

A Health Benefits Program for Columbia University Retirees Group 174485

Health Plan

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COLUMBIA UNIVERSITY RETIREES

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STOP FRAUD

Empire BlueCross BlueShield welcomes your help in preventing health insurance fraud. Fraud costs Empire and its customers millions of dollars each year. If you are aware of any illegal activity involving Empire BlueCross BlueShield, please make a confidential call to this phone number during normal business hours:

INTEGRITY HOTLINE: 1-800-I-C-FRAUD (423-7283).

The benefits described in this booklet are subject to the terms, conditions, limitations, and exclusions of the contract issued by Empire BlueCross BlueShield to Columbia University. If a difference exists between the information in this booklet and the actual Plan, the Plan governs. Please consult your group's Plan for additional information.

BENEFITS SUMMARY

HOSPITAL	
FACILITY BENEFITS	MEMBER PAYS
INPATIENT (<i>except Mental Health</i>) 365 days - semiprivate room and board ♦ hospital-provided services, facilities, supplies and equipment related to: ⇒ Anesthesia ⇒ Audiology ⇒ Blood and blood products ⇒ Cardiac rehabilitation ⇒ Casts, splints and surgical dressings ⇒ Drugs and medications ⇒ Lab/X-rays ⇒ Oxygen and respiration therapy ⇒ Physical therapy ⇒ Radiation therapy	Deductible and coinsurance. Retirees under age 65 who show proof of coverage under another group plan (minimum of 21 days of hospital coverage), will receive medical and prescription drug coverage. Hospital services are not covered.
PHYSICAL THERAPY, PHYSICAL MEDICINE, OR REHABILITATION	Deductible and coinsurance
MENTAL HEALTH Up to 30 days per calendar year	Deductible and coinsurance
EMERGENCY ROOM/FACILITY (<i>initial visit</i>) ♦ accidental injury ♦ sudden and serious medical condition	Deductible and coinsurance
OUTPATIENT ♦ surgery ♦ blood and blood products ♦ pre-surgical testing (within 7 days of surgery) ♦ chemotherapy ♦ hemodialysis ♦ mammography screening ♦ cervical cancer screening	Deductible and coinsurance

OTHER FACILITY BENEFITS	MEMBER PAYS
SUBSTANCE ABUSE DISORDERS Up to 60 outpatient visits which include 20 family counseling visits per calendar year	Deductible and coinsurance
HOME HEALTH CARE Up to 200 visits per calendar year	Coinsurance
OUTPATIENT KIDNEY DIALYSIS	Deductible and coinsurance
HOSPICE Up to 210 days per lifetime	Deductible and coinsurance
MEDICAL BENEFITS	MEMBER PAYS
HOME/OFFICE MEDICAL VISITS Physician and Specialist	Deductible and Coinsurance
WELL-CHILD CARE (covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics) <ul style="list-style-type: none"> ◆ In-hospital visits <ul style="list-style-type: none"> ⇒ Newborn: 2 in-hospital exams at birth following vaginal delivery ⇒ Newborn: 4 in-hospital exams at birth following c-section delivery ◆ Office visits <ul style="list-style-type: none"> ⇒ From birth up 1st birthday: 7 visits ⇒ Ages 1 through 4 years of age: 6 visits ⇒ Ages 5 through 11 years of age: 7 visits ⇒ Ages 12 up to 17 years of age: 6 visits ⇒ Ages 18 to 19th birthday: 2 visits ◆ Lab tests ◆ Immunizations (office visits are not required) 	\$0
INPATIENT VISITS	Deductible and Coinsurance
DIAGNOSTIC SCREENING & MAMMOGRAPHY	Deductible and Coinsurance
MATERNITY	Deductible and Coinsurance
SURGERY	Deductible and Coinsurance
SURGICAL ASSISTANT	Deductible and Coinsurance
ANESTHESIOLOGY	Deductible and Coinsurance
LAB & X-RAY	Deductible and Coinsurance
MENTAL HEALTH ◆ up to 30 inpatient visits per calendar year	Deductible and Coinsurance
ALLERGY TESTING & TREATMENT	Deductible and Coinsurance
SECOND SURGICAL OPINION	\$0
PHYSICAL THERAPY	Deductible and Coinsurance
PRIVATE DUTY NURSING	Deductible and Coinsurance
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, PROSTHETICS, & ORTHOTICS	Deductible and Coinsurance
AMBULANCE	Deductible and Coinsurance
CHIROPRACTIC CARE	Deductible and Coinsurance
PRESCRIPTION DRUG	Deductible and Coinsurance

MANAGE YOUR HEALTHCARE ONLINE

Register Today For Online Member Services

- ◆ Go to *www.empireblue.com*, where you can securely manage your health plan 24 hours a day, 7 days a week. Here's what you can do:
- ◆ Check and resolve claims
- ◆ Search for doctors and specialists
- ◆ Update your member profile
- ◆ Access pharmacy information and services
- ◆ Print plan documents
- ◆ Receive information through your personal "Message Center"

Plus much more

Here's What You'll Need to Do

- ◆ All members of your family 18 or older must register separately.
- ◆ Go to *www.empireblue.com*. Follow the simple registration instructions

Get Personalized Health Information – Including your Health IQ

Click on MY HEALTH from your secure homepage after you register to receive the following features:

- ◆ Take the *Health IQ* test and compare your score to others in your age group
- ◆ Find out how to improve your score – *and your health* – online
- ◆ Find out how to take action against chronic and serious illnesses
- ◆ Get health information for you and your family

Your Privacy Is Protected

Your information is protected by one of the most advanced security methods available.

Register today to experience hassle-free service!
www.empireblue.com

GENERAL INFORMATION

Introduction

Important: This is not an insured benefit Plan. The benefits described in this benefit book or any rider or amendments hereto are funded by Columbia University who is responsible for their payment. Empire BlueCross BlueShield provides administrative claims related services only (which includes the pricing, adjudication and payment of claims and handling of claim appeals) and does not assume any financial risk or obligation with respect to claim

The Health Care Program available through Columbia University is administered by Empire BlueCross BlueShield and offers valuable protection for you and your eligible dependents:

- ◆ hospitalization benefits -- which cover hospital inpatient and outpatient care, as well as certain expenses for care at home
- ◆ medical benefits -- which cover most kinds of medical expenses, such as home and office visits, prescription drugs, surgical expenses, hospital visits, certain types of therapy, diagnostic services and maternity care, to a lifetime maximum of benefits as follows:
 - For retirees under age 65 the lifetime maximum is \$1,000,000.
 - At age 65 the lifetime maximum is reduced to \$150,000.

Eligibility

You are eligible under the Local 693 Support Staff Association (SSA) Retiree Medical Plan, if you leave the University on or after age 55, and if you complete at least 10 years of continuous benefits-eligible service with the University after age 45.

Contact Columbia University Benefits at 212-851-7000 for more information on eligibility rules.

Coverage Category

Your coverage category indicates how many people your plan covers. You may choose:

- Individual, which covers only you
- Family, which covers you and two or more of the following:
 - Your spouse
 - Dependent children (natural or adopted)

Eligible Dependents

The following family members are eligible for coverage:

- Your spouse – (a partner to a marriage that is legally recognized in the jurisdiction in which it is performed.) Former spouses, as a result of a divorce or annulment of a marriage, are not considered eligible spouses.
- Your unmarried children (natural or adopted, including stepchildren and foster children)
 - Until the end of the calendar year in which each child reaches age 19, or
 - Until the child reaches age 26, as long as the child remains unmarried, is dependent on you, and is a registered full-time student at an accredited college or university (a dependent's full-time attendance at an accredited school of higher education must be documented annually), or
 - Until the date of his or her marriage
- Your unmarried children, regardless of age, who are incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap, and who became so incapable prior to attainment of the age at which the dependent coverage would otherwise terminate.

Adding or Removing a Dependent

If you need to change coverage categories or add or remove a dependent, you should contact Columbia University Benefits at 212-851-7000 for the appropriate forms. All changes to coverage must be in writing.

Your cost for coverage may change if you add a dependent midyear. Any change affecting payment of your premium should go through Columbia University.

The Internal Revenue Service (IRS) limits when you can add coverage for a dependent or make changes to your healthcare benefits elections during the year.

After initial enrollment you will only be able to change benefits for the remainder of the calendar year if you experience a “qualified life status change.”

Examples of qualified life status change include:

- Divorce;
- Birth, adoption or placement for adoption;
- Death of a dependent (spouse, child);
- A dependent losing eligibility for coverage, such as a child reaching maximum age; or losing coverage under another plan, such as a spouse/partner losing coverage from his or her employer;
- Spouse or eligible dependent being called to military duty in the U.S. Armed Forces;

Coverage must be applied for within 30 days of one of the qualifying special enrollment events described above.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee’s or Dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within thirty (30) days of the loss of Medicaid/CHIP or of the eligibility determination.

IMPORTANT Enrolling a newborn child or adopted newborn for a member who has individual (for self only), employee/spouse, or parent/child (two person coverage):

- If you acquire a new Dependent(s) through birth, adoption or placement for adoption, you may request special open enrollment.
- Special open enrollment must be requested within 30 days of the occurrence by contacting Columbia University Benefits and submitting a written request and child’s birth certificate, hospital record of birth (temporary, until birth certificate is received) or adoption certificate/court records. You can scan and email to hr-retirement@columbia.edu or fax to 212-851-7025 (secure fax).
- For birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption.
- If you do not switch to a parent\child, parent\children, or family contract and enroll your **eligible** newborn under that contract as described above, your newborn or proposed adopted newborn will NOT be covered under your Plan, except for newborn nursery charges incurred during the first 48 hours following a vaginal delivery or the first 96 hours following a c-section delivery.

Qualified Medical Child Support Orders (QMCSO). A court order, judgment or decree that:

- Provides for child support relating to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or
- Enforces a state medical child support law enacted under Section 1908 of the Social Security Act.

A Qualified Medical Child Support Order is usually issued when a parent receiving post-divorce custody of the child is not an employee.

You may request, without charge, the procedures governing the administration of a Qualified Medical Child Support Order determination from your Plan Administrator. Your Plan Administrator will notify Empire to process the enrollment for the covered person.

College Student Medical Leave. The plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a medically necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless dependent coverage ends earlier under another plan provision, such as the parent's termination of employment or the child's age exceeding the plan's limit.

- Medically necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a medically necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). [The plan must receive written certification from the child's physician confirming the serious illness or injury and the medical necessity of the leave or change in status.]
- Coverage continues even if the plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a plan changes during the extended period of coverage.

Our Role in Notifying You

There may be times when benefits and/or procedures may change. We or Columbia University will notify you of any change in writing. Announcements will go directly to you at the address that appears on our records or to your group benefits office.

If You Want More Information

At least once a year, Empire will send all members general descriptions of the reimbursement methodologies that Empire uses by individual provider type.

In addition, you may request any of the following information about Empire:

- ◆ The names, business addresses and official positions of Empire's Board of Directors, officers, controlling persons, owners and partners.
- ◆ Empire's most recently published annual financial statement.
- ◆ A sample of Empire's direct payment contracts.
- ◆ A consumer report regarding grievances filed with the Insurance Superintendent.
- ◆ Procedures Empire has established to protect confidentiality of medical records and other member information.
- ◆ A description of Empire's quality assurance program.
- ◆ A listing of our providers' affiliations with hospitals.
- ◆ A description of the contracting procedures and minimum qualification requirements for providers.
- ◆ Upon written request, specific written clinical review criteria for determining medical necessity.

Women's Health and Cancer Rights Act of 1998

This federal law applies to almost all health care plans, except Medicare Supplement and Medicare Risk plans, as of plan years beginning on or after October 21, 1998. The law imposes certain requirements on employee benefit plans and health insurers that provide medical and surgical benefits with respect to a mastectomy. Specifically, in the case of a participant or beneficiary who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the law requires coverage for:

- ◆ Reconstruction of the breast on which the mastectomy has been performed.
- ◆ Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- ◆ Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

The coverage described above shall be provided in a manner determined in consultation with the attending physician and the patient. This coverage is subject to all coverage terms and limitations (for example, Deductibles and Coinsurance) consistent with those established for other benefits under the plan.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Program or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

COMPREHENSIVE HOSPITAL AND MEDICAL BENEFITS

How the Program Works

The program offers you and your family a broad scope of hospital and medical benefits.

Benefit Period

The benefit period for this program begins on January 1st each year and ends on December 31st. Your annual deductible resets each January 1st.

Eligibility

You are eligible under the Local 693 Support Staff Association (SSA) Retiree Medical Plan, if you leave the University on or after age 55, and if you complete at least 10 years of continuous benefits-eligible service with the University after age 45.

Member Cost Share

If you are under age 65, there are two different levels of coverage. Your level of coverage will depend on whether you are insured under any other group medical plan with a minimum of 21 days of hospital coverage paid in full.

Under Age 65 - If you are not insured under any other group medical plan with a minimum of 21 days of hospital coverage paid in full.

Deductible	\$2,000 per each individual
Coinsurance (% paid by CU)	80% after deductible
Out-of-Pocket Maximum	\$750 per individual plus deductible

Under Age 65 – If you are insured under another group plan with a minimum of 21 days of hospital coverage paid in full.

You will receive medical and prescription drug coverage under this plan. As noted in the Benefit Summary, hospital services are not covered.

Deductible	\$150 individual \$450 family
Coinsurance (% paid by CU)	80% after deductible
Out-of-Pocket Maximum	\$750 per individual plus deductible

Over Age 65

Deductible	\$100 individual \$300 family
Coinsurance (% paid by CU)	80% after deductible
Out-of-Pocket Maximum	Not applicable

Lifetime Maximum

Under Age 65 – This lifetime maximum applies to anyone under age 65 regardless of other hospital coverage.

Lifetime Maximum	\$1,000,000 per person
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Over Age 65

Lifetime Maximum	\$150,000 per person
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Coinsurance

After you have satisfied your appropriate deductible, you will pay 20% of the covered charges until you reach the out-of-pocket maximum. When your deductible plus coinsurance reaches your out-of-pocket maximum, the plan will pay 100% of covered charges for the remainder of the calendar year (within plan limits).

If Medicare is your primary coverage

If you are age 65 or older, your plan coordinates with Medicare to cover 80% of Empire's maximum allowed amount, not to exceed 100% of Medicare's allowable charge.

The following is an example of a medical claim first processed by Medicare (primary coverage) and then Empire (secondary coverage):

Total charge from the provider	\$215.00
Primary coverage is Medicare	
Medicare's allowance	\$184.60
Medicare Annual Deductible	already met
Medicare Coinsurance	20%
Paid by Medicare	\$147.68
Secondary coverage is Empire	
Empire's allowance	\$215.00
Empire Annual Deductible	already met
Empire Coinsurance	20%
Empire's payment if member paid	\$172.00
Payment Calculation	
Empire's payment if primary	\$172.00
Subtract Medicare's payment	<u>-\$147.68</u>
Equals Empire's actual payment	\$ 24.32
Your Member Responsibility	
Balance after Medicare Payment	\$36.92
Minus Empire's Payment	<u>-\$24.32</u>
Equals Members responsibility	\$12.60

HOSPITAL BENEFITS

Benefits are provided in any participating hospital in Empire's operating area (28 counties of eastern New York including New York City). A participating hospital is one with which Empire Blue Cross and Blue Shield has a written agreement for the provision of care to its subscribers and which we specifically recognize as an acute care general or specialty hospital. A participating hospital may have a separate section or facility, specializing in treatment of one condition which is not covered by an agreement with that hospital.

Empire also participates in a national program administered by the Blue Cross and Blue Shield Association called the BlueCard Program. The BlueCard Program gives you access to care when you are outside of Empire's service area. By presenting your identification card to any Blue Cross and/or Blue Shield participating hospital, physician or other provider outside of Empire's service area anywhere in the United States, you are assured that you will receive the covered services you would be entitled to receive within Empire's service area and that you will benefit from the discounts that the participating providers have agreed to extend to their local Blue Cross and/or Blue Shield Plan. For more information about the BlueCard Program, please refer to the full disclosure statement in Addendum I.

Inpatient Days of Care

Depending on your specific plan, the benefits below may vary:

If you or an insured dependent is hospitalized (due to illness or injury) in any acute care, general or specialty hospital, your health care program will pay (after the deductible has been satisfied) 80% of covered expenses for the cost of semiprivate hospital room, board, special diets, general nursing services and other hospital services for 365 days a year subject to any limitations and exclusions.

Pre 65 retirees who show proof of coverage under another group plan (minimum of 21 days of hospital coverage), will receive medical and prescription drug coverage. Hospital services are not covered.

If you use a private room, the program will pay the hospital's average semiprivate room charge and you will be responsible for paying the difference.

Other Hospital Services

You are covered for the following if they are customarily provided by a hospital:

- ◆ Use of operating, cystoscopy and recovery rooms and equipment.
- ◆ Use of intensive care or special care units and equipment.
- ◆ Anesthesia supplies and use of anesthesia equipment.
- ◆ Oxygen and supplies and use of equipment for administration.
- ◆ All drugs and medicines for in-hospital use which are commercially available for purchase and readily obtainable by the hospital.
- ◆ Blood, blood products and blood derivatives and services and equipment related to its administration.
- ◆ Sera, biologicals, vaccines, intravenous preparations, dressings, casts and materials for diagnostic studies.
- ◆ Facilities, services, supplies and equipment related to physical and occupational therapy.
- ◆ Facilities, services, supplies, and equipment related to diagnostic studies, including laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations.
- ◆ Radiation and nuclear therapy.
- ◆ Chemotherapy.
- ◆ Facilities, services, supplies and equipment related to emergency medical care.
- ◆ Any additional medical, surgical or related services and supplies and equipment customarily provided by the hospital, unless specifically excluded from the contract.

Inpatient Mastectomy Stays

Inpatient hospital care includes coverage for an inpatient hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. The length of the stay will be determined by you and your doctor.

Maternity Care

Your benefits cover pregnancy and any pregnancy-related treatment. This includes services provided in participating birthing centers. Your maternity care benefits include, at a minimum, coverage for at least 48 hours after childbirth and any delivery other than a caesarean section. Following a caesarean section delivery, the plan provides, at a minimum, coverage for at least 96 hours.

If the mother decides to be discharged earlier than either 48 hours after childbirth for any delivery other than a caesarean section or 96 hours following a caesarean section she shall be entitled, upon request made within that time period, to one home care visit. This visit shall be delivered within 24 hours after discharge or of the time of the request, whichever is later. This home care visit is in addition to other home care benefits of this plan. In addition, this home care visit is not subject to the deductible or coinsurance.

Maternity care coverage also includes, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

Newborn Children

Benefits are available from birth for:

- ◆ The treatment of illness or injury
- ◆ Nursery care in an approved premature unit for an infant weighing less than 2,500 grams (5.5 pounds)
- ◆ Incubator care, regardless of the infant's weight.

Benefits for your newborn child also include, at a minimum, coverage for at least 48 hours following birth for any delivery other than a caesarean section. Following a caesarean section delivery, the plan provides, at a minimum, coverage for at least 96 hours.

Hospitalization benefits for the circumcision of infants is covered only after 30 days of age.

Mental Health Care

Hospital benefits for inpatient mental health care are provided for up to **30** days per calendar year in:

- ◆ Participating Hospitals or non-governmental general hospitals located outside our Plan area;
- ◆ Hospitals that have a special agreement with the Plan to provide this care, including:
 - ⇒ General hospitals of the New York City Health and Hospitals Corporation;
 - ⇒ Non-governmental psychiatric hospitals which have a special agreement with the Plan to provide this care;
 - ⇒ General hospitals operated by counties within or immediately adjacent to the Plan's operating area.

Note: 15 consecutive day rule will not apply – 15 day stay will not be required

Emergency Room

To be covered as emergency care, the condition must be a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

Emergency Services are defined as a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

Emergency Services are not subject to prior authorization requirements.

Your benefits cover the **first** visit for treatment of an emergency condition delivered in the emergency department of a Hospital.

EMERGENCY ROOM TIPS

- ◆ **Emergency Room care is the most expensive way to treat a routine ailment.**
- ◆ **Empire would not cover Emergency Room care in situations like the following:**
 - **Because it is late at night and the need for treatment is not sudden and serious.**
 - **Because the patient has no regular physician.**

To prevent your having to pay unnecessary charges and at the same time to get the care you need when you need it, just follow the simple instructions below.

What to Do in an Emergency

1. If you have questions about a health situation and/or emergencies, you should call your personal physician for advice. Your personal physician will direct you to the appropriate care setting.
2. Call an ambulance or go directly to an emergency room if you cannot call your personal physician in advance. If possible, go to the emergency room of the hospital where your personal physician is affiliated.

Emergency Care Outside Our Service Area

1. If you have a medical emergency while you are away from home and outside our service area (28 counties in New York State), follow Steps 1 and 2 above.
2. If you must go to an emergency room, show your member ID card at the hospital. If the hospital participates with another Blue Cross and Blue Shield plan, that plan will submit your claim to Empire.

Outpatient Services

You are covered for the same services that you would receive as a hospital bed patient. This includes all services, supplies and equipment given by the hospital as part of its regular inpatient care.

When you receive care in the emergency department of a Hospital, your hospital benefits pay for:

- ◆ Emergency first aid for an accidental injury;
- ◆ Emergency care for a sudden or serious illness;
- ◆ Surgery, including the treatment of fractures and dislocations and other procedures requiring the use of the hospital's surgical facilities;
- ◆ Presurgical testing -- if prescribed by your doctor and performed at the hospital where the surgery is scheduled to take place. If the surgery is cancelled because of these presurgical test findings, or as a result of a second surgical opinion, we will still cover the cost of these tests.
- ◆ Cancer chemotherapy including medications;
- ◆ Physical therapy related to either surgery or hospitalization for an illness, provided the therapy starts within six months after surgery or the date of discharge from the hospital. Benefits will end after 365 days from the date of surgery or the date of discharge from the hospital.
- ◆ Mammography screening at a doctor's request, when indicated by health history. In addition, covered women 35 years of age or older also receive coverage for routine annual mammography screenings, regardless of health history.
- ◆ Cervical cytology screening benefits are provided to women 18 years of age or older. We will pay for one pelvic exam per calendar year, including collection and preparation of a Pap smear and diagnostic services provided in connection with examining and evaluating of the Pap smear. These services must be given by a hospital employee and billed by the hospital.

Dialysis for Kidney Failure

Hospital benefits for hemodialysis or peritoneal dialysis are available where treatment is provided, supervised or arranged by the physician and the covered member is a registered patient with an approved kidney disease treatment center. These dialysis benefits will be available until the patient becomes eligible for Medicare.

Out of hospital benefits will be provided for dialysis at home or, if home dialysis is not feasible, in a free-standing facility or participating hospital with which Empire has an agreement for the provision of dialysis services.

For home treatment, the reasonable cost, as determined by Empire, for rental or purchase of equipment and necessary supplies will also be covered, when ordered by your physician. Coverage will not include any furniture, electrical or other fixtures, plumbing or professional assistance needed to perform the dialysis treatments at home.

Outpatient Alcoholism and/or Substance Abuse Treatment

Outpatient benefits for the diagnosis and treatment of alcoholism and/or substance abuse are available to each covered person and may be used in any combination for up to **60** visits per calendar year. Up to **20** of these visits may be used for family counseling, even if the patient's treatment has not yet begun. Family counseling is available to all persons covered under the patient's family contract. Benefits for family counseling are limited to one visit a day.

Within New York State, the program covers alcohol or substance abuse when treated at facilities certified by the New York State Division of Alcoholism and Substance Abuse Services.

Outside New York State, the program covers alcohol or substance abuse treatment at facilities with a treatment program approved by the Joint Commission on Accreditation of Health Organizations.

Benefits are provided for covered services rendered in government facilities, unless no charge would have been made in the absence of this insurance.

HOME CARE BENEFITS

Home Care benefits are available under a physician-approved plan of treatment when the necessary services are rendered through a New York State-certified home health agency. If you receive home care outside of New York State, the care must be provided by a nonprofit or public home care agency or hospital having an appropriate operating certificate to provide home care issued by the appropriate state agency. Benefits will be provided only if hospitalization or confinement in a skilled nursing facility would otherwise have been required. **This benefit is not subject to the deductible amount.**

The following services are covered for up to **200** visits per calendar year:

- ◆ Part-time professional nursing care supervised or provided by a registered nurse (R.N.).
- ◆ Part-time home health aide services (up to 4 hours of such care is equal to one home care visit).
- ◆ Physical, occupational or speech therapy.
- ◆ Necessary laboratory services, medical supplies, drugs and medicines prescribed by a physician.

When home care is provided through an agency that participates in an agreement with Empire to render such care, these additional services are covered:

- ◆ Medical social worker visits.
- ◆ X-ray and EKG services.
- ◆ Ambulance or ambulette to and from the hospital for needed care.

HOSPICE BENEFITS

The covered member has coverage for up to **210** days of inpatient hospice care in a hospice or hospital and home care and outpatient services provided by the hospice. The covered person must be certified by his or her primary attending physician as having a life expectancy of six months or less. In addition, the following applies:

- ◆ the hospice has accepted the covered member for its program;
- ◆ the hospice is both located in New York State and is certified pursuant to Article 40 of the New York Public Health Law, or
- ◆ the hospice is located outside of New York State, and is certified by the state in which the hospice organization is located.

Covered hospice and outpatient services include:

- ◆ Bed patient care, either in a designated hospice unit or in a regular hospital bed, and day care services provided by the hospice organization.
- ◆ Home care and outpatient services provided by the hospice and charged to you by the hospice are also covered. The services may include the following:
 - ⇒ Intermittent care by an RN, LPN or Home Health Aide.
 - ⇒ Physical therapy.
 - ⇒ Speech therapy.
 - ⇒ Occupational therapy.
 - ⇒ Respiratory therapy.
 - ⇒ Social services.
 - ⇒ Nutritional services.
 - ⇒ Laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms.
 - ⇒ Medical supplies.
 - ⇒ Drugs and medications prescribed by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary (not covered when the drug or medication is of an experimental nature).
 - ⇒ Medical care provided by the hospice physician.
 - ⇒ Durable medical equipment (rental only).
 - ⇒ Transportation between home and hospital or hospice organization when medically necessary.
 - ⇒ Five visits for bereavement counseling for the member's family, either before or after the member's death. Pastoral services are not covered.

MEDICAL BENEFITS

Covered Medical Expenses

Covered medical expenses include a wide range of medical services and supplies performed or recommended by a licensed practitioner for the treatment of an illness or injury. Practitioners include licensed physicians, dentists, podiatrists, optometrists, speech therapists, chiropractors, osteopaths, physical therapists, and psychologists and certified psychiatric social workers.

Once the deductible has been satisfied, medical benefits will provide 80% of maximum allowed amount for the following services:

- ◆ Physician charges for surgical care, surgical assistance, anesthesia, chemotherapy and radiation therapy.
- ◆ Maternity care, including charges for routine pre- and post-natal care of the mother and the services of an approved certified nurse-midwife. You may choose to receive the allowance for this benefit in 3 installments -- 2 for pre-natal care and the remaining payment for the delivery and post-natal care.
- ◆ Physician charges for in hospital medical care.
- ◆ Doctor visits in the home or office.
- ◆ Specialist consultation by a board certified specialist.
- ◆ Electroconvulsive therapy given for mental health care.
- ◆ Diagnostic X-ray and laboratory examinations.
- ◆ Mammography screening at a doctor's request, when indicated by health history. In addition, covered persons 35 years of age or older receive coverage for routine annual mammography screenings, regardless of prior health history.
- ◆ Cervical cytology screening benefits are provided to women 18 years of age and older. We will pay for one pelvic exam per calendar year, including Pap smear and diagnostic services provided in connection with examining and evaluating the Pap smear.
- ◆ Supplies and the use of medical equipment in connection with X-ray, laboratory and pathological examinations, anesthesia, physical therapy, blood and blood products, oxygen and insulin.
- ◆ Prescription drugs.
- ◆ Speech therapy.
- ◆ Private duty nursing service for the services rendered in the hospital by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), if billed separately, or services rendered outside the hospital by an RN when the attending physician certifies that the service is needed and the nurse is not a relative of the household.
- ◆ Prosthetic and orthotic appliances and durable medical equipment -- their purchase or rental.
- ◆ Professional ambulance service used locally to or from a hospital when related to an inpatient admission or for emergency outpatient care.

- ◆ Chiropractic benefits include manipulation of the spine and other parts of the body to eliminate nerve interference or its effects.
- ◆ Extended care facility benefits are available when services are incurred during the first 200 days of continuous confinement as an inpatient in an approved facility, provided such confinement commences within 14 days immediately following the termination of a confinement of at least three consecutive days in the hospital
- ◆ Second surgical opinion including required X-ray and laboratory tests with respect to proposed surgery when all of the following conditions are met:
 - ⇒ the second opinion is obtained through our Second Opinion Referral Service. To obtain a referral for a Second Opinion, contact our Second Opinion Referral Center at **1-800-249-8060**;
 - ⇒ the second surgical opinion is rendered following a recommendation by your **surgeon** that surgery be performed. We will not pay for a second opinion when the recommendation for surgery is made by your family physician or internist;
 - ⇒ the second surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature which is covered under your contract;
 - ⇒ the specialist who renders the second surgical opinion does not also perform the surgery for which the second surgical opinion was obtained.

If the need for an operation is not confirmed, we'll provide another consultation (a third opinion) if you ask for it. This consultation must also be arranged through our Second Opinion Referral Center. **This benefit is not subject to deductible or coinsurance.**

Diabetes Equipment and Supplies

Your plan covers medically necessary diabetes equipment and supplies. The equipment and supplies must be recommended or prescribed by a physician or certified nurse practitioner. Your plan covers:

- ◆ Blood glucose monitors, including monitors for the legally blind
- ◆ Testing strips for glucose monitors, including visual reading and urine testing strips
- ◆ Data management systems
- ◆ Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices
- ◆ Oral agents for controlling blood sugar
- ◆ Any additional medically necessary equipment and supplies required by the New York State Health Department.

Your plan also covers the following diabetes self-management education and diet information:

- ◆ Education by a physician, certified nurse practitioner, or their staff. Your plan covers the education as part of the office visit.
- ◆ Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian, or registered dietitian upon the referral of a physician or certified nurse practitioner. Such coverage must be provided in a group setting wherever practicable.
- ◆ Home visits for education when medically necessary.

This benefit will be subject to deductible and coinsurance that is no greater than those for an office visit.

Well Child Care

Your plan covers the following primary and preventive care services for covered dependents (covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics):

- ◆ In-hospital visits
 - ⇒ Newborn: 2 in-hospital exams at birth following vaginal delivery
 - ⇒ Newborn: 4 in-hospital exams at birth following c-section delivery
- ◆ Office visits
 - ⇒ From birth up 1st birthday: 7 visits
 - ⇒ Ages 1 through 4 years of age: 7 visits
 - ⇒ Ages 5 through 11 years of age: 7 visits
 - ⇒ Ages 12 through 17 years of age: 6 visits
 - ⇒ Ages 18 to 19th birthday: 2 visits
- ◆ Lab tests
- ◆ Immunizations (office visits are not required)

These services must be rendered by or under the supervision of a physician, or nurse or nurse practitioner licensed under Article 139 of the New York State Education Law.

Covered services include a physical exam, developmental assessment, anticipatory guidance, and laboratory tests ordered at the visit and performed either in the office or a laboratory.

Your plan also covers the following necessary immunizations, as appropriate: DPT (diphtheria, tetanus and pertussis), polio, MMR (measles, mumps and rubella), hepatitis B, hemophilus, tetanus-diphtheria, pneumococcal, meningococcal, and tetramune. Empire will cover additional immunizations as determined by the New York State Superintendent of Insurance and the Commissioner of Health.

Note: These services are not subject to any deductible or coinsurance provisions of your plan.

Bone Density Testing and Treatment

Standards for determining appropriate coverage include the criteria of the federal Medicare program and the criteria of the National Institutes of Health for the Detection of Osteoporosis. Bone mineral density measurements or tests, drugs and devices include those covered under Medicare and in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy X-ray absorptiometry. Coverage shall be available as follows:

- ◆ For individuals who are:
 - ⇒ Ages 52 through 65 - 1 baseline
 - ⇒ Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis)
 - ⇒ Under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)
- ◆ For individuals who meet the criteria of the above programs, including one or more of the following:
 - ⇒ Previously diagnosed with or having a family history of osteoporosis
 - ⇒ Symptoms or conditions indicative of the presence or significant risk of osteoporosis
 - ⇒ Prescribed drug regimen posing a significant risk of osteoporosis
 - ⇒ Lifestyle factors to such a degree posing a significant risk of osteoporosis
 - ⇒ Age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.

LIMITATIONS AND EXCLUSIONS

Hospitalization and medical benefits are not payable for:

- ◆ Services that in our judgment are not needed for your proper medical care or treatment. If services are rendered which cost more than other modalities of care, which are equally or more beneficial, benefits may be limited to the costs of the less expensive modality or treatment. All or any part of a hospital stay related to an unnecessary service is excluded.
- ◆ Government hospital services **unless** we have a participation agreement or special agreement with that hospital (and then only for the specific services to which the special agreement applies). However, this exclusion does not apply to United States Veteran's Administration or Department of Defense Hospitals, **except** for services in connection with a service-related disability. In the case of an emergency, we will provide benefits until the patient can be safely transferred to a participating hospital.
- ◆ Services and supplies for which coverage is available under Workers' Compensation or similar legislation.
- ◆ Any loss, or portion thereof, recovered or recoverable under mandatory no-fault automobile insurance.
- ◆ Charges which would not have been made -- or which are greater than those that would have been made -- if extended medical benefits were not available.
- ◆ Confinements for sanitarium-type, custodial or convalescent care, rest cures or care in a hospital, or a separate division of the hospital, where half the days of care provided by the hospital are part of stays more than 90 days in length.
- ◆ Routine care of the newborn, except as noted under the *Medical Benefits Covered Expenses* section.
- ◆ Travel, even though prescribed by a physician.
- ◆ Diseases or injuries received as a result of war.
- ◆ Hospital stays or any part of a hospital stay primarily for diagnostic studies unless such studies are performed in connection with specific symptoms and not as part of a general physical examination or check-up.
- ◆ Charges in excess of the maximum allowed amount.
- ◆ Services covered under government programs except Medicaid.
- ◆ Eyeglasses, contact lenses (except when medically necessary following cataract surgery) or hearing aids or the examination for their prescription or fitting.
- ◆ Services performed by unlicensed providers or by licensed practitioners beyond the scope of their license.
- ◆ Services performed by employees of a hospital or other institution except when such services are performed in the outpatient department of a hospital for diagnostic X-ray, laboratory and therapeutic procedures.

- ◆ Dental services except that benefits will be provided within the first 12 months after accidental injury to sound natural teeth for care needed as a result of the accident and for surgical excision of an impacted tooth.
- ◆ Foot care including care of corns, bunions (except capsular or bone surgery), calluses, nails of the feet, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, including fabrication of foot orthosis and arch supports.
- ◆ Elective cosmetic surgery, unless it is a result of accident or injury; reconstructive surgery unless it is part of an operation to treat an infection or disease, or if follows such an operation, or if it is performed to treat a functional defect resulting from a congenital disease or anomaly of a covered child.
- ◆ Active employees, their spouses, or those on disability who have elected Medicare as primary coverage; however, if neither you nor your spouse is an active employee, these benefits will be reduced by the amount received from Medicare for the same services.
- ◆ Referrals for pharmacy services, clinical laboratory, X-ray or imaging services by physicians or other health care practitioners to facilities in which they or an immediate family member have a financial interest or relationship, as prohibited by the New York Public Health Law.
- ◆ Technology including treatments, procedures, drugs, biologicals, or medical devices which, in our sole discretion, are not medically necessary in that they are

⇒ experimental or investigational;

⇒ obsolete or ineffective;

nor any hospitalization in connection with such technology.

"Experimental" or "investigational" means that the technology is:

- ⇒ not of proven benefit for either the particular diagnosis or treatment of the covered person's condition, **or**
- ⇒ not generally recognized by the medical community (as reflected in the published peer-reviewed medical literature) as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition.
- ⇒ Government approval of a technology is not necessarily sufficient to render it of proven benefit nor appropriate or effective for a particular diagnosis or treatment of a covered person's particular condition.

We may apply any or all of the following five criteria in determining whether a technology is experimental or investigative, obsolete, or ineffective:

1. Medical device, drug, or biological product must have received **final** approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug, or biological product for **another** diagnosis or condition may require that any or all of these five criteria be met.
2. Conclusive evidence (from the published peer-reviewed medical literature) must exist that the technology has a definite positive effect on health outcomes.
3. Demonstrated evidence (as reflected in the published peer-reviewed medical literature) must exist that over time the technology leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).

4. Proof (as reflected in the published peer-reviewed medical literature) must exist that the technology is at least effective in improving health outcomes, or is usable in appropriate clinical contexts in which established technology is not employable.
5. Proof (as reflected in the published peer-reviewed medical literature) must exist that improvement in health outcomes (as defined in #3 above) is possible in standard conditions of medical practice, outside clinical investigatory settings.

- ◆ Residential treatment services are not covered.
- ◆ Acupuncture, only in lieu of anesthesia.

COORDINATION OF BENEFITS

Occasionally, individuals have health care coverage under two programs. When this happens, the two programs will coordinate their benefit payments so that the combined payments do not exceed the actual expenses incurred.

Our Coordination of Benefits Program establishes which health coverage program has primary responsibility. The primary health coverage program will reimburse you first. When this contract is secondary, the total benefits paid by Empire will not exceed the amount Empire would have paid if this contract were primary.

To determine primary and secondary coverage, we use the following criteria:

- ◆ The health coverage program without a coordination of benefits provision similar to this one will have primary responsibility.
- ◆ The health coverage program listing the patient as the employee (rather than a dependent) will have primary responsibility.
- ◆ A dependent child covered under both parents' health coverage programs will receive coverage as follows:
 - ⇒ the program of the parent having his or her birthday earlier in the calendar year (only month and day are considered) will have primary responsibility
 - ⇒ if the parents have the same birthday the health coverage program covering the parent longer will have primary responsibility
 - ⇒ if the other health coverage program does not have a "birthday" provision and uses gender to determine primary responsibility the father's health coverage program will have primary responsibility.
- ◆ A dependent child covered either by divorced or separated parents who have no court decree of financial responsibility for the child's health care expenses, will receive primary coverage under the custodial parent's health care program.

If the parent with custody remarries, we use the following order to determine primary responsibility:

- ⇒ the program of the parent with legal custody
- ⇒ the stepparent's program
- ⇒ the program of the parent without legal custody.
- ◆ A dependent child covered by either divorced or separated parents who have a court decree specifying which parent has financial responsibility for the child's health care expenses will have primary coverage under that parent's contract if that parent's contract has actual knowledge of that decree.
- ◆ If the patient is both covered as an active employee or as a dependent of an active employee and has coverage under another health care program as either a laid-off employee, a retired employee, or a dependent, then the active employee's health coverage program will have primary responsibility. However, if the other health coverage program does not have this rule and the two contracts do not agree on which coverage has primary responsibility, then this rule will not apply.
- ◆ If none of the previous rules apply, the health program that has covered the patient the longest will have primary responsibility.

- ◆ To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you do not elect it.

HOW TO CLAIM BENEFITS

You must file a completed health insurance claim form (and any other supportive materials) within 18 months of the service date to receive reimbursement. Empire can only process claims submitted either in English or with an English translation. To protect you from unnecessary costs resulting from fraud and abuse, **we will only consider original bills or receipts** with your claim form. **Photocopies are not acceptable.** Please keep photocopies of the documents you send us since we cannot return the originals. Once a claim is processed, an Explanation of Benefits (EOB) will be sent directly to you.

Hospital Claims

Empire usually receives claims directly from participating hospitals/facilities. If the participating hospital or other facility does not submit a claim, however, you must send us the itemized hospital bill directly.

Inpatient Services

When admitted to a participating hospital as a registered inpatient, present your Empire identification card. The hospital will bill us directly and we will pay the hospital.

Outpatient Services

When treated in a participating hospital's outpatient department or emergency room, present your Empire BlueCross BlueShield identification card. The hospital will bill us directly and we will pay the hospital.

For either out-of-area or non-participating hospitals, you may have to pay the hospital's bill. When this happens, obtain an itemized hospital bill with the following information:

- ◆ Patient's name and date of birth
- ◆ Empire BlueCross BlueShield identification number
- ◆ Subscriber's name and address
- ◆ date of each service
- ◆ charge for each service.

Send the itemized bill (and receipt, if you paid the bill) to:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Medical Claims

When you receive care from a doctor, he or she will send us the claim and we will pay either you or the provider. If we send the payment to the provider, we will also send you a notice describing the payment. To ensure valid reimbursement for the services you receive, submit your claims with an itemized bill, whenever possible.

Please send us your claims as soon as possible after the service date. The itemized bill should include the following information:

- ◆ patient's name
- ◆ complete service date (month, day, year)
- ◆ diagnosis
- ◆ description of service(s) performed
- ◆ charge for each service
- ◆ provider's complete name and address.

Doctors' Services

You and/or the provider must complete a health insurance claim form. Before completing the form, be sure to read the instructions on the back. You must complete a separate claim form for each family member. Send the completed claim form with any supporting information to:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Other Services

To submit a claim for any of the services listed below, attach the provider's original itemized statement:

- ◆ **prescription drug charges** -- The pharmacy's bill must include:
 - ⇒ the patient's full name and address
 - ⇒ patient's I.D. number
 - ⇒ pharmacy's name and address
 - ⇒ name of prescribing doctor
 - ⇒ name, quantity, strength, and prescription number of drug purchased
 - ⇒ National Drug Code (NDC)
 - ⇒ purchase date and charge.
- ◆ **ambulance charges** -- Include the patient's full name and address, date of and reason for service, total mileage traveled, amount of charges, and a copy of the authorization for the ambulance.
- ◆ **supplies, durable medical equipment, and orthotic charges** -- Include a copy of the doctor's authorization, a description of the item, and an explanation of the item's medical necessity.

Carve-out Program

Carve-out is a program for subscribers who are eligible for Medicare. You will receive the same benefits as the non-Medicare members in your group. You or your health care provider should file a claim with Medicare, not Empire. After Medicare processes your claim, forward it to Empire for additional processing.

As a Carve-out subscriber, you must meet the same contractual requirements (e.g., deductibles, coinsurance, cost share maximum, etc.) as non-Medicare eligible employees. You must also meet the Medicare Part B deductible. That deductible, however, is automatically subtracted from any applicable Empire deductible. Therefore, you pay the same total deductible as your non-Medicare eligible colleagues.

Carve-out will not pay for a service that is not covered by your group's plan.

Medical Necessity

Empire regards services, supplies, or equipment provided by a hospital or covered provider of health services as medically necessary if Empire determines they are:

- ◆ consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or injury;
- ◆ in accordance with standards of good medical practice;
- ◆ not solely for the convenience of the patient, the family, or the provider;
- ◆ not primarily custodial, and;
- ◆ the most appropriate level of service for the patient's safety.

The fact that a covered provider may have prescribed, recommended, or approved a service, supply or equipment does not, in itself, make it medically necessary.

Claim Review

If we deny a claim, wholly or partly, you have the right to appeal our decision under the Employee Retirement Income Security Act of 1974 (ERISA). We will send you written notice of why the claim was denied. If your claim is ignored or denied, in whole or in part, you may file suit in federal court.

We will send you a written decision with an explanation within 60 days of receiving the appeal. If special circumstances require more time, we can extend the review period for up to 120 days from the date we receive the appeal. For review of a hospital or medical claim, write to:

Claim Review Coordinator
Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

You may also call Columbia University Benefits at 212-851-7000. If you call, have your Empire identification number handy as well as any claim-related documents.

Remember, if you either can't find the answer to your question in this booklet or have a question about a specific claim, you can either write to us at the address listed above or call your group benefit administrator. When writing, be sure to include all identifying information, including your Empire identification number, suffix, group number, and claim number.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan may have the right to recover payments it makes on your behalf from a party responsible for compensating you for your illnesses or injuries, as permitted by applicable law. When a right to recovery exists, the following will apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery, as permitted by applicable law, in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, as permitted by applicable law, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.

- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery, as permitted by applicable law. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan, as permitted by applicable law.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, to the extent permitted by applicable law, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.
- The Plan is entitled to reimbursement from any Recovery, to the extent permitted by applicable law, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan, to the extent permitted by applicable law.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

REIMBURSEMENT FOR COVERED SERVICES

MAXIMUM ALLOWED AMOUNT

This section describes how Empire determines the amount of reimbursement for Covered Services. Providers who have entered into an agreement with Empire to participate in Empire's provider network or who have agreed to render services to covered persons under Your Plan are referred to in this Rider as Participating Providers. Providers who have not signed any contract with Empire and are not in any of our networks are referred to as Nonparticipating Providers.

Reimbursement for services rendered by Participating and Nonparticipating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the Blue Cross and Blue Shield Association BlueCard Program section/Rider for additional information regarding services received outside of Empire's service area.

The Maximum Allowed Amount is the maximum amount of reimbursement Empire will pay for services and supplies:

- that meet the definition of services and supplies that are covered under Your Plan and are not excluded ("Covered Services");
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, Medical Management Programs or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met any applicable Deductible, Copayment or Coinsurance. In addition, when you receive Covered Services from a Nonparticipating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, Empire will, to the extent applicable, apply claim processing and reimbursement rules to the claim submitted for those Covered Services. These rules evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Empire's application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim submitted was inconsistent with procedure coding rules and/or our reimbursement policies.

For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Provider or other healthcare professional, Empire may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Nonparticipating Provider.

For Covered Services performed by a Participating Provider, the Maximum Allowed Amount is the rate the Provider has agreed with Empire to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for that service, they are prohibited by contract from sending you a bill, or otherwise attempting to collect amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent that you have not met your Deductible, or have a Copayment, Coinsurance, or other form of cost share under the terms of Your Plan. Please call Customer Service for help in finding a Participating Provider or visit www.empireblue.com.

For Covered Services that you receive from a Nonparticipating Provider, the Maximum Allowed Amount will be based on our Nonparticipating Provider fee schedule/rate or the Provider's charge, whichever is less. Empire's Out-of-Network Provider fee schedule/rate may be accessed by calling the Customer Service number on the back of your identification card. The Maximum Allowed Amount on our Nonparticipating fee schedule/rate has been developed by reference to one or more of several sources, including the following:

1. Amounts based on our Participating Provider fee schedule/rate;
2. Amounts based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually;
3. Amounts based on charge, cost reimbursement or utilization data;
4. Amounts based on information provided by a third party vendor, which may reflect one or more of the following factors: i) the complexity or severity of treatment; ii) level of skill and experience required for the treatment; or iii) comparable Providers' fees and costs to deliver care; or
5. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.

Providers who are not contracted for this Plan, but contracted for other Plans with Empire, are also considered Nonparticipating. The Maximum Allowed Amount reimbursement for services from these Providers will be based on Empire's Nonparticipating Provider fee schedule/rate as described above unless the contract between Empire and that Provider specifies a different amount.

Unlike Participating Providers, Nonparticipating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding Participating Providers or visit our website at www.empireblue.com.

Customer Service is also available to assist you in determining the Maximum Allowed Amount for a particular service from a Nonparticipating Provider. In order for Empire to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

Member Cost Share

For certain Covered Services and depending on Your Plan, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment and/or Coinsurance).

Your cost share amount and out-of-pocket maximums may vary depending on whether you received services from a Participating or a Nonparticipating Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Nonparticipating Providers. Please see the terms of this Certificate and the Schedule of Benefits for your cost share amounts and limitations, or call Customer Service to learn how Your Plan's benefits or cost share amounts may vary by the type of Provider you use.

Empire will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services regardless of whether such services are performed by a Participating Provider or a Nonparticipating Provider. Both services specifically excluded by the terms of Your Plan and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, your lifetime maximum, benefit caps, or day/visit limits. Note that no coverage is available for services provided by Nonparticipating Providers if Your Plan requires the services to be provided only by Participating Providers.

In some instances you may only be asked to pay the lower cost sharing amount that applies to Participating Provider services when you use a Nonparticipating Provider. For example, if you go to an Participating Hospital or Facility and receive Covered Services from a Nonparticipating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or Facility, to the extent you have coverage for those services, you will pay the cost share amounts that apply to Participating Providers for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Nonparticipating Provider's charge.

Authorized Services

In some circumstances, such as where there is no Participating Provider available for the Covered Service, We may authorize the cost share amounts that apply to Participating Provider services (such as Deductible, Copayment and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Nonparticipating Provider. In such circumstance, you must contact Empire in advance of obtaining the Covered Service. We will also authorize the cost share amounts that apply to Participating Provider services if you receive Emergency services from a Nonparticipating Provider. If we authorize Covered Services from a Nonparticipating Provider so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Nonparticipating Provider's charge. Please contact Customer Service for information or to request authorization.

TERMINATION, CONVERSION, AND CONTINUATION OF COVERAGE

Termination of Coverage

Your coverage may terminate for any of the following reasons:

- ◆ Empire terminates the contract
- ◆ Columbia University terminates the contract
- ◆ Columbia University fails to continue to meet our underwriting standards
- ◆ Columbia University fails to pay premiums
- ◆ you fail to pay premiums (if required)
- ◆ either you or your covered dependents no longer meet either Columbia University's or the contract's eligibility requirements
- ◆ you or your covered dependents have made a false statement on either an application for coverage or a health insurance claim form or have otherwise engaged in fraud

IMPORTANT INFORMATION

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

WHAT IS CONTINUATION COVERAGE?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. To be eligible, a qualified beneficiary must be enrolled in the plan on the day before the qualifying event. A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of the federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Columbia University Benefits or EBPA at 888-456-4576, of the birth or adoption.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including: open enrollment and special enrollment rights.

Notice of Qualifying Events:

Your plan will offer COBRA continuation coverage (generally, the same coverage that the qualified beneficiary had immediately before qualifying for coverage) to qualified beneficiaries only after your Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, your death, if your plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to Columbia University, or you becoming entitled to Medicare benefits (under Part A, Part B, or both, if applicable), Columbia University

must notify your Plan Administrator of the qualifying event.

For the other qualifying events, (your divorce or legal separation, or a dependent child's losing eligibility for coverage as a dependent child), you must notify your Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Columbia University Benefits at 212-851-7000 or EBPA at 888-456-4576.

HOW LONG WILL CONTINUATION COVERAGE LAST?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- Columbia University ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Columbia University Benefits or EBPA, of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

DISABILITY

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your plan administrator for additional information. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

To elect continuation coverage, you must complete the COBRA Continuation Coverage Election Form available from your Plan Administrator and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both Columbia University and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. Contact your Plan Administrator for additional information.

For employees eligible for trade adjustment assistance: The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

WHEN AND HOW MUST PAYMENT FOR COBRA CONTINUATION COVERAGE BE MADE?

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact your Plan Administrator or other party responsible for COBRA administration under the Plan to confirm the correct amount of your first payment.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the Election Notice. If you fail to make a periodic payment before the end of any applicable grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

FOR MORE INFORMATION

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from the Plan Administrator.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your Plan Sponsor or the Group Benefits Administrator responsible for COBRA administration for your group.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Under State Law

If you are not entitled to continuation of coverage under COBRA, you may be entitled to continue coverage under the New York State Insurance Law. These laws vary from those under COBRA, but generally also require continued coverage for up to 18, 29 or 36 months.

Call or write Columbia University or Empire to find out if you are entitled to temporary continuation of coverage under COBRA or under the New York State Insurance Law.

The Veterans Benefits Improvement Act of 2004

The Veterans Benefits Improvement Act of 2004, which amends the 1994 Uniformed Services Employment and Reemployment Rights Act (USERRA), extends the period for continuation of health care coverage as follows:

If a covered person's health plan coverage would terminate because of an absence due to military service, the person may elect to continue the health plan coverage for up to 24 months after the absence begins or for the period of service. Similar to COBRA, the person cannot be required to pay more than 102 percent (except where State requirements provide for a lesser amount) of the full premium for the coverage. If military service was for 30 or fewer days, the person cannot be required to pay more than the normal employee share of any premium.

Ending and Continuing Coverage

Columbia University reserves the right to amend or terminate its group health plan coverage provided to you at any time without prior notice or approval. The decision to end or amend the health plan coverage may be due to changes in federal or state laws governing welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason.

Certificates of Creditable Coverage after Termination

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a certificate of coverage must be issued to a Member and his or her covered Dependents who terminate from this Benefit Program. The information included on the Certificate of Creditable Coverage will include the names of any Members terminating, the date coverage under this Benefit Program ended, and the type of coverage provided under this Benefit Program. This Certificate of Creditable Coverage will provide a subsequent insurer or group Plan with information regarding previous coverage to assist it in determining any Pre-Existing Condition exclusion period or Affiliation Period. This Certificate of Creditable Coverage should be presented by the Member to his or her next Employer Group and/or when applying for subsequent group health insurance. A Certificate of Creditable Coverage will be issued to terminating Members within a reasonable amount of time after Empire has terminated membership. In addition, a terminated Member may request an additional copy of the Certificate of Creditable Coverage by contacting Member Services.

Medicare Eligible Members

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Deficit Reduction Act of 1984 (DEFRA), if your group employs 20 or more people, we will provide full benefits under this program when your group notifies us that you (as an active employee) or your spouse over age 65 or over, chooses the group's coverage as primary.

Under the Omnibus Budget Reconciliation Act of 1986 (OBRA), if your group employs 100 or more people, you (as an active employee) or your covered dependents who become entitled to Medicare disability may choose the group's coverage as primary by notifying us.

No matter what size your group, if you or your covered dependents are disabled due to end stage renal disease, this plan will be primary for 30 months. After that, Medicare will be primary, and you will no longer be covered by this plan. You may purchase Medicare Supplemental policy on a direct payment basis.

If you as an active employee or your spouse are not subject to TEFRA or OBRA (as described above) and are eligible for Medicare, you will receive the benefits described in this booklet. However, these benefits will be reduced by any benefits available under Medicare Supplemental, even if you have not enrolled in Medicare.

If you as an active employee over 65 or your spouse choose Medicare as primary coverage and if you are subject to TEFRA or OBRA, then group coverage will not continue. Instead, you may purchase a Medicare Supplemental policy on a direct payment basis through your local Blue Cross or Blue Shield Plan.

Disability and Continuation of Your Coverage

If you are totally disabled when coverage ends, coverage will continue for the disabled person only for expenses related to the injury or the illness which caused the total disability.

This coverage will continue as long as the covered person remains totally disabled, up to but not beyond December 31st of the calendar year in which coverage terminated.

Coverage will end before the above date if:

- you are no longer totally disabled, **or**
- you have received the maximum benefits of the contract, **or**
- you become eligible for total disability benefits under another group program, whichever comes first.

COMPLAINTS, APPEALS AND GRIEVANCES

An appeal is a request to review and change an adverse determination made when (i) Empire's Medical Management Program (MMP) or Mental and Behavioral Health Care Manager (MBHCM) determines a service is not Medically Necessary, or is excluded from coverage because it is considered Experimental or Investigational; or (ii) if we deny a claim, wholly or partly, for services already rendered, based on our utilization review process.

In the event that Empire renders an adverse determination without attempting to discuss such matter with the Covered Person's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the Covered Person's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, Empire shall provide notice as required pursuant to subsection 3 of this Section. Nothing in this Section shall preclude the Covered Person from initiating an appeal from an adverse determination.

Failure by Empire to make a determination within these described time periods shall be deemed to be an adverse determination subject to appeal rights pursuant to the standard and expedited appeal process of Section 4904 of the New York State Insurance law, described below

Standard Level 1 Appeals

The Covered Person (or the Covered Person's authorized representative, or health care provider) may file a formal appeal by telephone or in writing. An appeal must be filed within one hundred, eighty (180) calendar days from the date of receipt of notice of a denial of services. An appeal submitted beyond the one-hundred, eighty (180) day filing limit will not be accepted for review.

Empire will send written notice of acknowledgement of the appeal within fifteen (15) days of receipt of that appeal to the Covered Person or the Covered Person's authorized representative. The appeal will be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. A final determination will be made within the following timeframes after receiving all necessary information or medical records related to the appeal request:

- **Precertification.** We will complete our review of a precertification appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- **Concurrent.** We will complete our review of a concurrent appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- **Retrospective.** We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

Empire will provide a written notice of our determination to the Covered Person or the Covered Person's representative, and Provider within two (2) business days of reaching a decision. The decision will include the reason(s) for the determination, including the clinical rationale if the adverse determination is upheld, date of service, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will also specify what, if any, additional necessary information must be provided to or obtained by Empire in order to render a decision on appeal and an explanation of why the information is necessary. The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal.

If Empire does not make a decision within sixty (60) calendar days of receiving all necessary information to review your appeal, Empire will approve the service.

In addition, if the group is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Group members have certain rights and protections and the group may have duties as the Group Health Plan Administrator. Among them is the right to appeal a claim decision. Under ERISA, if we deny a claim, wholly or partly, the Covered Person may appeal our decision. The Covered Person will be given written notice of why the claim was denied, and of his right to appeal the decision. Then the Covered Person has 180 days to appeal our decision. The Covered Person (or his authorized representative) may submit a written request for review. The Covered Person may ask for a review of pertinent documents, and the Covered Person may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within sixty (60) days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed one-hundred, twenty (120) days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

Expedited Level 1 Appeals

Empire will speed up the appeal process (an “expedited appeal”) and deliver a rapid decision when the situation involves:

- i. Continuations or extensions of health care services, procedures or treatments already begun;
- ii. Additional required or provided care during an ongoing course of treatment; or
- iii. A case in which the Provider believes an expedited appeal is justified because delay in treatment would pose an imminent or serious threat to the Covered Person’s health or ability to regain maximum function, or would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

When requested under these circumstances, the following time frames will apply:

- Empire will provide the Covered Person or his Provider with reasonable access to our clinical reviewer within one (1) business day of receiving a request for an expedited appeal. The Provider and clinical peer reviewer may exchange information by telephone or fax.
- Empire will make a decision on an expedited appeal within the lesser of seventy-two (72) hours of receipt of the appeal request or two (2) business days following receipt of all necessary information about the case, but in any event within seventy-two (72) hours of receipt of the appeal.
- Empire will notify the Covered Person and his Provider immediately of the decision by telephone and will transmit a copy of the decision in writing within twenty-four (24) hours after the decision is made.
- If the Covered Person is not satisfied with the resolution of the expedited appeal, a further appeal may be made through the standard appeal process, as described in this subsection or through an external appeal agent if the appeal is based on Medical Necessity or Experimental or Investigational denials. The notice of appeal determination will include the time frame for external appeals as required by 4904 (C) (2) of the New York State Insurance Law.
- If Empire does not make a decision within two (2) business days of receiving all necessary information to review the Covered Person’s appeal, Empire will approve the service.

Standard Level 2 Appeals

If the Covered Person is dissatisfied with the outcome of the Level 1 Appeal, a Level 2 Appeal may be filed with Empire within sixty (60) business days from the receipt of the notice of the letter denying the Level 1 Appeal. If the appeal is not submitted within that timeframe, we will not review it and our decision on the Level 1 appeal will stand. Appeals may be filed by telephone or in writing.

We will make a decision within the following timeframes for Level 2 Appeals:

- Precertification. We will complete our review of a precertification appeal within 15 calendar days of receipt of the appeal.
- Concurrent. We will complete our review of a concurrent appeal within 15 calendar days of receipt of the appeal.
- Retrospective. We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

How to Request an Appeal

To submit an appeal, call Member Services at 1-800-342-9816, or write to the applicable address (es) listed below. Please submit any data to support your request and include your member identification number and if applicable, claim number and date of service.

Empire Appeal and Grievance Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Empire Behavioral Health Services
370 Bassett Road
Building 4, Floor 2
North Haven, CT 06473

External Review

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review. For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem National Accounts
ATTN: Appeals, P.O. Box 5073
Middletown, NY 10940 – 9073

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Complaints

A complaint is a verbal or written statement of dissatisfaction where Empire is not being asked to review and overturn a previous determination. For example: You feel you waited too long for an answer to your letter to Empire. If you have a complaint about any of the health care services your Plan offers, plan procedures or our customer service, call Member Services. Member Services may ask you to put your complaint in writing if it is too complex to handle over the telephone.

Empire Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Empire Behavioral Health Services
370 Bassett Road
Building 4, Floor 2
North Haven, CT 06473

We will resolve complaints within the following time frames:

- *Standard complaints.* Within 30 days of receiving all necessary information.
- *Expedited complaints.* Within 72 hours of receiving all necessary information.

Level 1 Grievance

A grievance is a verbal or written request for a review of an adverse determination concerning an administrative decision not related to medical necessity.

A Level 1 Grievance is your first request for review of Empire's administrative decision. You have one-hundred, eighty (180) calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the one-hundred, eighty (180) calendar day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge your grievance in writing within fifteen (15) calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance, and a description of any additional information required to complete the review.

We will make a decision within the following timeframes for 1st Level Grievances:

- *Pre-service (services have not yet been rendered).* We will complete our review of a pre-service grievance (other than an expedited grievance) within fifteen (15) calendar days of receipt of the grievance.
- *Post-service (services have already been rendered).* We will complete our review of a post-service grievance within thirty (30) calendar days of receipt of the grievance.

Level 2 Grievances

If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire. Empire must receive your request for a Level 2 Grievance by the end of the sixtieth (60th) business day after you receive our notice of determination on your Level 1 Grievance. If the Level 2 Grievance is not submitted within that timeframe, we will not review it and the decision on the Level 1 Grievance will stand. We will acknowledge receipt of the 2nd Level Grievance within fifteen (15) days of receiving the grievance. The written acknowledgement will include the name, address and telephone numbers of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance.

We will make a decision within the following timeframes for 2nd Level Grievances:

- *Pre-service.* We will complete our review of a pre-service grievance within fifteen (15) calendar days of receipt of the grievance.
- *Post-service.* We will complete our review of a post-service grievance within thirty (30) calendar days of receipt of the grievance.

Expedited Grievances

You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum timeframes:

- Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within seventy-two (72) hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two (2) business days in writing.

Decision on Grievances

Empire's notice of its Grievance decision (whether standard or urgent) will include:

- The reason for Empire's decision, or a written statement that insufficient information was presented or available to reach a determination
- The clinical rationale, if appropriate, and
- For Level 1 Grievances, instructions on how to file a Level 2 Grievance if you are not satisfied with the decision.

How to File a Grievance

To submit an appeal or grievance, call Member Services at the telephone number located on the back of your ID card, or write to the following address with the reason why you believe our decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

Empire Appeal and Grievance Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Empire Behavioral Health Services
370 Bassett Road
Building 4, Floor 2
North Haven, CT 06473

How You Can Participate in Policy Development

We welcome your input on policies that we have developed or you would like us to initiate. If you wish to share any ideas with us, we encourage you to write to us at:

Empire Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

We will forward your ideas to the department responsible for developing the type of policy involved, and your suggestions will be reviewed and considered. You will then receive a response to your comments. In addition, we review member complaints, member satisfaction information, new technology, and new procedures to determine if changes should be made to your benefits.

Provider Quality Assurance

Because your health care is so important, Empire has a Quality Assurance Program designed to ensure that our network providers meet our high standards for care. Through this program, we continually evaluate our network providers.

If you have a complaint about a network provider's procedures or treatment decisions, share your concerns directly with your provider. If you are still not satisfied, you can submit a complaint at the above address. Empire will refer complaints about the clinical quality of the care you receive to the appropriate clinical staff member to investigate.

We also encourage you to send suggestions to Member Services for improving our policies and procedures. If you have any recommendations on improving our policies and procedures, please send them to the Member Services address above.

STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA)

If your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have certain rights and protections under ERISA. Under ERISA you are entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report filed by the plan with the U.S. Department of Labor or Internal Revenue Service.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each covered member with a copy of this summary annual report.

Duties of the Plan Fiduciaries

In addition to creating certain rights for covered members, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called plan "fiduciaries," have a duty to do so prudently and in the interest of you and other covered members. Your employment cannot be terminated, nor can you be discriminated against in any way, to prevent you from obtaining your benefits or exercising your rights under ERISA.

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a covered member of the plan.

- Under ERISA, you have the right to have your Plan Administrator review and reconsider your claim. If we deny a claim, wholly or partly, you may appeal our decision. You will be given written notice of why the claim was denied, and of your right to appeal the decision. You have 180 days to appeal our decision. You, or your authorized representative, may submit a written request for review. You have the right to obtain copies of documents relating to the decision without charge. You may ask for a review of pertinent documents, and you may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within 60 days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing, containing specific reasons for the decision. If your claim for benefits is ignored or denied, in whole or in part, you may file suit in a state or federal court. A lawsuit for benefits denied under this coverage can be filed no earlier than 60 days after the claim was filed, and no later than two years from the date that the services were received. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- If you submit a written request for copies of any plan documents or other plan information to which you are entitled under ERISA and you do not receive them within 30 days, you may bring a civil action in a federal court. The court may require the Plan Administrator to pay up to \$110 for each day's delay until you receive the materials. This provision does not apply, however, if the materials were not sent to you for reasons beyond the control of the Plan Administrator.
- In the unlikely event that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. But if you lose, because, for example, the case is considered frivolous, you may have to pay all costs and fees.

If you have any questions about your plan, contact your Plan Administrator or Member Services at 1-800-342-9816.

If you have any questions about your rights under ERISA, contact the regional office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor

U.S. Department of Labor
Employee Benefits Security Administration (EBSA)
Director, New York Regional Office
33 Whitehall Street
New York, NY 10004
Telephone: 1-212-607-8600
Fax: 1-212-607-8681
Toll-Free 1-866-444-3272

Access to Information

In addition to calling Member Services for claim and benefit information, you can contact them for:

- The names, business addresses and official positions of Empire's Board of Directors, officers, controlling persons, owners and partners
- Empire's most recently published annual financial statement
- A consumer report of grievances filed with the Insurance Superintendent
- Procedures that protect confidentiality of medical records and information
- A copy of Empire's Drug Formulary
- A directory of participating providers
- A description of our quality assurance program
- A notice of specific individual provider affiliations with participating hospitals
- Upon written request, specific written clinical criteria for determining if a procedure or test is medically necessary

YOUR RIGHTS AND RESPONSIBILITIES

We are committed to:

- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- The member has the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms that the member can be reasonably expected to understand. When it is not advisable to give such information to the member, the information will be made available to an appropriate person acting on the member's behalf.

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 Retiree Medical and Life Insurance Benefits 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

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

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 Retiree Medical and Life Insurance Benefits Plan

Plan Sponsor and Administrator

Columbia University is the Plan Sponsor and Plan Administrator of the Columbia University Retiree Medical and Life Insurance Benefits 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 517

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 is Empire BlueCross Blue Shield
PO Box 1407, Church Street Station,
New York, New York 10008-1407
Attn: Member Services
1-800-342-9816

The cost of this Empire Plan is paid for by the University.

The Plan year is calendar and ends on 6/30.

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 Empire Blue Cross Blue Shield, 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 Empire Blue Cross Blue Shield 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 Retiree Medical and Life Insurance Benefits Plan
Plan Number:	517
Employer ID:	13-5598093
Plan Type:	Welfare Benefits Plan
Plan Year:	Fiscal, June 30
Plan Administration:	Self-Insured
Source of Plan Contributions:	The University
Source of Benefits:	Assets of the University

ADDENDUM I: BLUECARD PROGRAM

The BlueCard Program helps reduce your costs when you obtain care outside of the geographic area served by Empire from a provider who participates with another Blue Cross and/or Blue Shield Plan (“local Blue Plan”). Just show your Empire BlueCross BlueShield ID card to a participating provider and comply with the other terms in the certificate of coverage when receiving these services.

When you obtain health care through the BlueCard Program, the portion of your claim that you are responsible for (“member liability”) is, in most instances, based on the **lower** of the following:

- the billed amount that the participating provider actually charges for covered services, or
- the negotiated price that the local Blue Plan passes on to Empire.

The negotiated price may reflect:

- a simple discount from the provider’s usual charges, which is the amount that would be reimbursed by the local Blue Plan;
- an estimated price that has been adjusted to reflect expected settlements, withholds, contingent payment arrangements and any non-claim transactions with the provider; or
- the provider’s billed charges adjusted to reflect average expected savings that the local Blue Plan passes on to Empire. If the negotiated price reflects average savings, it may vary (more or less) from the actual price than it would if it reflected the estimated price.

Plans using the estimated price or average savings methods may adjust their prices in the future to ensure appropriate pricing. However, the amount you pay is considered the final price.

A small number of states have laws that require that your member liability be calculated based on a method that does not reflect all savings realized, or expected to be realized, by the local Blue Plan on your claim, or that requires that a surcharge be added to your member liability. If you receive covered health care services in any of these states, member liability will be calculated using the state’s statutory methods that are in effect at the time you receive care.

If you have any questions about the BlueCard Program, contact Member Services.