

# Columbia University Officers' Plan Administration Section

*This section applies to the Columbia Officer Health and Welfare Benefits Program SPDs: i.e., the Medical, Dental, Life Insurance, and Long-Term Disability SPDs*

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# Plan Administration

## **Plan Name and Plan Sponsor**

Officers' Health and Welfare Benefits Program

## **Plan Administrator**

Columbia University  
Benefits Office  
1901 Interchurch Center  
475 Riverside Drive  
New York, NY 10155  
(212) 870-3074

The administration of the plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator will also have the discretion to determine all matters relating to interpretation and operation of the plan. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator or delegate acted arbitrarily or capriciously.

## **Employer Identification Number**

13-5998093

## **Plan Number**

515

## **Plan Year**

For governmental filing and reporting purposes, the official plan year for the Officers' Health Care Program is January 1 through December 31.

## **Agent for Service of Legal Process**

If, for any reason, you wish to seek legal action, you may serve legal process on the Plan Administrator or to the Agent for Service of Legal Process at the following address:

Office of General Counsel  
412 Low Memorial Library  
Room 116  
535 West 116<sup>th</sup> Street  
New York, NY 10027  
212-854-5581 or 212-854-4974

## **Organizations Providing Insurance and/or Administrative Services**

Listed below are the names, addresses, and phone numbers of the organizations that provide insurance and/or administrative services. These services include administering claims and providing customer assistance.

## Medical

- Aetna HMO  
99 Park Avenue  
New York, NY 10016  
1-800-433-8531
- CIGNA Modified Indemnity Plan  
P.O. Box 2005  
Farmington, CT 06034  
1-800-462-7486
- CIGNA POS Plan  
1-800-832-3211

*New York and Connecticut*  
P.O. Box 2005  
Farmington, CT 06034  
1-800-832-3211

*Delaware, New Jersey, and Pennsylvania*  
P.O. Box 15553

*Wilmington, DE 19850-5553*  
1-800-832-3211

- HIP HMO  
7 West 34<sup>th</sup> Street  
New York, NY 10001  
1-800-HIP-TALK
- Oxford HMO and POS Plan  
48 Monroe Turnpike  
Trumbull, CT 06611  
1-800-879-2399

## Dental

Columbia Dental Plan  
630 West 168<sup>th</sup> Street  
P.O. Box 20  
New York, NY 10032  
212-305-0763

## Life Insurance

CNA Group Benefits  
P.O. Box 946790  
Maitland, FL 32794-6750  
1-800-303-9744

## Disability

CIGNA  
12225 Greenville Avenue  
Suite 1000  
Dallas, TX 75243  
1-800-362-4462

## **Funding Medium**

The POS Plans, Modified Indemnity Plan, and dental plans are self-insured plans. Benefits from these plans are paid from employee contributions, as applicable, and from the general assets of Columbia University, as needed. Columbia University has contracted with third party administrators—CIGNA, Oxford, and the Columbia University School of Dental and Oral Surgery—to administer these plans. The HMOs, life insurance, and long-term disability plans, however, are fully insured plans, which means the plan carriers assume financial responsibility for paying claims.

## **Future of the Plans**

It is Columbia University's intent that the Columbia University Officers' Health and Welfare Benefits Program will continue indefinitely. Columbia University reserves the right to change or end any of the plans at any time. Columbia University's decision to change or end any of the plans may be due to changes in the federal or state laws governing benefits, the requirements of the Internal Revenue Code or ERISA, the provisions of a contract or a policy involving an insurance company, or any other reason. Any such action would be taken in writing and maintained with the records of the plan.

## **Limitation on Assignment**

Your rights and benefits under the plan cannot be assigned, sold, or transferred to anyone else except under limited circumstances (e.g., qualified medical child support order or assignment to your health provider).

## **Continuation of Coverage**

According to the Consolidated Omnibus Budget Reconciliation Act (COBRA), you, your spouse/same-sex domestic partner, and your dependent child(ren) may elect to temporarily continue group medical and dental coverage if you lose your benefits under certain circumstances. You will be required to pay the full cost of coverage plus an administrative fee.

Individuals entitled to COBRA continuation are called qualified beneficiaries. They include you, your spouse/same-sex domestic partner, and your dependent child(ren) who are covered at the time of the qualifying event. In addition, a child who is born to you, adopted, or placed with you for adoption during the COBRA coverage period is also a qualified beneficiary and eligible for coverage.

COBRA continuation is available for a maximum of 18, 29, or 36 months, depending on the "qualifying events" under which you are eligible for the continuation. The maximum continuation period, if multiple circumstances should occur, is a total of 36 months. This means, if your dependents experience a second qualifying event within the original 18-month or 29-month period, they (but not you) may extend the COBRA continuation period

for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).

**Continuation of Coverage under COBRA**

Qualifying Events that Result in Loss of Coverage	Maximum Continuation Period		
	Employee	Spouse/ Same-Sex Domestic Partner	Child
Employee's work hours are reduced and results in loss of coverage	18 months	18 months	18 months
Employee terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee becomes entitled to Medicare as a retiree	N/A	36 months	36 months
Employee or dependent is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse/same-sex domestic partner legally separate or divorce	N/A	36 months	36 months
Employee becomes eligible for Medicare within 18 months prior to termination of employment or reduction in work hours	N/A	36 months	36 months
Child no longer qualifies as a dependent	N/A	N/A	36 months

\* 36-month period is counted from the date you become entitled to Medicare.

**Electing COBRA Continuation Coverage**

You and your covered dependents must choose to continue coverage within 60 days after the later of the following dates:

- The date you and your covered dependents would lose coverage as a result of the qualifying event; or
- The date the University notifies you and your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

## **Paying for COBRA Continuation Coverage**

If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 31 days of each due date. You are responsible for making payments each month in a timely manner. If you elect COBRA continuation, but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 31 days after the date it's due, your coverage will be terminated retroactively to the last day for which timely payment was made.

## **Cost**

The cost of COBRA medical is the full group cost of plan coverage per covered person plus a 2% administrative fee. (A spouse or dependent making a separate election will be charged the same rate as a single employee.)

### Cost for Disabled Beneficiaries

If you become disabled and receive long-term disability benefits, you may continue medical coverage provided you continue to make contributions toward the cost of coverage. However, the cost of medical coverage for your dependents under COBRA for the 19<sup>th</sup> through 29<sup>th</sup> months of coverage under the disability extension will be:

- 150% of the full cost of coverage for all dependents participating in the same coverage option as you are; and
- 102% for any dependent participating in a different coverage option than you are.

If you have a second qualifying event while you are receiving COBRA continuation for a disability, the rate for your dependents will depend on when the second qualifying event occurs:

- If a second qualifying event occurs *during the first 18 months of coverage*, then the 102% rate applies to the full 36 months, but
- If a second qualifying event occurs *during the 19<sup>th</sup> through 29<sup>th</sup> month*, then the rate for the 19<sup>th</sup> through 36<sup>th</sup> months of COBRA continuation is:
  - The 150% rate for all dependents participating in the *same* coverage option as you
  - The 102% rate for any family members in a *different* coverage option than you.

## **Changes in Coverage During the Continuation Period**

If coverage under the plans is changed for active employees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during annual enrollment, if a qualified change in status occurs, or at other times under the plans to the same extent that active employees may do so.

## **When COBRA Continuation Coverage Ends**

COBRA continuation for medical and dental coverage will end when the first of the following occurs:

- The applicable continuation period ends
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 31 days after it is due
- After the date COBRA is elected, the qualified beneficiary first becomes covered (as an employee or otherwise) under another group medical and/or dental plan not offered by Columbia University, which does not contain an exclusion of limitation affecting the person's pre-existing condition, or if the other plan does contain a pre-existing condition limit or exclusion, it does not apply, due to rules under the Health Insurance Portability and Accountability Act (HIPAA)
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare (this does not apply to other qualified beneficiaries who are not entitled to Medicare)
- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ends on the first day of the month at least 31 days from the date the final determination is issued. However, if a second qualifying event has occurred during the first 18 months, COBRA may continue based on that second qualifying event
- For newborns and children adopted or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends, unless a second qualifying event has occurred
- Columbia University terminates all group medical and/or dental coverage for all employees.

Contact Columbia University Faculty and Staff Services at 212-870-3074 for further details.

## **Continuation of Coverage for Employees in the Uniformed Services**

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Generally, if you are on a military leave covered under USERRA, you are entitled to the same rights and benefits that Columbia University provides to similarly situated employees on other types of leave.

If your military leave is for less than 31 days, you may continue your medical and dental coverages by paying the same amount charged to active employees for the same coverages. If your leave is for a longer period of time, you may be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of 18 months after the leave begins or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled work day following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days
- Return to or reapply for reemployment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for reemployment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

**Note:** *In times of national emergency and depending on circumstances, Columbia University may extend medical and dental coverage to you and your dependents at its discretion. This would be in addition to coverage provided by the United States military service.*

## **Death and Disability**

If you become disabled as defined by the Columbia University Long-Term Disability (LTD) Plan, you and your eligible dependents can continue medical and life insurance coverage until your LTD benefit payments end. After your coverage ends, you'll be able to continue medical coverage under [COBRA](#). However, if you meet the requirements of the Columbia University retiree medical plan (you are age 55 and have at least 10 years of service), you'll be eligible for medical coverage after your LTD coverage ends under the terms of the retiree medical plan. (You continue to accrue years of service for purposes of retiree medical while you are receiving LTD benefits.)

If you die while actively employed, your dependents will be eligible for lifetime medical coverage if you meet the criteria under the Columbia University retiree medical plan (you were age 55 with 10 years of service when you died). However, if you don't meet the eligibility requirements before your death, your dependents will be eligible for one year of continued medical coverage at the active employee rates, followed by 36 months of continued coverage under COBRA.

## Certificate of Coverage

If you lose your coverage under your Columbia University-sponsored medical plan, you will automatically be sent a certificate of coverage from the medical plan, which shows how long you had been covered under the plan. This document will provide you with proof of coverage that you may need to reduce any subsequent medical plan's pre-existing medical condition limitation period that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will also receive another certificate of coverage anytime within the 24 months after your coverage has ended. You may also request a certificate of coverage any time within the 24 months after your coverage has ended.

## Your Right To Appeal

If your claim under the medical or dental plan is denied in whole or in part, you (or your beneficiary) will be notified in writing or electronically by the claims administrator for that benefit plan within:

- 72 hours of receipt of an *urgent claim* for a group medical or dental plan. However, if you do not provide sufficient information, a three-step alternate procedure applies instead:
  - The claims administrator must notify you within 24 hours of receipt of the claim of the information necessary to complete the claim
  - You must be given a reasonable amount of time to provide the needed information (no less than 48 hours)
  - The claims administrator must notify you of its decision within 48 hours of receipt of the information.

Any request you make to extend an ongoing course of urgent care treatment (e.g., to be provided over a period of time or a specific number of treatments) beyond the period of time or number of treatments that has been approved by the group medical or dental plan, must be decided upon by the claims administrator as soon as possible. The claims administrator must notify you of the determination within 24 hours of receipt of the claim, provided the claim is made to the plan at least 24 hours prior to the expiration of the treatment.

- 15 days of receipt of a *pre-service claim* for a group medical or dental plan. A pre-service claim is any claim that must be approved before treatment can be obtained.
- 30 days of receipt of a *post-service claim* for a group medical or dental plan.

(For pre- and post-service claims, the claims administrator may have one extension of up to an additional 15 days if the claims administrator determines that an extension is necessary due to matters beyond the control of the plan. The claims administrator must notify you of the circumstances requiring the extension of time and the date by which the plan expects to provide a decision prior to the expiration of the initial 15-day period for pre-service claims and 30-day period for post-service claims.)

- 45 days of receipt of a *disability claim* for a group medical or dental plan. The claims administrator may have two extensions. First, the response date may be extended by 30 days if the claims administrator determines that the extension is necessary due to matters beyond the control of the plan. You must be notified of the circumstances requiring the extension and the date by which the plan expects to render a decision before the initial 45-day period expires. Second, another 30-day extension is permitted if the claims administrator again determines that, due to circumstances beyond the control of the plan, a decision cannot be rendered within the extension period. You must be notified of the circumstances requiring the additional extension and the date the plan expects to render a decision before the

first 30-day extension period expires.

- 90 days of receipt of a claim for *all other ERISA plans that are not group medical and dental plans and plans providing disability benefits* (180 days if special circumstances apply; if special circumstances require an extension, you will be notified in writing).

This written notice will include:

- The specific reason(s) for the denial
- References to specific plan provision(s) on which the denial is based
- A description of any additional materials or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) after a denial on appeal
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, as well as a statement of your right to bring an action under ERISA Section 502(a)
- Group medical and dental plans and plans providing disability benefits must also provide the following information:
  - A copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the denial or provide a notice that such material was relied upon and that a copy will be provided to you upon request free of charge
  - If the denial is based on a medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
  - If the denial is under a group medical or dental plan and involves urgent care, a description of the expedited review process applicable to such claims. Under the expedited review process, the notice of a denial may be provided orally by the deadlines applicable to the plan for responding to urgent care claims, provided that a written or electronic notification is provided to you no more than three days after the oral notification.

You or your authorized representative may review all documents related to any denial of benefits. If you disagree with the claims administrator's decision, you have 60 days after receiving notice of the denial to appeal the decision; for group medical and dental plans and any plan providing disability benefits, you have 180 days. This request should be in writing and sent to the claims administrator, which handles the day-to-day administration of the plans for the Plan Administrator at the following address:

## **Medical**

CIGNA Modified Indemnity Plan  
P.O. Box 2005  
Farmington, CT 06034

CIGNA POS Plan  
*New York and Connecticut*  
P.O. Box 2005  
Farmington, CT 06034  
*Delaware, New Jersey, and Pennsylvania*  
P.O. Box 15553  
Wilmington, DE 19850-5553

Oxford HMO and POS Plan  
48 Monroe Turnpike  
Trumbull, CT 06611

## **Dental**

The Columbia Dental Plan  
630 West 168<sup>th</sup> Street  
P.O. Box 20  
New York, NY 10032

The plan must provide a reasonable opportunity for a "full and fair review" (i.e., an appeal) of the claim and denial:

- You must have at least 60 days to initiate an appeal (180 days to initiate a claim appeal for group medical and dental plans and any plan providing disability benefits)
- You must be given the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits
- You must be given, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as relevant to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether it was relied upon in making the benefit determination
  - Demonstrated compliance, in making the benefit determination, with the rule's required administrative processes and safeguards
  - For group health plans and plans providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for your diagnosis, regardless of whether it was relied upon in making the benefit decision.
- Provide for a review that takes into account all comments, documents, records, and other information that you submit relating to the claim, regardless of whether it was

submitted or considered in the initial benefit determination

- Reviews of denials by group medical and dental plans and plans having disability benefits also must:
  - Not defer to the initial denial
  - Be conducted by an appropriate named fiduciary who is not the named fiduciary who made the denial on the claim that is being appealed and who is not the subordinate of such individual
  - If the denial is based partly or entirely on a medical judgment, including whether a particular treatment, drug, or other item is experimental, require the named fiduciary to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment
  - Provide for the identification of such health care professional who was consulted
  - Require that any health care professional who is consulted not be the health care professional who was consulted regarding the denial on the claim that is the subject of the appeal and who is not the subordinate of such individual.
- Group medical and dental plans must also provide an expedited review process for urgent care. Under the expedited review process, your requests for expedited appeals of denials must be allowed to be submitted orally or in writing, and all necessary information (including the plan's decision on review), will be transmitted between you and the plan by telephone, fax, or other available similarly expeditious method. As mentioned previously, this expedited review process also must be described in the notice of a denial.

In general, the claim appeal will be reviewed in detail and you'll receive written notification of a decision or outcome within:

- 72 hours of receipt of an *urgent claim* for a group medical or dental plan
- 30 days of receipt of a *pre-service claim* for a group medical or dental plan
- 45 days of receipt of a *disability claim* for a group medical or dental plan. (An additional 45-day extension is available if the claims administrator determines that special circumstances require an extension of time for processing. A written notice of the extension must be provided to you before the initial 45-day period expires and must indicate the special circumstances requiring the extension of time and the date by which the plan expects to render the determination on review.)
- 60 days of receipt of a *post-service claim* for a group health plan
- 60 days of receipt of a claim *for all other types of ERISA plans that are not group medical and dental plans and plans providing disability benefits* (120 days if special circumstances apply; if special circumstances require an extension, you will be notified in writing).

All determinations of appeals made by the claims administrator are final and binding.

## Your Rights Under ERISA

As a participant in the Columbia University Officers' Health Care Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge at the Benefits Office and at other specified locations, such as work sites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
- Obtain copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial reports. The Plan Administrator is required, by law, to provide each participant with a copy of the summary annual report
- Continue health care coverage for yourself, your spouse/same-sex domestic partner or dependents if there is a loss of coverage under the plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plans on the rules governing your COBRA continuation rights.

In addition to creating rights for plan participants, ERISA imposes duties upon those who are responsible for operation of the employee benefit plan. Those 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 your employer, or any other person, may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a health benefit or exercising your rights under ERISA.

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

Under ERISA, you can take steps to enforce the preceding 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 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 to be frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. 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 U.S. Department of Labor, Pension and Welfare Benefits Administration, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

## Your Employment

Your eligibility or your right to benefits under the Columbia University benefit plans should not be interpreted as a guarantee of employment. Columbia University's employment decisions are made without regard to the benefits to which you are entitled upon employment.