

Prescription

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INTRODUCTION

Columbia University is pleased to provide you with this Summary Plan Description (SPD), which describes the prescription health benefits available to you and your covered family members under the Columbia University Medical Plan. It includes summaries of:

Who is eligible

Services that are covered, called Covered Health Services

Services that are not covered, called Exclusions

How benefits are paid

Your rights and responsibilities under the Medical/Prescription Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan – including previously released Benefits in Brief. You are responsible for using this SPD and other resources provided to you to understand your benefits.

The rest of this description provides details about how the coverage works as well as information about who is eligible, processes and events that can affect coverage, administrative information, and your rights as a participant in the Plan. Please note that the words “you” and “your” refer to eligible covered persons enrolled in the Plan.

If there is a conflict between this SPD and any summaries provided to you and/or any verbal representations, this SPD will govern in every respect and instance.

How To Use This SPD

- Please read the entire SPD and share it with your family.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at www.hr.columbia.edu or request printed copies by contacting the Columbia University HR Benefits Service Center at 212-851-7000.

OVERVIEW OF THE PRESCRIPTION PLAN

Columbia University offers choices of medical plans so that you can select the option that best meets the needs of you and your family. The same prescription plan is automatically provided to you when you elect medical coverage at Columbia University. The prescription plan is the same for all medical plans at Columbia University.

What the Plans Cover

All the healthcare plans (medical and prescription) cover medically necessary health care services provided for the purpose of preventing, diagnosing or treating an acute sickness, injury, mental illness, substance abuse or symptoms.

All plan coverage is subject to conditions, limits and exceptions explained in the sections, “Covered Services” and “Services Not Covered”. Columbia University and Medco administers the prescription drug benefit plan. Columbia University and Medco assume no responsibility for the outcome of any covered prescription.

The Plans described in the following pages of this booklet are a benefit plan provided by Columbia University. These benefits are not insured with Medco or any of their affiliates but are paid from Columbia University funds. Medco provides certain administrative services under the Plan including claim determination, application of copays and limitations.

Medically Necessary Services

The Plan covers only *medically necessary* prescriptions and related supplies that are provided for the purpose of preventing, diagnosing or treating an acute sickness, injury, mental illness, substance abuse or symptoms subject to the terms and conditions of the plan. In addition, certain preventive care services are covered within limitations.

For a service or supply to be considered medically necessary, it must be:

Ordered by a licensed physician

Supported by national medical standards of practice and is consistent with conclusions of prevailing medical research (based on well-conducted, randomized, controlled trials or well-conducted cohort studies)

Consistent with the diagnosis of the condition

Required for reasons other than the convenience of the patient or his/her physician

Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the selected Claims Administrator.

Other than experimental or educational in nature.

The fact that a physician prescribed the product or the fact that it may be the only treatment for a particular injury, illness or pregnancy does not mean that it is a medically necessary product or supply as defined above. The definition of “medically necessary” used in this SPD relates only to benefit coverage and may differ from the way you or your doctor define medical necessity.

Claim Filing Deadline

This Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for prescription expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

You have 12 months to submit a claim for a covered service to your health plan. While most in-network providers automatically submit claims on behalf of the patient, there are many situations when this does not occur. If you receive services from non-participating pharmacy, you are responsible for submitting your claim for a covered service within the 12 months from the date of incurral.

Group Plan Coverage Instead of Medicaid

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

Pre-Existing Conditions

There are **no** pre-existing condition limits under the Columbia University medical and prescription plans.

Prior Authorization Requirements

Certain products and/or supplies require you to obtain preauthorization from Medco for you to receive the maximum benefits under the plan. You must get authorization before the product is purchased; otherwise, your benefits will be subject to a significant reduction in reimbursement. See the prior authorization section below.

Financial Penalty If You Do Not Get Preauthorization

With all plans, you must obtain **preauthorization** before receiving certain products; otherwise, your benefits will be significantly reduced. Note that each health plan calls this process something different including “pre-certification” or “prior authorization”. If you do not obtain preauthorization as required, the Plan will significantly reduce payment for all expenses related to the condition, and your additional cost will not count toward your out-of-pocket maximum. Become familiar with the specific services that require preauthorization. If you have questions, call Medco’s member services (phone number on your member ID card).

Overview of the Prescription Plan

You are automatically enrolled in the Medco Prescription Plan when you elect medical coverage from Columbia University. Medco has over 59,000 retail participating pharmacies. When you use a participating pharmacy, you’ll save money and avoid filing a claim form since reimbursement is processed electronically.

Participating Pharmacy

When you use a participating pharmacy you do not have to submit claim forms to receive reimbursement for your expenses. The plan pays the pharmacy directly. In addition, if the charges exceed the negotiated rates, you are not responsible for the difference in cost. Participating pharmacies are not permitted to bill you for any balance.

Non-Participating Pharmacy

The prescription plan allows you the flexibility to use non-participating pharmacies - at any time. However, your cost toward your healthcare expenses is significantly higher because there are no negotiated fees. In addition, the plan limits the amount they will pay for any product obtained outside of the network. This maximum amount they will reimburse is known as the “Reasonable & Customary” (R&C) limit. ***You are responsible for paying the full amount of any charges that exceed this limit.***

In addition, you must file claim forms with Medco for each product and wait for reimbursement.

ADMINISTRATIVE AND LEGAL INFORMATION ABOUT THE PLAN

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 22, 2010. You should contact your State for further information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/Pages/default.aspx Phone: 1-800-635-2570
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP website: http://www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA - CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx	

Phone: 602-417-5422	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	MONTANA - Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://mediciadprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 208-334-5747 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-922-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.khpa.ks.gov Phone: 1-800-635-2570	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x5254
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: www.dhh.louisiana.gov/offices/?ID=92 Phone: 1-888-342-0555	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNEASOTA – Medicaid	NEW YORK – Medicaid

Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	North Carolina – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services.medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Phone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml Medicaid Phone: 1-800-359-9517 CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml CHIP Phone: 1-800-359-9517	Medicaid Website: http://www.famis.org/ Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnerproviders.medicaidassistance/doingbusiness/003670053.htm . Phone: 1-800-644-7730	Website: http://ihrsa.sites/DCS/COB/default.aspx Phone: 1-800-562-6136
RHODE ISLAND – Medicaid	WEST VIRGINIA - Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Services
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Your Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all group health plans protect the confidentiality of your health information. The Plan and Columbia University will not use or further disclose information that is protected by HIPAA (referred to as protected health information or “PHI”) except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law.

When you enroll in the Columbia University Medical Plan, you consent to and authorize the Plan to share your claims data when appropriate. For example, a condition management program administrator (e.g. asthma management) may be notified by your health plan when your medical claims activity suggests that you or a family member may have a chronic condition. As a result, you may be contacted to participate in voluntary condition management programs.

By law, Columbia University has required all of its business associates to also observe HIPAA’s privacy rules. The Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Columbia University. The Plan reserves the right to modify its practices with respect to medical information.

You have certain rights under HIPAA with respect to your protected health information, including the right to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the United States Department of Health and Human Services. If you have any questions on this issue, you should contact the HIPAA Privacy Office. To exercise your HIPAA rights under Columbia University medical plans, contact:

Privacy Officer
Columbia University HR Benefits
Studebaker 4th Floor, MC 8705
615 West 131st Street
New York, NY 10027

Email: hrprivoff@columbia.edu

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option.

The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan:
 - Employee only;
 - spouse only;
 - Employee and spouse;
 - Dependent child(ren) only; Employee and Dependent child(ren);
 - Employee, spouse and Dependent child(ren).

Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
 - divorce or legal separation;
 - cessation of Dependent status (such as reaching the limiting age);
 - death of the Employee;
 - termination of employment;
 - reduction in work hours to below the minimum required for eligibility;
 - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
 - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
 - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or

Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases:
 - due to failure of the employer or other responsible entity to remit premiums on a timely basis;
 - when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or
 - when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual.

This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

Special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be denied enrollment. You will not be enrolled in this plan if you do not enroll within 30 days of the date you become eligible, unless you are eligible for special enrollment.

Your ERISA Rights

As a participant in the medical (including prescription drug), dental, flexible spending accounts, long-term disability and life insurance benefits described in this SPD, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). You are entitled to receive a yearly summary of each plan's financial report. You may examine all the official documents related to the Plans in the Columbia University HR Benefits department. If you wish, you can obtain your own copies of Plan documents by writing to HR Benefits. You may have to pay a reasonable charge to cover the cost of postage and photocopying.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who administer the plans. These people are called "fiduciaries" and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person or organization, may terminate you or otherwise discriminate against you in any way in order to prevent you from obtaining your Plan benefits or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator.

If you have a claim for a welfare benefit which is denied in whole or in part, you must receive a written explanation of the reason for the denial. For the medical, dental, life and long-term disability plans, the reason for the denial is explained in the Explanation of Benefits (EOB) or denial letter. (Please see the section Claim Review and Appeals Procedures under each Plan.) For the other plans covered under ERISA, you have the right to have the Plan Administrator review and reconsider the claim by submitting a request for appeal within 60 days of the denial. The request may be made by you or your authorized representative and should include the reason you are requesting a review of the claim, as well as any additional information that supports your claim. A review of your claim will take place no later than 120 days after receipt of your appeal. If your claim is still denied, you may file suit in a state or federal court. If you have any questions about your rights under ERISA, you may contact the nearest office of the U.S. Department of Labor.

Group Plan Coverage Instead of Medicaid

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

Medicare Part D - Prescription Drug Coverage

Medicare prescription drug coverage (or Medicare Part D) is available to anyone who is eligible for Medicare. When you reach age 65, private health insurance companies may contact you to offer you Medicare prescription drug plans. These plans must provide at least a standard level of coverage defined by Medicare.

If you enroll in Medicare Part D, you will pay a separate premium for that benefit. You will also pay your premium for Columbia medical coverage, which includes prescription drug coverage.

What this Means to You

Medicare prescription drug coverage was designed primarily for those who do not have access to employer-sponsored prescription drug coverage. As an active Columbia employee (or covered dependent) eligible for Medicare, keep these points in mind as you consider whether to enroll in a Medicare prescription drug plan:

- **If you are enrolled in a Columbia University Medical Plan**, your prescription coverage is, on average for all plan participants, at least as good as the standard Medicare prescription drug coverage.

- Under the new law, this means **you have creditable coverage and do not have to enroll in Medicare Part D**. You will not be penalized if you decide to enroll in Medicare prescription coverage later.

There's no advantage to doubling-up on prescription coverage. If you join a Medicare prescription drug plan, you continue to receive your medical and prescription benefits through Columbia University. You will pay the full premium for your Columbia University (medical and prescription drug) coverage as well as the premium for Medicare Part D. Since your benefits under the Columbia plan will be primary, it is unlikely you will receive much benefit, if any, from Medicare.

If you choose to drop your Columbia health coverage and enroll in a Medicare prescription drug plan, you will not be able to re-enroll in a Columbia University plan until the next Open Enrollment period, unless you have a life status change.



The enrollment period for Medicare Part D will be November 15 through December 31 each year. You may also enroll when you first become Medicare eligible, or after leaving University employment when you are age 65 or older.

Important Reminder

If you enroll in a Medicare prescription drug plan after May 15, 2006, you may need to provide a copy of the Columbia Prescription Drug Plan information to show that you have had creditable coverage. That means you will not have to pay a higher premium for Medicare prescription drug coverage. You may receive information about creditable coverage through Columbia University at other times in the future, such as the next period you can enroll in Medicare prescription drug coverage and/or if your Columbia University prescription drug coverage changes. You may also request a copy of this information by contacting the HR Benefits Service Center.

Medicare Prescription Drug Coverage

Creditable Coverage Disclosure Notice for Retirees of Columbia University as of June 15, 2008

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Columbia University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

What This Means To You As A Retiree Of Columbia University

As a retiree of Columbia University (or covered dependent) eligible for Medicare, you should keep the following points in mind as you consider whether to enroll in a Medicare prescription drug plan:

Medicare prescription drug coverage was designed primarily for those who do not have access to employer-sponsored prescription drug coverage.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

If you are enrolled in a Columbia University Medical Plan, you are already covered by prescription drug coverage that is — on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Should I Have Columbia University Prescription Drug Coverage And Medicare Prescription Drug Coverage?

In most circumstances, there is no advantage to “doubling up” on coverage. If you join a Medicare prescription drug plan, you will continue to receive your medical and prescription benefits through Columbia University. However, the amount you pay for your Columbia University coverage, where applicable, will not be reduced, and you may pay a separate premium for Medicare prescription drug coverage. **Your benefits under the Columbia University retiree medical plan will be secondary to Medicare and your Columbia University Medical Plan prescription drug benefits will be reduced by benefits paid under the Medicare prescription drug plan.**

When Can I Join A Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. You may also enroll when you first become Medicare eligible or after separating employment with the University if you are age 65 or older.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If You Terminate Columbia University Coverage Or Employment and you are Medicare Eligible

If you drop or lose your Columbia University coverage (for example, you do not pay a required premium) and you do not join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan in the future.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

If you choose to drop your University-sponsored health coverage in order to enroll in a Medicare prescription drug plan, you will not be able to re-enroll in a Columbia University Medical Plan until the next Open Enrollment period, unless you have a qualified life status change.

For more information about Medicare’s prescription drug coverage:

- Visit <http://www.medicare.gov> for personalized help

- Call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048)

About This Notice

This notice, as required by Law, contains important details about how your prescription drug coverage through the Columbia University Retiree Medical and Life Plan compares to Medicare prescription drug coverage available in 2008 and today. Please read this notice carefully and keep it for future reference.

You may need to refer to this information in the future. If you enrolled in a Medicare prescription drug plan after May 15, 2006, you may need to provide a copy of this notice to show that you do not have to pay a higher premium for Medicare prescription drug coverage. You are not required to pay more since you have had Creditable Coverage (or coverage that is at least as good as the standard Medicare prescription drug benefit) through a Columbia University Medical Plan.

You may receive information about creditable coverage through Columbia University at other times in the future, such as the next period you can enroll in Medicare prescription drug coverage and/or if your Columbia University prescription drug coverage changes. You may also request another copy of this information by calling the HR Benefits Service Center at (212) 851-7000 or via email at hr-retirement@columbia.edu.

Columbia University reserves the right to change, amend, or terminate any benefit plan as it deems appropriate. This notice in no way guarantees or implies that Columbia University's retiree medical plans will continue into the future nor does it guarantee or imply that the coverage and/or costs will remain the same in the future.

Statement of the University's Rights

This document is not a contract or agreement for employment. Employment with Columbia University is "at-will"—nothing in this document changes your right and the University's right, to end your employment at any time and for any reason. Employment at Columbia University is not guaranteed for any period of time.

The Plan Administrator has full power and discretion to resolve all issues concerning eligibility, status, entitlement to benefits, and any other interpretations under the Plan. Such interpretations or rulings will be binding on all parties. The Plan Administrator has the right to delegate some of these duties to third party providers, such as the claims administrators for the medical plans. As the Plan Administrator's delegates, the claims administrators have the authority to make decisions relating to benefit claims.

The University intends that the terms of the Plan described in this SPD, including those relating to coverage and benefits, are legally enforceable, and that the Plan is maintained for the exclusive benefit of participants, as defined by law.

Although Columbia University expects to continue the Plan, it reserves the right to amend, modify or discontinue all or any part of the Plan or any plan or coverage at any time for any or all employees including active, disabled and former employees participating in the Columbia University Medical Plan. In the event of termination of the Plan, no benefits will be paid for incidents or events occurring after the date of termination.

No oral or written communication will be effective in amending The Plan unless it is by way of a formal amendment. Complete details, terms and conditions relating to each element of the plans are contained in the relevant plan documents; the specific provision and language of these documents will govern in every respect and instance.

To the extent this SPD provides a general description of the tax results that may be applicable to coverage under the Plan, Columbia University assumes no responsibility for your own personal tax status, or for any tax consequences resulting from any claims made contrary to current tax law. Please consult your tax advisor for further information on the tax treatment of your benefits.

Plan Information

The name of the Plan is:

Columbia University Group Benefits Plan

Plan Sponsor and Administrator

Columbia University is the Plan Sponsor and Plan Administrator of the Columbia University Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
Columbia University
Studebaker Bldg., MC 8703
615 West 131st Street
New York, NY 10027
(212) 851-7000

Employer Identification Plan Number (EIN): 135598093 515

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Claim Office of your selected health plan (e.g. Aetna, CIGNA, UHC, etc.). The phone number is listed on your member Identification card.

The cost of the Plan is shared by the Employee and Employer.

The Plan year is calendar and ends on 12/31.

Plan Trustees

A list of Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements. A copy is available for examination from the Plan Administrator upon written request.

Claim Administrator

The Plan Administrator delegates to your selected health plan (e.g. Aetna, CIGNA, UHC, Medco, etc.) the discretionary authority to interpret and apply plan terms and to make factual

determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to your selected health plan the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the University. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process – Medical Plan
Columbia University
Studebaker Bldg., MC 8703
615 West 131st Street
New York, NY 10027
(212) 851-7000

Legal process may also be served on the Plan Administrator.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Columbia University Welfare Benefit Plan
Plan Number:	501
Employer ID:	13-5598093
Plan Type:	Welfare benefits plan
Plan Year:	Calendar
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and University
Source of Benefits:	Assets of the University

ELIGIBILITY FOR BENEFIT COVERAGE

Officers and Support Staff

If you are a full-time active Columbia University Officer, you and your family are eligible for medical coverage under the Columbia University Medical and Prescription Plan.

If you are a full-time or part-time (with scheduled hours greater than or equal to 20 hours per week) Support Staff employee you are eligible for the Columbia University Medical and Prescription Plan.

Benefits for Part-Time Officers of Administration

As a regular part-time Officer of Administration, you are eligible to participate in the Columbia University Medical Plan, provided you meet the following requirements:

- You are a regular Officer of Administration
- Your scheduled work week must be at least 20 hours per week but less than 35 hours per week
- You are a Grade 10 position or higher at Morningside, Lamont or Nevis
- You are a Grade 103 or higher at Columbia University Medical Center or Harlem Hospital
- Regular part-time positions are those without a planned end date.

Temporary part-time employees are not eligible for part-time benefits. Temporary positions are those approved for a temporary period of time and have an end date.

When Your Benefits Start

Officers

You are eligible for medical benefits on your date of hire. However, your benefits will commence as soon as administratively feasible after your hire date. In most cases, benefits will start 3 to 4 weeks after your date of hire due to administrative processes that must be initiated internally and with external medical insurance administrators.

Support Staff

You are eligible for medical benefits after a wait period as defined by your collective bargaining agreement. Please refer to your agreement for your eligible start date. Your benefits will commence as soon as administratively feasible after your hire date. In most cases, benefits will start 3 to 4 weeks after your eligible date due to administrative processes that must be initiated internally and with external medical insurance administrators.

Officers and Support Staff

In order to receive benefits, you must enroll within 31 days of your date of hire. You must select the coverage you want and whom you want to cover. If you do not enroll within 31 days of your date of hire, you will not have any medical benefit coverage for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period held annually in the fall. The benefit choices you make at that time take effect the following January. See the section, How To Enroll.

Exception for Newborns

Any Dependent child born while you are covered under one of the Columbia University health plans (Aetna, CIGNA, UHC, HIP) will automatically be covered on the date of his or her birth for a period of 31 days. However, *you must enroll your newborn in your coverage by notifying Columbia University HR Benefits Service Center no later than 31 days after the birth.* If you do not elect to cover your newborn child within 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Your Eligible Dependents

You can also elect to cover your dependents. Your eligible dependents include your:

- Legal Spouse
 - Same-sex domestic partner or civil union partner, provided your partner is:
 - Is at least 18 years old
 - Is not related to you by blood
 - Is not legally married to another person
 - In the case of a civil union partnership, is entered into a certified civil union under applicable state law that recognizes a relationship between people of the same gender or treats a relationship between people of the same gender as marriage
- And** meets two or more of the following requirements:
- ◆ Shares the same principal residence with you full-time and for the past 12 continuous months
 - ◆ Shares financial responsibilities with you, such as co-ownership of property, joint financial accounts, etc.
 - ◆ Has power of attorney for medical purposes
- Unmarried legally dependent children, including adopted children, foster children and stepchildren of your spouse or same-sex domestic partner, provided that you declare the child(ren) as dependents on your federal income tax return. Dependent children are covered:
 - Until the end of the calendar year in which they turn 19;
 - Over the age of 19 as long as they remain full-time students. Note: Coverage ends the end of the month or 21 days (whichever is greater) of the date that they cease to be a full-

time student (e.g. graduate) or the end of the calendar year in which they turn age 26, whichever is earlier

- If a court has appointed you legal guardian (for any child from birth to age 19, or to age 26 if a full-time student)
- At any age if they have a mental or physical disability provided he/she is incapable of self-sustaining employment and who chiefly depends upon you for support. You must either apply for continued coverage when you are initially eligible for benefits or prior to the end of the Plan (calendar) year in which the dependent turns age 19. Approval by your medical insurance carrier (Aetna, CIGNA, UHC or your HMO) is required. See How to Continue Coverage for a Disabled Child, below.

Eligible dependent children does not include:

- A dependent who lives outside the United States, unless he or she is living with you or attending a college or university full time; or
- A dependent who is in the military or similar forces anywhere; or a dependent who is employed by the University

How to Continue Coverage for a Disabled Child

Coverage for an unmarried mentally or physically disabled child who is not capable of self-sustaining employment and who depends chiefly upon you for support and maintenance may continue coverage beyond age 19:

If you're an eligible employee when your child meets this definition, you must apply for continued coverage before the end of the calendar year in which he or she turns age 19.

If you're a newly eligible employee and your disabled child is older than age 19 when you are electing coverage, you may apply to cover your child when your coverage begins.

To cover a disabled child who is over age 19, you must complete and submit the required form(s) to your medical plan carrier— Aetna, CIGNA, UHC or your HMO. Forms are available from the HR Benefits Service Center at 212-851-7000.

Your medical carrier may request that you provide proof of your child's incapacity and dependency within 31 days of the date coverage would have otherwise ended. You must supply this proof to your medical carrier within the requested timeframe or the Plan will no longer pay benefits for that child.

Who is Not Eligible for the Plan

The term "employee" in this document does not include:

Officers whose appointments are incidental to their educational program at the University

Officers who are classified as non-benefited or casual employees in accordance with University personnel policies and procedures

Officers whose terms of employment are subject to a collective bargaining agreement unless the agreement specifically provides for their participation in the Medical Plan

Any individual who has entered into an oral or written agreement with the University whereby such individual acknowledges his or her status as an independent contractor and that he or she

is not entitled to participate in the University's employee benefit plans, notwithstanding that such person is later determined by a court of competent jurisdiction or the Internal Revenue Service (IRS) to be a common law employee for tax purposes.

Any individual who is performing services for the University under a leasing arrangement entered into between the University and some other person, notwithstanding the fact that he or she is later determined by a court of competent jurisdiction or the IRS to be a common law employee or a leased employee.

An employee who is a non-resident alien who received no earned income from the University that constitutes income from sources within the United States (as defined by the IRS).

Temporary Part-Time employees

You Are Responsible for Covering Only Eligible Dependents

You are responsible for ensuring that only your eligible dependents are enrolled in the Medical and Dental Plans. An employee who covers an individual whom he or she knows does not meet the definition of an eligible dependent will be subject to disciplinary action up to and including dismissal and may be liable for other punishment under the law. If the University learns that you have enrolled an ineligible dependent (such as a *former* spouse or a child over the age limit), the dependent will not be covered by the Plan for any medical and/or dental expenses incurred while he or she was ineligible.

You will be required to repay all costs to the University of providing coverage and any benefits paid to you. Also, if you don't notify the University when a dependent has become ineligible, the dependent could lose his or her ability to continue coverage under COBRA health care continuation rules.

Report Changes in Dependent Eligibility

When a dependent is no longer eligible, it is your responsibility to notify the Columbia University HR Benefits department *within 31 days of the change*. Examples of changes include, but are not limited to, divorce, child no longer a student, etc. Contact the Columbia University HR Benefits Service Center at 212-851-7000 to report any changes in the status of your dependents within 31 days.

Verify Student Status to Avoid Loss of Coverage

A full-time student is a student who is taking 12 or more credit hours at an accredited educational institution, or as defined as full-time by the institution. You must provide proof of your child's student status.

Each year, your selected health plan will request verification, which may include the following forms of proof of student status:

A signed letter from the Registrar or Dean of Students

A copy of your dependent child's current semester official class schedule

A copy of the current term tuition bill

School name

Student name

Term

Credit Hours: 12 or more (9 or more if graduate students) or indication of full-time status.

In addition, you may be asked to provide the following information:

Medical plan member ID (located on your ID card)

Medical plan account number (located on your ID card)

If you do not provide all the requested information in the timeframe designated by your medical and/or dental plan, **your child's coverage will automatically be terminated.**

Proof of Eligibility

Columbia University has a responsibility to ensure that only eligible expenses are paid from the benefit Plans. This is a requirement of the Internal Revenue Service (IRS) regulations that govern qualified benefit plans.

You must be prepared to provide satisfactory proof that your enrolled dependents meet the eligibility requirements. Audits are conducted periodically each year to ensure that all dependents continue to meet the eligibility requirements of the benefit plans. If you are selected for an audit, you will receive a letter detailing the audit process. Examples of proof of dependent eligibility include, but are not limited to, birth certificates for each covered child, a marriage license, etc. **If you cannot provide proof that your dependent is eligible for coverage, his or her coverage will be terminated.**

You Choose Who to Cover Under Your Benefits

You must select from one of the following coverage options to ensure your dependents have medical and dental benefits:

Yourself only

Yourself and your legal spouse or yourself and your same-sex domestic partner

Yourself and a child or children

Family

Qualified Medical Child Support Order (QMCSO)

Federal law requires the University to honor a QMCSO issued by a state court as part of a judgment or decree under state domestic relations law or under a law relating to medical child support. A QMCSO relates to and must specify that it arises from medical child support. You will be notified if the Plan Administrator receives a QMCSO that requires you to provide coverage for your dependent identified in the QMCSO.

If a QMCSO is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a

settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;

The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;

The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

The order states the period to which it applies; and

If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

If You and Your Spouse or Same-Sex Domestic Partner Work for the University

If you and your spouse work for the University and are eligible for medical coverage, you may choose your coverage in either of the following ways:

One spouse makes the medical choice for the entire family, including eligible dependent children, if any. In this case, the other spouse must select "No Coverage."

Each spouse can make his or her own medical choice. In this case, all eligible dependent children must be covered by one spouse or the other.

ENROLLMENT

How to Enroll

Newly Eligible Employee

If you are newly hired, you must enroll for benefits within 31 days of your date of hire. If you do not make your benefit elections during your first 31 days of employment, you and any eligible dependents will not receive Medical and Prescription benefit coverage from Columbia University for the remainder of the calendar year.

You will be notified of your benefits on-line enrollment opportunity via email. If you do not receive this notice within 2 weeks of your date of hire, please contact the HR Benefits Service Center at 212-851-7000.

Annual Enrollment Opportunities

After your initial enrollment, you have the opportunity to make changes each fall during the Benefits Open Enrollment period. You will receive notification from the University about this opportunity to change your health plan and the eligible dependents that you want to cover. The selections you make during annual Benefits Open Enrollment are effective the following January 1.

Making Changes to Your Benefits During the Year

After your initial enrollment, or after annual Benefits Open Enrollment, you will be able to change your benefits for the remainder of the calendar year only if you experience a “qualified life status change.” Columbia University healthcare benefits are governed by The Internal Revenue Service (Section 125), which limits when you can make changes to your benefit elections as well as the type of changes you are permitted to make.

Examples of a qualified life status change include:

Marriage, divorce

Beginning or end of a same-sex domestic partnership

Birth, adoption, or placement for adoption

Death of a dependent

Dependent loses eligibility for coverage (child reaches maximum age, spouse/domestic partner loses non-University coverage from their employer)

Change in home address that changes your provider network access

A permanent change in the way you commute to work (applies to the Transit/Parking program)

Spouse or eligible dependent called to military duty in the United States armed forces.

Job promotions and/or transfers that change the benefit offerings within job grade and/or bargained benefits.

If you experience a qualified life status change, you must make any benefits changes within 31 days of the event, through the CU Benefits Enrollment System at

www.hr.columbia.edu/benefits or contact the Columbia University HR Benefits Service Center at 212-851-7000. You may be required to provide proof (e.g., marriage certificate, birth certificate) in order to make changes to your benefit selections. Your benefit changes must be consistent with the nature of your qualified life status change.

Adding Your Newborn Child

For a newborn's hospital and medical and prescription expenses to be eligible for reimbursement, you must add your child through the Columbia University (CU) Online Benefits Enrollment System at www.hr.columbia.edu/benefits within 31 days of the child's birth.

Your Cost

Officers

You and Columbia University share the cost of your coverage. Each year, the University determines its level of support for benefit coverage for you and your eligible dependents. Costs vary depending on the plan you choose, your annual pay and the number of eligible dependents that you cover.

Information about your share of the cost is provided with your enrollment materials when you are newly hired and is also provided to you each year during the fall annual Benefits Open Enrollment period.

Your contributions toward the cost of coverage are regularly deducted from your University paycheck on a pre-tax basis as allowed under Internal Revenue Service Section 125. Your pre-tax “premium” for healthcare coverage is based on these factors:

The plan you select

The coverage level you select (individual vs. family, etc.)

Your Annual Benefits Salary

Your **Annual Benefits Salary** is calculated as of July 1 each year and is the greater of: (1) your benefits-eligible salary or (2) your year-to-date University income, including certain approved additional and private practice compensation. If you are newly hired, your Annual Benefits Salary is calculated from your compensation at date of hire through the following July 1.

Support Staff

You and Columbia University share the cost of your coverage. The cost of coverage for you is negotiated as part of your collective bargaining agreement. Costs vary depending on the plan you choose and the number of eligible dependents that you cover.

Information about your share of the cost is provided with your enrollment materials when you are newly hired and is also provided to you each year during the fall annual Benefits Open Enrollment period.

Your contributions toward the cost of coverage are regularly deducted from your University paycheck on a pre-tax basis as allowed under Internal Revenue Service Section 125. Your pre-tax “premium” for healthcare coverage is based on these factors:

The plan you select

The coverage level you select (individual vs. family, etc.)

Your Cost for Same-Sex Domestic Partner/Civil Union Partner

Federal income tax rules require that your contributions toward the coverage of a same-sex domestic partner or civil union partner be deducted from your pay on an after-tax basis. In addition, University contributions toward premiums for covering your domestic or civil union partner are taxable to you.

WHEN COVERAGE ENDS

This section summarizes what happens to your medical coverage when certain events occur including:

- Your employment ends
- You become disabled
- You take a leave of absence
- You or a covered family member dies.

Generally, in situations when Columbia University-provided coverage ends, you and your eligible dependents will be provided with the opportunity to continue coverage for a period of time under COBRA continuation rules. See the section, COBRA Continuation Rights.

When Your Employment Ends

If your employment with the Columbia University ends, your Columbia University-sponsored medical coverage for you and your dependents ends after 21 days or the end of the month – whichever is greater.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Columbia University will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- 21 days after your employment ends or the end of the month – whichever is greater.
- the date the Plan ends;
- the last day of the month you stop making the required “premium” contributions;
- the last day of the month you are no longer eligible;

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required “premium” contributions;
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

However, you may continue the medical coverage in effect for you and your eligible dependents for up to 18 months under COBRA provisions. Under COBRA, the same plans are available as under the Columbia University Medical Plan and the same rules apply for eligible dependents and qualifying changes in status. See the section, COBRA Continuation Rights.

When Your Employment Ends – Are You Eligible for Retiree Medical Benefits?

If you are separated from your job and you have 10 years of service after age 45, you may be eligible for Retiree Medical coverage sponsored by the University. You must meet any service and age requirement at the time your employment ends. Subsequent attainment of the required age after you leave the Columbia University will count toward the requirement for Columbia University Retiree Medical benefits and eligibility for medical coverage continuation under these provisions.

If you qualify for Columbia University Retiree Medical, you and your covered dependents will remain covered by your selected medical plan until the end of the month in which your employment ends or if later, the end of the month in which your severance period ends. At that point, you will move into Columbia University Retiree Medical Plan. (However, if you or your eligible dependents are eligible for Medicare due to disability or because you are age 65 or older, Medicare becomes the primary plan for the individual who is Medicare eligible.)

Contact the HR Benefits Service Center at 212-851-7000 if you think you have attained the age and service requirements.

If You Become Disabled

If you become disabled, your medical coverage can continue based on the type of disability and the length of your disability.

- If you receive salary continuance: Any “premium” contributions you make for Columbia University benefits will continue on a before-tax basis. Your coverage continues without change under the medical plan in effect when your disability began.
- If you receive temporary disability benefits: Any contributions you make for Columbia University benefits will be on an after-tax basis. Coverage continues under the medical plan in effect when your disability began.
- If you receive Long Term Disability benefits: Any “premium” contributions you make for Columbia University will be on an after-tax basis.

Coverage continues for the remainder of the calendar year under the medical plan in effect when your long term disability began. For the next two calendar years, coverage will continue under the Columbia University program. Medicare health insurance coverage generally becomes available if you have been entitled to Social Security benefits for two years. You must enroll for Medicare when available. For additional information about the need to apply for Medicare, please contact the Columbia University Retiree Service Center at 212-851-7000 For Medicare information, please contact 1-800-Medicare (1-800-633-4227).

If You Take a Leave of Absence

In general, during an approved leave of absence, the coverage in effect before the leave will continue provided that you make the necessary monthly premium payments. However, additional rules apply to military leaves or you may qualify for a protected leave under the Family and Medical Leave Act (see the next page). Please contact the HR Benefits Service Center to discuss these rules.

Please note that for certain coverages to remain in effect during your leave of absence, you must pay the monthly premium costs associated with them. You will be billed separately for these coverages by Employee Benefit Plan Administrators (EBPA), an outside vendor. The HR Benefits Service Center will notify EBPA of your leave of absence status and calculate the monthly costs for those coverages that will require payment during your leave.

EBPA will bill you for these monthly costs using a payment coupon. Payment must be remitted to EBPA at the address shown on the payment coupon. Failure to make the required premium payments will result in termination of coverage retroactive to the date for which the last contribution was received.

Coverage While on a Leave Under the Family and Medical Leave Act of 1993 (FMLA)

You're entitled by Federal law to up to 12 weeks of unpaid leave under the FMLA for specified family medical purposes, such as the birth or adoption of a child, or to care for a spouse, child, or parent who is seriously ill or for your own illness. You are entitled to continue your group health coverage under Columbia University Medical Plans during your FMLA leave period at the same rate as if you were still at work, as long as you continue to make payments. If you don't timely return to covered employment after your leave ends, you are entitled to COBRA continuation coverage.

Coverage While on Military Duty in the United States Armed Forces

If you enter the United States armed forces, you'll be offered the opportunity to continue medical coverage for yourself and your covered dependents based on the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You may elect to either stop or continue your medical coverage during the period of your military absence. If you elect to continue your medical coverage:

- During the first six months of your military absence, you will continue to pay your portion of the cost for the medical coverage you have in effect at the time your military absence began.
- During the seventh through the 24th month of your military absence, you will be directly billed for the cost of the medical coverage you have in effect at the time your military absence began, or, in the following calendar year, based on the coverage and cost in effect under COBRA rules. No further medical coverage will be provided beyond the twenty-fourth month of a military absence.

If you choose not to continue coverage during the period of military service, you're entitled to have your coverage reinstated provided you timely return to employment with the Company. No additional exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted by USERRA are dependent on uniformed service that ends honorably.

If You Die

If you die, your surviving dependents who are covered under the Columbia University Medical Plan at the time of your death will receive:

- Medical and prescription coverage for 1 year following the date of your death, free of

charge.

- COBRA benefits will then be offered following the one year period of free coverage.

If you were eligible for Retiree Medical benefits at the time of your death, your surviving dependents will be given the choice between COBRA or Retiree Medical coverage.

If Your Eligible Dependent Dies

If an eligible dependent dies, you can change your medical plan and coverage tier. Any change must be made within 31 days of your dependent's death; otherwise, you'll have to wait until the next fall annual Benefits Open Enrollment period.

Other Events Ending Your Coverage

Your coverage may also end when any of the following happen. If your coverage is terminated for any of the reasons below, you will be provided written notice that coverage has ended on the date the Plan Administrator identifies in the notice.

- Fraud, Misrepresentation or False Information - occurs when there has been fraud or misrepresentation, or the Employee knowingly gave their selected health plan or Columbia University false material information. Examples include false information relating to another person's eligibility or status as a Dependent. Columbia University reserves the right to demand that you pay back any reimbursement paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
- Material Violation – occurs when there was a material violation of the terms of the Plan.
- Threatening Behavior – occurs when you have committed acts of physical or verbal abuse that pose a threat to Columbia University's staff or the staff of your selected health plan staff.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms “Uniformed Services” or “Military Service” mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular

contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

When Coverage Ends for Your Dependents

When you drop coverage for one or more of your covered dependents either during Benefits Open Enrollment or through a Qualified Change in Status, coverage will end as follows:

Spouse

End of the month or 21 days (whichever is greater) following the date of your divorce, or commencement of other medical coverage (through spouse's employer, etc.).

Same-Sex Domestic Partner

End of the month or 21 days (whichever is greater) following the dissolution of the partnership or commencement of other medical coverage (through partner's employer).

Child

The coverage end date varies based upon the following situations:

Reaches Age 19: Coverage ends December 31st of the calendar year in which your child turned 19.

Full-time student over age 19 graduates: End of the month or 21 days whichever is greater following the date of graduation or the date your child is no longer a student.

Full-time student reaches age 26 (and has not yet graduated): Coverage stops the end of the month in which the child reached age 26

Coverage of Students on Medically Necessary Leave of Absence

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

- a) The date that is one year after the first day of the medically necessary leave of absence; or
- b) The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A “medically necessary leave of absence” is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

COBRA Continuation Rights

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Columbia University is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
 - an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
 - an Employee's former Spouse.
- Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Columbia University files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)

of that determination.

²This is a qualifying event for any Retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, you Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a Provider,

inform that Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Benefits Service Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period

is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes eligible for, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

GENERAL INFORMATION ABOUT THE PRESCRIPTION PLAN

Retail pharmacy (participating) — 30-day supply; \$10 co-pay for generic; \$20 for brand name
Mail Order — 90-day supply; \$15 co-pay for generic; \$40 for brand name

When you enroll in any Columbia University Medical Plan as an active employee, you are also covered under the Columbia University Prescription Drug Plan through Medco Health Solutions, Inc. You will receive a prescription drug card from Medco which you need to present to your pharmacist when filling a prescription. In the event you lose your card or need a card for a covered dependent, you should contact Medco at 1-800-230-0508 or register on-line at www.medcohealth.com.

You can choose to fill your prescription by mail order which can save you time and money.

DISPENSING AND REIMBURSEMENT LIMITS

Dispensing limits:

- 30-day supply if filled at your pharmacy; 90-day supply if mail service is used
- One-year period after prescription is written
- You have up to 18 months from the date of disbursement or date of prescription written to submit a claim for reimbursement

Reimbursement limits:

- 18 months after a prescription is written
- Only the number of refills authorized by your doctor
- \$15,000 lifetime limit on infertility oral or injectable medication

COVERED DRUGS

The following are covered benefits unless listed as an exclusion below

- ◆ Federal Legend Drugs
- ◆ State Restricted Drugs
- ◆ Compounded Medications of which at least one ingredient is a legend drug
- ◆ Insulin
- ◆ Needles and Syringes
- ◆ OTC diabetic supplies (except Glucowatch/sensors)
- ◆ Yohimbine
- ◆ Contraceptive injections
- ◆ Inhaler assisting devices
- ◆ Legend prenatal or pediatric fluoride vitamins, hematinics, or folic acid
- ◆ Hemophilia factors
- ◆ Fertility medications (all dosage forms, \$15,000 lifetime limit combined with all oral and injectable fertility related medications)
- ◆ Self injectables - List is subject to change - contact Medco if you receive a prescription for a product not listed below:

* Heparin

- * Low Molecular Weight Heparins (Lovenox(r),Fragmin Innohep(r),Normiflo)
- * Glycosaminoglycans (i.e. Orgaran(r))
- * Fondaparinux (Arixtra(r))
- * Erythroid Stimulants (i.e. Epogen(r), Procrit(r), Aranesp(r))
- * Myeloid Stimulants (i.e. Leukine(r), Neupogen(r))
- * Platelet Proliferation Stimulants (i.e. Neumega(r))
- Hormones:
- * Octreotide (Sandostatin(r))
- * Somatuline Depot
- * GnRH analogs
- * Leuprolide (Lupron/Eligard (all dosage forms)
- * Histrelin (Supprelin(r))
- * Growth Hormones/Growth Hormone Releasing Hormones
- * Somatrem (Protropin(r))
- * Somatropin (e.g. Nutropin(r))
- * Sermorelin (e.g. Geref(r))
- * Growth Hormones Receptor Antagonists
- * Somavert (r)
- Diabetes Therapy:
- * Insulins
- * Glucagon
- * Symlin
- * Byetta
- Miscellaneous:
- * Calcitonin (human and salmon)
- * Desmopressin (DDAVP(r))
- Immunomodulation:
- * Leuprolide (Lupron/Eligard(all dosage forms)
- * Glatiramer (Copaxone(r))
- * Interferons (Alfa, Alfacon-1, Beta and Gamma)
- * Interferon A-2b/ribavirin (i.e. Rebetron(r))
- Miscellaneous:
- * Dihydroergotamine (i.e. D.H.E-45(r))
- * Sumatriptan (Imitrex(r))
- * Etanercept (Enbrel(r))
- * Anakinra (Kineret(r))
- * Adalimumab (Humira(r))
- * Emergency Allergic Reaction Kits
- * Terparatide (Forteo(r))
- * Fuzeon
- * Xolair
- * Raptiva
- * Apokyn
- * Arcalyst
- * Relistor

- * Mozobil
- * Methotrexate 25mg/mL
- * Simponi (golimumab)
- * Cimzia Syringe(r)
- * Acthar Gel

QUANTITY LEVEL LIMITS

- ◆ Oral, transdermal, or intervaginal contraceptives for females only, limited to 30 days supply or 1 cycle, whichever is less per claim.
- ◆ Drugs used to treat impotency (all dosage forms-except Yohimbine) for males only, age 18 and older limited to 30 days supply or 8 units, whichever is less per claim.
- ◆ Stadol NS limited to a 30 day supply or 4 units of 2.5ml (10ml) whichever is less per claim.

PRIOR AUTHORIZATION REQUIRED FOR THE FOLLOWING

- ◆ Legend Anti-obesity Preparations
- ◆ Penlac Solution
- ◆ Panretin gel
- ◆ Retin-A and co-brands (all dosage forms) – IVR
- ◆ Interferons (Alpha & Gamma only)
- ◆ Human Growth Hormones
- ◆ Myeloid Stimulants
- ◆ Platelet Proliferation Stimulants (Neumega)
- ◆ Gleevec

EXCLUSIONS

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".

- ◆ Non-Federal Legend Drugs
- ◆ Non systemic contraceptives, devices, or implants
- ◆ Injectable medications (except as listed)
- ◆ Multi-source brand drugs when DAW=2 submitted (DAW = I rule)
- ◆ All other vitamins
- ◆ Smoking deterrents
- ◆ Ostomy supplies
- ◆ Dental fluoride products
- ◆ Glucowatch/sensors
- ◆ Mifeprex
- ◆ Therapeutic devices or appliances
- ◆ Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only (i.e. Renova®, Vaniqa®, Tri-Luma®, Botox-Cosmetic®, Solage®, Avage, Epiquin®).
- ◆ Allergy Serums
- ◆ Biologicals, Immunization agents or Vaccines
- ◆ Blood or blood plasma products
- ◆ Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.

- ◆ Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- ◆ Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- ◆ Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- ◆ Charges for the administration or injection of any drug.

- Drugs that are most commonly prescribed for cosmetic or non-medically necessary treatment are excluded by the plan. However, they may be covered if they are prescribed for medically necessary treatment.

ROUTINE QUESTIONS

If there is any question about this insurance or a claim payment, an explanation may be requested from Medco by calling 1-800-230-0508.

HOW TO FILE A CLAIM

FILING A CLAIM FOR BENEFITS

If you need to submit a claim for reimbursement you need to send the receipt of payment to Medco along with the appropriate form. The form can be found on the HR Benefits Website, the Medco website or by calling Medco at 1-800-230-0508.

HOW TO APPEAL A CLAIM DECISION

If you wish to appeal a denial or restriction based upon your medical circumstances, the first level of appeal is done by the member or physician. Contact the Medco Health Appeals Unit at 1-800-841-5409.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.