according to the other plan’s coordination rules it determines its benefits after the Benefits of this Plan have been determined; and

(b) the rules set forth in Section 6.2 would require this Plan to determine its Benefits before the other plan.

6.4 Payment. When this coordination of benefits provision operates to reduce the total amount of Benefits otherwise payable as a Participant or provider under this Plan during any claim determination period, each Benefit that would be payable in the absence of this provision will be reduced proportionately and the reduced amount will be charged against any applicable Benefit limit of this Plan.

Under no circumstances will (a) this Plan be obligated to pay an amount greater than the amount for which it would be obligated in the absence of a coordination provision, or (b) will Benefits payable under this Plan and all other plans exceed the total covered charges.
6.5 **Right to Receive and Release Necessary Information.** For the purposes of determining the applicability of and implementing the terms of this Section or any provision of similar purpose of any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other organization or person any information with respect to any person which it deems to be necessary for these purposes. Any person claiming Benefits under this Plan will furnish to the Plan Administrator any information necessary to implement this Section.

6.6 **Facility of Payment.** Whenever payments, which should have been made under this Plan have been made under any other plan, the Plan Administrator will have the right, exercisable alone and in the sole discretion of the Plan Administrator, to pay over to any organization making the payment in any amount it determines are warranted to satisfy the intent of this Section. The amounts so paid will fully discharge the Participating Employers’ liability hereunder to the extent of such payment.

6.7 **Coordination with Medicare.** Section 6.2 notwithstanding, the following rules will be used to establish the order of Benefit determination when the Participant is also entitled to Medicare:

(a) The Plan shall be secondary when the Participant is eligible for Medicare; and

(b) The Plan shall be secondary when the Participant is a disabled employee except when a Participant is entitled to or enrolled in Medicare solely due to End Stage Renal Disease (as defined by Medicare), in which case, the Plan shall be primary for the first 30 months after the Participant becomes entitled to Medicare.
SECTION VII

REQUIRED NOTICES

7.1 COBRA Notices. Within the period permitted by law following the occurrence of a Qualifying Event, the Plan Administrator shall provide any Participant and/or Eligible Dependent who is a Qualified Beneficiary with respect to such qualifying event with a copy of the notice of COBRA rights required by Code Section 4980B in a manner permitted by law. Notwithstanding the foregoing, the Plan Administrator shall provide such other COBRA notices as required under ERISA § 606(a), including:

(a) an initial general notice of COBRA rights to each Participant and their Spouse (if applicable) at the time such Employee becomes covered under a Component Plan which is a group health plan;

(b) a notice to each Qualified Beneficiary not later than 14 days after receipt of notice of a Qualifying Event (by the Employer or Qualified Beneficiary, as required) or such later time as prescribed by ERISA Section 606(a)(4);

(c) a notice of unavailability of COBRA coverage following receipt of a notice of a Qualifying Event; and

(d) a notice of an early termination of COBRA coverage.

7.2 Copy of QMCSO Procedure. Upon receipt by the Plan of a medical child support order as defined in Section 609(a) of ERISA (“QMCSO”), the Plan Administrator shall provide the Participant and each alternate payee listed in the order with a copy of the Plan’s qualified medical child support order procedure in a manner permitted by law.

7.3 Minimum Hospital Stay. To the extent required by the Newborns’ and Mothers’ Health Protection Act of 1996, as amended from time to time, each Component Plan may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Component Plan may not, under federal law, require that any provider obtain authorization from the Component Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). A Component Plan may require, as a condition of the Participant reducing their out-of-pocket costs, a Participant to notify it in advance of a hospital admission in connection with a childbirth. This Section will not create any rights in excess of the minimum required by law.
SECTION VIII

CLAIMS AND REVIEW PROCEDURES

The following Sections 8.1 and 8.2 shall apply only to the extent the applicable Component Plan does not include claims and review procedures:

8.1 Medical Claims and Appeals. For urgent care claims (claims that, unless the special deadlines for response to such claim are followed, either could seriously jeopardize the claimant’s life, health or ability to regain maximum function, or in a physician’s opinion would subject the claimant to severe pain that cannot be adequately managed without the requested treatment) and pre-service claims (claims that require approval of the benefit before receiving medical care), the Plan Administrator will notify the claimant of its benefit determination (whether adverse or not) within the following time frames: (i) 72 hours after receipt of a claim initiated for urgent care (a decision can be provided orally, as long as a written or electronic notification is provided within three days after the oral notification), and (ii) 15 days after receipt of a pre-service claim.

For post-service claims (claims that are submitted for payment after the claimant receives medical care), the Medical Plan Provider will notify the claimant of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For urgent care claims, if the claimant fails to provide the Medical Plan Provider with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Medical Plan Provider shall notify the claimant within 24 hours of receiving the claim of the specific information needed to complete the claim. The claimant then has 48 hours to provide the information needed to process the claim. The claimant will be notified of a determination no later than 48 hours after the earlier of (i) the Medical Plan Provider’s receipt of the requested information, and (ii) the end of the 48-hour period within which the claimant was to provide the additional information, if the information is not received within that time.

For pre and post-service claims, a 15-day extension may be allowed to make a determination, provided that the Medical Plan Provider determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Medical Plan Provider must notify the claimant before the end of the first 15- or 30- day period of the reason(s) requiring the extension and the date it expects to provide a decision on the claim. If such an extension is necessary due to the claimant’s failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. The claimant has 45 days to provide the information needed to process the claim.

If an extension is necessary for pre- and post-service claims due to the claimant’s failure to submit necessary information, the Plan’s time-frame for making a benefit determination is stopped from the date the Medical Plan Provider sends the claimant an
extension notification until the date the claimant responds to the request for additional information.

In addition, if the claimant or their authorized representative fails to follow the Plan’s procedures for filing a pre-service claim, the claimant or their authorized representative, must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the failure. Notification may be oral, unless the claimant or their authorized representative requests written notification. This paragraph only applies to a failure that is (i) a communication by the claimant or their authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, or (ii) is a communication that names the claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

With respect to concurrent care claims, if an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the claimant’s request to extend the treatment is an urgent care claim as defined in this Section 8.1, the claimant’s request will be decided within 24 hours, provided their request is made at least 24 hours prior to the end of the approved treatment. If the claimant’s request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described in this Section 8.1. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the claimant’s request to extend treatment is a non-urgent circumstance, their request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

The Medical Plan Provider will provide claimants with a notification of any adverse benefit determination, which will set forth (i) the specific reason(s) for the adverse benefit determination, (ii) references to the specific Plan provisions on which the benefit determination is based, (iii) description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary, (iv) a description of the Plan’s appeal procedures and the time limits applicable to those procedures, including a statement of claimants’ right to bring a civil action under ERISA after an appeal of an adverse benefit determination, (v) any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge upon request, (vi) if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request, and (vii) if the adverse benefit determination
concerns a claim involving urgent care, a description of the expedited review process applicable to the claim.

If a claimant receives an adverse benefit determination, he/she may ask for a review. The employee or the authorized representative has 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. Claimants have the right to (i) submit written comments, documents, records and other information relating to the claim for benefits, (ii) request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits (for this purpose, a document, record, or other information is treated as “relevant” to the claim if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination, demonstrates compliance with the administrative processes and safeguards required in making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for diagnosis, regardless of whether such statement was relied upon in making the benefit determination), (iii) a review that takes into account all comments, documents, records and other information submitted by the claimant related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination, (iv) a review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person’s subordinate, (v) a review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual (this applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)), (vi) the identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision, (vii) in the case of a claim for urgent care, an expedited review process in which the claimant may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination, and all necessary information, including the Plan’s benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly prompt method.

Ordinarily, a decision regarding a claimant’s appeal will be reached within 36 hours after receipt of a claimant’s request for review of an urgent care claim, 15 days after receipt of a claimant’s request for review of a pre-service claim, and 30 days after receipt of a claimant’s request for review of a post-service claim.

The Medical Plan Provider’s notice of an adverse benefit determination on appeal will contain all of the following information: (i) the specific reason(s) for the adverse benefit determination, (ii) references to the specific Plan provisions on which the benefit determination is based, (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records
and other information relevant to the claim, (iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant’s right to obtain the information about such procedures, and a statement of the right to bring an action under ERISA after exhaustion of the Plan’s claims procedures, (v) any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination or a statement that a copy of this information will be provided free of charge upon request, and (vi) if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the claimant is still dissatisfied with the benefit determination, they may submit a written request to the office where the claim was originally submitted for further review within 180 days after receiving the decision, together with any additional information in support of their request. A decision on this review of the claim will be given to the claimant in writing, explaining the reasons for the decision, with reference to the applicable provisions of the Plan. Ordinarily, this decision will be reached within 72 hours after receipt of the claimant’s request for review of an urgent care claim, 30 days after receipt of the claimant’s request for review of a claim initiated before the service has been provided, and 60 days after receipt of the claimant’s request for review of a claim initiated after the service has been provided.

The Medical Plan Provider will notify the claimant of any adverse benefit determination, including (i) the specific reason(s) for the adverse benefit determination, (ii) references to the specific Plan provisions on which the benefit determination is based, (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, (iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant’s right to obtain the information about such procedures, and a statement of the right to bring an action under ERISA, (v) any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge upon request, and (vi) if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that an explanation will be provided free of charge upon request.

8.2 **All Other Claims and Appeals.** If any person believes they are being denied any rights or benefits under the Plan in connection with a claim for life insurance benefits or eligibility under the Plan, such person may file a claim in writing with the Medical Plan Provider. If they receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the Medical Plan Provider will notify them of the adverse determination within a reasonable period of time, but not later than 90 days after receiving the claim. This 90-day period may be extended for up to an additional 90 days, if the Medical Plan Provider determines that special
circumstances require an extension of time for processing the claim, and notifies the claimant, before the initial 90-day period expires, of the special circumstances requiring the extension of time and the date by which the Plan expects to render a determination.

In the event an extension is necessary due to the claimant’s failure to submit necessary information, the Plan’s time frame for making a benefit determination on review is tolled from the date the Medical Plan Provider sends the claimant the extension notification until the date the claimant responds to the request for additional information.

The Medical Plan Provider will provide the claimant with a notification of any adverse benefit determination, which will set forth: (i) the specific reason(s) for the adverse benefit determination, (ii) reference to the specific Plan provisions on which the benefit determination is based, (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why that material or information is necessary, and (iv) a description of the Plan’s appeal procedures and time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under ERISA after an adverse determination on appeal.

The claimant, or their authorized representative, has 60 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. Claimants have the right to (i) submit written comments, documents, records, and other information relating to the claim for benefits, (ii) request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim for benefits. (For this purpose, a document, record, or other information is treated as “relevant” to the claim if it: was relied upon in making benefits terminations, was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination, or demonstrates compliance with the administrative processes and safeguards required in making the benefit determination), and (iii) a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The Medical Plan Provider will notify the claimant of the Plan’s benefit determination on review within a reasonable period of time, but not later than 60 days after the receipt of the request of review by the Plan. This 60-day period may be extended for up to an additional 60 days, if the Medical Plan Provider determines that special circumstances require an extension of time for processing the claim, and notifies the claimant, before the initial 60-day period expires, of the special circumstances requiring the extension of time and the date by which the Plan expects to render a determination on review.

In the event an extension is necessary due to the claimant’s failure to submit necessary information, the Plan’s time frame for making a benefit determination on review is tolled from the date the Medical Plan Provider sends the extension notification until the date the claimant responds to the request for additional information.
The Medical Plan Provider’s notice of an adverse benefit determination on appeal will contain all of the following information: (i) the specific reason(s) for the adverse benefit determination, (ii) reference to the specific Plan provisions on which the benefit determination is based, (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, and (iv) a statement describing any voluntary appeal procedures offered by the Plan and the right to obtain the information about such procedures, and a statement of the claimant’s right to bring an action under ERISA after an adverse determination on appeal.

8.3 Exhaustion of Administrative Remedies. Claimants will not be entitled to challenge the Medical Plan Provider’s determinations in judicial or administrative proceedings without first complying with the administrative claims procedures set forth in the applicable Component Plan or under this Section, as appropriate. All such claims must be brought within the timeframes set forth above for the claimant’s type of claim. The decisions made pursuant to applicable administrative claims procedures are final and binding on the claimant and any other party. A claimant may, however, seek an external review if their claim meets the conditions set forth in this Section. If the claimant has complied with and exhausted the appropriate claims procedures and intends to exercise their right to bring civil action under ERISA Section 502(a), the claimant must bring civil action under ERISA Section 502(a) within one year after the date of the final claim decision on appeal, or if shorter, the date specified in the Component Plan. If the claimant does not bring such action within such period, the claimant will be barred from bringing an action under ERISA related to their claim.
SECTION IX

ADMINISTRATION

9.1 Administration. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive purposes of providing benefits to the Participants and their beneficiaries and defraying reasonable administrative expenses of the Plan, and operated consistently for similarly situated individuals. Except as provided in Section 8, the Plan Administrator will be the “named fiduciary” of the Plan, within the meaning of Section 402(a) of ERISA for all Component Plans that are subject to ERISA.

9.2 Administrator.

(a) Appointment. The Committee will be appointed by Columbia University, and will have the specific delegated powers and duties described in this Section and such further powers and duties as may be delegated to it by Columbia University, as further described in the Columbia University Health and Welfare Administrative Committee Charter. Any member of the Committee may resign or be removed by Columbia University. The Committee shall be composed of three members: (1) the Provost; (2) the Executive Vice President of Finance, and (3) the Executive Vice President for Health and Biomedical Sciences. The Committee will select a Chairman and may select a Secretary (who may, but need not, be a member of the Committee) to keep its records or to assist it in the doing of any act or thing to be done or performed by the Committee. The Secretary will keep a record of all meetings and forward all necessary communications to the Columbia University. The members of the Committee who are employed by Columbia University will serve without compensation for their services on the Committee, but all reasonable expenses incurred in the performance of their duties will be paid by the Columbia University.

(b) Action. A majority of the members of the Committee at the time in office will constitute a quorum for the transaction of business at any meeting. Any determination or action of the Committee may be made or taken by a majority of the members present at any meeting thereof or without a meeting by a resolution or written memorandum concurred in by a majority of the members then in office. The Committee may adopt such bylaws and regulations as it deems desirable for the conduct of its affairs and may adopt such rules as it deems necessary, desirable, or appropriate. All rules and decisions of the Committee will be uniformly and consistently applied to all Participants in similar circumstances.

9.3 Liability and Indemnification. Each person who is a named fiduciary or a member of any committee or board comprising a named fiduciary shall be indemnified by Columbia University against costs, expenses and liabilities (other than amounts paid in settlement to which Columbia University does not consent) reasonably incurred by them in connection with any action to which they may be a party by reason of their service as a named fiduciary except in relation to matters as to which they shall be adjudged in such action to
be personally guilty of gross negligence or willful misconduct in the performance of their duties. The foregoing right to indemnification shall be in addition to such other rights as the person may enjoy as a matter of law or by reason of insurance coverage of any kind, but shall not extend to costs, expenses and/or liabilities otherwise covered by insurance or that would be so covered by any insurance then in force if such insurance contained a waiver of subrogation. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which the person may be entitled pursuant to the bylaws of Columbia University. Service as a named fiduciary shall be deemed in partial fulfillment of the person’s function as an employee, officer, or director of Columbia University, if the person serves in that capacity as well as in the role of named fiduciary. 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.

9.4 Powers and Authority of Plan Administrator. The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator’s powers will include those duties outlined in the Columbia University Health and Welfare Administrative Committee Charter. All actions and determinations of the Plan Administrator will be final and binding upon all Retired Employees, Eligible Dependents, beneficiaries, Columbia University, the Employer and any other interested parties.

9.5 Records and Reports. The Plan Administrator will maintain such records of its activities and of Participants and operations as it deems necessary and appropriate. Plan records pertaining to Columbia University or Retired Employees (subject to any privacy and confidentiality protections required by law or established by the Plan Administrator’s rules) will be available for examination by Columbia University at reasonable times during normal business hours. The Plan Administrator’s Plan records pertaining to a Participant will be available for examination by such Participant upon written request at reasonable times during normal business hours.

To the extent required by applicable law, the Plan Administrator will provide each eligible Retired Employee from time to time with a written explanation of the Plan in form and substance sufficient to satisfy the summary plan description requirements of Department of Labor Regulations Sections 2520.102-2 through 2520.102-4. Upon written request, the Plan Administrator will furnish a Participant (or beneficiary) with a copy of the latest updated summary plan description, the latest annual report, any trust agreement, contract, or other instrument under which the Plan is established or operated, within 30 days of the request.

The Administrator will make such reports to Columbia University as it will reasonably request, and such reports to government authorities as applicable law will require.
SECTION X

SUBROGATION AND RIGHT OF REIMBURSEMENT

10.1 Third Party Causation. If a Participant or Eligible Dependent:

(a) suffers an injury or sickness because of a Third Party’s (as defined in Section 10.4 hereof) act or omission; and

(b) as the result of the injury or sickness incurs medical expense which are covered charges under the Plan, the Plan will have a right of reimbursement to the extent any payment is made by the Plan and the Participant or Eligible Dependent recovers from the Third Party.

The Plan, at its sole option, will also have subrogation rights to any claim or right of action which the Participant or Eligible Dependent may have against the responsible Third Party, to the extent that the Plan’s intervention is necessary to recover any payment made by the Plan.

10.2 Participant Requirements. The Participant or Eligible Dependent must:

(a) notify the Plan Administrator or Plan Administrator of the identity of the responsible Third Party and of any proceedings which the Participant or Eligible Dependent initiates against the Third Party;

(b) execute the necessary documents or do whatever is reasonably requested by the Plan Administrator to secure the Plan’s rights under this Section;

(c) give the Plan a lien against the responsible Third Party directing such Third Party to pay the Plan any amount due to the Plan under this Section; and

(d) give the Plan Administrator notice of the terms of any settlement or proposed settlement with the Third Party.

10.3 Reimbursement of the Plan. If a Participant or Eligible Dependent recovers a payment of any kind from the responsible Third Party or such Third Party’s insurer as: a legal judgment; an arbitration award; a settlement; or otherwise, the Participant or Eligible Dependent must reimburse the Plan for the lesser of:

(a) the amount of payment made by the Plan; or

(b) the amount recovered from the Third Party less any reasonable legal fees for which the Participant or Eligible Dependent is responsible related to such recovery.

The Plan shall retain the right of reimbursement out of any recovery obtained regardless of whether or not the Participant or Eligible Dependent is made whole.
10.4 Third Party. For purposes of this Section, Third Party shall mean any person or entity whose act or omission caused or is alleged to have caused a Participant or Eligible Dependent to suffer an injury or sickness for which medical expenses are incurred and are covered charges under the Plan.
SECTION XI

AMENDMENT OR TERMINATION OF PLAN

11.1 Amendment of the Plan. Columbia University shall have the right at any time by instrument in writing, duly executed and acknowledged by its Board (or its delegate), to modify, alter, amend or delete the Plan in whole or in part. Columbia University shall have the limited right to amend the Plan at any time, retroactively or otherwise, in such respects and to such extent as may be necessary to fully comply with applicable laws and regulations, and if and to the extent necessary to accomplish such purpose, such amendment may decrease or otherwise affect benefits to which Participants may have become entitled, notwithstanding any provision herein to the contrary. Such amendment shall be binding upon all Participants and Eligible Dependents (including those individuals on continuation coverage under COBRA).

Notwithstanding the preceding paragraph, the Plan Administrator will have the right to amend any provision of the Plan that is administrative, procedural, or ministerial in nature, and any written policy, rule, procedure or similar action adopted by the Administrator that is inconsistent with any administrative, procedural or ministerial provision of the Plan will be deemed an amendment.

11.2 Termination of the Plan. Columbia University reserves the right at any time to terminate or partially terminate the Plan at any time. Termination of the Plan shall apply to all Participants (including those on COBRA continuation coverage). Upon Plan termination, Benefits for claims incurred before the termination date will be paid under the terms of the Plan as in existence on the termination date.

Should Columbia University decide to terminate or partially terminate the Plan, the Plan Administrator shall be notified of such termination in writing and shall proceed at the direction of Columbia University to take such steps as are necessary to discontinue the operation of the Plan in an appropriate and timely manner.

11.3 Amendment or Termination of Component Plan. Sections 11.1 and 11.2 will not govern the amendment or termination of any Component Plan. The Employer is under no obligation to offer any specific Component Plan hereunder and may change the Component Plan at any time through administrative action. Any amendment to a Component Plan shall constitute an amendment to the Plan.
SECTION XII
MISCELLANEOUS

12.1 Limitation of Rights. Neither the establishment, maintenance and provisions of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator or any Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

12.2 Non-assignable Rights. Unless specifically permitted by the Benefit Plan Materials, the right of any Participant to receive any benefits under the Plan (including the right to file a lawsuit against the Plan, any Component Plan, the Employer, the Plan Administrator, or any Plan fiduciary with respect to the Plan) will not be alienable by assignment. The right of any Participant to receive any benefits under the Plan will not be subject to any claims by any creditor of or claimant against the Participant; and any attempt to reach such amounts by any such creditor or claimant, or any attempt by the Participant 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 a Participant 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 Employer to be liable for, or subject to, any manner of debt or liability of any Participant.

12.3 No Guarantee of Tax Consequences. Neither the Plan Administrator nor any Employer may make any commitment or guarantee that any amounts paid to or for the benefit of a Participant from this Plan or any Component Plan will be excludable from the Participant’s gross income for federal or state tax income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether a payment from any benefit is excludable from the Participant’s gross income for federal and state income tax purposes.

12.4 Governing Law and Forum Selection. The Plan will be construed, administered and enforced according to the laws of the State of New York to the extent not preempted by federal law. Any legal action (whether in law, in equity or otherwise) must be brought in the U.S. District court of the Southern District of New York, where the Plan is administered.

12.5 Word Usage. Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine, or neuter form.
12.6 **Titles Are For Reference Only.** The titles are for reference only. In the event of a conflict between a title and the content of a Section, the content of the Section shall control.

12.7 **No Vested Interest.** No person shall have any right, title or interest in or to the assets of the Employer because of the Plan.

12.8 **Refunds Due to Favorable Experience.** Any and all refunds of premiums by insurance carriers under insured benefits that result from better than expected experience shall be the sole property of Columbia University except as further provided herein, Columbia University shall use such refunds to reduce its cost of providing benefits under the Plan.

In the event that benefits under a Component Plan are fully paid by Participant contributions, refunds arising from such insured coverages will be used to reduce the cost of such benefits to covered Participants under such plan in subsequent Plan Years as may be required by applicable law or regulations.

12.9 **No Funding; Facility for Payment of Premiums.** No provision of this Plan shall operate to require prefunding of benefits, nor the establishment of a trust to hold Retiree or Employer contributions. Premiums for insured coverages shall be paid according to the rules established by the applicable insurance carrier and Columbia University shall simply facilitate the transfer of payments thereto.

12.10 **Delegation of Responsibilities.** The Employer in its sole discretion may delegate any of its fiduciary responsibilities under the Plan to another person or persons pursuant to a written instrument that specifies the fiduciary responsibilities so delegated to each such person. To the extent that the Employer delegates fiduciary functions to other persons or such fiduciary functions are granted to such other persons under the terms of the Plan, the Employer delegates certain fiduciary responsibilities to the claim administrator, as applicable under the Component Plans. The claim administrator has discretion to interpret the terms of the Plan, to make factual findings, and to determine eligibility for benefits. The decision of the claim administrator shall not be overturned unless arbitrary and capricious.
SECTION XIII

HIPAA PRIVACY AND SECURITY

13.1 Privacy Policy Incorporated by Reference. The Columbia University Health Plan HIPAA Privacy Policy (the “Privacy Policy”) sets forth the privacy policies and procedures applicable to the Plan. The terms of the Privacy Policy, as amended from time to time, are hereby incorporated by reference. Any defined terms used herein, will have the meaning given to them in the Privacy Policy. Permitted Disclosures of PHI. The Plan may disclose a Plan Participant’s protected health information (“PHI”) to an Employer to the extent not inconsistent with the HIPAA regulations, for the following purposes:

(a) The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to a participating Employer information on whether the individual is participating in the Plan, or is enrolled in or has dis-enrolled from a health insurance issuer or HMO offered by the Plan.

(b) The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to an Employer, provided that the Employer requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

(c) The Plan may disclose PHI to an Employer to carry out plan administration functions that the Employer performs, provided the disclosure is consistent with the Privacy and Security Rules.

13.3 Restriction on Plan Disclosure to Employer. Except as otherwise permitted or required by law, the Plan will not disclose PHI to the Employer except upon the Plan’s receipt of the Employer’s certification that the Employer agrees with the conditions and restrictions in the Privacy Policy, and that the Employer will: (a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that the Employer creates, receives, maintains or transmits on behalf of the Plan; (b) ensure that adequate separation of the Plan and the Employer is established, and that such adequate separation is supported by reasonable and appropriate security measures; (c) ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Plan agree to implement reasonable and appropriate security measures to protect such Electronic PHI; and (d) report to the Plan any security incident, as defined in 45 C.F.R. § 164.304, about which the Employer becomes aware. The Plan will not disclose PHI to the Employer for the purpose of employment-related actions or decisions.

13.4 Adequate Separation Between the Plan and Employer. The Employer and Plan have adequate separation as is established by the Privacy Policy and the following:

(a) Employees With Access to PHI. The employees or other individuals under the control of the Employer who may access PHI received from the Plan are those Responsible Employees set forth in the Privacy Policy.
(b) **Use Limited to Plan Administration.** The access to and use of PHI by the individuals described in (a), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Employer for the Plan.
IN WITNESS WHEREOF the Employer has caused this instrument to be executed by its duly authorized officers, as of the ___ day of ______________, 2018

COLUMBIA UNIVERSITY

By: ______________________________
Name: Daniel Driscoll
Title: Vice President Human Resources
APPENDIX A

COMPONENT PLANS

1. The Employer offers Participants and their Eligible Dependents certain health care and welfare benefits which include those listed below. Each such program and various options thereunder shall constitute a Component Plan.

   (a) Individual or family health care benefits under an indemnity program (whether or not insured);
   (b) Individual or family participation in one of certain managed care plans;
   (c) Prescription drug benefits; and
   (d) Group Life Insurance plan

The coverage under (d) above is provided by CINGA.

2. As of July 1, 2018 the coverages under (a), (b) and (c) above are provided by

   (a) For Officers:
       (i) UnitedHealthcare Indemnity plans;
       (ii) UnitedHealthcare HMO;
       (iii) UnitedHealthcare Choice Plus 100;
       (iv) Aetna Medicare Advantage PPO plans; and
       (v) OptumRX Prescription plan.

   (b) For Support Staff:
       (i) Empire Blue Shield Blue Cross Major Medical.

3. Except as may be provided in the applicable collective bargaining agreements, the Employer is under no obligation to offer any specific Component Plan(s) or insurer hereunder and may terminate or amend the Component Plans at any time.

4. Except as expressly provided herein, the operation of the plans described above shall be governed by the Benefit Plan Materials, which describes such Component Plan.