

**COLUMBIA UNIVERSITY GROUP TERM LIFE  
INSURANCE PLANS**

**SUMMARY PLAN DESCRIPTION (SPD)  
FOR MEMBERS OF  
LOCAL 241  
TRANSPORT WORKERS UNION (TWU) OF  
AMERICA**

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# **OVERVIEW**

Group Term Life and Dependent Life insurance coverage is available to help provide you and your family with financial protection in the event of you or a family members' death. If you die, the full amount of your Group Term Life insurance is paid to your beneficiary.

The Plan can also pay a living benefit from the Group Term Life Plan. If you become terminally ill, the Plan will pay out a portion of your death benefit while you are living. Any amount you receive will reduce the benefit paid to your beneficiary.

Columbia University offers three Group Term Life Insurance Plans:

- Basic Term Life Insurance Plan
- Accidental Death and Dismemberment Insurance Plan
- Optional Term Life Insurance Plan

You are automatically covered for the Basic Term Life Insurance Plan and Accidental Death and Dismemberment Insurance Plan at no cost to you.

Optional Life Insurance is voluntary. You pay for the cost and you need to make an election to receive these benefits.

Each year, you will be notified of the cost for Optional Life Insurance benefits.

The Life Insurance Plans are fully insured and administered by The Standard Life Insurance Company of New York (The Standard).

## **Who's Eligible**

All active, full-time and part-time members of Local 241, Transport Workers Union (TWU) Of America are eligible to participate in the Basic Term Life, Accidental Death and Dismemberment and Optional Term life insurance plans.

- Full-time employees must be scheduled to work 35 hours per week
- Part-time employees must be scheduled to work 20 hours per week

# **WHEN LIFE INSURANCE COVERAGE BEGINS**

## **New Hires**

Basic Life Insurance coverage is effective after completing six months of employment with the University.

Optional Life Insurance coverage, if elected within 31 days of your start date will automatically become effective after completing six months of employment with the University. However, if you are not “Actively at Work” or deemed Actively at Work, coverage will be delayed until after you return to work for at least one full day.

“Actively at Work” means you are performing all of the material duties of your job at Columbia University, wherever these duties are normally carried out.

If you are Actively at Work on your last scheduled working day, you will be deemed Actively at Work on a scheduled non-working day (e.g. New Year’s Day) if you are not disabled or a leave of absence.

## **Annual Benefits Open Enrollment**

Coverage or increases elected during the annual Benefits Open Enrollment, will be effective as of the following January 1. However, if you are not Actively at Work or deemed Actively at Work, coverage or increases will be delayed until after you return to work for at least one full day.

Additionally, if evidence of insurability is required and your evidence has not been approved on the date your coverage or increase would normally become effective, your coverage will automatically increase to the highest level allowed without providing evidence of insurability.

The additional coverage requiring evidence of insurability will be “on hold” by CU HR Benefits until it is approved by The Standard Life Insurance Company of New York. If approved, you will be notified in writing and the additional coverage will be effective on the date your coverage increase would normally become effective or the first day of the month following approval by The Standard, whichever is later. If the additional coverage is denied, you will receive an explanation for the denial and your coverage will remain increased to the highest level allowed without evidence of insurability.

## **If You Do Not Change Your Life Insurance Election During the Annual Benefits Open Enrollment**

Your current Columbia life insurance election will continue at an updated coverage amount at applicable rates based upon your new benefit salary and age.

## **Effective Date for Changes Due to a Qualified Life Status Change**

Coverage or increases elected **within 31 days** of a Qualified Life Status Change will be effective on the later of the date you apply or the date of the event. You will have an opportunity to change your benefit coverage selection during the next annual Benefits Open Enrollment period.

However, if you are not Actively at Work or deemed Actively at Work on such date, a change in coverage will be delayed until after you return to work for at least one full day.

If medical evidence of insurability is required, a change in coverage will be effective on the date it is approved.

If medical evidence is not approved you will receive the highest level of insurance allowed without approval.

## **Effective Date for Changes Due to a Salary Increase**

Increases in Basic or Optional Life Insurance due to a salary change will be effective the beginning of each calendar year based on your salary as of July 1<sup>st</sup> of the prior year. However, if you are not Actively at Work or deemed Actively at Work on the effective date, a change in coverage will be effective as soon as you are Actively at Work. In the situation of a reduced salary as a result of changing to a part-time schedule reduction in Basic & Optional Life Insurance will be effective on the date of the salary reduction.

## **Naming a Beneficiary**

You designate your beneficiary for the Basic and Optional Life Insurances. You can add or change your beneficiary information online at any time by clicking on the CU HR website at [www.hr.columbia.edu/hr](http://www.hr.columbia.edu/hr).

If you don't name a beneficiary or your primary and contingent beneficiaries are not living at the time of your death, benefits may be paid to your spouse, your children, parents, your siblings, or your estate, at The Standard's discretion and in accordance with the provisions of the group life policy and any applicable state laws.

# LIFE INSURANCE PLANS

## Basic Term Life Insurance Plan

The Basic Term Life Insurance Plan is provided automatically by Columbia University at no cost to you and without providing medical evidence of insurability.

The maximum amount of Basic Term Life Insurance is one times your salary up to \$50,000. This is paid by the University on your behalf. Annual Benefits Salary is used to calculate your Basic Term Life Insurance coverage.

## Optional Term Life Insurance Plan

You may elect Optional Term Life Insurance coverage in addition to your Basic Term Life Insurance coverage. You may choose additional amounts of coverage of one, two, three, four or five times your Annual Benefits Salary up to a maximum of \$1,000,000 (including your coverage for Basic Term Life Insurance):

- 1 times annual benefits salary
- 2 times annual benefits salary
- 3 times annual benefits salary
- 4 times annual benefits salary
- 5 times annual benefits salary

Your Annual Benefits Salary is based on your pay on July 1 of the prior year. Your benefit is calculated as Annual Benefits Salary times elected level rounded up to the next \$1,000. For example if your Annual Benefit Salary is \$52,400 and you elect 2 times annual benefit salary your coverage amount is \$105,000 (2 x \$52,400 = \$104,800). You pay the full cost for each \$1,000 of coverage.

## Cost of Optional Term Life Insurance Coverage

Rates are based upon your age and coverage amount. Please refer to Benefits in Brief at [www.hr.columbia.edu](http://www.hr.columbia.edu) for your monthly cost.

Age at Paycheck	Age at Paycheck
Less than 25	50 to 54
25 to 29	55 to 59
30 to 34	60 to 64
35 to 39	65 to 69
40 to 44	70 to 74
45 to 49	75 or older

You pay a monthly premium for each \$1,000 of coverage. Your benefit is determined using your pay on July 1 of the previous year, rounded to the next highest \$1,000. If you reach a “milestone” birthday during the year (e.g., 25, 30, 35), you move to a different age bracket and premium rate. Your premium will increase effective with the next Benefits Open Enrollment.

## **Medical Evidence of Insurability**

Your Optional Term Life Insurance election requires you provide medical evidence of insurability and be approved by The Standard in the following instances:

- When your coverage level under Optional Term Life Insurance first exceeds 3 times your salary or \$500,000
- If you elect to add or increase Optional Life Insurance

The Standard will send an Evidence of Insurability Form to you if evidence of insurability is required. Please complete the form, which outlines your medical history, within 60 days and submit it to The Standard Life Insurance Company of New York for approval. In some cases, an Independent Medical Examination may be required, arranged, and paid for by The Standard.

If during a Life Status Change you elect to increase or start life insurance and have been previously denied by The Standard for insurance you will not be approved for the elected amount.

## **New Hires**

You may elect Optional Term Life Insurance up to a maximum of three times your Annual Benefits Salary or \$500,000 without providing medical evidence of insurability.

## **If Denied Evidence of Insurability**

Your coverage will remain as it was prior to your election if you were not newly eligible for the benefit.

- New Hire – If denied your coverage will be set to the highest allowable amount without evidence of insurability (the lesser of 3x Annual Benefit Salary or \$500,000)
- Life Event – If denied your coverage remains as it was prior to election.
- Annual Enrollment – If denied your coverage remains as it was prior to election.

# **LIFE INSURANCE COVERAGE DURING DISABILITY**

## **Waiver of Premium**

If your employment ends because you become disabled and you are under age 60, you may apply for a “Waiver of Premium.” This means you will not have to pay premiums for your life insurance coverage as long as you meet the definition of Total Disability as defined by The Standard.

## **Refund of Premiums**

The Standard will refund up to 12 months of premiums you paid for insurance after you became Totally Disabled.

If you have any questions about “Waiver of Premium”, please contact the HR Benefits Service Center at 212-851-7000. You can also call The Standard at 1-800-628-8600 or visit their website at [www.standard.com](http://www.standard.com).

## **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE PLAN**

You receive AD&D insurance equal to one times your base salary (as calculated on July 1 each year and rounded up to the nearest \$1,000) up to a maximum of \$50,000.

AD & D coverage is provided at no cost to you.

The types of losses that are covered under the AD&D Plan are listed below.

<b>COVERED LOSSES</b>	<b>AD&amp;D BENEFITS AMOUNTS</b>
Life	100%
One hand or one foot	50%
Sight in one eye	50%
Two or more of one hand or one foot or sight in one eye	100%

# **FEATURES AND EXCLUSIONS**

## **Assignment of Your Life Insurance**

You may assign your Basic and Optional Term Life Insurance benefits if the amount of coverage is \$25,000 or more. You may not assign such coverage for compensation or any other kind of consideration. You may assign any rights, benefits, or privileges that you have under these Plans, including your right to name a beneficiary or to convert your coverage to an individual policy.

To the extent you assign your rights under any Life Insurance Plan, your ability to make changes, including changes to your beneficiary and/or coverage levels, will be limited and must be agreed to by the assignee. However, no assignment will be binding on The Standard unless it is in a form acceptable to The Standard, accepted in writing by The Standard and filed at The Standard's Home Office.

## **Accelerated Death Benefit**

This feature allows you to request payment of your life insurance if you have a terminal illness with a life expectancy of 12 months or less. The Basic and Optional Life Insurance Plans allow for the accelerated payment of unassigned life insurance benefits. Your spouse, assignee or irrevocable beneficiary, if any, must consent to this payment.

You may request payment generally up to 75% of the amount of coverage in effect at the time of your request. The minimum amount available is the lesser of \$50,000 or 25% of your insurance coverage. The maximum accelerated payment may not exceed \$500,000.

Your life insurance coverage will be reduced by the amount of the accelerated benefit payment. If you do not qualify for Waiver of Premium, the ongoing premium payment in effect prior to the payment of the Accelerated Benefit must continue after payment of the Accelerated Benefit for Insurance coverage to remain in force.

The accelerated benefit is paid as a lump sum directly to the insured, and may be taxable as income. It is payable only once during the individual's lifetime. It is not payable for terminal illness resulting from injury to self, while sane or insane.

## **Exclusions Regarding Death Benefit**

No benefit/increased benefit will be paid under the Optional Life Insurance Plan for death resulting from suicide, while sane or insane, within two years of the effective date of coverage or increase in coverage. A refund of applicable premiums will be distributed to the beneficiary.

## Taxes on Your Life Insurance – Imputed Income

Internal Revenue Service (IRS) regulations require that you be taxed on the *cost* or *value* of any employer-provider group life insurance that is more than \$50,000. This value is known as “*imputed*” income and is shown on your paycheck. It also appears on your annual W-2 statement.

You automatically receive Basic Term Life Insurance of one times your salary up to \$50,000 at no cost to you. If you elect Optional you will pay Federal Withholding Tax, Social Security Tax (FICA), Medicare Insurance tax and New York City Wage Tax (if applicable) on the value of that life insurance.. Applicable taxes are deducted from each paycheck.

Your imputed income is determined by age-related rates set by the federal government similar to premium rates. The rates are for each \$1,000 of coverage per month. Since the value of Basic Life Insurance **over** \$50,000 is taxable, you should multiply the amount in excess of \$50,000 by the applicable IRS rate per \$1,000 of coverage, multiplied by 12 months to determine your imputed income for the year. The table below shows the imputed IRS rates used to calculate imputed income for amounts of life insurance benefits in excess of \$50,000. The rate used is based on your age as of the end of the calendar year in which you were covered.

### IRS Table Used for Imputed Income

<b>Age</b>	<b>Rate per \$1,000 per month</b>
Under 25	\$.05
25 - 29	\$.06
30 - 34	\$.08
35 - 39	\$.09
40 - 44	\$.10
45 - 49	\$.15
50 - 54	\$.23
55 - 59	\$.43
60 - 64	\$.66
65 - 69	\$1.27
70 +	\$2.06

For example, a 49-year-old employee with a total \$150,000 of Group Term Life Insurance (Basic plus Optional Life Insurance) would have \$100,000 subject to imputed income (\$150,000 minus \$50,000). This will result in an additional \$180 in income on his or her federal income tax return (\$100,000 divided by 1,000, multiplied by .15 (from the table above), then multiplied by 12 months).

## **WHEN LIFE INSURANCE COVERAGE ENDS**

Basic and/or Optional Life Insurance coverage ends upon your termination of employment transfer to employment in an ineligible class or when your contributions end.

Upon the end of your coverage you have the right to convert your coverage to an individual, direct-pay policy with The Standard. In addition, you also have the right to take your Basic and Optional Life Insurance with you. It is a “portable” benefit.

Conversion and/or portability forms will be mailed to your home directly from The Standard when you become eligible for conversion or portability.

### **Conversion of Your Group Term Life Insurance to an Individual Policy**

The Standard will issue an individual policy of life insurance to you if you apply for it in writing during the application period. The application period is the 31-day period after the date your Basic and/or Optional Life Insurance benefits end as described above.

The individual policy will be issued to you, without providing evidence of insurability, subject to these conditions:

1. It will be on one of the forms usually issued by The Standard
2. The premium will be based on the class of risk to which you belong, your age on the effective date of the policy and the term and amount of the policy.
3. It may not exceed the amount of insurance.
4. It will not take effect until after the application period ends.

However, if the covered individual dies during the application period, The Standard will pay a death benefit, even if a conversion policy was not applied for. The death benefit will be the highest amount for which a personal policy could have been issued.

### **Portability of Your Group Term Life Insurance**

Both Basic Term Life and Optional Term Life Insurance are portable. This means if your coverage ends for reasons other than retirement you may elect to take your coverage with you. You can continue your insurance by paying premiums based on your age and The Standard’s portable life insurance rates.

You will have 31 days after your Life Insurance Coverage otherwise ends to return your election to The Standard. You will receive a notice from The Standard explaining the portability options available to you.

The maximum amount of life insurance you may continue on your own is the amount in effect for at least 6 months prior to the date you leave the University or \$750,000, whichever is less. You may not port coverage that you convert. The minimum amount you may port is \$25,000. You will be billed directly for this coverage and if you do not make payments within the 31-day grace period, the coverage will end and may not be reinstated.

For more information please call The Standard at 1-800-378-2409.

## **HOW TO FILE A CLAIM**

### **How to Submit Claims to The Standard**

All claim forms can be obtained from The Standard by calling 1-800-628-8600. You can also find the forms at [www.hr.columbia.edu/hr](http://www.hr.columbia.edu/hr) under the HR Forms Library.

In submitting claims for Life Insurance benefits, you must complete the appropriate claim form and submit the required proof of loss within 90 days after the date of the loss. Proof of loss for a “Waiver of Premium” must be submitted within 12 months after the end of the 180 days Waiting Period.

Claim forms must be submitted directly to The Standard at the address located on the claim form.

### **Initial Determination**

After The Standard receives your claim for benefits, The Standard will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date The Standard receives your claim. If The Standard notifies you within that period that additional information is needed, you will have 45 days to provide that information.

If The Standard denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim is denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because The Standard did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

## **Appealing the Initial Determination**

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary, can request a review of your claim by The Standard. This request for review should be sent in writing to The Standard's office which processed the claim within 60 days after you or, if applicable, your beneficiary, received notice of denial of the claim.

When requesting a review, please state the reason you or, if applicable, your beneficiary, believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate.

Upon your written request, The Standard will provide you free of charge with copies of relevant documents, records, and other information. The Standard will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date The Standard received your request for review. If The Standard notifies you within that period that additional information is needed, you will have 45 days to provide that information.

If The Standard denies the claim on appeal, The Standard will send your beneficiary a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal.

## **Time Limits on Legal Actions**

Legal action regarding a claim denial can not be taken until 60 days after The Standard receives proof of loss.

## **Routine Questions**

If there is any question about a claim payment, an explanation may be requested from The Standard by calling 1-800-628-8600.

# **Claims Involving Disability Determinations in connection with Life and Accidental Death or Dismemberment Insurance**

## **Claim Submission**

For any claim which requires a determination of disability in connection with Life insurance, the claimant must complete the appropriate claim form and submit the required proof as described in the certificate. Claims forms must be submitted in accordance with the instructions on the claim form.

## **Initial Determination**

After The Standard receives your claim involving a disability determination, The Standard will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date we received your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case The Standard may have up to two (2) additional extensions of 30 days each to provide you such notification.

If The Standard needs an extension, it will notify you prior to the expiration of the initial 45-day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of The Standard's notice requesting further information and an extension until The Standard receives the requested information from the date you receive the extension notice requesting further information from The Standard.

If The Standard denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because The Standard did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria relied upon, that you may request a copy free of charge. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

## **Appealing the Initial Determination**

If The Standard denies your claim, you may appeal the decision. Upon your written request, The Standard will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to The Standard at the address indicated on the claim form within 180 days of receiving The Standard's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of Plan
- Reference to the initial decision
- An explanation on why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim. After The Standard receives your written request appealing the initial determination, The Standard will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and The Standard's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, The Standard will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination. The Standard will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after The Standard's receipt of your written request for review, except that under special circumstances The Standard may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, The Standard will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from The Standard's notice to you of the need for an extension to when The Standard receives the requested information does not count toward the time The Standard is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from The Standard.

If The Standard denies the claim on appeal, The Standard will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. If an internal rule, protocol, guideline or other

criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria relied upon, that you may request a copy free of charge. Upon written request, The Standard will provide you free of charge with copies of documents, records and other information relevant to your claim.

## **KEY LIFE INSURANCE TERMS**

(These definitions apply when the following terms are used.)

### **Actively At Work**

This means that you are performing all of the essential functions of your job at Columbia University where these duties are normally carried out or where requested by Columbia University. Actively at Work includes vacation but does not include approved or unapproved leave of absences.

### **Beneficiary**

This is the individual(s) you have designated on the appropriate form or on line in the Columbia University Online Benefits Enrollment System to receive the benefit payable from your policy should you die.

### **Disability**

Own occupation: You will be considered Disabled, if because of injury or illness you are unable to perform all the material duties of your own occupation.

Any Occupation: After Long Term Disability benefits have been payable for 24 months, you will be considered Disabled if your injury or illness makes you unable to perform all the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience.

The risk of your insurance policy is borne by the insurance carrier, The Standard. All decisions related to this benefit are made by The Standard.

### **Illness**

This means any physical or mental illness, including pregnancy (unless specifically excluded).

### **Injury**

This means any accidental loss or bodily harm.

### **Leave Of Absence**

If you are approved by your management to be absent from work at Columbia University, you are on a leave of absence.

### **Retirement Plan**

The Columbia University Retirement Plan.

**Total Disability**

Totally Disabled means that, as a result of illness, Injury, or Pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

# **STATEMENT OF ERISA RIGHTS**

## **Statement of Employee Rights Under ERISA**

As a participant in the Columbia University Group Term Life Insurance Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which provides that all Plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent Action by Plan Fiduciaries**

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

### **Enforcing Your Rights**

If your claim for an employee benefit is denied or ignored, in whole or in part, you have a right to know why this was done and to obtain copies of documents relating to the decision without charge. In addition, you must receive a written explanation of the reason for the denial, and have the right to have your claim reviewed and reconsidered upon request, all within certain time schedules.

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

### **Assistance with Your Questions**

If you have any questions about the Plan, you should contact the Columbia University HR Benefits Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## PLAN INFORMATION

<b>Plan Sponsor</b>	<b>Columbia University</b> 615 West 131st Street, MC 8703 Studebaker Floor 4 New York, NY 10027 (212) 851-7000
<b>Employer ID Number</b>	<b>13-5598093</b>
<b>Plan Name and Number</b>	<b>Columbia University Group Term Life Insurance Plans: 515</b> When requesting additional information about the Plan from the Department of Labor, refer to the plan number.
<b>Plan Administrator</b>	<b>Columbia University Human Resources Office of the Vice President</b> 615 West 131st Street, MC 8705 Studebaker Floor 4 New York, NY 10027 (212) 851-7000
<b>Agent for the Service of Legal Process</b>	<b>Columbia University Office of the General Counsel</b> 412 Low Memorial Library, MC 4308 535 West 116th Street New York, NY 10027 (212) 870-2286 Service of process may also be made on the Plan Trustees.
<b>Plan Year</b>	January 1 through December 31
<b>Type of Plan and Funding</b>	The Life Insurance Plan is a welfare plan providing basic and optional life insurance benefits. Basic Life Insurance benefits are fully insured and funded by the University. Optional Life Insurance benefits are funded through employee contributions.

## CONTACT INFORMATION

If, after reading this chapter, you have questions about the Columbia University Group Term Life Insurance Plans, you may use the following resources to obtain more information.

For more information or claims assistance, contact or call:

The Standard Life Insurance Company of New York  
(800-628-8600)  
Policy Number 645510  
[www.standard.com](http://www.standard.com)

For all Benefits-related questions, contact or call:

Columbia University HR Benefits Service Center  
615 West 131st Street, MC 8703  
Studebaker Floor 4  
New York, NY 10027  
Phone: (212) 851-7000  
Secure fax: (212) 851-7025  
Email: [hrbenefits@columbia.edu](mailto:hrbenefits@columbia.edu)  
HR website: [www.hr.columbia.edu](http://www.hr.columbia.edu)