COLUMBIA UNIVERSITY

Flexible Benefits Plan Document

(IRS Section 125 Plan)

(Amended and Restated Effective as of April 24, 2012)

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ARTICLE I

ESTABLISHMENT OF PLAN

1.1 Purpose and Organization

Columbia University (the "University") has established and maintains the Columbia University Section 125 Plan (the "Plan") to provide its Employees the means to elect to obtain benefits available under the plans identified in Section 1.4, sometimes referred to hereinafter as the "Constituent Plans," through the use of salary reduction arrangements described under Article IV of the Plan.

1.2 Effective Date

The Plan was originally effective as of January 1, 1993, and is now amended and restated effective as of May 1, 2012.

1.3 Qualification

The Plan is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"). With the exception of the Health Care FSA, the Plan is not intended to be an employee benefit plan under Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document is intended to satisfy the writing requirements of Proposed Treasury Regulation Section 1.125-1(c).

1.4 Constituent Plans

The Plan is a master plan and is composed of the four Constituent Plans identified in this section. Each Constituent Plan is intended to qualify as a cafeteria plan under Section 125 of the Code and is established for the exclusive benefit of Participants, their Spouses and their Dependents. Notwithstanding any other provision of the Plan, an Employee electing one or more benefits under the Plan shall be subject to any specific provisions, conditions, requirements, limitations, and exclusions of the Constituent Plans for which such Employee has elected a benefit. All such Constituent Plans are hereby incorporated into the Plan by reference to the extent that they apply to the operation of the Plan. The Constituent Plans, which are a part of this Plan and included herein, are as follows:

The Dependent Care Flexible Spending Account (the "Dependent Care FSA"), as set forth in Appendix A, is part of this Plan and is intended to qualify as a dependent care assistance program under Section 129 of the Code, which permits Employees to pay for Dependent Care Expenses (as defined in Appendix A) with pre-tax dollars. The benefits provided under this Plan are intended to be eligible for exclusion from income under Sections 125(a) and 129(a) of the Code. The Dependent Care FSA shall be interpreted and applied in a manner consistent with this intent. Appendix A is intended to satisfy the writing requirements of Code Section 129(d)(1).

The Health Care Flexible Spending Account (the "Health Care FSA"), as set forth in Appendix B, is part of this Plan and is intended to be an employee welfare benefit plan under Section 3(3) of ERISA. Appendix B is intended to satisfy the writing requirements of Section 402 of ERISA. This Plan is intended to qualify as a qualified benefits plan that is a health care flexible spending arrangement as defined under Section 106(c)(2) of the Code and Proposed Treasury Regulation Section 1.125-5, which permits Employees to pay for Qualifying Medical Expenses (as defined in Appendix B) with pre-tax dollars. The benefits provided hereunder are intended to be eligible for exclusion from income to the extent provided under Sections 105(b), 106 and 125(a) of the Code, as applicable. The Health Care FSA shall be interpreted and applied in a manner consistent with this intent.

The Heath Savings Account ("HSA") Program, as set forth in Appendix C, is established and maintained to permit HSA-Eligible Employees to make pre-tax contributions to a Health Savings Account pursuant to Section 223 of the Code to cover "qualified medical expenses," as defined in Section 223(d)(2) of the Code. The HSA Program shall be interpreted and applied in a manner consistent with this intent. The terms of the HSA Program are fully included in the Plan.

The Section 125 Payment Plan is established and maintained to permit Employees to pay, under Sections 105, 106 and 125 of the Code, their share of the cost of medical, dental and/or vision plan coverage under the Employer's health insurance plans listed on Appendix D (the "Health Plans") with pre-tax dollars. The Section 125 Payment Plan shall be interpreted and applied in a manner consistent with this intent. The terms of the Section 125 Payment Plan are fully included in the Plan.

1.5 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the University in its sole and absolute discretion, and, in accordance with the provisions of Article VIII, may amend or terminate the Plan or any provision of the Plan at any time.

ARTICLE II

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings.

2.1 Affiliate

Affiliate means any entity affiliated with the University within the meaning of Code Section 414(b) with respect to members of a controlled group of corporations, Code Section 414(c) with respect to trades or businesses under common control with the University, Code Section 414(m) with respect to affiliated service groups, and any other entity required to be aggregated with the University under Section 414(o) of the Code. No entity shall be treated as an Affiliate for any period during which it is not part of the controlled group, under common control or otherwise required to be aggregated under Code Section 414.

2.2 Child

Child means the following with respect to the Participant: biological child, stepchild, legally adopted child, and foster child, as well as any child placed with the Participant for adoption, any eligible child for whom the Participant is responsible under court order, a child for whom the Participant is appointed legal guardian, and, solely with respect to the Section 125 Payment Plan, and any rights related thereto, the Participant's domestic partner's child.

2.3 Claims Administrator

Claims Administrator means the person(s) or entity (or entities) authorized and responsible for receiving and reviewing claims for benefits under the Plan and the Constituent Plans; determining what amount, if any, is due and payable; and making appropriate disbursements to persons entitled to benefits under the Plan and the Constituent Plans.

2.4 Code

Code means the Internal Revenue Code of 1986, as amended, from time to time. All references to any section of the Code shall be deemed to refer not only to such section but also to any amendment thereof and any successor statutory provision.

2.5 Committee

Committee means the committee authorized by the University's Board of Trustees to act on its behalf with respect to administration and claims review under the Plan.

2.6 Compensation

Compensation means the base salary or wages paid to an Employee by the Employer in each Plan Year that is currently includable in gross income and required to be reported on the Employee's Form W-2.

2.7 Constituent Plan

Constituent Plan means any of the employee benefit plans identified as Constituent Plans in Section 1.4.

2.8 Coverage Period

Coverage Period means a Plan Year, except that with respect to the Health Care FSA, Coverage Period means a Plan Year and the Grace Period following the close of such Plan Year, as permitted under Proposed Treasury Regulation Section 1.125-1(e).

Notwithstanding the foregoing, for purposes of Sections 105, 125 and 129 of the Code, and the regulations thereunder, the Plan Year or the portion of the Plan Year remaining after an Employee first becomes a Participant in the Plan and one or more of the Constituent Plans, and any applicable Grace Period, shall be the Employee's Coverage Period under the Plan and Constituent Plans.

2.9 Dependent

Dependent means any individual who is a tax dependent of the Participant as defined in Code Section 152, with the following exceptions: (a) for purposes of health coverage (to the extent funded under the Section 125 Payment Plan and for purposes of the Health Care FSA and HSA Program), a dependent is defined as in Code Section 152 (determined without regard to Sections 152(b)(1), (b)(2) or (d)(1)(B)), or as a Participant's Child until the last day of the year in which the Child attains age 26; and (b) for purposes of the Dependent Care FSA, a dependent means a "qualifying individual" as defined in Appendix A.

2.10 Dependent Care FSA

The Dependent Care FSA is the plan set forth in Appendix A. The Dependent Care FSA is established for the purpose of permitting an Employee to receive, in lieu of taxable compensation, reimbursement by the Employer of the cost of dependent care assistance incurred by the Employee or the Employee's Spouse.

2.11 Employee

Employee means any individual employed by the Employer who is normally scheduled to work at least thirty (30) hours per week, other than an employee who is part of a unit of employees covered by a collective bargaining agreement, unless such collective bargaining agreement expressly provides for the inclusion of such person. The term Employee shall not include any individual classified by the Employer at the time services are provided as either an independent contractor

or an individual who is not classified by the Employer as an Employee but who provides services to the Employer through another entity for that period the individual is so initially classified, even if such individual is later retroactively reclassified as an employee during all or any part of such period pursuant to applicable law or otherwise.

2.12 Employer

Employer means Columbia University or any Affiliate participating in the Plan.

2.13 ERISA

ERISA means the Employee Retirement Income Security Act of 1974, as amended. All references to any section of ERISA shall be deemed to refer not only to such section but also to any amendment thereof and any successor statutory provision.

2.14 Grace Period

Grace Period means the period of up to the fifteenth day of the third month immediately following the end of each Plan Year, during which a Participant who has unused benefits or contributions relating to his Health Care FSA from the immediately preceding Plan Year, may incur Qualifying Medical Expenses and be paid or reimbursed for those Qualifying Medical Expenses from the unused benefits or contributions as if the expenses had been incurred in the immediately preceding Plan Year, pursuant to Proposed Treasury Regulation Section 1.125-1(e). To the extent any unused benefits or contributions from the immediately preceding Plan Year exceed the Qualifying Medical Expenses incurred during the Grace Period, those remaining unused benefits or contributions shall be forfeited.

2.15 Health Care FSA

The Health Care FSA is the plan set forth in Appendix B, which shall include a Health Care FSA Account or a Limited Purpose/Post-Deductible Health Care FSA Account, as elected by the Participant. The Health Care FSA is established for the purpose of permitting an Employee to receive, in lieu of taxable compensation, reimbursement by the Employer of certain uninsured medical expenses incurred by the Employee, the Employee's Spouse and/or Dependents.

2.16 Health Care FSA Account

Health Care FSA Account has the meaning prescribed by Section 2.3 of Appendix B.

2.17 Health Savings Account/HSA

Health Savings Account or HSA means a health savings account within the meaning of Code Section 223.

2.18 Health Savings Account Program/HSA Program

The HSA Program is the plan set forth in Appendix C. The HSA Program is established for the purpose of permitting an HSA-Eligible Employee to receive, in lieu of taxable compensation, reimbursement by the HSA of "qualified medical expenses" (as defined in Code Section 223(d)(2)) incurred by the Employee, the Employee's Spouse and/or Dependents.

2.19 High Deductible Health Plan/HDHP

High Deductible Health Plan or HDHP means a plan that is intended to qualify as a high deductible health plan under Code Section 223(c)(2), as described in materials provided separately by the Employer. A High Deductible Health Plan may or may not be the sole medical insurance plan eligible for pre-tax salary reduction funding hereunder.

2.20 HSA-Eligible Employee

HSA-Eligible Employee means an individual who is eligible to contribute to an HSA under Code Section 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.

2.21 Limited Purpose/Post-Deductible Health Care FSA Account

Limited Purpose/Post-Deductible Health Care FSA Account is a combination limited purpose health care FSA account and post-deductible health care FSA account, as described in Section 2.5 of Appendix B.

2.22 Participant

Participant means any Employee who has elected to participate in the Plan and in one or more of the Constituent Plans.

2.23 Plan

Plan means the Columbia University Section 125 Plan as herein set forth and as amended from time to time.

2.24 Plan Administrator

Plan Administrator means the University.

2.25 Plan Year

Plan Year means the calendar year.

2.26 Restated Effective Date

Restated Effective Date means May 1, 2012.

2.27 Section 125 Payment Plan

The Section 125 Payment Plan is established for the purpose of providing that an Employee's share of the cost of insurance premiums or other costs of benefit coverage under the Health Plans listed on Appendix D is to be paid by the reduction of the Employee's compensation.

2.28 Spouse

Spouse means an individual of the opposite sex who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

2.29 University

University means Columbia University or any successor by merger, consolidation, purchase or otherwise.

ARTICLE III

ELIGIBILITY, PARTICIPATION, AND COVERAGE

3.1 Eligibility

Each Employee shall be eligible to participate in the Section 125 Payment Plan, the Dependent Care FSA and the Health Care FSA within 31 days of the date of hire or classification as an Employee.

Each Employee who qualifies as an HSA-Eligible Employee shall be eligible to participate in the HSA Program upon his or her fulfillment of the service requirement for enrollment in a High Deductible Health Plan offered by the Employer.

3.2 Participation

An Employee shall become a Participant in the Plan and one or more of the Constituent Plans as soon as practicable following the filing of the completed form(s) or completion of enrollment materials prescribed by the Plan Administrator for such purpose.

A. Coverage During Leave of Absence.

1. Paid Leave.

During a paid leave of absence, a Participant continues to participate in the Constituent Plans in which he or she elected to participate, except that participation in the Dependent Care FSA shall be suspended on the day on which the Participant's paid leave begins. Except as provided below, if the Participant returns to active employment in the same Plan Year as the paid leave began, participation in the Dependent Care FSA shall be automatically reinstated as of the date of such return to active employment, and any salary reduction agreement shall be reinstated and adjusted to reflect the period of suspension. If the Participant experienced a *Change in Status*, as described in Section 5.1(E)(3)(b), in connection with or during the period of absence, the Participant may, upon return to active employment, make a new election and salary reduction agreement with respect to the Dependent Care FSA in accordance with the rules prescribed in Section 5.1(E)(3)(b).

2. Unpaid Leave.

A Participant who is on an approved unpaid leave of absence may continue coverage under the Constituent Plans in which he or she elected to participate, except that participation in the Dependent Care FSA shall be suspended on the day on which the unpaid leave begins.

B. Date Coverage Ceases.

An Employee shall terminate participation in the Plan and/or Constituent Plan(s) on the earliest of:

1. the date he ceases to be an Employee, or if later, and solely with respect to the Health Care FSA, a COBRA Continuee;

2. except as provided in Sections 3.2(A)(2) and 3.2(F), the last day of the last pay period for which a Participant's salary is reduced as required for Plan participation;

3. the date that the Plan and/or the relevant Constituent Plan(s) are terminated; or

4. the date as of which the Employee elects to discontinue his participation in the Plan or a Constituent Plan in accordance with the terms of the Plan and/or Constituent Plan.

C. Effect of Terminated Coverage.

Upon a Participant terminating participation in the Plan, the Participant's salary reduction agreement shall automatically terminate. A Constituent Plan's terms governing the Participant's selected benefits control whether and to what extent coverage and benefits under that Constituent Plan continues.

D. Reinstatement of Coverage.

1. If Previously Suspended.

Except as hereinafter provided, a former Participant whose participation has been suspended pursuant to Section 3.2(A)(2) and who returns to active service for the Employer during the same Plan Year that he or she took the unpaid leave of absence shall automatically resume participation in the Constituent Plan(s) in which such Participant participated with appropriate adjustment to any salary reduction agreement to reflect the period of suspension, provided that such Participant may revoke his or her prior election

and salary reduction agreement and make new benefit elections to the extent provided in Section 5.1(E)(3)(b).

2. If Previously Terminated.

A former Participant who is reemployed by the Employer during the same Plan Year that his or her employment terminated may make new elections under the Constituent Plan(s), subject to Section 5.1(C), upon the Employee satisfying the eligibility requirements of Section 3.1, provided that, in the event of reemployment by the Employer within thirty (30) days of the Participant's termination date absent the occurrence of a *Change in Status*, as described in Section 5.1(E)(3)(b), including a *Change in Status* that occurs while the Employee was separated from the service of the Employer (but excluding the prior termination or current recommencement of employment with the Employer), the rehired Employee's prior benefit elections will be reinstated for the remainder of the Plan Year.

E. Coverage under Family and Medical Leave Act and Section 609 of ERISA.

1. Family and Medical Leave Act of 1993.

If not otherwise provided for herein, the Plan shall provide such coverage for a Participant as may be required, and any provision of this Article III shall be modified to the extent necessary to comply with the Family and Medical Leave Act of 1993 ("FMLA"), and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

2. Section 609 of ERISA.

If not otherwise provided for herein, the Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order under Section 609(a) of ERISA or to an adoptive child solely to the extent required by Section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with Section 609 of ERISA and the rulings and regulations issued thereunder.

3. Coverage Contingent Upon Contribution.

Any coverage provided as a result of this Section 3.2(E) shall be conditioned upon payment of applicable contributions with respect to the Employee.

F. Failure to Make Contributions to the Plan.

1. Notwithstanding anything herein to the contrary, effective as of January 1, 2010, in the event a Participant's Compensation for a payroll period is less than his or her elected pre-tax contributions with respect to all Constituent Plans pursuant to his or her salary reduction agreement, the Participant's available pre-tax contributions will first be applied to the Section 125 Payment Plan, then to the Health Care FSA, then to the HSA Program, and finally to the Dependent Care FSA. The Participant will continue to be covered under any Constituent Plan for which his or her available pre-tax contributions did not cover the entire elected amount, for a period of up to sixty (60) days from the date of non-payment of the required payment. Any such missed pre-tax contributions will be deducted from the Participant's next payroll payment.

2. Solely with respect to a Participant described in Section 3.2(F)(1) above and notwithstanding anything herein to the contrary, such Participant shall be permitted to make after-tax payments to the Plan in an amount equal to his or her elected, but unpaid, pre-tax contributions, during the sixty (60) day period following such non-payment. If no such after-tax payment is made, the Participant's coverage under the applicable Constituent Plan will terminate on the sixty-first (61st) day after the date of such non-payment, and the Participant will not be eligible to resume participation under the Constituent Plan for the remainder of the Plan Year.

ARTICLE IV

BENEFITS

4.1 Benefit Options

As a condition of Plan participation, Participants must elect either:

A. to receive the full unreduced compensation benefit described in Section 4.2, or

B. to forego all or part of the unreduced compensation benefit described in Section 4.2 and make pre-tax contributions in exchange for one or a combination of benefits described in Section 4.3.

An Employee who fails to make an affirmative election on or before the specified due date for the initial Plan Year in which the Employee is eligible shall be deemed to have elected to receive the full unreduced compensation benefit described in Section 4.2.

A Participant's elections under this Plan for any Plan Year with respect to the Section 125 Payment Plan benefit, as described in Section 4.3, shall continue beyond the Plan Year until revoked by the Participant in accordance with the terms of the Plan. In the event of such continuation, the Participant shall be deemed to have elected to continue the same benefits and coverages that are then in effect for such Participant for such Plan Year (with an adjustment under the enrollment form and corresponding salary reduction agreement thereunder with respect to the Section 125 Payment Plan to the extent there has been an announced change in the periodic cost to Participants).

4.2 Unreduced Compensation Benefit

In lieu of all or some of the benefits described in Section 4.3 that a Participant otherwise could elect, he or she may elect to receive unreduced compensation in an amount equal to the value of the benefits not elected. The unreduced compensation benefit shall be subject to the Employer's regular payroll practices; applicable local, state, and federal income tax withholding; and other applicable deductions. The unreduced compensation benefit shall not be deemed to be additional Compensation. The unreduced compensation benefit shall cease whenever the Participant goes on an unpaid leave of absence, terminates employment, or the Employer determines, in its sole discretion, that Compensation is not payable to such Employee.

4.3 Benefits

By electing one or more benefits hereunder, a Participant shall convert a portion of his or her Compensation for the Plan Year into contributions to the Constituent Plan that governs the selected benefit. The Constituent Plan's terms, as amended from time to time, shall govern a Participant's rights and obligations under it. Participants may elect one or more of the following benefits:

A. Section 125 Payment Plan Benefit.

An Employee eligible to participate in the Health Plans may elect to pay premiums under such plans on a pre-tax basis.

B. Dependent Care FSA Benefit.

An Employee may elect participation in the Dependent Care FSA, which permits Participants to pay for dependent care expenses on a pre-tax basis, subject to the limitations set forth in Appendix A.

C. Health Care FSA Benefit.

An Employee may elect participation in the Health Care FSA, which permits Participants to pay for Qualifying Medical Expenses on a pre-tax basis, subject to the limitations set forth in Appendix B.

D. HSA Program.

An HSA-Eligible Employee may elect to make pre-tax contributions to the HSA to cover qualified medical expenses, subject to the limitations set forth in Appendix C.

The Employer shall contribute amounts corresponding to the benefits that Participants select to the Constituent Plan(s) governing the Participants' selected benefits. Except for contributions made pursuant to Section 4.3(D) above or as provided in Section 5.1(E)(3)(a), Participants forfeit unused salary reductions, if any. Forfeitures may not be cashed out or applied toward any other Plan benefit.

Distributions from the HSA (whether before or after termination of employment) and all other matters relating to a Participant's HSA are outside of this Plan and are to be handled by the Participant and his or her trustee/custodian in accordance with the terms of their agreement.

4.4 Limits For Certain "Key" Employees

Benefits payable under the Plan to each key employee, as defined in Code Section 416(i)(1), shall be limited to the extent necessary to avoid violating Code Section 125(b)(2).

4.5 Notification of Benefit Amounts

The Plan Administrator shall provide written notification to Employees and Participants regarding the cost of the benefits prior to the initial and annual enrollment/election periods. The cost of benefits shall be the cost of the premium under the various options offered under the Health Plans, and the minimum/maximum contributions that may be made under the other Constituent Plans.

ARTICLE V

PROCEDURES

5.1 Enrollment/Election Procedures

A. Forms and Agreements.

Employees may enroll, make elections, and direct the Employer to make salary reductions only by filing and/or completing the appropriate forms or agreements with the Plan Administrator before the deadline described in Section 5.1(C).

B. Annual Enrollment.

Approximately 30 to 60 days before each Plan Year begins, the Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing elections for the forthcoming Plan Year.

C. Deadlines.

1. Enrollment/Election for New Employees.

The deadline for enrolling and making initial elections shall be the thirty-first (31st) day following the date the Employee becomes eligible in accordance with Section 3.1 or such other period as the Plan Administrator may prescribe. Salary reduction agreements that are timely filed shall be effective as of the date filed with the Plan Administrator or, if later, the Employee's initial eligibility date.

2. Annual Enrollment/Election.

For Participants and Employees who are eligible as of the first day of a Plan Year, the deadline for enrolling and making elections shall be the date the Plan Administrator specifies, but no later than the day preceding the first day of the Plan Year to which the enrollment, elections, and salary reduction agreement apply.

3. Revocation of Elections/New Elections

All election changes or revocations made under Section 5.1(E)(3) of the Plan, shall be made in accordance with Treasury Regulation Section 1.125-4, and must be made no later than thirty-one (31) days following an event described therein, or such longer period, if any, required by applicable law.

D. Validity of Enrollment/Election Forms and Salary Reduction Agreements.

1. Plan Administrator Approval.

Enrollment/election forms and salary reduction agreements shall take effect only if valid, as determined by the Plan Administrator, in its sole and absolute discretion.

2. Remedial Modification or Rejection.

The Plan Administrator may modify or reject any enrollment/election form and/or salary reduction agreement or take other action it deems appropriate under rules uniformly applicable to similarly situated persons to satisfy nondiscrimination requirements of Code Section 125(c), provided that the Plan Administrator notifies the Participant within sixty (60) days of such modification or rejection. Any remedial modification, rejection, or other action the Plan Administrator takes shall be on a reasonable basis that does not discriminate in favor of highly compensated participants or individuals, as defined in Code Section 125(e)(1) and (2), respectively, or key employees, as defined in Code Section 416(i)(1).

E. Changing Elections for Constituent Plans other than the HSA Program.

1. General Rule.

Section 5.1(E) shall not apply to the HSA Program, changes to which shall be governed by Section 5.1(F). For all other Constituent Plans, all elections and salary reduction agreements shall remain in force during the entire Plan Year to which they apply unless changed or revoked as provided for in this Section 5.1(E). During annual enrollment, however, Participants shall be permitted to make new benefit elections or change existing ones for the forthcoming Plan Year.

2. Supplemental Elections.

Section 5.1(E)(1) notwithstanding, the Plan Administrator, in its sole and absolute discretion, may approve a supplemental election to correct an enrollment/election form or salary reduction agreement that is invalid for any reason other than failing to submit it on time solely to the extent such approval would not violate Code Section 125.

3. Revocation of Elections.

Elections and salary reduction agreements in effect for a Plan Year shall be revoked on separation from the Employer's service and may be revoked due to the occurrence of an event described in this Section 5.1(E)(3). Otherwise, except as provided in Section 3.2(D), elections and salary reduction agreements for a Plan Year shall be irrevocable.

a. Separation from Service.

Election and salary reduction agreements of a Participant shall be revoked (as provided in Section 3.2(C)) upon the Participant's separation from service. Regardless of previous claims or reimbursements, the Plan Administrator shall reimburse a Participant for any premium amounts the Participant already incurred for the Section 125 Payment Plan benefit described in Section 4.3(A) and relating to the period after the effective date of termination of coverage.

b. Change in Status.

A Participant may revoke an election during a Plan Year and make a new election for the remaining portion of the Coverage Period if, under the facts and circumstances, (i) a *Change in Status* (as defined below) occurs and (ii) the change satisfies the *Consistency Rule*, as described below. Notwithstanding the foregoing, all election changes made pursuant to this paragraph 5.1(E)(3)(b) shall be made in accordance with Treasury Regulation Section 1.125-4(c). Election and salary reduction changes must be consistent with the *Change in Status* and shall take effect prospectively only, but in no event earlier than the date of the *Change in Status*.

Change in Status shall mean:

(1) events that change the Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation and annulment,

(2) events that change the Employee's number of Dependents, including birth, death, adoption, placement of a child for adoption,

(3) events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent, including a termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, change in worksite, and change in employment status that affects the individual's eligibility under the Plan,

(4) events that cause the Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance,

(5) a change in the place of residence of the Employee, Spouse or Dependent, or

(6) solely with respect to the Section 125 Payment Plan and Health Care FSA, any other event permitted under Code Section 125 and Treasury regulations thereunder.

An election change shall satisfy the *Consistency Rule*, if the election change is on account of and corresponds with a *Change in Status* that affects eligibility for coverage under the applicable Constituent Plan.

Notwithstanding the preceding sentence,

(i) an election change shall also be treated as consistent with a *Change in Status* if the election change is on account of and corresponds with a *Change in Status* that affects expenses covered under the Dependent Care FSA;

(ii) an election change with respect to the Section 125 Payment Plan and/or the Health Care FSA benefit shall also be treated as consistent with a *Change in Status* if the election change is made upon the Employee's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage under such plans and the election change is to cancel coverage for such affected individual; and

(iii) an election change shall also be treated as consistent with a *Change in Status* if such election change is to cease or decrease coverage for the Employee, Spouse and/or Dependent who has gained eligibility under another plan if coverage for such individual becomes effective or is increased under such other plan, as a result of a change in marital status or a change in employment status.

c. Special Enrollment Rights.

A Participant may revoke an election for coverage under the Section 125 Payment Plan and make a new election during a Plan Year that corresponds with the special enrollment rights provided under Code Section 9801(f) with respect to the Health Plans, provided that such election shall be made within the time period prescribed by the Code or the Treasury Regulations promulgated thereunder. Notwithstanding anything to the contrary, such election shall be made retroactively to the date of the event in the case of the marriage, birth, adoption or placement for adoption, of a Dependent of the Participant.

d. Certain Judgments, Decrees and Orders.

If a judgment, decree, or order ("Order") resulting from a divorce, legal separation, annulment or change in legal custody (including, but not limited to, a qualified medical child support order defined in Section 609 of ERISA) requires accident or health coverage for an Employee's child who is a Dependent of the Employee, an Employee may (1) change his or her election to provide coverage for the child (provided that the Order requires the coverage under the Plan); or (2) change his or her election to cancel coverage for the child if the Order requires that another individual (including the Employee's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

e. Medicare or Medicaid.

A Participant may revoke an election and make a new prospective election change to cancel or reduce coverage of that Participant, Spouse and/or Dependent if the Participant, Spouse and/or Dependent who is enrolled in the Section 125 Payment Plan and/or the Health Care FSA becomes entitled to coverage (and becomes enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of

benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant, Spouse and/or Dependent loses eligibility for Medicare or Medicaid, the Participant may make a prospective election to commence or increase coverage of such Participant, Spouse and/or Dependent under the Section 125 Payment Plan and/or the Health Care FSA.

f. Changes in Cost or Coverage.

The following provisions, to the extent applicable, apply only to the Section 125 Payment Plan.

(1) If during the Plan Year the cost of benefits described under Section 4.3(A) increases or decreases during a Plan Year and such change results in a corresponding change in the cost or premium with respect to the Participants under the terms of the Plan, then the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the salary reductions of affected Participants;

(2) Upon the occurrence of either a significant increase or a significant decrease in the cost of a benefit described under Section 4.3(A) during a Plan Year, elections may be made by Participants (A) to revoke such coverage and, in lieu thereof, to receive coverage (on a prospective basis only) under another benefit that provides similar coverage or (B) to discontinue coverage under the applicable plan or program if no other similar coverage is available, in the case of a significant increase in the cost of a benefit, or to commence participation in the applicable plan or program with such a decrease in cost, in the case of a significant decrease in the cost of a benefit;

(3) Upon the occurrence of a significant curtailment of coverage that does not result in a loss of coverage under a plan to which a benefit is described under Section 4.3(A) during a Plan Year, a Participant receiving such curtailed coverage may revoke such coverage, if and only if, such Participant elects to receive coverage (on a prospective basis only), in lieu thereof, under another benefit that offers similar coverage;

(4) Upon the occurrence of a significant curtailment of coverage that results in a complete loss of coverage under a benefit described under Section 4.3(A), a Participant may either elect (i) to revoke the election for such coverage and, in lieu thereof, to receive coverage (on a prospective basis only) under another benefit that provides similar coverage or (ii) to discontinue coverage under the applicable plan or program if no other similar coverage is available;

(5) Upon the addition of a new benefit or if coverage under an existing benefit described under Section 4.3(A) is significantly improved during the Plan Year, Employees may make a new election for coverage under the new or improved benefit (on a prospective basis only) and Participants may revoke an election and, in lieu thereof, make a new election for coverage under the new or improved benefit (on a prospective basis only);

(6) With respect to the benefits described under Section 4.3(A), a Participant may change an election (on a prospective basis only) that is on account of, and corresponds with, a change made under another plan in which the Participant's Spouse and/or Dependent participates if (A) the other cafeteria plan or qualified benefits plan permits participants to make an election change as specified under applicable Treasury regulations or (B) the benefit described under Section 4.3(A) permits a Participant to make an election for a period of coverage that is different from the period of coverage under the other cafeteria plan or qualified benefits plan;

(7) With respect to the benefits described under Section 4.3(A), a Participant may elect coverage (or to add coverage) on a prospective basis under the Plan for the Participant or the Participant's Spouse and/or Dependent if the Participant or the Participant's Spouse and/or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution; and

(8) To the extent permitted under Treasury Regulations or any applicable provision of law.

g. FMLA or Approved Unpaid Leave.

With respect to the Section 125 Payment Plan benefit and the Health Care FSA benefit, a Participant taking FMLA leave or an approved unpaid leave ("Authorized Leave") may (i) revoke an existing election, or (ii) continue such coverage, provided that the Participant makes all required payments to the Employer on a timely basis in accordance with one (or, if appropriate a combination) of the following available payment options:

(1) Pay-As-You-Go Method. A Participant shall periodically contribute the Participant's share of the cost of providing such benefits on the same schedule as contributions would be made if the Participant were not on an Authorized Leave or on any other payment schedule determined by the Plan Administrator in accordance with Title 29 of the Code of Federal Regulations §825.210(c) and other applicable law;

(2) Pre-Pay Method. A Participant may, but in no event is required to, accelerate all or any part of the Participant's remaining contributions for the Plan Year and deduct the same from the final payment of salary or other compensation prior to the commencement of an Authorized Leave; or

(3) Catch-Up Method. A Participant may periodically contribute his or her share of the cost of providing such benefits over the remainder of the Plan Year following the Participant's return to active employment or, if such Participant does not return to active employment, pay those amounts within 30 days of such Participant's termination of employment, provided that the Participant executes and the Employer approves an agreement (to be provided by the Plan Administrator) prior to the commencement of an Authorized Leave setting forth that: (i) the Participant elects to continue such benefits during the Authorized Leave; (ii) the Employer assumes responsibility for advancing payments on behalf of the Participant during the Authorized Leave; and (iii) the Participant agrees to contribute the advanced amounts upon the return from Authorized Leave in the time and manner prescribed by the Plan Administrator or, if the Participant does not return to active employment, to pay those amounts within 30 days of the termination date provided.

F. Changing Elections for the HSA Program.

An Employee may elect to increase, decrease or revoke a pre-tax election to make contributions for the HSA Program described in Appendix C at any time on a prospective basis. Any change in an HSA election shall become effective no later than the first of the month following the University's receipt of a completed election change form. No other Constituent Plan election changes can occur as a result of a change in an HSA election except as otherwise described in Section 5.1(E). For example, a participant generally would not be able to terminate an election under the Health Care FSA in order to be eligible for the HSA, unless one of the exceptions described in Section 5.1(E) (such as a change in status) for the Health Care FSA otherwise applies.

5.2 Claims Procedures under the Plan and the Constituent Plans

Any claim by a Participant with respect to eligibility, participation, contributions, benefits or other aspects of the operation of the Plan or any of the Constituent Plans shall be made in writing to the Claims Administrator for such purpose. A Participant seeking reimbursement of a Dependent Care Expense or Qualifying Medical Expense incurred during a Coverage Period shall submit an application in writing to the Claims Administrator in accordance with the requirements of Section 6.2 of Appendix A or Section 6.3 of Appendix B, as applicable. Alternately, with respect to Qualified Medical Expenses, a Participant may make use of a debit card, if such usage is available to the Participant, in accordance with the terms and conditions of the applicable cardholder agreement, and consistent with Proposed Treasury Regulation Section 1.125-6.

With regard to a claim that is denied in whole or in part, the Claims Administrator shall provide to the Participant a written notification of the decision within thirty (30) days of receipt of the claim (this period may be extended by the Claims Administrator for an additional fifteen (15) days for matters beyond the control of the Claims Administrator, including in cases where a claim is incomplete). The Claims Administrator shall provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Claims Administrator is expected to be made. Where a claim is incomplete, the extension notice shall also specifically describe the required information and shall allow the Participant forty-five (45) days from receipt of the notice in which to provide the specified information. The period for making the determination shall be tolled, where the claim is incomplete, from the date on which the extension notice is sent to the Participant until the date on which the Participant responds to the plan's request for information. The notice of a denied claim shall specify the following: (i) a specific reason or reasons for the denial; (ii) the specific plan provision on which the denial is based; (iii) a description of any additional material or information necessary for the Participant to validate the claim and an explanation of why such material or information is necessary; (iv) appropriate information of the steps to be taken if the Participant wishes to appeal the Claims Administrator's decision, including the Participant's right to submit written comments and have them considered, the

Participant's right to review (upon request and at no charge) relevant documents and other information, and the Participant's right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of the claim.

If the Participant's claim is denied in whole or part, the Participant (or the Participant's authorized representative) may request review upon written application to the Committee. The Participant's appeal must be made in writing within one hundred and eighty (180) days of the Participant's receipt of the notice that the claim was denied. If the Participant does not timely appeal the claim, the Participant shall have no right to appeal the denial and no right to file suit in court. If a Participant timely appeals a claim, the Participant's written appeal should state the reasons why the claim should not have been denied and shall include any additional facts and/or documents that support the claim. The Participant shall have the opportunity to ask additional questions and make written comments, and may review (upon request and at no charge) documents and other information relevant to the Participant's appeal.

The Committee shall review and decide a Participant's appeal in a reasonable time not later than sixty (60) days after the Committee receives the Participant's request for review. The Committee may, in its discretion, hold a hearing on the denied claim. If applicable, any medical expert consulted by the Committee in connection with the Participant's appeal shall be different from and not subordinate to any expert consulted by the Claims Administrator in connection with the initial claim denial. The identity of a medical expert consulted by the Committee in connection with the Participant's appeal shall be provided to the Participant. If the decision on review affirms the initial denial of the Participant's claim, the Participant shall be furnished with a notice of adverse benefit determination on review setting forth: (i) the specific reason(s) for the decision on review; (ii) the specific plan provision(s) on which the decision is based; (iii) a statement of the Participant's right to review (upon request and at no charge) relevant documents and other information; (iv) if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion shall be provided free of charge to the Participant upon request; and (v) a statement of the Participant's right to bring suit under ERISA § 502(a) (where applicable).

All interpretations, determinations and decisions of the Committee with respect to any claim shall be deemed final, conclusive and binding on the Participant and the Employer. This section shall be interpreted in a manner consistent with Department of Labor Regulation § 2560.503-1 and shall not be interpreted as to expand the rights of Participants beyond the rights that are provided in the regulations. All claims under an insurance policy shall be forwarded to the insurance company and determined by the insurance company pursuant to its claim procedures.

5.3 Legal Remedy

Before pursuing a legal remedy, a Participant (a "Claimant") shall first exhaust all claims, review, and appeals procedures required under the Plan.

5.4 Payment Procedures

A. Facility of Payment.

If a Claimant dies before all amounts payable under the Plan have been paid, or if the Claims Administrator determines that the Claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the Claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the Claimant may be paid to any other person or institution reasonably determined by the Claims Administrator to be entitled equitably thereto and without prejudice therefor. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

B. Forfeiture.

The Claims Administrator shall take reasonable steps to ascertain the whereabouts of a Claimant so as to effect delivery of benefits payable under the Plan. If a Claimant has not collected benefits payable to him or her within 15 months from the date the claim was filed, the Claims Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such Claimant as shown on the records of the Administrator, deem the Claimant's right to such benefit waived. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable.

C. Pre-paid Contributions of Terminated Participants.

In the event a Participant terminates employment after electing to accelerate contributions as permitted under Section 5.1(E)(3)(g) during an Authorized Leave, any remaining pre-paid contributions relating to the period beginning with the cessation of participation in the Plan through the end of the Plan Year shall be returned to the former Participant by the Plan.

ARTICLE VI

CONTRIBUTIONS AND PLAN ASSETS

6.1 Contributions

A. Employer Contributions.

The Employer shall pay the cost of benefits listed in Section 4.3 pursuant to the Constituent Plans, sponsored by or offered through the Employer, to which such benefits are offered provided that the Participant shall authorize salary reduction in a corresponding amount pursuant to Section 6.1(B). For HSA-Eligible Employees who elect to participate in the HSA Program described in Appendix C, the Employer may contribute a portion of the contributions as provided in the initial and annual open enrollment materials furnished to HSA-Eligible Employees.

The maximum amount of Employer contributions under the Plan for any Plan Year shall be the aggregate of all salary reductions for all Participants subject to such limitations as may be imposed under the Plan.

Notwithstanding any contrary Plan provision, an Employer shall not be obligated to contribute to the Plan after it is terminated except to the extent required to pay the cost of benefits outstanding on the date the termination is adopted or, if later, effective.

B. Salary Reductions.

As a condition of Plan participation, Employees must agree to direct the Employer to reduce their Compensation and make pre-tax contributions to the plan(s) governing their selected benefit(s).

The salary reduction of a Participant shall equal the sum of the cost of the benefits selected by the Employee. Any election of benefits shall be null and void unless the Employee authorizes salary reduction as provided for herein. The Employer must take salary reductions and apply them as directed, except that the Employer may not apply a salary reduction for a selected benefit to any other benefit nor may a salary reduction be applied during a subsequent Plan Year to any participating plan that provides benefits or coverage.

Notwithstanding anything in this Plan to the contrary, with respect to salary reductions under the Health Care FSA authorized for a Plan Year beginning on and after January 1, 2007, such salary reductions may be applied during the Grace Period immediately following the close of such Plan Year, as permitted under Proposed Treasury Regulation Section 1.125-1(e).

6.2 Funding

The Employer shall make payments provided for in Section 6.l(A) solely from its general assets. Nothing herein shall be construed to require the Employer to maintain any fund or segregate any amount for the benefit of any person and no person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under the Plan may be made.

With respect to cost of the benefits described in Section 4.3, the Employer shall transmit such amounts to the applicable Constituent Plan.

ARTICLE VII

ADMINISTRATION

7.1 Plan Administrator

The University or such other person or person(s) as the University shall designate, shall serve as the Plan Administrator for the Constituent Plans and the Plan. The Plan Administrator shall be the "named fiduciary" for purposes of ERISA with respect to the Health Care FSA. The Plan Administrator may delegate its duties hereunder to a Claims Administrator or to a third party administrator.

7.2 Plan Administrator's Duties

The Plan Administrator shall:

A. manage and carry out the Plan's operation and administration according to the Plan's terms and for Participants' exclusive benefit;

B. maintain:

1. whatever records and data are necessary or desirable for the Plan's proper operation and administration, and

2. the Plan's governing documentation for inspection by anyone who participates or is eligible to participate in the Plan;

C. notify Employees eligible to participate in the Plan of:

1. the Plan's availability and terms,

2. the benefits available for election,

3. the maximum annual salary reduction amounts for each available benefit, and

4. the procedures for enrolling and making and changing elections;

D. supply eligible Employees with any forms and agreements they must complete;

E. prepare and file all annual reports or returns, plan descriptions, financial statements, and other documents required by law or under the Plan's terms; and

F. record its and the Employer's acts and determinations regarding the Plan and preserve these records in its custody.

7.3 Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Employer, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan and the Constituent Plans. (For purposes of this Section 7.3, all references to the "Plan" shall mean the Plan and each of the Constituent Plans.) Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

A. require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;

B. make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan;

C. interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;

D. determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;

E. determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;

F. determine the amount of benefits payable, if any, to any person or entity in accordance with the provisions of the Plan; to inform the Employer or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part;

G. delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;

H. engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan; and

I. pay all reasonable and appropriate expenses incurred in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

7.4 Finality of Decisions

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan, except with respect to any decisions reserved to the Claims Administrator. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Participants and all other interested parties.

7.5 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 as specified in Section 9.17. 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.

7.6 Liability Insurance

The University may obtain liability coverage at the University's expense to insure any employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

7.7 Reserved Powers

The University reserves the powers, among others:

A. to adopt the Plan;

B. to amend or terminate the Plan according to Article VIII; and

C. to appoint and remove any Claims Administrator or Plan Administrator.

ARTICLE VIII

AMENDMENT OR TERMINATION OF PLAN

8.1 Right to Amend or Terminate the Plan

Except as provided in Section 8.2 and notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the University's Board of Trustees (or an authorized committee thereof) reserves the unlimited right to amend or terminate the Plan.

The University reserves the right to withdraw any authority delegated hereunder and/or to delegate such authority to other persons or entities.

8.2 Effect of Amendment or Termination

Any amendment or termination of the Plan shall be effective at such date as the University shall determine except that no amendment or termination shall be retroactive if contrary to applicable law.

ARTICLE IX

MISCELLANEOUS

9.1 No Employment Rights

Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against the Employer or its members, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

9.2 Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested.

9.3 No Property Rights

No one has any right, title, or interest in the property of the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

9.4 No Assignment of Benefits

Except as provided in Sections 5.4 and 3.2(E)(2), benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void.

9.5 Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

9.6 Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

9.7 Misrepresentation or Fraud

A Participant who receives benefits under the Plan on behalf of him/herself and/or a Dependent as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan with respect to such individual(s) and may be liable for all costs of collection, including attorney's fees and court costs, to the extent permitted by law. The Plan Administrator shall decide such matters on a case by case basis.

9.8 Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan or the Constituent Plans must first exhaust such plan's claims, review and appeal procedures. Unless otherwise provided by law, the University and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan, any Constituent Plan or such plan's administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

No action at law or in equity concerning a denial of benefits under the Plan or any Constituent Plan may be commenced by a Claimant (or an agent or representative acting on behalf of a Claimant) more than 120 days after the Claims Administrator has made its decision with regard to the relevant claim.

9.9 Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of New York.

9.10 Governing Instrument

This document, together with the documentation incorporated by reference in Section 1.4 and Section 4.3 shall constitute the legal instrument governing the Plan. In case of conflict between this document and any other writing or evidence, the terms of this document shall govern.

9.11 Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

9.12 Captions and Headings

The captions and headings of an Article, Section or provision of the Plan are for convenience and reference only and shall not be considered in interpreting the terms and conditions of the Plan.

9.13 Notices

No notice or communication in connection with the Plan made by a claimant or an Employee shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

9.14 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

9.15 Parties' Reliance

The Employer, the Plan Administrator, the Claims Administrator and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Employer or its employees, except for willful misconduct or willful breach of duty to the Plan.

9.16 Disclaimer

The Employer makes no assertion or warranty about:

A. whether Plan benefits are or will be excludable from a Participant's gross income for federal or state income tax purposes, or

B. whether any other tax treatment is or will be applicable.

9.17 Expenses

All expenses of the Plan shall be paid from forfeitures, Employee contributions, or by the Plan, unless otherwise paid by the Employer. For HSA benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's HSA trustee/custodian. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

9.18 Employees' Tax Obligations

A. Tax Consequences

The intent of the Employer that the Plan and the Constituent Plans qualify for a particular tax treatment under the Code is not a guarantee of any particular tax consequence or tax exclusion for Participants. Participants must notify the Plan Administrator if they have reason to believe a payment under the Plan is not excludable from their gross income.

B. Liability and Payment

If the Plan Administrator determines at any time after a Plan Year's end that Employees' salary reductions or other Employer contributions exceeded limits allowed by law for any reason including, but not limited to, erroneous information, administrative error, or a final determination that the Plan does not qualify as a cafeteria plan under Code Section 125 for the Plan Year, then Participants must:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess salary reductions or other Employer contributions, and

2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess salary reductions or other Employer contributions been treated as taxable income.

ARTICLE X

ADOPTION OF THE PLAN BY EMPLOYERS; WITHDRAWAL OF EMPLOYERS FROM THE PLAN

10.1 Adoption of Plan by Employers

Subject to the provisions of this Section, the Plan may be adopted by any Affiliate which the University authorizes to adopt the Plan and which, by appropriate corporate action, adopts the Plan. In such event, the University may determine the effective date of the Plan as to any such Affiliate and each such Affiliate shall thereupon be included within the term Employer. The University may also determine the terms and conditions upon which any such Employer may adopt the Plan.

10.2 Withdrawal of Employers from Plan

Any Employer which has adopted the Plan in accordance with Section 10.1 may withdraw from the Plan by giving written notice of its intention to withdraw to the University, and any Employer which has ceased to be an Affiliate or has failed to meet its current costs of the Plan shall withdraw upon the request of the University.

10.3 Payments Upon Withdrawal

In the event of withdrawal from the Plan, the withdrawing Employer shall be required to pay to the remaining Employers an amount sufficient to provide coverage for Benefits elected by Employees of the withdrawing Employer and which are due and unpaid by the withdrawing Employer prior to withdrawal. Any amounts paid by the withdrawing Employer for Benefits which are not available under the Plan by reason of such withdrawal shall be refunded to such withdrawing Employer.

IN WITNESS WHEREOF, this Plan has been adopted by the University as of the Restated Effective Date.

COLUMBIA UNIVERSITY

By: Louis Bellandino

APPENDIX A

THE DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

ARTICLE I

PLAN ESTABLISHMENT

1.1 Purpose

The Dependent Care Flexible Spending Account (the "Dependent Care FSA") is created exclusively for Employees to reimburse Participants for Dependent Care Expenses.

1.2 Qualification

The Dependent Care FSA is intended to qualify as a dependent care assistance program under Section 129 of the Code. The Plan's reimbursements of Dependent Care Expenses are intended to be eligible for exclusion from Participants' gross income under Code Section 129(a). This document is intended to satisfy the writing requirements of Code Section 129(d)(1).

1.3 Incorporation By Reference

Articles II, V (except for Sections 5.2 through 5.4), VI, VII, VIII, IX and X of the Plan are incorporated by reference wherever they apply to the Dependent Care FSA's operation.

1.4 Duration

The Dependent Care FSA is established with the intention of being maintained for an indefinite period of time; however, the University, in its sole and absolute discretion, and in accordance with the provisions of Article VIII of the Plan, may amend or terminate the Dependent Care FSA or any provision of the Plan.

ARTICLE II

DEFINITIONS

When capitalized in this document, these words and phrases have the following meanings:

2.1 Dependent Care Expenses

Dependent Care Expenses means expenditures for dependent care as described in Section 4.5.

2.2 Dependent Care FSA Account

Dependent Care FSA Account means the account established on behalf of a Participant electing coverage under the Dependent Care FSA for the purpose of recording the amount by which the Participant has elected to reduce his compensation with the amount of such reduction to be generally used to reimburse the Participant and the Participant's Spouse for Dependent Care Expenses. A Participant's Dependent Care FSA Account shall be credited, as of each pay date, with the amount by which the Participant has elected to reduce his compensation for purposes of reimbursement of Dependent Care Expenses, and shall be debited with each reimbursement of Dependent Care Expenses. A separate Dependent Care FSA Account shall be established for a Participant with respect to each Plan Year.

2.3 Exclusions

Exclusions means the exclusions in Article V.

2.4 Maximum Annual Benefit

Maximum Annual Benefit means the total salary reductions a Participant authorizes to his or her Dependent Care FSA Account, according to the election requirements of Section 6.1, for Dependent Care Expense reimbursement. The Maximum Annual Benefit shall not exceed the lesser of:

A. $5,000 (or $2,500 for a married Participant filing a separate federal income tax return) as those amounts may be adjusted from time to time by the Internal Revenue Service for the Plan Year, and

B. the Participant's earned income (as defined in Section 129(e)(2) of the Code) (or, if less, the Participant's spouse's earned income if the Participant is married at the end of his or her tax year) as defined in Section 4.6(B)(2).

2.5 Participant

Participant means an Employee who satisfies the participation requirements of Article III.

2.6 Qualifying Individual

Qualifying Individual means (i) a dependent of an Employee, as defined under Code Section 152(a)(1), who is under the age of 13; and (ii) a dependent (including an individual described in Section 152 of the Code) or Spouse of an Employee who is *physically or mentally disabled* and who resides with the Employee for more than half the calendar year. For purposes of (i), the child of divorced parents shall be treated as a Qualifying Individual with respect to the custodial parent (within the meaning of Code Section 152(e)(3)(A)).

Physically or mentally disabled means: (i) incapable of caring for one's own hygienic or nutritional needs or (ii) requiring another person's full-time attention for one's own safety or the safety of others.

The status of a person qualifying as a Qualifying Individual is determined on a daily basis by the Plan Administrator.

ARTICLE III

PARTICIPATION

An Employee is a Participant and participates in the Dependent Care FSA during those periods in which the Employee:

A. participates in the Plan; and

B. has allocated an amount to his or her Dependent Care FSA Account.

Except for Dependent Care Expenses incurred before Dependent Care FSA coverage ceases and subject to satisfying the procedural requirements of Article VI, no benefits are payable after coverage terminates.

ARTICLE IV

DEPENDENT CARE FSA BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Participants shall be entitled to reimbursement for Dependent Care Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Dependent Care FSA Account for each Employee who elects the Dependent Care FSA benefit. The Dependent Care FSA benefit that the Employee elected under the Plan shall be divided by the number of pay periods during the Plan Year that such election is to be effective to determine the amount credited to the Employee's Dependent Care FSA Account each pay period over the period for which the Employee's election is to be effective.

4.3 Statement of Account

On or before January 31 following the close of each calendar year, the Plan Administrator shall provide to each Participant a statement of the amounts paid by the Employer for Dependent Care Expenses with respect to such Participant. This reporting requirement may be satisfied by the distribution of an IRS Form W-2 to the Participant.

4.4 Amount Payable

Subject to the procedural requirements of Article VI, payable Dependent Care Expenses may not exceed the Dependent Care FSA benefit the Participant had credited in accordance with Section 4.2 to his or her Dependent Care FSA Account under the Plan, subject to the limitations in Section 6.3, less any payments previously made during the Coverage Period — up to the Maximum Annual Benefit. If any balance remains in a Participant's Dependent Care FSA Account at the end of a Coverage Period after all reimbursements have been made, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurring during a subsequent Coverage Period nor returned to the Participant and the Participant shall forfeit all rights with respect to such balance. Any amounts forfeited under this Section 4.4 shall not be segregated or invested in an interest bearing account, but shall remain the property of the Employer to be used to pay the expenses of administering the Dependent Care FSA Accounts, to cover expense losses, to fund or enhance Dependent Care FSA benefits available from time to time, or used in any other manner as the Plan Administrator in its discretion, exercised in an uniform and nondiscriminatory manner, directs.

4.5 Dependent Care Expenses

Dependent Care Expenses means *employment-related* expenses that a Participant *incurs*—while employed—for:

A. Household services, and

B. *Care* of a Qualifying Individual.

Employment-related, as defined in Code Section 21(b)(2), means incurred to enable a Participant to be gainfully employed. In the case of a married Participant, to be employment-related, the expense must also enable the Participant's Spouse to: be gainfully employed, actively seek gainful employment, or be a *full-time student*, unless the Spouse is a Qualifying Individual.

Incurs refers to the date services resulting in employment-related expenses are provided—not the date charged, billed, or paid.

Household services means ordinary and usual services necessary to maintain a Participant's home and rendered as part of a Qualifying Individual's care.

Care means services primarily to assure the well-being and protection of at least one Qualifying Individual.

Full-time student means a person enrolled at and attending an educational organization (as defined in Section 21(e)(8) of the Code) during each of five (5) calendar months of the Participant's tax year for the number of course hours that the institution considers to be a full-time course of study.

4.6 Limits

A. On What the Dependent Care FSA Pays

(1) For Care Furnished Outside Participant's Household

Dependent Care Expenses for care provided outside a Participant's home and/or in a *Qualified Dependent Care Center* is reimbursed only if such care is furnished to a Qualifying Individual described in Section 2.6(i) or described in 2.6(ii) who regularly spends at least 8 hours each day in the Participant's home.

Qualified Dependent Care Center means a facility:

a. in compliance with all applicable state and local laws and regulations,

b. providing care for more than six (6) persons (other than facility residents) and

c. receiving a fee, payment or grant for providing services for any of the persons (regardless of whether such facility is operated for profit).

(2) To Certain "Highly Compensated" Employees

Benefits payable under the Dependent Care FSA to each highly compensated employee, as defined in Code Section 414(q), are limited to the extent necessary to avoid violating Code Section 129(d)(8).

B. On Reimbursements

(1) Dependent Care FSA Reimbursements

Dependent Care FSA reimbursement for Dependent Care Expenses is excludable from a Participant's gross income only to the extent the Dependent Care Expense does not exceed:

a. the sum of the Participant's actual salary reductions for the Plan Year, or, if less,

b. the Maximum Annual Benefit.

(2) Aggregate Dependent Care Reimbursement

The amount of Dependent Care Expenses reimbursed during a Participant's taxable year by all plans, including the Dependent Care FSA, that qualify as dependent care plans under Code Section 129 may not exceed:

a. $5,000 (or $2,500 for a married Participant filing a separate federal income tax return),

or, if less,

b. the Participant's *earned income* (or if less, the Participant's Spouse's *earned income*, if the Participant was married at the end of his or her tax year).

Earned income means wages, salaries, tips, and other compensation, as defined in Section 32(c) of the Code.

Earned income does not include pensions, annuities, social security payments, workers' compensation, unemployment compensation, or a nonresident alien's income not connected with United States business.

Earned income is computed without considering community property laws.

Earned income of a Spouse who is a full-time student, as defined in Section 4.5, or who is a Qualifying Individual, as defined in Section 2.6(ii), is deemed to be not less than $250 per month for Participants with one Qualifying Individual or $500 per month for Participants with two or more Qualifying Individuals.

(3) Reporting Identifying Information Limit

Dependent Care FSA reimbursement for Dependent Care Expenses shall be made only if the Participant provides the Claims Administrator with the name, address and taxpayer identification number (or other information acceptable to comply with federal reporting requirements) of each dependent care service provider furnishing dependent care services to the Participant.

C. Remedial Modifications or Rejection

The Plan Administrator may modify or reject any enrollment and election form and/or salary reduction or take other action it deems appropriate to comply with the limitations set forth in this Section 4.6.

ARTICLE V

EXCLUSIONS

5.1 General Rules

A. The Dependent Care FSA pays only those Dependent Care Expenses incurred by an Employee:

(1) during the current Coverage Period,

(2) while the Employee is a Participant,

(3) to allow the Participant (and Spouse, if married) to continue gainful employment (or, if married and the Spouse is unemployed, to allow the Participant's Spouse to actively seek gainful employment or be a full-time student, as defined in Section 4.5, unless the Spouse is described in Section 2.6(ii) of the Plan).

B. Except as provided in Section 5.l(A)(3), the Dependent Care FSA does not reimburse amounts paid for Dependent Care Expenses incurred while a Participant (or Spouse, if married) is off work for any reason, except for short, temporary absences from work, such as vacation or minor illness, provided that the care-giving arrangement requires the Participant to pay for care during the absence, in accordance with Treasury Regulation Section 1.21-1(c).

5.2 Specific Exclusions

The Dependent Care FSA does not reimburse amounts paid in connection with:

A. a Qualifying Individual's overnight camp;

B. services rendered by:

(1) a Participant's (and if married, the Participant's Spouse's) child (within the meaning of Code Section 151(c)(3)) under age 19 at the Plan Year's end, or

(2) a person for whom the Participant (or if married, the Participant's Spouse) is entitled to a federal income tax deduction under Code Section 151(c) for the Participant's tax year.

5.3 Conditional Exclusions

Unless incidental, minimal, and inseparable from the cost of caring for a Qualifying Individual, the Dependent Care FSA pays no charges in connection with a Qualifying Individual's:

A. food,

B. clothing, or

C. education (for a child below kindergarten)[1].

The Dependent Care FSA pays no charges in connection with a Qualifying Individual's:

D. education in kindergarten or higher grade level, or

E. transportation between the Participant's home and the place where dependent care is provided.

ARTICLE VI

PROCEDURES

6.1 Enrollment and Election Procedures

Employees may enroll and make elections only by filing and/or completing the appropriate forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in Article V of the Plan.

6.2 Claim Procedures

A Participant who has incurred Dependent Care Expenses during a Coverage Period to which his or her validly filed salary reduction agreement relates may apply to the Claims Administrator for reimbursement of such Dependent Care Expenses by submitting an application in writing to the Claims Administrator, in such form as the Claims Administrator may from time to time prescribe. Such applications must include:

(a) The date and nature of the expense with respect to which reimbursement is requested;

(b) The name of the person, organization or entity to which to expense was paid;

(c) A written statement (which may be a bill or invoice) from an independent third party stating that dependent care assistance expenses have been incurred and the amount of such expenses;

[1] Nursery or preschool expenses for a child under kindergarten age are eligible.

(d) A statement from the Participant that the Dependent Care Expense has not been reimbursed and is not reimbursable under any other plan (excluding this plan and the Plan); and

(e) Such other information as the Claims or Plan Administrator may from time to time require, including but not limited to verification of dependent, student or marital status, level of earned income, or physical or mental handicap.

The Claims Administrator may require such application to be accompanied by bills, invoices, receipts, cancelled checks, or other statements showing the amounts of such expenses, together with any additional documentation which the Claims Administrator may request. Participants are not entitled to submit claims under this Plan for advance reimbursement of future or projected expenses.

6.3 Frequency of Payment

Subject to Section 4.4, the Plan Administrator shall reimburse a Participant for Dependent Care Expenses incurred during a Coverage Period for which the Participant submits documentation in accordance with Section 6.2. In no event shall the Dependent Care Expenses reimbursed exceed: (i) the aggregate salary reduction contributions for the Coverage Period in which the expense was incurred that have been credited to the Participant's Dependent Care FSA Account at the time the Participant's claim for reimbursement of Dependent Care Expenses is processed by the Plan Administrator minus (ii) the aggregate amount of Dependent Care Expenses relating to such Coverage Period which already have been debited from the Participant's Dependent Care FSA Account. The Plan Administrator may (but shall not be required to) pay, with the written authorization of the Participant, any such reimbursement directly to the individual or institution providing the dependent care assistance in lieu of reimbursing the Participant.

6.4 Deadline for Filing a Claim

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services or supplies received, is received by the Claims Administrator within 90 days (or such other deadline as adopted by the Claims Administrator) from the last day of the Plan Year to which the claim relates, or if earlier, from the date the Participant ceases participation under the Plan. Failure to submit a properly completed claim form within the prescribed period shall neither invalidate nor reduce a claim if it is shown that it was not reasonably possible to furnish the claim form within that time and that the claim form was submitted as soon as reasonably possible.

6.5 Form of Payment

All payments provided for under the Dependent Care FSA shall be paid in cash or by check from the general funds of the Employer; provided, however, that such payments shall be reduced by the amount of any payments made to the Employee or his or her dependents, beneficiaries or estate from any trust or special or separate fund established by the Employer to assure such payments.

IN WITNESS WHEREOF, this Plan has been adopted by the University as of the Restated Effective Date.

COLUMBIA UNIVERSITY

By: Lois Ballantine

APPENDIX B

THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT

ARTICLE I

PLAN ESTABLISHMENT

1.1 Purpose

The Health Care Flexible Spending Account (the "Health Care FSA") is created exclusively to reimburse Participants for Qualifying Medical Expenses.

1.2 Qualification

A. ERISA

The Health Care FSA is an *employee welfare benefit plan*, as defined in ERISA. This document is intended to satisfy the writing requirements of ERISA Section 402.

B. Internal Revenue Code

The Health Care FSA is intended to qualify as a qualified benefits plan that is a health care flexible spending arrangement as defined under Section 106(c)(2) of the Code and Proposed Treasury Regulation Section 1.125-5 and that the benefits provided under the plan be eligible for exclusion from Employee's gross income to the extent provided under Sections 105(b), 106 and 125(a), as applicable. This document is intended to satisfy the writing requirements of Treasury Regulation Section 1.105-11(b)(1)(i).

1.3 Incorporation By Reference

Articles II, V, VI, VII, VIII, IX and X of the Plan are incorporated by reference wherever they apply to the Health Care FSA's operation.

1.4 Duration

The Health Care FSA is established with the intention of being maintained for an indefinite period of time; however, the University, in its sole discretion and in accordance with the provisions of Article VIII of the Plan, may amend or terminate the Health Care FSA or any provision of the plan.

ARTICLE II

DEFINITIONS

When capitalized in this document, these words and phrases have the following meanings:

2.1 COBRA Continuee

COBRA Continuee means an individual who continues participation in the Health Care FSA pursuant to Section 6.2.

2.2 Exclusions

Exclusions means the exclusions in Article V.

2.3 Health Care FSA Account

Health Care FSA Account means the account established on behalf of a Participant who elects such Health Care FSA Account under the Health Care FSA for the purpose of recording the amount by which the Participant has elected to reduce his compensation with the amount of such reduction to be generally used to reimburse the Participant and the Participant's Dependents for Qualifying Medical Expenses. A Participant's Health Care FSA Account shall be credited, as of the beginning of each Plan Year or as of such other date (other than the beginning of a Plan Year) that a Participant begins making contributions to a Health Care FSA Account pursuant to the terms of the Plan, with an amount equal to the total amount by which the Participant's compensation shall be reduced for purposes of reimbursement of Qualifying Medical Expenses for such Plan Year or for the remainder of such Plan Year, as applicable. A Participant's Health Care FSA Account shall be debited with each reimbursement of Qualifying Medical Expenses. A separate Health Care FSA Account or Limited Purpose/Post-Deductible Health Care FSA Account, as applicable, shall be established for a Participant with respect to each Plan Year.

2.4 HIPAA

The Health Insurance Portability and Accountability Act of 1996.

2.5 Limited Purpose/Post-Deductible Health Care FSA Account

Notwithstanding any other provision of this Appendix B, a Participant may elect to enroll in a Limited Purpose/Post-Deductible Health Care FSA Account if offered by Employer in lieu of a Health Care FSA Account, for the applicable Plan Year. The Limited Purpose/Post-Deductible Health Care FSA Account is a combination limited purpose health FSA Account and post-deductible health FSA described in Proposed Treasury Regulation Section 1.125-5(m)(5), which shall be subject to all of the terms and conditions described in this Appendix B, except as follows:

A. ***Limited Purpose Health Care FSA Account*** - Prior to the date that the Participant's HDHP deductible, if any, under Code Section 223(c)(2)(A)(i) is satisfied for the current Plan Year (the "Deductible Satisfaction Date"), the only Qualifying Medical Expenses that may be reimbursed by such Participant under the Limited Purpose/Post-Deductible Health Care FSA Account for the Coverage Period are dental and vision expenses described in Section 2.8, and not otherwise excluded by Section 2.8, and preventive care expenses as defined in Code Section 223(c)(2)(C). The Limited Purpose/Post-Deductible Health Care FSA Account of any Participant who does not reach his or her Deductible Satisfaction Date or does not participate in an HDHP with respect to a Plan Year, shall remain subject to this Clause (A) for the entirety of the Plan Year.

B. ***Post-Deductible Health Care FSA Account*** - Effective on the Participant's Deductible Satisfaction Date, the Limited Purpose/Post-Deductible Health Care FSA Account shall also reimburse such Participant for any Qualifying Medical Expense that is incurred after the Deductible Satisfaction Date and during the Coverage Period in which such Deductible Satisfaction Date occurs.

A Participant's Limited Purpose/Post-Deductible Health Care FSA Account shall be credited, as of the beginning of each Plan Year or as of such other date (other than the beginning of a Plan Year) that a Participant begins making contributions to a Limited Purpose/Post-Deductible Health Care FSA Account pursuant to the terms of the Plan, with an amount equal to the total amount by which the Participant's compensation shall be reduced for purposes of reimbursement of Qualifying Medical Expenses for such Plan Year or for the remainder of such Plan Year, as applicable. A Participant's Limited Purpose/Post-Deductible Health Care FSA Account shall be debited with each reimbursement of Qualifying Medical Expenses. A separate Limited Purpose/Post-Deductible Health Care FSA Account or Health Care FSA Account, as applicable, shall be established for a Participant with respect to each Plan Year.

2.6 Maximum Annual Benefit

Maximum Annual Benefit means the total salary reductions a Participant authorizes to his or her Health Care FSA Account with respect to a Plan Year, according to election procedures of Section 6.1, for Qualifying Medical Expense Reimbursement, which amount shall not be more than $10,000, provided that the Maximum Annual Benefit per Plan Year for Plan Years beginning on or after January 1, 2013, shall be $2,500 (as may be adjusted for inflation).

2.7 Participant

Participant means an Employee who satisfies the participation requirements of Article III.

2.8 Qualifying Medical Expenses

Qualifying Medical Expenses means expenses incurred by a Participant or his or her Dependent for "medical care" as defined in Code Section 213(d), including amounts paid for (1) hospital bills, doctor, dental and vision bills, (2) medicines or drugs, only if the medicine or drug (i) requires a prescription, (ii) is an over-the-counter medicine or drug and the individual obtains a prescription, or (iii) is insulin, and (3) health care products that are used for medical care, only to the extent that the Participant or Dependent incurring the expense is not reimbursed for the expense through insurance or otherwise (other than under this Plan). Qualifying Medical Expenses shall not include premiums for other health plan coverage or COBRA coverage, including premiums paid for health plan coverage under a plan maintained by the company of the Participant's Dependents.

ARTICLE III

PARTICIPATION

An Employee is a Participant and participates in the Health Care FSA during those periods in which the Employee:

A. participates in the Plan; and

B. has allocated an amount to his or her Health Care FSA Account.

Except for Qualifying Medical Expenses incurred before Health Care FSA coverage ceases and subject to satisfying the procedural requirements of Article VI, no plan benefits shall be payable after coverage terminates.

ARTICLE IV

HEALTH CARE FSA BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Participants shall be entitled to reimbursement for Qualifying Medical Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Health Care FSA Account for each Employee who elects the Health Care FSA benefit. The Health Care FSA benefit elected by the Employee under the Plan shall be credited to his or her Health Care FSA Account as of the first day that the Employee's election is effective.

4.3 Amount Payable

Subject to the procedural requirements of Article VI including the limitation set forth in Section 6.5, payable Qualifying Medical Expenses may not exceed the Health Care FSA benefit the Participant elected to be credited to his or her Health Care FSA Account for the Coverage Period, less any payments previously made during the Coverage Period — up to the Maximum Annual Benefit. After the expiration of the deadline for filing claims under Section 6.6 and after all timely filed claims have been paid or finally denied, any remaining credits to a Participant's Health Care FSA Account shall be forfeited and may not be cashed out or applied toward any other Plan benefits.

4.4 Limits

The Health Care FSA shall reimburse Qualifying Medical Expenses only to the extent the charge is not compensated for by any prepaid health coverage, group health plan, medical insurance, or otherwise. Qualifying Medical Expenses shall include deductibles and co-payments if not reimbursed through coordination of benefits with a secondary payor.

ARTICLE V

EXCLUSIONS

5.1 General Rules

A. The Health Care FSA shall pay only those Qualifying Medical Expenses incurred by an Employee or the Employee's Dependent:

1. during the current Coverage Period, and

2. while the Employee is a Participant.

B. The Health Care FSA shall not reimburse amounts paid for services or supplies that merely improve health or morale generally.

ARTICLE VI

PROCEDURES

6.1 Enrollment and Election Procedures

Employees may enroll and make elections only by filing and/or completing the appropriate forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Plan.

6.2 COBRA Continuation of Coverage

If the Participant is a "covered employee" who experiences a "qualifying event" as defined in Section 4980B of the Code and Sections 601 through 608 of ERISA, such individual shall be permitted to elect to continue coverage under this plan within the time period and upon the conditions specified in such Sections of the Code and ERISA, for the continuation period set forth therein, subject to earlier termination for any of the reasons permitted therein. To the extent that such COBRA Continuee does not have compensation from the Employer, he or she shall be required to pay after-tax contributions equal to the cost of coverage on a monthly basis (which may be up to 102% of the cost of coverage and, in cases of disability, up to 150% of the cost of coverage during the 11-month extension of COBRA coverage available in such cases).

6.3 Claim Procedures

A Participant who has incurred a Qualifying Medical Expense during a Coverage Period to which his or her validly filed salary reduction agreement relates may apply to the Claims Administrator for reimbursement of such Qualifying Medical Expense by submitting an application in writing to the Claims Administrator, in such form as the Claims Administrator may from time to time prescribe. Such applications must include:

(a) The date and nature of the expense with respect to which reimbursement is requested;

(b) The name of the person, organization or entity to which to expense was paid;

(c) A written statement (which may be a bill or invoice) from an independent third party stating that medical expenses have been incurred and the amount of such expenses;

(d) A statement from the Participant that the Qualifying Medical Expense has not been reimbursed and is not reimbursable under any other plan (excluding this plan and the Plan); and

(e) Such other information as the Claims or Plan Administrator may from time to time require.

The Claims Administrator may require such application to be accompanied by bills, invoices, receipts, cancelled checks, or other statements showing the amounts of such expenses, together with any additional documentation which the Claims Administrator may request. Participants are not entitled to submit claims under this Plan for advance reimbursement of future or projected expenses. Alternately, a Participant may make use of a debit card, if such usage is available to the Participant, in accordance with the terms and conditions of the applicable cardholder agreement, and consistent with Proposed Treasury Regulation Section 1.125-6.

6.4 Debits to Accounts

A Participant's Health Care FSA for the Coverage Period shall be debited from time to time in the amount of any payment pursuant to Section 4.3 of Qualifying Medical Expenses to or for the benefit of the Participant with respect to whom it was established. In no event shall the amount debited at any time during the Coverage Period for a Qualifying Medical Expense incurred in such Coverage Period exceed (i) the full salary reduction amount elected by the Participant under this plan for the Plan Year, minus (ii) the aggregate amount for Qualifying Medical Expenses relating to such Coverage Period which already have been debited to the Participant's Health Care FSA Account.

6.5 Deadline for Filing a Claim

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services or supplies received, is received by the Claims Administrator within 90 days (or such other deadline as adopted by the Claims Administrator) from the last day of the Plan Year to which the claim relates, or if earlier, from the date the Participant ceases participation under the Plan. Failure to submit a properly completed claim form within the prescribed period shall neither invalidate nor reduce a claim if it is shown that it was not reasonably possible to furnish the claim form within that time and that the claim form was submitted as soon as reasonably possible.

ARTICLE VII

HIPAA

HIPAA and the privacy regulations issued thereunder give Participants and their Spouses and Dependents under the plan certain rights with respect to their health information, and require that the plan protect the privacy of Participants', Spouses' and Dependents' personal health information. To the extent that HIPAA and the privacy regulations issued thereunder are applicable to the Health Care FSA, the following provisions apply.

Since the Plan is required to keep health information confidential, before the Plan can disclose any of health information to the University, in the University's capacity as the Plan sponsor, the University agrees to keep the health information about Participants and their Spouses and Dependents that the University receives from the Plan ("Protected Health Information") and to handle that health information in a way that enables the Plan to follow the rules in HIPAA and certifies to the following:

- Unless it has written permission from the relevant Participant, Spouse and/or Dependent, the University shall use or disclose that Protected Health Information only for Plan administration, as otherwise permitted by this Plan document, or as required by law.

- The University shall not disclose Protected Health Information to any of its agents or subcontractors unless the agents and subcontractors agree to handle the Protected Health Information and keep it confidential to the same extent as is required of the University in this Plan document.

- The University shall not use or disclose Protected Health Information for any employment-related actions or decisions, or with respect to any other benefit or other employee benefit plan sponsored by the University without specific written permission from the relevant Participant, Spouse and/or Dependent.

- The University shall report to the Plan's Privacy Officer if anyone at the University becomes aware of any use or disclosure of Protected Health Information that is inconsistent with the provisions set forth in this Plan document.

- The University shall allow Participants and their Spouses and Dependents, through the Plan, to inspect and photocopy their Protected Health Information, to the extent, and in the manner, required by HIPAA.

- The University shall make available to the Plan Participants, Spouses and Dependents their Protected Health Information for amendment and incorporation of any such amendments to the extent, and in the manner, required by HIPAA.

- The University shall make available to the Secretary of the U.S. Department of Health and Human Services ("HHS") its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.

- The University shall keep a written record of certain types of disclosures it may make of Protected Health Information, so that it may make available to the Plan the information required for the Plan to provide an accounting of certain types of disclosures of Protected Health Information.

- The following categories of employees or workforce under the control of the University are the only Plan sponsor workforce who may obtain Protected Health Information in the course of performing the duties of their job with or on behalf the University: the Plan's Privacy Officer, the Director of Personnel of the University and employees in the Human Resources Department of the University. These employees shall be permitted to have access to and use the Protected Health Information only to perform the Plan administration functions that the University provides for the Plan.

- The employees and workforce listed above shall be subject to disciplinary action and sanctions for any use or disclosure of Protected Health Information that violates the rules set forth in this Plan document. If the University becomes aware of any such violations, the University shall promptly report the violation to the Plan's Privacy Officer and shall cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual(s) whose privacy has been violated.

- The University shall return to the Plan or destroy all Protected Health Information received from the Plan when there is no longer a need for the information. If it is not feasible for the University to return or destroy the Protected Health Information, then the University shall limit its further use or disclosures of any Protected Health Information that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

- The University hereby acknowledges that the Health Care FSA, and any administrative or other shared staff that assists, even in part, in administration of the Health Care FSA is the only component of the Plan that is designated as covered by and subject to HIPAA privacy and security rules. The Plan's components that furnish or administer any other benefits are not covered by or subject to HIPAA, and are hereby treated separately from the Plan's health plan functions for purposes of HIPAA compliance.

- If an employee or member of the workforce of the Plan or the Plan sponsor performs duties for both the HIPAA-covered component of the Plan and the non-HIPAA covered components of the Plan, such employee or workforce member may not use or disclose Protected Health Information created or received in the course of his or her work for the HIPAA-covered component of the Plan, in connection with such employee or workforce member's duties for the non-HIPAA covered components of the Plan, if such a use or disclosure would be prohibited by HIPAA if the HIPAA-covered component of the Plan and the non-HIPAA covered components of the Plan were separate legal organizations.

There are also some special rules under HIPAA related to "electronic health information." Electronic health information is generally Protected Health Information that is transmitted by, or maintained in, electronic media. "Electronic media" includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

The University shall take additional action with respect to the implementation of security measures (as defined in 45 C.F.R. § 164.304) for electronic Protected Health Information. Specifically, the University, in its capacity as Plan sponsor, shall:

- 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;

- Ensure that adequate separation between the Plan and the University as an Employer is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;

- Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect that information;

- Report to the Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information system; and

- Comply with any other requirements that the Secretary of HHS may require from time to time with respect to electronic Protected Health Information by the issuance of additional regulations or other guidance pursuant to HIPAA.

Contact Person / Privacy Officer

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

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

IN WITNESS WHEREOF, this Plan has been adopted by the University as of the Restated Effective Date.

COLUMBIA UNIVERSITY

By: Lou Bellardine

APPENDIX C

HEALTH SAVINGS ACCOUNT PROGRAM

ARTICLE I

PLAN ESTABLISHMENT

1.1 Purpose

The purpose of this Appendix C is to set forth the provisions governing the Health Savings Account (HSA) Program. The HSA Program is created exclusively to permit an HSA-Eligible Employee to make contributions to an Eligible HSA.

1.2 Qualification

The HSA Program is a Constituent Plan under the Plan that provides for a Health Savings Account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2). The HSA Program is an elective pre-tax option under the Plan, and is intended to constitute accident and health plan coverage under Code Section 106.

1.3 Incorporation by Reference

Articles II, V, VI, VII, VIII, IX and X of the Plan are incorporated by reference wherever they apply to the HSA Program's operation.

1.4 Duration

The HSA Program is established with the intent of being maintained for an indefinite period of time; however, the University, in its sole and absolute, and in accordance with the provisions of Article VIII of the Plan, may amend or terminate the HSA Program or any of the provisions herein.

1.5 Use of Terms

Terms used in this Appendix C shall have the same meanings as the terms defined in Article II of the Plan, unless separately defined in this Appendix C. All of the terms and provisions in Articles I through IX of the Plan shall apply to this Appendix C, except that where the provisions of this Appendix C and Articles I through IX of the Plan conflict, the provisions of this Appendix C shall govern.

ARTICLE II

Definitions

2.1 Eligible HSA

An Eligible HSA, as used in this Appendix C, means an HSA that is established and maintained by an HSA-Eligible Employee through the HSA trustee or custodian selected by the University and offered in conjunction with the Employee's enrollment in a High Deductible Health Plan sponsored by the Employer.

ARTICLE III

PARTICIPATION AND TERMS

3.1 Participation, Contributions and Elections

HSA-Eligible Employees may elect to contribute to the HSA Program on a prospective basis by enrolling under the terms of Section 3.2 of the Plan. As described in Section 5.1(F) of the Plan, such election can be increased or decreased prospectively at any time during the Plan Year, effective no later than the first of the month following the University's receipt of a completed election change form. Subject to the terms and conditions of Articles I through IX of the Plan and this Appendix C, as part of an Employee's participation under the terms of Article III of the Plan, any HSA-Eligible Employee may elect to contribute an amount to an Eligible HSA.

3.2 Annual Contribution Limits

The maximum amount that an HSA-Eligible Employee may elect to contribute to an Eligible HSA during the Plan Year is the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (*i.e.*, single or family) for the calendar year in which the contribution is made, determined pursuant to Code Section 223(b)(2) ($3,100 for single and $6,250 for family are the statutory maximum amounts for 2012).

If the HSA-Eligible Employee attains (or will attain) age 55 by the end of any calendar year, the annual contribution limit is increased by the catch-up limit applicable for that calendar year (as determined pursuant to Code Section 223(b)(3)) ($1,000 in 2010 and thereafter).

The annual contribution limit shall be reduced by any HSA contributions made by an Employer on behalf of the HSA-Eligible Employee. For an HSA-Eligible Employee who elects to participate in an HDHP sponsored by the Employer, the Employer may make a contribution to the HSA-Eligible Employee's HSA as provided in the initial and annual open enrollment materials furnished to Employees. The annual contribution limit (and the catch-up limit, if applicable) shall be prorated by the number of months during the Plan Year in which the Employee is an HSA-Eligible Employee unless the Employee is enrolled in a High Deductible Health Plan prior to December 1 of a given year and remains enrolled in a High Deductible Health Plan through the end of the calendar year, in which case the Employee may elect the

entire annual contribution limit (including the additional catch-up contribution, if otherwise eligible). However, in order for such Employee's contribution to retain its tax-favored status, the Employee must remain covered by an HDHP for 12 months after the end of the year in which he or she enrolled in an HDHP sponsored by the Employer.

ARTICLE IV

MISCELLANEOUS

4.1 Administration of the HSA Program

The Employer shall transfer any pre-tax HSA contribution amounts elected by an HSA-Eligible Employee directly to the HSA trustee or custodian. The Plan Administrator shall maintain records of such HSA contribution amounts, and shall provide this information to the Employer so that the Employer may appropriately report this information on the Employee's Form W-2. The University shall have no responsibility, authority or control over such HSA contribution amounts once such amounts are transferred to the HSA trustee or custodian.

4.2 HSA Program and ERISA

The HSA benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis and any employer contributions to such HSA as set forth in Section 3.2. Terms and conditions of coverage and benefits (*e.g.*, eligible medical expenses, claim procedures, etc.) shall be provided and are set forth in the HSA, not this Plan. The HSA Program is not an employer-sponsored employee welfare benefit plan within the meaning of Section 3(1) of ERISA. It is savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2). The University's only involvement with the HSA Program is to forward to the HSA provider(s) contributions that Employees make via pre-tax salary reductions and that the University contributes on behalf of Employees, and to select an HSA trustee or custodian to facilitate the establishment of an HSA by HSA-Eligible Employees who enroll in a High Deductible Health Plan sponsored by the Employer. The Committee shall maintain records to keep track of HSA contributions Employees make via pre-tax salary reductions and that the University contributes on behalf of Employees, but it shall not create a separate fund or otherwise segregate assets for this purpose. The University has no authority or control over the funds deposited into an HSA.

4.3 Tax Treatment of HSA Contributions and Distributions

The tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

IN WITNESS WHEREOF, this Plan has been adopted by the University as of the Restated Effective Date.

COLUMBIA UNIVERSITY

By: Louis Bellantine

APPENDIX D

THE HEALTH PLANS

The purpose of this Appendix D is to list the medical, dental and vision benefits (the "welfare benefits") provided under the Employer's Health Plans offered to Eligible Employees under the Plan on either a pre-tax or after-tax basis. The welfare benefits as of the Restated Effective Date are listed below. From time to time the University may add or delete welfare benefits either by amendment of this Appendix D or by addition of a new Appendix.

NOTE: If a domestic partner or the child of a domestic partner does not qualify as a "dependent" of the Employee, as "dependent" is defined under Code Section 152 without regard to the gross income requirement of Code Section 152(d)(1)(B), the Employee shall be treated as having taxable compensation equal to the difference between (1) the fair market value of any coverage provided under the Health Plans for the domestic partner and/or the child of the domestic partner and (2) the amount, if any, paid by the Employee for such coverage. In addition, any pre-tax payments made pursuant to the Section 125 Payment Plan with respect to a domestic partner and/or the child of a domestic partner who does not qualify as the Employee's "dependent" will be treated as taxable compensation. This taxable compensation shall be treated as wages reportable on the Employee's Form W-2 and is subject to income tax and social security tax withholding.

MEDICAL

Aetna – Officers HDHP Plan
Cigna – Officers POS 100 Plan
UHC – Officers POS 100 Plan
Aetna – Officers POS 90 Plan
Cigna – Officers POS 90 Plan
UHC – Officers POS 90 Plan
Aetna – Officers POS 80 Plan
Cigna – POS 80 Plan
UHC – POS 80 Plan

DENTAL

Aetna Columbia Dental Plan