Teachers College, Columbia University
Retiree Medical Plan
Summary Plan Description for Retirees
Effective January 1, 2016

June 16, 2016
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Introduction

This summary, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, “EOCs”), is intended to serve as the Summary Plan Description (“SPD”), as required by the Employee Retirement Income Security Act of 1974 (“ERISA”). The SPD describes the Retiree Medical benefits provided by Teachers College, Columbia University Retiree Medical Plan (the “Plan”) for eligible retirees and their eligible dependents.

The Plan provides benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Newborns’ and Mothers’ Health Protection Act (NMHPA), and the Genetic Information Nondiscrimination Act (GINA).

All benefits are provided under insurance or HMO contracts. All benefits are summarized in this document and in the EOCs (as defined below).

This summary should be read in connection with the EOCs (see Appendix A for a list of EOCs). The EOCs are provided by the insurance companies, HMOs and service providers. If there is ever a conflict or a difference between what is written in this summary and the EOCs with respect to the specific benefits provided, the EOCs shall govern unless otherwise provided by any federal and state law. If there is a conflict between the EOCs and this summary with respect to the legal compliance requirements of ERISA and any other federal law, this summary will rule.

The applicable EOCs describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverage will be provided for out-of-network services. A directory of participating network providers will be provided, automatically, at no cost to you. You may also access the provider directory on the insurance company’s website https://www.oxhp.com/ or you can call the insurance company at the phone number indicated in the EOC. You will also be informed about any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Plan.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator identified on page 2.

Teachers College, Columbia University ("the College") reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.
## HIGHLIGHTS OF YOUR BENEFIT PLANS

Below is key information you need to know about your benefit plans:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Teachers College, Columbia University Retiree Medical Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Number</td>
<td>502</td>
</tr>
<tr>
<td>Plan Sponsor</td>
<td>Teachers College, Columbia University 525 W. 120th Street New York, NY 10027 (212) 678-3175</td>
</tr>
<tr>
<td>Employer Identification Number</td>
<td>13-1623202</td>
</tr>
<tr>
<td>Plan Administrator</td>
<td>Teachers College, Columbia University 525 W. 120th Street New York, NY 10027 (212) 678-3175</td>
</tr>
<tr>
<td>Agent for Service of Legal Process</td>
<td>Office of the General Counsel</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 through December 31, however the first plan year will be July 1, 2011 through December 31, 2011.</td>
</tr>
<tr>
<td>Plan Type</td>
<td>Welfare benefit plan providing retiree Medical benefits</td>
</tr>
<tr>
<td>Source of Contributions</td>
<td>The cost of contributions will either be covered by contributions from Teachers College, Columbia University, contributions by the retiree, or will be shared by Teachers College, Columbia University and the retiree. Where Teachers College, Columbia University and its retirees share the cost of coverage, Teachers College, Columbia University shall contribute the difference between the amount retirees contribute and the amount required to pay benefits under the Plan. The Plan Administrator will notify retirees annually as to what the contribution rates will be. The College, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse the College for their contributions, unless otherwise provided in that group insurance contract or required by applicable law.</td>
</tr>
</tbody>
</table>

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Teachers College  
Retiree Summary Plan Description 2016
Plan Document

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

Plan Amendment and Termination

Teachers College, Columbia University reserves the right to amend the Plan in whole or in part, or to completely discontinue the Plan at any time. For example, the College reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. The College also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any Plan amendment, termination or other action by the College will be done in accordance with the College’s normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of the College, the Plan shall terminate unless the Plan is continued by a successor to the College.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to the College to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

ELIGIBILITY

Benefits Upon Retirement

Upon retirement, eligible faculty and professional staff may participate in the following benefits:

Life Insurance - The group term coverage provided by the College will end upon retirement. The retiree may convert to a direct payment Life Insurance Policy within 30 days of retirement without a physical examination.

Dental and Vision Insurance - Coverage ceases upon retirement, but may be continued through COBRA. After the COBRA continuation period is exhausted there is no provision for conversion.

Medical Insurance –

Full-time faculty, instructional staff and professional staff with certain years of eligible service may be eligible for retiree medical coverage under the Plan. Details of your eligibility and the benefits available to you will depend on when you were hired and when you retire.

For professorial faculty and instructional staff, “eligible service” described herein shall minimally be for the term of the complete academic year of September 1 – May 31. For all others, “eligible
service” described herein shall be for the term of the complete calendar year, commencing with the employee’s anniversary date in an eligible position.

Retirees Hired Before January 1, 2006 who Retire before September 1, 2011 (and certain faculty who retire before September 1, 2013)

If you retired from the College on or after January 1, 2006 but before September 1, 2011 you may elect to enroll in the Plan. The same provisions apply to eligible faculty who have, by August 31, 2011, entered into irrevocable agreements to retire before September 1, 2013.

To be eligible, you must:

- have at least 15 continuous years of eligible service immediately prior to your retirement date;
- retire at age 55 or later; and
- retire on or after January 1, 2006, but
  - before September 1, 2011 if you are not a faculty member who has, by May 31, 2011, entered into irrevocable agreements to retire before September 1, 2011; OR
  - before September 1, 2013 if you are a faculty member who has, by August 31, 2011, entered into irrevocable agreements to retire before September 1, 2013).

You may elect to cover your eligible Spouse if he or she were covered at the time of retirement. The premium costs associated with the medical coverage for you and your Spouse will be fully paid by the College until the later of your death or the death of your Spouse.

You may elect to cover your eligible Dependent Children under the Plan, if they were covered at the time of your retirement. Your Dependent Children will be eligible for benefits up to the end of the year of the child’s 26th birthday. You pay the employee portion of two-party coverage toward the cost for Dependent Child coverage.

Upon reaching Medicare-eligible age, claims will be adjudicated by the Plan so that it will be assumed that Medicare Part B coverage will be your primary insurance and the College’s retiree medical coverage will be your secondary insurance, paying claims after calculating the amount that Medicare would have paid it if was first processed through Medicare. This arrangement will also be applicable to your covered Spouse and/or dependents, where applicable.

The College’s insurance will process the respective claims, recognizing applicable deductibles and other plan limits, up to 100% of the original claim. If Medicare’s payment pays the amount that would otherwise be attributed to deductible, copayment or coinsurance, Aetna will pay the remainder of the respective claim, within the limits identified by the plan.

In order to be eligible for this level of coverage and contribution, full-time, tenured faculty must retire by August 31, 2013 and enter into an irrevocable agreement to retire by August 31, 2011. In order to be eligible for this level of coverage and contribution, all eligible employees other than full-time, tenured faculty must retire by August 31, 2011 and provide notice of retirement by June 1, 2011. If the notice timeline is not met, employees who retire will receive coverage as specified in the following section of this SPD.

Retirees Hired Before January 1, 2006 who Retire on or after September 1, 2011 (except certain faculty who retire by September 1, 2013)

If you were hired before January 1, 2006, and retire from the College on or after September 1, 2011, you may elect to enroll in the Plan.
To be eligible, you must:

- have 15 continuous years of eligible service immediately prior to your retirement date;
- retire at age 55 or later;
- have been hired before January 1, 2006; and
- retire on or after September 1, 2011 (for non-faculty) or September 1, 2013 (for faculty).

This provision does NOT apply to full-time, tenured faculty eligible to retire by August 31, 2013 and who, prior to August 31, 2011, enter into an irrevocable agreement to retire before September 1, 2013. Such faculty are covered by the section above (“Retirees Hired Before January 1, 2006 who Retire on or after January 1, 2006 but before September 1, 2011 and certain faculty who retire before September 1, 2013”).

If you elect to continue coverage, you and the College will share in the monthly expense of the insurance. Your contribution will be based upon:

- Your eligibility for (and election and maintenance of) Medicare Part A and Part B.
- Your age at the time of retirement.
- The number of years of continuous, eligible service.

You may elect to cover your eligible Spouse under the Plan if he or she were covered at the time of retirement. You pay the full cost of coverage toward the cost for your Spouse’s coverage. Coverage will continue until the later of your death or the death of your Spouse.

You may elect to cover your eligible Dependent Children if they were covered at the time of your retirement. Your Dependent Children will be eligible for benefits up to the perspective child’s 26th birthday. You pay the retiree payment for each dependent child the full cost for each Dependent Child coverage.

Upon reaching Medicare-eligible age, claims will be adjudicated by the Plan so that it will be assumed that Medicare Part B coverage will be your primary insurance and the College’s insurance will be your secondary insurance, paying claims after calculating the amount that Medicare would have paid if it was first processed through Medicare. This arrangement will also be applicable to your covered Spouse and/or dependents, where applicable. Your benefits will be coordinated with other coverage under a non-duplication of benefits provision.

**Retirees who Retire on or after May 1, 2011 with Less than 15 Years of Service**

If you retire as a member of the full-time faculty, instructional staff, professional staff or administration on May 1, 2011 or later, you may to elect to enroll in the Plan.

To be eligible, you must:

- Have at least five continuous years of eligible service immediately prior to your retirement date;
- Retire at age 60 or later; and
- Have participated in the College’s health plan for eligible full-time faculty, instructional staff and professional staff directly prior to retirement.

If you elect to continue coverage, you will pay the full monthly cost of the insurance. You may elect coverage for yourself only. There is no dependent coverage.

Upon reaching Medicare-eligible age, claims will be adjudicated by the Plan so that it will be assumed that Medicare Part B coverage will be your primary insurance and the College’s insurance will be your secondary insurance, paying claims after calculating the amount that Medicare would
have paid it if was first processed through Medicare. Your benefits will be coordinated with other coverage under a non-duplication of benefits provision.

**ELECTION OF RETIREE MEDICAL COVERAGE**

Once you provide the Human Resources Office with written notice of your intent to retire on a specified date, the Human Resources Office will contact you to ask if you would like to begin coverage immediately upon retirement by completing the necessary enrollment form(s). Your coverage will begin on the first of the month following your retirement or following your submission of enrollment form(s) to Human Resources, whichever comes later.

**Hired Prior to 2006 who Retired Prior to September 1, 2011 (and certain faculty who retire prior to September 1, 2013):**

If you retired prior to September 1, 2011 (September 1, 2013 for eligible faculty who, prior to August 31, 2011, entered into an irrevocable agreement to retire before September 1, 2013) you may elect retiree medical coverage at any time by contacting the submitting the necessary enrollment form to the Human Resources Office. You may terminate coverage once you have elected it but may only reenroll if you provide proof of comparable coverage for the entire duration of your break in coverage. This proof must be provided to the College at the time of re-enrollment. The only exception to this rule is that if you were terminated from retiree coverage because you enrolled in Medicare Part D and you then terminate Part D coverage, you may reenroll in the College plan on January 1 of the following year by enrolling during the next open enrollment period.

You may elect retiree medical coverage for your Spouse and Dependent Children enrolled in the College plan, once you have enrolled in the Plan. Your Spouse and Dependent Children may elect coverage during one of the following enrollment entry points:

- At the time of your enrollment into the plan, after your retirement;
- When your Spouse initially becomes eligible for Medicare (if earlier than the date you first become eligible for Medicare), after your retirement and after his/her retirement.

If you do not elect coverage during one of the enrollment entry points listed above, your Spouse and Dependent Children will not be eligible for retiree medical coverage in the future. The only exceptions to this rule are:

- if you were terminated from retiree coverage because you enrolled in Medicare Part D and you then terminate Part D coverage, you may reenroll in the College plan on January 1 of the following year (with any eligible dependents previously enrolled) by enrolling during the next open enrollment period; or
- if your coverage has been terminated as described in an earlier section because you or your Spouse (who either retired or became Medicare-eligible on or after January 1, 2007) were not enrolled in Medicare Part A and Part B or other comparable coverage, you and/or your Spouse may reenroll in the Plan at the next open enrollment period after being terminated from the Plan once you and/or your Spouse show proof of Medicare Part A and Part B enrollment or other comparable coverage to the College.

Except as noted in the section describing continued coverage upon death of the retiree (page 12), if you are no longer eligible for retiree medical coverage then your dependents may not continue coverage in the Plan.
There is no annual enrollment opportunity to elect Retiree coverage for yourself or your Spouse or Dependent Children. However, you may change your elected coverage (i.e., Aetna Access Plan, Aetna Direct Plan, Aetna Exclusive Plan or Aetna Value Plan) each year during open enrollment. You must provide a list of eligible Dependents at time of retirement for possible future enrollments, along with proof of age and dependency. Children who are not covered at the time of your retirement and/or a Spouse who is not covered under the Plan at the time of retirement will not be eligible for coverage under this plan.

Eligible retirees age 65 and over must be enrolled in Medicare Part A and Part B of upon enrolling in the plan or their 65th birthday, whichever comes later, in order to receive full plan benefits. Medicare will be the primary insurer, and the College’s Plan will be secondary. Reimbursement of expenses will not be duplicated between Medicare and the College retiree medical program. The level of coordination of benefits will depend on when you were hired and when you retire as described above.

A retiree age 65 and over must provide a copy of his or her Medicare card at the time of retirement. A retiree who reaches age 65 after retirement must send a copy of his or her Medicare card to Human Resources once he or she receives the card.

If you elect Medicare Part D, Retiree medical coverage under this Plan will terminate. However, if you later drop Medicare Part D, you may re-enroll for Retiree medical benefits under this Plan, effective January 1 of the year following proof that you have dropped Medicare Part D.

**Retirees Hired Prior to 2006 who Retire On or After September 1, 2011:**

If you were hired prior to January 1, 2006 and retired on or after September 1, 2011 (September 1, 2013 for eligible faculty) you must elect retiree medical coverage at any of the following enrollment entry points:

- At the time of retirement;
- When you become initially eligible for Medicare, after your retirement; or
- When your Spouse initially becomes eligible for Medicare (if earlier than the date you first become eligible for Medicare), after your retirement and after his/her retirement.

If you do not elect coverage at one of these three times, or if you terminate coverage once you have elected it, you may not elect coverage in the future. You may terminate coverage once you have elected it but may only re-enroll if you provide proof of comparable coverage for the entire duration of your break in coverage. The only exceptions to this rule are:

- if you were terminated from retiree coverage because you enrolled in Medicare Part D and you then terminate Part D coverage, you may reenroll the following year by enrolling during the College’s open enrollment period; or
- if your coverage has been terminated as described in an earlier section because you or your Spouse (who either retired or became Medicare-eligible on or after January 1, 2007) were not enrolled in Medicare Part A and Part B or other comparable coverage, you may reenroll in the Plan at the College’s open enrollment period after being terminated from the Plan once you show proof of Medicare Part A and Part B enrollment or other comparable coverage to the College.

You may elect retiree medical coverage for your Spouse and Dependent Children enrolled in the College plan, once you have enrolled in the plan. Your Spouse and Dependent Children may elect coverage during one of the following enrollment entry points:
At the time of your retirement;
When you become eligible for Medicare;
When your Spouse initially becomes eligible for Medicare (if earlier than the date you first become eligible for Medicare), after your retirement and after his/her retirement.

Election for your Spouse and Dependent Children may occur separately from yours as long as you are enrolled in the Plan at the time they enroll, and it occurs at the entry points listed above. If you do not elect coverage during one of the enrollment entry points listed above, your Spouse and Dependent Children will not be eligible for retiree medical coverage in the future.

There is no annual enrollment opportunity to elect retiree medical coverage if you have previously waived coverage. However, you may change the plan you have elected (i.e., Aetna Access Plan, Aetna Direct Plan, Aetna Exclusive Plan or Aetna Value Plan) each year during the College’s open enrollment period. Eligible Dependent Children not covered at the time of your retirement may not elect coverage in the future except as permitted in the bullets listed above. Eligible Dependent Children who are covered at the time of your retirement may not elect coverage in the future except as permitted in the bullets listed above. Dependent Children who are not covered at the time of your retirement and/or a Spouse who is not covered under the Teachers College Group Health Insurance Plan (for active employees) at the time of retirement will not be eligible for coverage under this Plan.

Eligible retirees age 65 and over must be enrolled in Medicare Part A and Part B upon enrolling in the Plan or on their 65th birthday, whichever comes later, in order to receive full plan benefits. Medicare will be the primary insurer, and the College’s retiree medical coverage will be secondary. Reimbursement of expenses will not be duplicated between Medicare and the College retiree medical program. The level of coordination of benefits will depend on when you were hired and when you retire as described above.

A retiree age 65 and over must provide a copy of his or her Medicare card at time of retirement. A retiree who reaches age 65 after retirement must send a copy of his or her Medicare card to Human Resources once he or she receives the card.

If you elect Medicare Part D, Retiree medical coverage under this Plan will terminate. However, if you later drop Medicare Part D, you may re-enroll for Retiree medical benefits under this Plan, effective January 1 of the year following proof that you have dropped Medicare Part D.

**Retire on or after May 1, 2011 with Less than 15 Years of Service:**

If you retired on or after May 1, 2011 at age 60 or older and you have 5 or more years of continuous eligible service, you must elect retiree medical coverage for yourself only either:

- At the time of retirement; or
- When you become initially eligible for Medicare.

If you do not elect coverage at one of these two times, you may **not** elect coverage in the future. The only exceptions to this rule are:

- If you were terminated from retiree coverage because you enrolled in Medicare Part D and you then terminate Part D coverage, you may reenroll in the College plan on January 1 of the following year by enrolling during the next open enrollment period; or
- If your coverage has been terminated as described in an earlier section because you (if you either retired or became Medicare-eligible on or after January 1, 2007) were not enrolled in Medicare Part A and Part B or other comparable coverage, you may reenroll in the Plan at the
next open enrollment period after being terminated from the Plan once you show proof of Medicare Part A and Part B enrollment or other comparable coverage to the College.

There is no annual enrollment opportunity to elect Retiree coverage if you have previously waived coverage. However, you may change the medical plan assignment (i.e., Aetna Access Plan, Aetna Direct Plan, Aetna Exclusive Plan or Aetna Value Plan) each year during open enrollment.

Eligible retirees age 65 and over must be enrolled in Medicare Part A and Part B upon enrolling or their 65th birthday, whichever comes later, in order to receive full plan benefits. Medicare will be the primary insurer, and the College’s retiree medical coverage will be secondary. Reimbursement of expenses will not be duplicated between Medicare and the College retiree medical program. The level of coordination of benefits will depend on when you were hired and when you retire as described above.

A retiree age 65 and over must provide a copy of his or her Medicare card at time of retirement. A retiree who reaches age 65 after retirement must send a copy of his or her Medicare card to Human Resources once he or she receives the card.

If you elect Medicare Part D, Retiree medical coverage under this Plan will terminate. However, if you later drop Medicare Part D, you may re-enroll for Retiree medical benefits under this Plan, effective January 1 of the year following proof that you have dropped Medicare Part D.

### Subsequent Employment at the College

Retirees must notify the Plan Administrator in writing prior to accepting an offer of subsequent employment at the College. This notification can be presented via email at Glazer@tc.edu or via mail at Human Resources, Teachers College, 525 West 120th Street, New York, NY 10027.

### Subsequent Employment of Those Retiring To Take Advantage of Pre-September 1, 2011 Retiree Benefits

An employee who retires prior to September 1, 2011 (or, for faculty, prior to September 1, 2013), retaining pre-September 1, 2011 retiree medical benefits, cannot return to employment at Teachers College and retain those pre-September 1, 2011 retiree medical benefits. Rather, an employee who “retires” but then returns to work at TC shall be eligible only for the post-September 1, 2011 retiree medical benefits for which he/she would have been eligible if he/she had remained employed.

This rule is subject to these exceptions only:

- At the request of the Provost, retired faculty members and instructional staff may remain at TC on a part-time basis for limited purposes such as teaching courses crucial to the continued work of the College, continuing externally funded research, or directing an externally funded Center or Institute while retaining pre-September 1, 2011 retiree medical benefits.
- At the request of the President or responsible Vice President, retired professional staff members may remain at TC on a part-time basis to assist with a transition for a limited period of time while retaining pre-September 1, 2011 retiree medical benefits.

For purposes of this policy, part-time employment means no more than 60% of full-time employment.
This Policy applies only to those who retire after the date the plan changes were announced, September 11, 2010.

**Subsequent Employment of Those Retirees Hired Before January 1, 2006 who Retire after the Pre-September 1, 2011 Retiree Benefits**

As indicated on page 5 of this Summary Plan Description, an employee must be in an eligible position for fifteen consecutive years immediately prior to the retirement date to be eligible to elect retiree medical benefits under this Plan. For this reason, an employee who retires on or after September 1, 2011 (or, for faculty, on or after September 1, 2013), but then returns to work at TC for less than fifteen consecutive years in an eligible position will no longer be eligible to elect retiree medical benefits. In addition, an employee retiring after September 1, 2011 (or, for faculty, on or after September 1, 2013) who returns to a benefits-eligible position at the College must relinquish their rights to the retiree medical benefit.

This rule is subject to the following exception:

- At the request of the Provost, retired faculty members and instructional staff may remain at TC on a part-time professional staff basis for limited purposes such as teaching courses crucial to the continued work of the College, continuing externally funded research, or directing an externally funded Center or Institute while retaining retiree medical benefits.

For purposes of this policy, part-time employment means no more than 60% of full-time employment.

**Making Changes to Retiree Medical Benefits:**

You may make changes to the medical plan you had previously elected every November, during the College’s open enrollment period, for the following calendar year. You may not enroll/add yourself, your Spouse or your Dependent Children at that time.

**Termination of Retiree Medical Benefits:**

1) You may terminate your retiree medical coverage at any time. If your coverage is terminated, the coverage of your Spouse and Dependent Children will also be terminated. If you terminate your benefits due to your enrolling in Medicare Part D, you may only be able to re-enroll during open enrollment for benefits effective on January 1 of the following year.

2) You will lose your coverage (and that of your Spouse/Dependent Child) if you fail to make your payment by the 1st of each month.

3) You will lose your coverage if you enroll in Medicare Part D. However, if you later drop Medicare Part D, you may re-enroll for Retiree medical benefits under this Plan to be effective on January 1 of the following calendar year. The reenrollment must take place during the College’s open enrollment period, which generally occurs over a period of time during the month of November.

4) You may terminate your coverage under this plan for your Spouse and Dependent Children at any time. Unless your coverage is terminated as described in items 1, 2 and 3, your coverage under this plan will be maintained after the termination of coverage for your Spouse and/or Dependent Children.
Spouse and Dependent Coverage Upon the Death of the Retiree (Regardless of whether the retiree was covered under the Retiree Medical Plan)

- If your surviving Spouse was covered at the time of your retirement but not covered by the Retiree Medical Plan at the time of your death, s/he will assume the retiree "self" contribution rate (depending on the age of the surviving Spouse), and will be able to enroll once reaching Medicare-eligible age. If your surviving Spouse had reached Medicare-eligible age prior to your death, s/he will not be able to enroll into the plan. Once enrolled, s/he will remain covered as long as s/he continues to pay the premium in a timely manner (if applicable).
- If your surviving Spouse was covered by the Retiree Medical Plan at the time of your death, s/he will assume the retiree "self" contribution rate (depending on the age of the surviving Spouse). Once enrolled, s/he will remain covered as long as s/he continues to pay the premium in a timely manner (if applicable).
- If your eligible Dependent Children of record at the College were not covered by the Retiree Medical Plan at the time of your death, they can enroll with your surviving Spouse once the Spouse reaches Medicare-eligible age.
- If your eligible Dependent Children were covered by the Retiree Medical Plan at the time of your death, they can remain covered for as long the plan terms provide for Dependent Children, as long as your surviving Spouse continues to pay the premium in a timely manner.
- Any surviving Spouse not covered and Dependent Children not covered at the time of your retirement will not be eligible for this plan.
- These provisions only apply if the rules for coverage in place when you retired allow for Spouse or dependent coverage. If your category of retiree medical coverage does not permit Spouse or dependent coverage, your dependents would not be eligible for surviving Spouse and dependent coverage under this section.

Spouse and Dependent Coverage Upon the Death of Active Employee Prior to Retirement

- If you meet the eligibility criteria for the Retiree Medical Plan at the time of your death:
  - Your Spouse who is covered on the active plan will be considered for the Retiree Medical Plan under the terms that you retired. There will be two entry points: 1) within 30 days of your death and 2) upon your surviving Spouse’s becoming Medicare-eligible.
  - Your eligible Dependent Children of record at the College at the time of your death may enroll with your surviving Spouse when s/he enrolls at one of the two entry points above.
- If you have not met the eligibility terms upon passing, your covered dependents would be eligible for continuation of benefits for up to 36 months under the terms and contribution costs defined under COBRA.
- These provisions only apply if you met the age and service requirements that would have permitted Spouse and dependent coverage under the Retiree Medical Plan. If, based on the age and service requirements and timing of possible retirement at the time of your death, you would only been eligible for a category of retiree medical coverage does not permit Spouse or dependent coverage, your dependents would not be eligible for surviving Spouse and dependent coverage under this section.

ELIGIBLE DEPENDENTS

Retirees may enroll eligible dependents in the Plan. The following dependents are eligible for enrollment:

- Your legally married Spouse, whether of the same or opposite sex;
Your children who were covered at the time of retirement who are under age 26 if they are not eligible for any other employer-sponsored coverage (except for coverage as a dependent under their other parent’s plan), regardless of their marital status, student status, and whether or not they live with you or you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO) who were covered at the time of retirement; and
- Your mentally or physically disabled adult Dependent Children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation), provided that the child was disabled prior to age 26. These Dependent Children must have been covered at the time of retirement.

Dependent Children are defined as your:
- Biological children;
- Stepchildren;
- Legally adopted children;
- Foster children;
- Children who are placed in your home for adoption; and
- Children for whom you are appointed as legal guardian and who are chiefly dependent on you for support and maintenance.

For retirees enrolled in the Plan prior to May 5, 2015, the following dependents are eligible for enrollment:
- Your legally married Spouse, whether of the same or opposite sex;
- Your same sex domestic partner (as defined below) if the domestic partner was covered under the Plan at the time of retirement. For purposes of this Plan, your same sex domestic partner has the same rights, privileges, responsibilities and coverage as a “Spouse”;
- Your children and your domestic partner’s children who were covered at the time of retirement who are under age 26 if they are not eligible for any other employer-sponsored coverage (except for coverage as a dependent under their other parent’s plan), regardless of their marital status, student status, and whether or not they live with you or you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO) who were covered at the time of retirement; and
- Your or your same sex domestic partner’s mentally or physically disabled adult Dependent Children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation), provided that the child was disabled prior to age 26. These Dependent Children must have been covered at the time of retirement.

Dependent Children are defined as your:
- Biological children;
- Stepchildren;
- Legally adopted children;
- Foster children;
- Children who are placed in your home for adoption; and
- Children for whom you are appointed as legal guardian and who are chiefly dependent on you for support and maintenance.

Your “domestic partner” means a same-sex domestic partner of a Teachers College, Columbia University eligible employee who meets the following requirements:

1. You are each other’s sole domestic partner and intend to remain so indefinitely.
2. You are of the same sex and neither of you is married to another.
3. You are at least (18) years of age and mentally competent to consent to contract.
4. You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
5. You have shared a household together for at least six months prior to the request and intend to do so indefinitely.
6. Neither of you has been registered as a member of another domestic partnership within six months.

Your domestic partner’s children are eligible for coverage if they meet all of the requirements of the applicable EOCs and your domestic partner is enrolled for coverage and they were covered prior to your retirement and if your retiree benefits provide for coverage for such dependents.

Documentation and Misrepresentation

You are required to provide proof of your dependents’ eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents’ coverage to be irrevocably terminated immediately (retroactively to the extent permitted by law). Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Additional Eligibility Requirements

Please see the applicable EOCs for additional eligibility requirements.

Tax Consequences of Domestic Partner Benefits

Unless your same sex domestic partner or his or her Dependent Children, if any, are considered your federal tax dependents under the Internal Revenue Code for health benefit purposes as described below, the Internal Revenue Service currently treats as imputed income to you the value of the coverage provided for your same sex domestic partner and his or her Dependent Children, if any, less any contributions paid by you on an after-tax basis for this coverage. This means that the value of coverage provided under this Plan to such individuals may be taxable to you. In general, a domestic partner (or his or her child) who is a member of your household qualifies as your tax dependent for health benefit purposes if:

- He or she receives more than 50% of his or her financial support from you;
- He or she lives with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- He or she is a citizen, national or legal resident of the United States, or a resident of Canada or Mexico, or is a child being adopted by a United States citizen or natural;
- He or she is not a section 152 qualifying child dependent on another taxpayer’s filed return or is a section 152 qualifying child dependent on another taxpayer’s return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to consult with your tax advisor to determine if your domestic partner and his or her Dependent Children are your federal tax dependents, and to review the tax consequences of electing domestic partner benefit coverage.

In general, state income tax treatment of domestic partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in select states. Please speak to your tax advisor regarding whether your domestic partner and his or her
children, if any, qualify for the special state income tax treatment. If they do qualify, you must notify Human Resources in writing of this special state income tax status to avoid potential taxation.

**Qualified Medical Child Support Orders**

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. You may obtain a copy of the Teachers College, Columbia University procedures governing QMCSO determinations, free of charge, by contacting Teachers College, Columbia University, 525 W. 120th Street, New York, NY 10027, (212) 678-3175.

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the plan administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO may include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don’t reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

**Notification**

You must notify Human Resources at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 10027, in writing within 60 days in the event of divorce, or in the event your child ceases to meet the eligibility requirements for benefit coverage, in order for you and your dependents to elect COBRA coverage. For more information about your duty to notify the College in such an event, see the COBRA section of this SPD.

You must notify Human Resources at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 10027, in writing within 60 days in the event of the death of your Spouse or child. In the event that you do not notify the College within 60 days from the event, you will be responsible for any premiums associated with the coverage of the individual after the date of his/her death if timely notice is not received. A representative from your estate must notify Human Resources at Teachers College in writing within 60 days in the event of your death. In the event that a representative from your estate does not notify the College within 60 days from the event, your estate will be responsible for any health plan costs or premiums associated with your coverage after your death.

**Additional Eligibility Information**

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this summary, and any conditions and limitations to eligibility, are contained in the EOCs provided by the applicable insurance companies and/or service providers.

**COVERED AND NON-COVERED SERVICES**

Refer to the EOC provided by your applicable insurance company and/or service provider for a specific listing of covered and non-covered services under your benefits.
Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother’s or newborn’s attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours following a Cesarean section).

HIPAA Privacy

This Plan has been operated and administered in compliance with the privacy requirements issued under the Health Insurance Portability and Accountability Act of 1996, effective as of April 14, 2004.

CLAIMS AND APPEAL PROCESS

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the EOCs for more information.

Filing a Claim

The claims filing procedures are set forth in the EOCs, which are listed in Appendix A. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the EOCs. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure.

<table>
<thead>
<tr>
<th>Claims Administrators – Fully Insured</th>
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</thead>
</table>

Teachers College, Columbia University provides the following benefits under the Plan through contracts with the insurance companies listed below. The medical benefits of the Plan are guaranteed under contracts of insurance with the insurance companies listed below. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

<table>
<thead>
<tr>
<th>Medical</th>
<th>Aetna Life Insurance Company</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>151 Farmington Avenue</td>
</tr>
<tr>
<td></td>
<td>Hartford, CT 06156</td>
</tr>
<tr>
<td></td>
<td>Group #869791</td>
</tr>
</tbody>
</table>
Claim-Related Definitions

*Claim*

Any request for plan benefits made in accordance with the plan’s claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

*Urgent Care Claims*

“Urgent care claims” are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise.

*Pre-service Claims*

“Pre-service claims” are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

*Post-Service Claims*

“Post-service claims” are claims involving the payment or reimbursement of costs for health care that has already been provided.

*Concurrent Care Claims*

“Concurrent care claims” are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an “urgent care claim,” “pre-service claim,” or “post-service claim,” depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

*Adverse Benefit Determination*

If the Plan does not fully agree with your claim, you will receive an “adverse benefit determination” — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.
Initial Claim Determination

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan’s review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria, or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.
Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for “concurrent care” decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to “days” means calendar days.

<table>
<thead>
<tr>
<th>Time frame for Providing Notice</th>
<th>Urgent Care Claims</th>
<th>Non-Urgent “Pre-Service” Claims</th>
<th>Non-Urgent “Post-Service” Claims</th>
<th>“Concurrent Care” Decision to Reduce Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice of determination (whether adverse or not) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.</td>
<td>Notice of determination (whether adverse or not) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.</td>
<td>Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.</td>
<td>Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.</td>
<td></td>
</tr>
<tr>
<td>Extensions</td>
<td>The Plan has up to 15 days, if necessary due to matters beyond the Plan’s control, and must provide extension notice before initial 15-day period ends.*</td>
<td>The Plan has up to 15 days, if necessary due to matters beyond the Plan’s control, and must provide extension notice before initial 30-day period ends.*</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Period for Claimant to Complete Claim</td>
<td>You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).</td>
<td>You have at least 45 days to provide any missing information.</td>
<td>You have at least 45 days to provide any missing information.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the following chart. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as shown on page 16.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

The Claims Administrator will provide you with written notification of the Plan’s determination on review, within the time frames described on page 21. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims)
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims) and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

**Time Frames for Appeals Process**

The claims appeals procedures for a specific benefit are set forth in the EOCs for that benefit. Please consult the EOC for the specific benefit involved. Where not otherwise covered by the EOCs, the following procedures will apply.

The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a “notice of benefit determination on review”) starts when the appeal is filed in accordance with the Plan’s procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to “days” mean calendar days. The Plan can require two levels of mandatory appeal review.

<table>
<thead>
<tr>
<th>Medical Benefits</th>
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<tbody>
<tr>
<td><strong>Urgent Care Claims</strong>*</td>
</tr>
<tr>
<td>Period for Filing Appeal</td>
</tr>
<tr>
<td>Time frame for Providing Notice of Benefit Determination on Review</td>
</tr>
<tr>
<td>Extensions</td>
</tr>
</tbody>
</table>
Acts of Third Parties

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan’s procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else’s fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person’s behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney’s fees and costs) you incur in obtaining the funds.

The Plan’s sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;

Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and

Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers’ compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan’s efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan’s subrogation or recovery rights outlined in this Summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

**RECOVERY OF OVERPAYMENT**

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

**Non-assignment of Benefits**

Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant’s child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and Teachers College, Columbia University from any further liability to the extent of such payment.
**Misstatement of Fact**

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

**WHEN COVERAGE ENDS**

Your coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the insurance contract or agreement, or by discontinuance of contributions by Teachers College, Columbia University;
- The end of the period for which you paid your required contribution, if the contribution for the next period is not paid when due.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions due to exclusions for certain medical procedures) are described in the EOCs.

Coverage for your Spouse, domestic partner and Dependent Children terminates when your coverage terminates, unless your coverage termination is due to your death. In case of your death, your surviving Spouse will be covered as if he or she is the retiree. Their coverage will also cease for other reasons specified in the EOCs. In addition, their coverage will terminate:

- For your Dependent Child, the end of the year in which your Dependent Child attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support);
  - Note: Your Dependent Children may also be eligible for an extension of benefits up to the end of the month when s/he turns 29 years of age, if residency, employment and other requirements are met, in accordance with New York law. Please refer to your EOC for details.
- The end of the month in which your legally married Spouse, domestic partner or child is no longer considered an eligible dependent.

For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered Spouse and Dependent Child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit plan. Refer to your EOCs for more information on conversion.

**COBRA**

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your Spouse and Dependent Children who lose coverage for certain specified situations.
Federal law does not recognize your domestic partner as your Spouse and a domestic partner is not recognized as a COBRA qualified beneficiary. However, your domestic partners may elect COBRA-like coverage. COBRA rights and protections do not apply to this extension of domestic partner coverage.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your Spouse and Dependent Children, and what you need to do to protect the right to receive it.

COBRA applies to medical benefits offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

For additional information about your rights and obligations under the Plan and under federal law, you should contact the College (the “Plan Administrator”):

Human Resources
Teachers College, Columbia University
525 W. 120th Street
New York, NY 10027
(212) 678-3175

What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a “qualifying event”. After a qualifying event occurs, and any required notice of that event is properly provided to the College, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a “qualified beneficiary.” You, your Spouse, and your Dependent Children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event. The Plan will offer your domestic partner the right to elect COBRA coverage.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan’s group health coverage elected by the qualified beneficiaries, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun “you” in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

Who Is Covered

Retiree. If you are retiree of the College, you will have the right to elect COBRA if you lose your group health coverage under the Plan because the employer declares bankruptcy under Chapter 11.

Spouse. If you are the Spouse of a retiree of the College, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:
- Divorce or legal separation from your Spouse. Also, if your Spouse (the retiree) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation; or
- You lose your group health coverage under the Plan because the employer declares bankruptcy under Chapter 11.

**Dependent Children.** If you are a Dependent Child of a retiree, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events happen:

- The parent-retiree’s divorce;
- You, the Dependent Child, cease to meet the definition of a “Dependent Child” under the Plan; or
- You lose your group health coverage under the Plan because the employer declares bankruptcy under Chapter 11.

**Newly Eligible Child:** If you, the former employee of the College, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan’s eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing WageWorks, Inc. (see contact information below) with notice of the new child’s birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify WageWorks, Inc. as described in this SPD, you will not be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired Dependent Child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee’s continuation coverage, if enrolled in a timely fashion, subject to the Plan’s rules for adding a new dependent.

**QMCSO.** A child of the covered employee who is receiving benefits under the Plan pursuant to a QMCSO received by the College during the covered employee’s period of employment with the College is entitled to the same rights to elect COBRA as an eligible Dependent Child of the covered employee.

**When is COBRA Coverage Available**

When the qualifying event is bankruptcy, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify the College of this qualifying event.

For a qualifying event which is a divorce or legal separation of the employee and Spouse or a Dependent Child’s losing eligibility for coverage, a COBRA election will be available to you only if you notify the College (see contact information below) in writing within 60 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family
member) are responsible for providing the required notice. The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event;
- The signature, name and contact information of the individual sending the notice.

In addition, you must to provide documentation supporting the occurrence of the qualifying event, if the College requests it. Acceptable documentation includes a copy of the divorce decree or Dependent Child(ren)’s birth certificate(s), driver’s license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand deliver this notice to Human Resources at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the College within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan’s COBRA election notice and mail it to Wageworks, Inc., the COBRA Administrator at the address listed below under Contact Information. (An election notice will be provided to qualified beneficiaries at the time of the qualifying event.) Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan.

Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to elect COBRA. If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections. Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the retiree does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a Spouse or Dependent Child may elect different coverage than the retiree elects.

A covered retiree or Spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.
Coverage. If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to “similarly retirees” employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. “Similarly situated” refers to a current retiree or Dependent Child(ren) who has not had a qualifying event.

Medicare and Other Coverage. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary’s COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

When you complete the election form, you must notify Wageworks, Inc. if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and retiree contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

All COBRA premiums must be paid by check or money order. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator at the address listed below under Contact Information.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.
COBRA coverage is not effective until you elect it and make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

**Duration of COBRA**

If you lose Plan coverage because of the bankruptcy of the employer, the law requires that you be given the opportunity to maintain COBRA coverage until the death of the retiree, or in the case of surviving Spouse or Dependent Children, for up to 36 months after the death of the retiree. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

**Early Termination of COBRA**

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the maximum period for any of the following reasons:

- the College no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee); or
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, the College reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. The College, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

**Contact Information**

If you have any questions about COBRA coverage or the application of the law, please contact:

**COBRA Administrator**
WageWorks Inc.
10375 N Baldev Court
PO BOX 991
Mequon WI 53072-0991
877-502-6272 (tel)
877-220-3249 (fax)
Plan Sponsor
Human Resources
Teachers College, Columbia University
525 W. 120th Street
New York, NY 10027
(212) 678-3175

You may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa

Keep Your Plan Informed of Address Changes
In order to protect your and your family’s rights, you should keep Teachers College, Columbia University and the COBRA Administrator informed of any changes in your and your family members’ addresses. You should also keep a copy, for your records, of any notices you send to Teachers College, Columbia University or the COBRA Administrator.

SPOUSE DEPENDENT CHILD SPOUSE DEPENDENT CHILD ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits
You can:

- Review at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, EOCs, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Association. There is no charge for this review.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including EOCs and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage
You may continue health care coverage for yourself, Spouse and/or Dependent Child(ren) if there is a loss of coverage under the Plan because 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 Plan for the rules governing your COBRA continuation coverage rights.
Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on 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 your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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, 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 (if any) 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 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 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 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 Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
PLAN ADMINISTRATION AND OTHER GENERAL PLAN INFORMATION

Teachers College, Columbia University is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in an EOC. The College has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and the College will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor the College will be liable in any manner for any determination made in good faith.

The College may designate other organizations or persons to carry out specific fiduciary responsibilities for the College in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

The College will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

Power and Authority of the Insurance Company

The medical benefits under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between Teachers College, Columbia University and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not the College.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan.
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan.

The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.
Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your EOCs or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.
APPENDIX A — EVIDENCE OF COVERAGE DOCUMENTS

This summary should be read in combination with the insurance contracts, evidence of coverage documents (together and individually referred to as “EOCs”) provided by the insurance companies and service providers.

The EOCs are intended to describe the Teachers College, Columbia University benefits available to you as a retiree of the College, and, when read with this summary, are intended to meet ERISA’s SPD requirements.

Please see the EOCs for details of Plan benefits.

For additional information or for copies of the EOCs, please contact the Plan Administrator.

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<tr>
<th>Coverage</th>
<th>Evidence of Coverage Name</th>
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<tbody>
<tr>
<td>Aetna Access Plan</td>
<td>A Guide to Your Aetna Coverage</td>
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<td>Aetna Exclusive Plan</td>
<td>A Guide to Your Aetna Coverage</td>
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<td>Aetna Direct Plan</td>
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