

**COLUMBIA UNIVERSITY**  
**RETIREE MEDICAL AND LIFE INSURANCE**  
**BENEFITS PLAN DOCUMENT**

**As Amended and  
Restated Effective  
January 1, 2023**

**COLUMBIA UNIVERSITY**  
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**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”) has established this Plan to provide medical and life insurance benefits to eligible Retired Employees of the Employer and their dependents. The Plan also includes a Retiree health reimbursement arrangement, which is a component of the Plan for the benefit of certain of its retirees. The underlying individual insurance policies in which eligible retirees enroll are not intended to be sponsored by the Employer and are not governed by ERISA, except to the extent required by law, in which case such policies shall be considered a component of this Plan. The health reimbursement arrangement is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (“Code”), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This Plan is also intended to be exempt from the Affordable Care Act as a separate “retiree-only” plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2).

Effective as of January 1, 2023, for Retired Employees, the participant contributions, as identified in Section 5.3, remain unchanged. Non-Grandfathered Officers and their Eligible Dependents are eligible for Benefit Credits to be contributed to their HRA Accounts, in the amounts identified in Section 6.2.

The Employer intends to maintain this Plan for the Participants and their Eligible Dependents but retains the right to amend or terminate this Plan as provided in Section XIII.

- 1.2. Effective Date. The effective date of this restatement of the Plan is January 1, 2023.
- 1.3. Relationship of Plan to Via Benefits and Via Benefits Policies. For non-Grandfathered Officers and their Eligible Dependents, the purpose of the Plan is to provide reimbursement of certain medical expenses to non-Grandfathered Officers and their Dependents who are eligible for and have enrolled in Medicare Part A and B, and who have voluntarily elected to enroll in Via Benefits and to purchase a Via Benefits Policy to provide coverage to supplement their Medicare benefits. Neither Via Benefits itself, nor any of the Via Benefits Policies, shall be considered part of, or a benefit provided under, the Plan, and under no circumstances shall the Employer have any responsibility or liability for the failure of any Via Benefits Policy to provide coverage for any medical benefit or treatment. Notwithstanding the foregoing, to the extent the Department of Labor or other applicable regulatory agency determines that the Via Benefits Policies shall be considered to be sponsored by the Employer, then such policies shall be considered to be a component of this Plan for all purposes, retroactive to the earliest applicable date of such determination.
- 1.4. Insured Programs. It is intended that this document cover the insured and self-insured programs 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

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.



## **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 Credits” shall mean the amount, if any, credited to a non-Grandfathered Officer’s or their Eligible Dependent’s HRA Account in each Plan Year for purposes of determining the amount of benefits for which the Participant is entitled to be reimbursed pursuant to Section 6.2.
- 2.3. “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 administrative services agreements, Insurance Contracts, and/or Summary Plan Descriptions for each Component Plan.
- 2.4. “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.
- 2.5. “Catastrophic Coverage Reimbursement” shall mean expenses incurred by the Participant in each Plan year in excess of the level of catastrophic expense established each year by the Social Security Administration pursuant to Medicare Part D.
- 2.6. “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.
- 2.7. “Code” shall mean the Internal Revenue Code of 1986, and regulations and rulings issued thereunder as amended from time to time.
- 2.8. “Combined Account” shall mean that only one HRA Account will be established for all Participants in a single family and all Benefit Credits for all such Participants will be credited to such HRA Account.
- 2.9. “Component Plan” shall mean any of the plans listed in Appendix A of this Plan.
- 2.10. “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.

- 2.11. “Eligible Dependent” shall mean the following:
- (a) a Participant’s Spouse
  - (b) a Participant’s Domestic Partner
  - (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
    - (iii) 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.
- 2.12. “Eligible Expense” shall mean an expense incurred by a non-Grandfathered Officer or any Eligible Dependent for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease).
- 2.13. “Employee” shall mean any individual employed by Columbia University on a full or part-time basis.
- 2.14. “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.
- 2.15. “ERISA” shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.
- 2.16. “Via Benefits” shall mean the private insurance policy Via Benefits designated by the Administrator.
- 2.17. “Via Benefits Policy” shall mean a MediGap, Medicare Supplement, or similar insurance policy purchased by a non-Grandfathered Officer or Eligible Dependent through Via Benefits.
- 2.18. “Grandfathered Officer” shall mean any Officer who retired before July 1, 1994, and who is otherwise eligible to participate in the Plan.
- 2.19. “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.

- 2.20. “HRA Account” shall mean the bookkeeping account established pursuant to Section 6.1 to determine the amount of Eligible Expenses for which a Participant is eligible to be reimbursed pursuant to the Plan.
- 2.21. “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.
- 2.22. “International Participant” shall mean a non-US resident traveling outside of the United States who is otherwise eligible under Section III of the Plan upon his or her return to the United States.
- 2.23. “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.
- 2.24. “Medicare Eligibility Date” shall mean the date as of which a non-Grandfathered Officer, Spouse, Domestic Partner or Dependent first becomes eligible to enroll in Part A and B of Medicare.
- 2.25. “Officer” shall mean an Employee who is eligible to participate in the Columbia University Retirement Plan for Officers.
- 2.26. “Participant” shall mean any Retired Employee 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.
- 2.27. “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.
- 2.28. “Plan Administrator” shall mean the Employer or such person, committee or entity as may be appointed from time to time by the Employer to supervise the administration of the Plan.
- 2.29. “Plan Year” shall mean the period from July 1 to the following June 30.
- 2.30. “QMCSO or Qualified Medical Child Support Order” shall mean a “medical child support order” that satisfies the requirements of the QMCSO Procedures.
- 2.31. “Qualified Beneficiary” shall mean an individual who is a “qualified beneficiary” under Code section 4980B.
- 2.32. “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.

- 2.33. “Retired Employee” or “Retiree” shall mean any former Employee who meets the eligibility criteria set out in Section III.
- 2.34. “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.
- 2.35. “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.
- 2.36. “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.
- 2.37. “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.
- 2.38. “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 benefits eligible service after the age of 45 under the Columbia University Retirement Plan for Officers. Officers receiving benefits under the Columbia University Long Term Disability 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. Notwithstanding the foregoing, the only Component Plan available to non-Grandfathered Officers who have attained age 65 shall be the HRA Account, subject to the additional eligibility terms and conditions as described in Section IV. You must be enrolled in a Columbia university medical plan as an active employee in order to be eligible for the retiree medical benefit once you retire.
  - (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 who retired on or before January 1, 1999 at age 60. If employee retires under disability, the attainment of age 55 is waived. You must be enrolled in a Columbia university medical plan as an active employee in order to be eligible for the retiree medical benefit once you retire.
  - (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 retires under disability, the attainment of age 55 is waived. You must be enrolled in a Columbia university medical plan as an active employee in order to be eligible for the retiree medical benefit once you retire.
  - (d) Supporting Staff and District 65. 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 retires under disability, the attainment of age 55 is waived. You must be enrolled in a Columbia university medical plan as an active employee in order to be eligible for the retiree medical benefit once you retire.
  - (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. You must be enrolled in a Columbia university medical plan as an active employee in order to be eligible for the retiree medical benefit once you retire.

3.2. Enrollment and Participation.

- (a) Initial Eligibility. Upon first becoming eligible to participate in this Plan, a Retired Employee and his 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 VII) or to continue his 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 coverage under this Plan, however once coverage is waived, the Participant and his Spouse/Domestic Partner/Eligible Dependents will not be eligible for any future medical coverage until a designated annual Open Enrollment period, or once per year if no election was made during the Open Enrollment period. 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

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 Eligible

Employees 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 discontinued;
  - (c) the date the Participant dies if such Participant has no covered Spouse or Domestic Partner;
  - (d) the date the Participant voluntarily waives coverage.

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.

Notwithstanding the foregoing, a non-Grandfathered Officer who is participating in a Component Plan providing medical coverage shall lose eligibility upon attaining age 65 (subject to any applicable COBRA continuation rights) and become eligible to enroll in the HRA Account, as described in Section IV.

- 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 fails to make the required contributions, if any, to the Plan;
  - (b) the date the Plan is discontinued;
  - (c) the date the Spouse/Domestic Partner/Eligible Dependent dies;
  - (d) the date the Spouse/Domestic Partner/Eligible Dependent waives coverage.

Notwithstanding the foregoing, the Spouse or Domestic Partner of a non-Grandfathered Officer who is participating in a Component Plan providing medical coverage shall lose eligibility upon attaining age 65 (subject to any applicable COBRA continuation rights) and become eligible to enroll in the HRA Account, as described in Section IV.

**SECTION IV**  
**ELIGIBILITY AND PARTICIPATION FOR NON-GRANDFATHERED OFFICERS**

41. Eligibility. “Non-Grandfathered Officers” include those individuals who otherwise meet the eligibility criteria provided in Section 3.1(a) who have further attained age 65. Subject to the conditions and limitation of the Plan, each non-Grandfathered Officer shall be eligible to participate on the later of the Effective Date of the Plan or the date he or she satisfies the requirements of paragraph (a) and (b) of Section 4.2. To be eligible for the health reimbursement arrangement, a non-Grandfathered Officer must be enrolled in the Employer’s medical coverage as of his or her retirement date. Notwithstanding the foregoing, an International Participant who is not enrolled in the Employer’s medical coverage at the time of retirement but who otherwise meets the eligibility criteria in Section 3.1(a) shall be eligible for coverage under this Section IV as long as such individual enrolls pursuant to the process established by the Plan Administrator within three months following the date such individual enrolls in Medicare.
42. Enrollment and Participation.
- (a) Enrollment in Medicare. In order to participate in the Plan, a non-Grandfathered Officer must enroll in Medicare Part A and B, and maintain his or her Medicare Part A and B coverage. A non-Grandfathered Officer will be eligible to enroll in the HRA account three months prior to his or her Medicare Eligibility Date, the month of his or her Medicare Eligibility Date and three months after his or her Medicare Eligibility Date. A non-Grandfathered Officer will be given a two-month extension after this window closes to enroll in a HRA Account. If a non-Grandfathered Officer does not enroll in a HRA Account by the end of the enrollment period, he or she will no longer be eligible to participate in the HRA Account.
  - (b) Purchase of Individual Health Insurance. In order to participate in the Plan, a non-Grandfathered Officer must enroll in a medical plan on Via Benefits to access his or her HRA Account. A non-Grandfathered Officer must have also completed any enrollment forms or procedures required by the Plan Administrator.
  - (c) Other Exceptions and Special Rules. A non-Grandfathered Officer who is otherwise eligible to participate in the Plan, but who is receiving assistance under Medicaid shall not be required to obtain a Via Benefits Policy that would adversely affect his or her eligibility for Medicaid.
43. Participation by Dependents.
- (a) The Spouse or Domestic Partner of a non-Grandfathered Officer shall be eligible to participate in the Plan in the same manner as if he or she were a non-Grandfathered Officer. When an eligible Spouse or Domestic partner attains his or her Medicare Eligibility Date, he or she may enroll in Medicare Part A and B on Via Benefits and become a Participant in the Plan even if the non-Grandfathered Officer has not yet attained his or her Medicare Eligibility Date. If the Spouse or



Domestic Partner has not yet attained his or her Medicare Eligibility Date at the time the non-Grandfathered Officer attains his or her Medicare Eligibility Date, the Spouse or Domestic Partner shall not be required to enroll in Via Benefits, and shall not participate in the HRA Account, until he or she attains his or her individual Medicare Eligibility Date. A Spouse or Domestic Partner who fails to enroll in Medicare Part A and B, and to enroll in Via Benefits and obtain a Via Benefits Policy, within the three months following the date such individual attains his or her Medicare Eligible Date shall not thereafter be eligible to participate regardless of whether the non-Grandfathered Officer becomes a participant.

- (b) If a Spouse or Domestic Partner remarries (or enters into a new domestic partnership), his or her new spouse or domestic partner is not eligible.
- (c) A Dependent other than a Spouse or Domestic Partner is ineligible to participate in the Plan, unless a disabled child of a non-Grandfathered Officer, Spouse or Domestic Partner is either covered, or eligible to be covered, when he or she attains his or her Medicare Eligibility Date, in which event the Dependent may become a Participant by enrolling in Medicare Part A and B and obtaining a Via Benefits Policy as provided in Section 4.2.
- (d) An individual who is a Participant as the Spouse or Domestic Partner of a non-Grandfathered Officer and later becomes a non-Grandfathered Officer in his or her own right shall be eligible to participate in the Plan as a non-Grandfathered Officer on the date he or she becomes a non-Grandfathered Officer, provided that he or she satisfies the requirements of Section 4.2(a) and (b).
- (e) A non-Grandfathered Officer may be required to provide proof of Dependent status such as a marriage certificate or birth certificate, upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in benefits provided under the Plan.
- (f) The Plan will allow reimbursement of Eligible Expenses for a child of a non-Grandfathered Officer in accordance with a Qualified Medical Child Support Order (“QMCSO”) to the extent the QMCSO does not require coverage not otherwise offered under the Plan. The Plan Administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan’s QMCSO procedures referenced in Section 9.2. The Plan Administrator will notify both the non-Grandfathered Officer and the affected child once a determination has been made.

44. Termination of Participation. An individual shall cease to be covered under the Plan, as a non-Grandfathered Officer, upon the earliest of the following events:

- (a) The last day of the month in which the non-Grandfathered Officer’s coverage under Medicare Part A and B, or his or her Via Benefits Policy, is terminated, for failure to pay premiums or otherwise, unless he or she obtains a new Via Benefits Policy without a gap in coverage;

- (b) The last day of the month in which the non-Grandfathered Officer or any member of his or her family submits a falsified, altered, or fraudulent claim;
  - (c) The date the non-Grandfathered Officer ceases to be eligible for any reason;
  - (d) The date the non-Grandfathered Officer is rehired by the Employer as an active employee;
  - (e) The date of the non-Grandfathered Officer's death; or
  - (f) The end of the day as of which the Plan is terminated or amended so as to no longer apply to the non-Grandfathered Officer.
45. An individual shall cease to be covered under the Plan, as an Eligible Dependent, upon the earliest of the following events:
- (a) The date the Eligible Dependent ceases to be an Eligible Dependent for any reason;
  - (b) The date the Eligible Dependent ceases to make the required premium payments;
  - (c) The date that the Eligible Dependent ceases to be eligible for Medicare (unless he or she remains eligible under another provision of the Plan);
  - (d) In the case of an Eligible Dependent spouse; the date of divorce from the non-Grandfathered Officer;
  - (e) The date of the non-Grandfathered Officer's death, if the sponsor ceases to make Benefit Credits to the Eligible Dependent, as reflected in the Plan Information Appendix;
  - (f) The effective date of any amendment terminating eligibility under the Plan; or
  - (g) The date the Plan is terminated.

**SECTION V**  
**PARTICIPANT CONTRIBUTIONS**

- 5.1. Officers who retired before January 1, 1987: Officers who retired before January 1, 1987 are not required to contribute for health coverage hereunder.
- 5.2. 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 the Plan Administrator.
- 5.3. Officers who retired after June 30, 1994 and before December 31, 2011: Please refer to Section 6.2 on HRA Benefit Credits
- 5.4. Officers who retired after January 1, 2012: Please refer to Section 6.2 on HRA Benefit Credits

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

The Plan Administrator may choose the basis and frequency for Participant contributions. Notwithstanding any other provision to the contrary, the Employer reserves the right to amend or revise the basis for determining contributions for Officers in accordance with Section 11.1.

There is no charge for participation in the HRA Account for a post-65 non-Grandfathered Officer. Any cost for Via Benefits Policies are the responsibility of the non- Grandfathered Officer (and his or her Spouse or Domestic Partner).

- 5.5. 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, the Employer reserves the right to amend or revise the basis for determining contributions for Support Staff in accordance with Section 11.1.
- 5.6. Contributions for Life Insurance. There are no contributions required for life insurance coverage. Life insurance benefits are only available to Grandfathered Officers.

**SECTION VI**  
**PARTICIPANT CONTRIBUTIONS FOR NON-GRANDFATHERED OFFICERS**

- 6.1. Establishment of Accounts. An HRA Account shall be established for each non-Grandfathered Officer Participant who is eligible to receive a Benefit Credit, which shall be credited with the amount of the Benefit Credit to which the Participant is entitled and shall be used by the non-Grandfathered Officer to pay for Eligible Expenses. An HRA Account is merely a bookkeeping account on the Employer's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Employer's general assets.
- 6.2. Benefit Credits. The Account of each Participant who participates for an entire Plan Year shall be credited with a Benefit Credit in January of each year as set forth below:
- (a) Non-Grandfathered Officers retired after 01/01/2012.
    - (i) \$220 annual Benefit Credit.
    - (ii) \$110 Spouse/Domestic Partner HRA Benefit Credit (if applicable).
  - (b) Non-Grandfathered Officers retired between 07/01/1994 and 01/01/2012.
    - (i) \$440 annual Benefit Credit.
    - (ii) \$220 Spouse/Domestic Partner HRA Benefit Credit (if applicable).
  - (c) The Employer may change the amount of the Benefit Credit at any time.
  - (d) Participants may also qualify for Catastrophic Coverage Reimbursement, as described in Section 6.4, below.
- 6.3. Reimbursement of Expenses.
- (a) If a non-Grandfathered Officer and his or her Spouse or Domestic Partner are both Participants, each may be eligible for a Benefit Credit as provided above. Dependents other than Spouses or Domestic Partners are not eligible for a Benefit Credit.
  - (b) One HRA Account will be established for all Participants in the non-Grandfathered Officer's family.
  - (c) Benefit Credits will be credited to HRA Accounts by the Employer in the full amount before the start of each calendar year and will be reduced from time to time by the amount of any Eligible Expenses for which the Participant is reimbursed under the Plan. At any time, the Participant may receive reimbursement for Eligible Expenses up to the amount in his or her HRA Account.
  - (d) Only Eligible Expenses incurred while a non-Grandfathered Officer or an Eligible Dependent is a Participant in the Plan may be reimbursed from an HRA Account.

Eligible Expenses are “incurred” when the medical care is provided, not when the Eligible Dependent is billed, charged or pays for the expense. Health insurance premiums are incurred for the coverage period to which they apply. An expense that has been paid but not incurred (e.g. pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

- (e) If the Participant fails to maintain his or her Medicare Part A and B enrollment or his or her Via Benefits Policy, any remaining balance in his or her HRA Account may be used to reimburse Eligible Expenses incurred prior to the termination of participation, but any remaining balance shall be forfeited and may not be used to reimburse Eligible Expenses incurred after termination of participation.
- (f) If the non-Grandfathered Officer dies with no Eligible Dependents who are Participants in the Plan, his or her HRA Account is immediately forfeited upon death, but the deceased non-Grandfathered Officer’s estate or representatives may submit claims for Eligible Expenses incurred by the non-Grandfathered Officer and his or her Eligible Dependents up to and including his or her date of death. Claims must be submitted within 180 days of his or her death.
- (g) If the non-Grandfathered Officer dies with one or more Eligible Dependents who are Participants, his or her HRA Account shall continue and the Eligible Dependents who are Participants can continue to submit Eligible Expenses for reimbursement. Claims must be submitted within 180 days of his or her death.
- (h) The following expenses may not be reimbursed from an HRA Account:
  - (i) expenses incurred for qualified long term care services;
  - (ii) expenses incurred for covered Part D prescription drugs;
  - (iii) expenses incurred prior to the date that the non-Grandfathered Officer became a Participant in the HRA;
  - (iv) expenses incurred after the date that the non-Grandfathered Officer ceased to be a Participant in the HRA;
  - (v) expenses that have been reimbursed by another plan or for which the non-Grandfathered Officer plans to seek reimbursement under another health plan; and
  - (vi) any other expenses specifically identified as excluded in the Plan Information Appendix.
- (i) A non-Grandfathered Officer or Eligible Dependent may not obtain reimbursement of any Eligible Expenses incurred after the date his or her eligibility ceases. He or she has 180 days after their eligibility ceases, however, to request reimbursement of Eligible Expenses incurred before eligibility ceased.

- (j) If a non-Grandfathered Officer or Eligible Dependent does not use all of the amounts credited to his or her HRA Account during a Plan Year, those amounts will be forfeited.

6.4. Catastrophic Coverage Reimbursement. Catastrophic Coverage Reimbursement is provided under this Plan. Catastrophic Coverage Reimbursement begins after a Participant has reached the higher of:

- (a) The Catastrophic Coverage level as defined by Medicare for the applicable year; or
- (b) The level set by the Plan Administrator.

The Plan shall also reimburse each Participant who has either a Medicare Advantage or MediGap Via Benefits Policy for all covered prescription drug expenses incurred by the Participant in each Plan Year in excess of the level of level of “catastrophic” expense established each year by the Social Security Administration pursuant to Medicare Part D. Benefits pursuant to this Section 6.4 are not limited by the balance in a Participant’s Account, and are not charged against the Account. Only covered prescription drug expenses incurred by a Participant while participating in the Plan are eligible for reimbursement.

6.5. Erroneous Payments. If it is later determined that a non-Grandfathered Officer or their Eligible Dependent received an overpayment or a payment was made in error (e.g., reimbursed from a HRA Account for an expense that is later paid by another medical plan), the non-Grandfathered Officer or Eligible Dependent will be required to refund the overpayment or erroneous reimbursement to the Employer. If the non-Grandfathered Officer or Eligible Dependent does not refund the overpayment or erroneous payment, the Employer reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to him or her from the Employer. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt.

**SECTION VII**  
**BENEFIT OPTIONS AND PAYMENT OF BENEFITS**

- 7.1. 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.
- 7.2. 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 VIII**  
**COORDINATION OF BENEFITS**

81. 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 trustee 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.
82. 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;

(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; and

(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.

83. 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 8.2 would require this Plan to determine its Benefits before the other plan.

84. 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.

85. 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.
86. 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.
87. Coordination with Medicare. Section 8.2 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;
  - (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 IX**  
**REQUIRED NOTICES**

91. 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 his or her 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.
92. 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.

**SECTION X**  
**CLAIMS AND REVIEW PROCEDURES**

The following Sections 10.1 and 10.2 shall apply only to the extent the applicable Component Plan does not include claims and review procedures. Any claim for benefits must be filed no later than one year after the date such claim accrued, otherwise the claim will be denied as untimely.

- 10.1. 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 Plan Administrator 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 Plan Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator 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 Plan Administrator'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 Plan Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Plan Administrator 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 Plan Administrator sends the claimant an extension notification until the date the claimant responds to the request for additional information.

In addition, if the claimant or his authorized representative fails to follow the Plan's procedures for filing a pre-service claim, he or his 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 his authorized representative requests written notification. This paragraph only applies to a failure that is (i) a communication by the claimant or his 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 10.1, the claimant's request will be decided within 24 hours, provided his 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 10,1. 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, his 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 Plan Administrator 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 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 may ask for a review. He or his 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 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 Plan Administrator’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, he may submit his written request to the office where the claim was originally submitted for further information in support of his 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 Plan Administrator 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.

Any civil action must be brought no later than six months following the final determination on appeal.

102. Life Insurance Claims and Appeals. If any person believes he is being denied any rights or benefits under the Plan in connection with a claim for life insurance benefits, such person may file a claim in writing with the Plan Administrator. If he receives an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the Plan Administrator will notify him of the adverse determination within 90-day period may be extended for up to an additional 90 days, if the Plan Administrator both 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 Plan Administrator sends the claimant the extension notification until the date the claimant responds to the request for additional information.

The Plan Administrator 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 his 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 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 Plan Administrator 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 Plan Administrator both 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 of the Plan Administrator sends the extension notification until the date the claimant responds to the request for additional information.

The Plan Administrator'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.

Claimants must use and exhaust the Plan's administrative claims and appeals procedures before bringing a suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause claimants to lose their right to sue regarding an adverse benefit determination. Any civil action must be brought no later than six months following the final determination on appeal.

## **SECTION XI** **ADMINISTRATION**

- 11.1. Plan Administrator. The administration of the Plan shall be under the supervision of the Plan Administrator, who, if not Columbia University, shall act with the advice of Columbia University. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms and those of the Component Plans, for the exclusive benefit of persons entitled to participate in such Plans without discrimination among them. The Plan Administrator will have full power to administer the Plan in its entirety subject, however, to the requirements of ERISA. In particular, the Plan Administrator's powers will include, but will not be limited to, the following authority with respect to the Plan and all Component Plans (to the extent not inconsistent with the terms of such Component Plan):
- (a) To make and enforce such rules and regulations as deemed necessary or proper for the efficient administration of the Plan;
  - (b) To interpret the Plan, his interpretation thereof to be final and conclusive on all persons claiming benefits under the Plan;
  - (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;
  - (d) To compute the amount of contributions required to be paid by Participants or other persons and benefits (if any) which will be payable to any Participant or other person in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits will be paid;
  - (e) To authorize the payment of benefits (if any);
  - (f) To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan; and
  - (g) To allocate and delegate his responsibilities under the Plan and to designate other persons to carry out any of his responsibilities under the Plan, any such allocation, delegation or designation to be by written instrument and in accordance with Section 405 of ERISA.

In carrying out its duties and exercising its powers under subsection (a) through (e) above and with respect to the administration of the claims and review procedures under Section X

(or in carrying out its duties or exercising its powers as plan administrator or otherwise under any Component Plan), the Plan Administrator will have discretion to interpret and apply the terms of the Plan, and the Plan Administrator's determination of any question will be subject to review (by a court or otherwise) only for an abuse of discretion.

- 11.2. Examination of Records. The Plan Administrator will make available to each Participant such of his records as pertain to him, for examination at reasonable times during normal business hours.
- 11.3. Reliance on Tables, Etc. In administering and interpreting the Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by any accountant, counsel or other expert who is employed or engaged by the Plan Administrator.
- 11.4. Named Fiduciary. The Plan Administrator will be a "named fiduciary" for purposes of Section 402(a)(1) of ERISA with authority to control and manage the operation and administration of the Plan, and will be responsible for complying with any reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA as applicable to the Plan.
- 11.5. Compensation and Bonding of Plan Administrator. Unless otherwise agreed to by the Employer, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by the Employer. Unless otherwise determined by the Employer or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.
- 11.6. Expenses. All expenses of the Plan shall be paid from Participant contributions or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.
- 11.7. Liability Insurance. The Employer may obtain liability coverage at the Employer's expense to insure any person serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or any other Employee who was delegated to perform the Plan Administrator's duties.
- 11.8. Indemnification. To the extent permitted by law and not prohibited by its charter and by-laws, Columbia University will indemnify and hold harmless every individual serving as Plan Administrator or as a fiduciary of the Plan (whether a named fiduciary or otherwise), and the estate of such individual if he is deceased, from and against all claims, loss, damages, liability, and reasonable cost and expenses, incurred in carrying out his fiduciary or other responsibilities, unless due to the gross negligence, bad faith or willful misconduct of such individual; provided that counsel fees and amounts paid in settlement must be approved by Columbia University and provided costs and expenses which are covered by a liability insurance policy maintained by Columbia University, or by the Plan or by an individual fiduciary. The preceding sentence will not apply to an insurance company or outside service provider (or to any Retiree of neither of the foregoing) unless Columbia University otherwise specifies in writing.

- 11.9. Plan Records. The Plan Administrator shall cause to be maintained such records and accounts as may be reasonably necessary or desirable for the proper management and administration of the Plan, shall render such statements to the Employer or its delegate(s) as the Employer may request, and shall report to the Employer no less frequently than annually with regard to the matters for which it is responsible hereunder. The Plan Administrator shall also cause to be maintained for inspection by any individual who participates or is eligible to participate in the Plan, a copy of the document governing the Plan; the latest annual report, summary annual report, and summary plan description; and any amendments or changes to these documents. Upon written request, the Plan Administrator shall provide to such participating or eligible individuals a copy of these documents and may impose a reasonable charge, as permitted by law, for such copies.

**SECTION XII**  
**SUBROGATION AND RIGHT OF REIMBURSEMENT**

- 12.1. 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 12.4 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.

- 12.2. 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.

- 12.3. Reimbursement of the Plan. If a Participant or Eligible Dependent recovers a payment of 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.

- 12.4. 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 XIII** **AMENDMENT OR TERMINATION OF PLAN**

- 13.1. 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 through its delegates, the Senior Vice President of Columbia University or the Vice President of Human Resources), to modify, alter, amend or delete the Plan in whole or in part. Columbia University or its delegates as listed above 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 may amend Appendix A or may attach a substitute Appendix A to describe the Component Plans in effect from time to time hereunder without following the procedures otherwise required for an amendment of this Plan.

- 13.2. Termination of the Plan. Columbia University reserves the right at any time to terminate or partially terminate the Plan. 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.

- 13.3. Amendment or Termination of Component Plan. Sections 13.1 and 13.2 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 XIV**  
**MISCELLANEOUS**

- 14.1. Limitation of Rights. Neither the establishment 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.
- 14.2. Non-assignable Rights. The right of any Participant to receive any reimbursement or benefit under the Plan shall not be alienable by the Participant by assignment, transfer or any other method, and will not be subject to be his creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.
- 14.3. 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.
- 14.4. Governing Law and Forum Selection. The Plan will be construed, administered and enforced according to the laws of the State of New York. Any action brought against the Plan or its fiduciaries must be brought in federal court in the Southern District of New York.
- 14.5. 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.
- 14.6. 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.
- 14.7. No Vested Interest. No person shall have any right, title or interest in or to the assets of the Employer because of the Plan.
- 14.8. 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.

14.9. 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.

14.10. Health Insurance Portability and Accountability Act (HIPAA) - Privacy.

(a) Permitted Uses and Disclosures of Protected Health Information (PHI). The Employer may only use and disclose protected health information it receives from the Plan as permitted and/or required by, and consistent with the HIPAA Privacy and Security regulations found at 45 CFR Part 164, Subpart A. This includes, but is not limited to, the right to use and disclose Participant's protected health information (including electronic protected health information) in connection with payment, treatment and health care operations.

The Plan will disclose protected health information to the Employer only upon receipt of a certification by the Employer that the plan documents have been amended to incorporate all the required provisions as described below.

***The Employer agrees to:***

- (1) Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;
- (2) Ensure that any agents, including a subcontractor, to whom it gives protected health information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
- (4) Ensure that any agent, including subcontractor, to whom it gives electronic protected health information, agrees to implement reasonable and appropriate security measures to protect such information;
- (5) Not use or disclose the information for employment-related actions and decisions or in connection with any other Benefit or employee Benefit plan of the Employer;
- (6) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware;

- (7) Report to the Plan any security incident of which the Employer becomes aware;
  - (8) Make available protected health information in accordance with individuals' rights to review their protected health information;
  - (9) Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA Privacy rules;
  - (10) Make available the information required to provide an accounting of disclosures in accordance with the HIPAA Privacy rules;
  - (11) 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 the Department of Health and Human Services (HHS) for purposes of determining compliance by the Plan with the HIPAA Privacy rules; and
  - (12) If feasible, return or destroy all protected health information received from the Plan that the Employer still maintains in any form. The Employer will retain no copies of protected health information when no longer needed for the purpose for which disclosure was made. An exception may apply if such return or destruction is not feasible, but the Plan must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- (b) Separation of Employer and the Plan. The Employer's HIPAA Privacy Policy details which persons are considered "Responsible Employees", as defined under HIPAA.

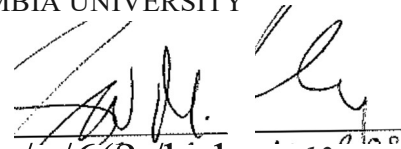
The Employer shall restrict the access to and use of protected health information by such employees and other persons described above to the Plan administration functions that the Employer performs for the Plan, including payment and health care operations.

Access to and use by such Employees and other persons described in this section shall be restricted to the Plan administration functions that the Employer as plan sponsor performs for the Plan. No other persons shall have access to protected health information. The Employer shall ensure that the separation between the Plan and the Employer is supported by reasonable and appropriate security measures. Any incidents of noncompliance by such individuals with the provisions of this section shall subject such individuals to disciplinary action and sanctions, including the possibility of termination of employment. The Employer will report such noncompliance to the Plan and will cooperate with the Plan to correct the noncompliance, impose an appropriate disciplinary action or sanction, and mitigate the effect of noncompliance.

- (c) To the extent that this Plan contains Benefits or Component Plans other than those covered by the HIPAA Privacy rules, this Section shall pertain only to those Benefits or Component Plans which are covered under HIPAA 's Privacy rules.

IN WITNESS WHEREOF the Employer has caused this instrument to be executed by its duly authorized officers, as of the \_\_\_ day of \_\_\_\_\_, 2022.

COLUMBIA UNIVERSITY



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## 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 participation in one of certain managed care plans
  - (b) Prescription drug benefits
  - (c) Health Reimbursement Account
  - (d) Group Life Insurance plan
2. The coverages under (a) - (c) above are provided by
  - (a) For Officers:
    - (i) United Healthcare and Aetna Medicare Advantage Plans (except for non-Grandfathered Officers that have reached age 65); and
    - (ii) Via Benefits (health reimbursement arrangement for non-Grandfathered Officers that have reached age 65)
  - (b) For Support Staff: Empire Blue Shield Blue Cross Major Medical.

The coverage under (d) above is provided by Cigna Life Insurance.
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 change 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.