Columbia University in the City of New York
Prescription Drug for Officers and Support Staff
Express Scripts

Effective: January 1, 2014

January 2014
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Introduction

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

- Who is eligible
- Services that are covered, called Covered Health Services
- Services that are not covered, called Exclusions
- How benefits are paid
- Your rights and responsibilities under the Medical Plan

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

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

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

How To Use This SPD

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

Overview of the Prescription Plan

Columbia University in the City of New York offers choices of medical plans so that you can select the option that best meets the needs of you and your family. The prescription plan is automatically provided to you when you elect any one of the medical plans at Columbia University.

What the Plans Cover

All the healthcare plans (medical and prescription) cover medically necessary health care services provided for the purpose of preventing, diagnosing or treating an acute Sickness, Injury, mental disorder, substance use disorder or symptoms.

Only eligible preventive care services that follow age and gender guidelines are covered. Tally plan coverage is subject to conditions, limits and exceptions explained in the sections, “Covered Services” and “Exclusions”. Columbia University in the City of New York and Express Scripts administer the prescription drug benefit plan and assume no responsibility for the outcome of any covered prescription.
The Plans described in the following pages of this booklet are a benefit plan provided by Columbia University in the City of New York. These benefits are not insured with Express Script is or any of their affiliates but are paid from Columbia University in the City of New York funds. Express Scripts provides certain administrative services under the Plan including claim determination, application of Copays, and limitations.

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

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

- Ordered by a licensed Physician
- Supported by national medical standards of practice and is consistent with conclusions of prevailing medical research (based on well-conducted, randomized, controlled trials or well-conducted cohort studies)
- Consistent with the diagnosis of the condition
- Required for reasons other than the convenience of the patient or his/her Physician
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the selected Claims Administrator
- Other than experimental or educational in nature

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

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

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

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

Pre-Existing Conditions
There are no pre-existing condition limits under the Columbia University in the City of New York Group Benefits Plan.

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

Financial Penalty If You Do Not Get Preauthorization
With all plans, you must obtain preauthorization before receiving certain products; otherwise, your benefits will be significantly reduced. Note that each health plan may call this process something different including “pre-certification”, or “prior authorization.” If you do not obtain preauthorization as required, the Plan will significantly reduce payment for all expenses related to the condition, and your additional cost will not count toward your Out-of-Pocket Maximum. Become familiar with the specific services that require preauthorization. If you have questions, call your Express Scripts member services (phone number is located on back of your member ID card).

Overview of the Prescription Plan
You are automatically enrolled in the Express Scripts Prescription Plan when you elect medical coverage from Columbia University. Express Scripts has over 64,000 retail participating pharmacies. When you use a participating pharmacy, you’ll save money and avoid filing a claim form since reimbursement is processed electronically.

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

Non-Participating Pharmacy
The prescription plan allows you the flexibility to use non-participating pharmacies—at any time. However, your cost toward your healthcare expenses is significantly higher because there are no negotiated fees. In addition, the plan limits the amounts they will pay for any product obtained outside the network. Your claim reimbursement will be based on the 190% of the Medicare Maximum Allowable Charge. You are responsible for paying the full amount of any changes that exceed this limit.

In addition, you must file claim forms with Express Scripts for each product and wait for reimbursement.
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Medicaid</th>
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<tbody>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Medicaid Phone (In state): 1-800-866-3513</td>
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<td>Medicaid Phone (Out of state): 1-800-221-3943</td>
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<tr>
<td>ALASKA – Medicaid</td>
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<tr>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></td>
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<tr>
<td>State</td>
<td>Program</td>
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<td>IDAHO – Medicaid and CHIP</td>
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<td>INDIANA – Medicaid</td>
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<td>NEBRASKA – Medicaid</td>
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<td>IOWA – Medicaid</td>
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<td>NEVADA – Medicaid</td>
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<td>KENTUCKY – Medicaid</td>
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<td>State</td>
<td>Medicaid/CHIP Information</td>
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<td>LOUISIANA</td>
<td>Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a> Phone: 1-888-695-2447</td>
</tr>
<tr>
<td>NEW JERSEY</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710</td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td>Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Phone: 1-800-462-1120</td>
</tr>
<tr>
<td>NEW YORK</td>
<td>Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> Phone: 1-800-541-2831</td>
</tr>
<tr>
<td>MINNESOTA</td>
<td>Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a> Click on Health Care, then Medical Assistance Phone: 1-800-657-3629</td>
</tr>
<tr>
<td>NORTH CAROLINA</td>
<td>Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a> Phone: 919-855-4100</td>
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<tr>
<td>MISSOURI</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005</td>
</tr>
<tr>
<td>NORTH DAKOTA</td>
<td>Website: <a href="http://www.nd.gov/dhs/services/medicaidservice/medicaid/">http://www.nd.gov/dhs/services/medicaidservice/medicaid/</a> Phone: 1-800-755-2604</td>
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<tr>
<td>OKLAHOMA</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742</td>
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<tr>
<td>OREGON</td>
<td>Website: <a href="http://www.ahcccaa.org">http://www.ahcccaa.org</a> Phone: 603-271-5218</td>
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<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
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<tr>
<td>Oregon</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.oregonhealthykids.gov">www.oregonhealthykids.gov</a></td>
<td>1-800-699-9075</td>
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<tr>
<td></td>
<td></td>
<td><a href="http://www.hijossaludablesoregon.gov">www.hijossaludablesoregon.gov</a></td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Medicaid</td>
<td><a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Medicaid</td>
<td><a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a></td>
<td>401-462-5300</td>
</tr>
<tr>
<td>Washington</td>
<td>Medicaid</td>
<td><a href="http://hrsa.dshs.wa.gov/premiumytm/Apply.shtm">http://hrsa.dshs.wa.gov/premiumytm/Apply.shtm</a></td>
<td>1-800-562-3022</td>
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<td></td>
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<td>ext. 15473</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Medicaid</td>
<td><a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
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<tr>
<td></td>
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<td></td>
<td>HMS Third Party Liability</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Medicaid</td>
<td><a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>1-888-828-0059</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Medicaid</td>
<td><a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a></td>
<td>1-800-362-3002</td>
</tr>
<tr>
<td>Texas</td>
<td>Medicaid</td>
<td><a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a></td>
<td>1-800-440-0493</td>
</tr>
</tbody>
</table>
To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
www.cms.hhs.gov  
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

Your Privacy Rights

Health Insurance Portability & Accountability Act (HIPAA)

Notice of Privacy Practices For Protected Health Information

With the growth of information technology, the protection of private medical information has become a national concern. Congress addressed these concerns with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), whose privacy provisions, applicable to all health plans providers, went into effect on April 14, 2003.

Disclosure Limitations

The Federal Health insurance Portability and Accountability Act and related privacy rules requires Columbia University in The City of New York to keep your health information private. The Columbia University Health Plan – which includes Aetna HDHP and its HSA, Aetna POS, Cigna OAP, Cigna POS, United Healthcare POS, Cigna International, Express Scripts Rx, the Aetna Columbia Dental Plan, and the Healthcare Flexible Spending Account – has always maintained the strictest privacy and confidentiality standards in the use and handling of your health insurance information.

Under HIPAA, health plan providers and designated Columbia University Human Resources employees can only disclose your protected health information for a limited number of purposes:

- To make or obtain payments
- To conduct healthcare operations
- To recommend treatment alternatives
- To provide information about health related benefits and services
- To communicate with an individual – that is, a friend or family member – involved in your care or the payment for your care (if authorized by you)
- To comply with a federal, state or local requirement
- To comply with a court order or administrative proceeding
- To conduct health oversight activities
- To counter serious threats to your health or safety
- For law-enforcement purposes
- For specified government functions
• For worker’s compensation
• To disclose your information to you
• To third party non- Columbia business associates that perform services for us or on our behalf, such as vendors
• To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law
• To use or disclose your private health information to assist entities engaged in the procurement, or transplantation of cadaver organs, eyes, or tissue

Otherwise, neither the health plan providers nor Columbia University Human Resources can disclose information about your or your dependents’ health insurance, dental insurance, prescription drug coverage, healthcare FSA, HSA or medical plan enrollment with anyone other than the covered individual. This includes:

• Other offices of the University, as well as employees in Columbia Human Resources not involved in health plan administration
• Spouses or other family members not directly involved in your care or the payment for your care (unless authorized by you)

Your rights regarding your health information include:

• The right to request restrictions beyond those outlined above
• The right to receive confidential communications (for example) at only a specified phone number or email address
• The right to inspect and copy your private health information
• The right to be notified in the event the plan(or a business associate) discovered a breach of unsecured protected health information
• The right to prohibit the use of genetic information for underwriting purposes, except for underwriting for long term care policies

The right to a paper copy of the Notice of Columbia University Health Plan’s Privacy Practices, sent to all Columbia employees on April 14, 2003, distributed to all subsequent new hires, and available on the web at www.hr.columbia.edu/benefits.

Privacy Officer
To exercise your HIPAA rights under Columbia Health plans, please contact Columbia’s designated Privacy Officer at:

Privacy Officer
Columbia Benefits
Studebaker 4th Floor, MC 8705
615 West 131st Street
New York, NY 10027
Email: hrprivoff@columbia.edu
Secure Fax: 212-851-7025
Or

The Federal Secretary of the Department of Health and Human Services
Hubert H. Humphrey Building SW
200 Independence Avenue
Washington, DC 20201

Authorization Forms

For HIPAA authorization forms, please visit the HR website at www.hr.columbia.edu/forms-docs/forms.

If You Have Questions

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 nearest Regional or District Office of 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 Office are available through EBSA’s website.)

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

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

The special enrollment events include:

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

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

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

- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee’s or Dependent’s other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases:
  - due to failure of the employer or other responsible entity to remit premiums on a timely basis;
  - when the person no longer resides or works in the other plan’s service area and there is no other COBRA or continuation coverage available under the plan; or
  - when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual.
  This does not include termination of an employer’s limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

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

Individuals who enroll in the Plan due to a special enrollment event will not be denied enrollment. You will not be enrolled in this plan if you do not enroll within 31 days of the date you become eligible, unless you are eligible for special enrollment.

**Your ERISA Rights**

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

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

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

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

**Women’s Health and Cancer Rights Act (WHCRA)**

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

**Obtaining a Certificate of Creditable Coverage**

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will automatically be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, call the toll-free customer service number on the back of your ID card.

**Creditable Coverage Disclosure Notice**

**Medicare Prescription Drug Coverage for Active Employees over Age 65 and Medicare-Eligible Retirees (or Covered Medicare-Eligible Dependents) of Columbia University**

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

What this Means to You as an Employee or Retiree of Columbia University

As an employee or retiree of Columbia University (or covered dependent) eligible for Medicare, you should keep the following points in mind as you consider whether to enroll in a Medicare Prescription Drug Plan.

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

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

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

Should You Have Columbia University Prescription Drug Coverage and Medicare Prescription Drug Coverage?

In most circumstances, there is no advantage to doubling-up on coverage. If you join a Medicare Prescription Drug Plan, you continue to receive your medical and prescription benefits through Columbia University. However, the amount you pay you pay for your Columbia University coverage, where applicable, will not be reduced, and you may pay a separate premium for Medicare prescription drug coverage. Since your benefits under the active Columbia plan will be primary, it is unlikely you will receive much benefit, if any, from Medicare. In addition, your benefits under the Columbia University retiree medical plan will be secondary to Medicare, and your Columbia University Medical Plan prescription drug benefits will be reduced by benefits paid under the Medicare Prescription Drug Plan.

When Can You Join a Medicare Prescription Drug Coverage Plan?

You can join a Medicare Prescription Drug Plan when you first become eligible for Medicare and each year from October 15-December 7. You may also enroll when you first become Medicare eligible, or after separating employment with the University if you are age 65 or older.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you also will be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.
What Happens If You Terminate Your Columbia University Health Coverage or Employment

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

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

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

For More Information About Medicare’s Prescription Drug Coverage:

- Visit www.medicare.gov for personalized help
- Call 800-MEDICARE (800-633-4227; TTY users should call 877-486-2048)

Remember: Please keep this Credible Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Statement of the University’s Rights

This document is not a contract or agreement for employment. Employment with Columbia University in the City of New York 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 in the City of New York 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 in the City of New York 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 in
the City of New York Group Benefits 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 in the City of New York 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.

Your Relationship with Pharmacies
The relationship between you and any Pharmacy is that of Provider and patient. Your Pharmacy is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own Pharmacy;
- are responsible for paying, directly to your Pharmacy, any amount identified as a member responsibility, including Copayments, and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your Pharmacy, the cost of any non-Covered Health Service;
- must decide if any Pharmacy treating you is right for you (this includes Participating Pharmacies you choose and Pharmacies to whom you have been referred); and
- must decide with your Provider what care you should receive.

Interpretation of Benefits
Columbia University in the City of New York and Express Scripts have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Columbia University in the City of New York has delegated the claim fiduciary responsibilities of the plan to Express Scripts.

Information and Records
Columbia University in the City of New York and Express Scripts may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Columbia University in the City of New York and Express Scripts may request additional information from you to decide your claim for Benefits. Columbia University in the City of New York and Express Scripts Express Scripts will keep this information confidential. Columbia University in the City of New York and the Claims Administrator may also use your de-identified data for commercial purposes, including research, as permitted by law.
By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Columbia University in the City of New York and Express Scripts Express Scripts with all information or copies of records relating to the services provided to you. Columbia University in the City of New York and Express Scripts Express Scripts have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee’s enrollment form. Columbia University in the City of New York and Express Scripts Express Scripts agree that such information and records will be considered confidential.

Columbia University in the City of New York and Express Scripts have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Columbia University in the City of New York is required to do by law or regulation. During and after the term of the Plan, Columbia University in the City of New York and Express Scripts and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Columbia University in the City of New York recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from Express Scripts, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Columbia University in the City of New York and Express Scripts will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

**Incentives to You**

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Columbia University in the City of New York recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

**Worker’s Compensation Not Affected**

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers’ compensation insurance.

**Future of the Plan**

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company’s decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.
If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

**Plan Document**

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. Copies of these documents, as well as the latest summary annual reports of Plan operations and Plan descriptions as filed with the Internal Revenue Service and the U.S. Department of Labor, are available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of these documents by written request to the Plan Administrator, for a nominal charge.

**Plan Information**

The name of the Plan is:
Columbia University in the City of New York Group Benefits Plan

**Plan Names**

**Prescription Drug Plan – Express Scripts Plan Sponsor and Administrator**

Columbia University in the City of New York is the Plan Sponsor and Plan Administrator of the Columbia University Group Benefits Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Group Benefits Plan
Columbia University in the City of New York
Studebaker Bldg., MC 8703
615 West 131st Street
New York, NY 10027
(212) 851-7000

**Employer Identification Number (EIN):** 13-5598093

**Plan Identification Number:** 515

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

The office designated to consider the appeal of denied claims is:
The Claim Office of Express Scripts. ). The phone number is listed on your member Identification card.

The cost of the Plan is shared by the Employee and Employer.
The Plan year is calendar and ends on 12/31.

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

Plan Type
The plan is intended to be an “employee welfare benefit plan” within the meaning of ERISA Section 3(1).

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

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

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

Agent for Legal Process – Group Benefits Plan
Columbia University in the City of New York
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 Group Benefits Plan
Eligibility for Benefit Coverage

Officers and Support Staff
If you are a full-time active Columbia University Officer, you and your family are eligible for medical coverage under the Columbia University in the City of New York Medical and Prescription Plan.

If you are a full-time or part time (with scheduled hours greater than or equal to 20 hours per week) Support Staff employee (except for members of Local 1199, Local 32B-32J, Local 100, MEBA and MM&P), you and your family are eligible for the Columbia University Medical and Prescription Plan.

Benefits for Part-Time Officers of Administration
As a regular part-time Officer of Administration, you are eligible to participate in the Columbia University in the City of New York Medical and Prescription Plan, provided you meet the following requirements:

- You are a regular Officer of Administration
- Your scheduled work week must be at least 20 hours per week but less than 35 hours per week
- You are a Grade 10 position or higher at Morningside, Lamont or Nevis
- You are a Grade 103 or higher at Columbia University Medical Center

Regular part-time positions are those without a planned employment end date.

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

When Your Benefits Start

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

Support Staff
You are eligible for Benefits the first day of the month following completion of the applicable waiting period as defined by your collective bargaining agreement. In order for your Benefits to be effective on your earliest enrollment date, you must enroll within 31 days of your hire. You must select the coverage...
you want and whom you want to cover. If you do not enroll within 31 days of your date of hire, you will not have any group health plan coverage for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period held annually in the fall. The benefit choices you make at that time take effect the following January. See the section, How To Enroll.

Exception for Newborns
Any Dependent child born while you are covered under one of the Columbia University in the City of New York health plans (Aetna, CIGNA, UHC) will automatically be covered on the date of his or her birth for a period of 31 days. However, **you must enroll your newborn in your coverage no later than 31 days after the birth.** Go to the CU Benefits Enrollment System at [www.hr.columbia.edu/benefits](http://www.hr.columbia.edu/benefits) to report the birth; if you need assistance, call the Columbia Benefits Service Center at 212-851-7000. If you do not elect to cover your newborn child within 31 days, coverage for that child will end on the 31st day. No Benefits for expenses incurred beyond the 31st day will be payable.

**Your Eligible Dependents**
You can also elect to cover your Dependents. Your eligible Dependents include your:

- Legal Spouse
- Same-sex Domestic Partner or civil union partner, provided your partner is:
  - Is at least 18 years old
  - Is not related to you by blood
  - Is not legally married to another person
  - In the case of a civil union partnership, is entered into a certified civil union under applicable state law that recognizes a relationship between people of the same gender or treats a relationship between people of the same gender as marriage
  
  **And** meets two or more of the following requirements:

  - Shares the same principal residence with you full-time and for the past 12 continuous months
  - Shares financial responsibilities with you, such as co-ownership of property, joint financial accounts, etc.
  - Has power of attorney for medical purposes
- Legally dependent children, including adopted children, foster children and stepchildren of your Spouse or same-sex Domestic Partner, provided that you declare the child(ren) as dependents on your federal income tax return.
- Dependent children in the active Medical and Prescription Plans are covered:
  - Until the end of the month in which they turn 26;
  - If a court has appointed you legal guardian (for any child from birth to 26);

  Dependent children in the retiree Medical and Prescription Plans are covered:

  - Until the end of the calendar year in which they turn 19;
  - Over the age of 19 as long as they remain full-time students. Note coverage ends at the end of the month in which they cease to be a full-time student (e.g. Graduate) or the end of the calendar year in which they turn age 26, whichever is earlier

  And for all active and retiree plans:

  - At any age if they have a mental or physical disability provided he/she is incapable of self-sustaining employment and who chiefly depends upon you for support. You must either apply for continued coverage when you are initially eligible for Benefits or prior to the end of the Plan
month in which the Dependent turns age 26. Approval by your medical insurance carrier (Aetna, CIGNA, or UHC) is required. See How to Continue Coverage for a Disabled Child, below.

Eligible Dependent children do not include:

- a dependent who is employed by the University; or
- injuries occurring during military service.

**How to Continue Coverage for a Disabled Child**

Coverage for an unmarried mentally or physically disabled child who is not capable of self-sustaining employment and who depends chiefly upon you for support and maintenance may continue coverage beyond age 26:

- If you’re an eligible Employee when your child meets this definition, you must apply for continued coverage before the end of the month in which he or she turns age 26.
- If you’re a newly eligible Employee and your disabled child is older than age 26 when you are electing coverage, you may apply to cover your child when your coverage begins.

To cover a disabled child who is over age 26, you must complete and submit the required form(s) to your medical plan carrier—UHC. Forms are available from the Columbia Benefits Service Center at 212-851-7000.

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

**Who is Not Eligible for the Plan**

The term “employee” in this document does not include:

- Officers whose appointments are incidental to their educational program at the University
- Officers who are classified as non-benefited or casual employees in accordance with University personnel policies and procedures
- Officers whose terms of employment are subject to a collective bargaining agreement unless the agreement specifically provides for their participation in the Medical Plan
- Any individual who has entered into an oral or written agreement with the University whereby such individual acknowledges his or her status as an independent contractor and that he or she is not entitled to participate in the University’s employee benefit plans, notwithstanding that such person is later determined by a court of competent jurisdiction or the Internal Revenue Service (IRS) to be a common law employee for tax purposes.
- Any individual who is performing services for the University under a leasing arrangement entered into between the University and some other person, notwithstanding the fact that he or she is later determined by a court of competent jurisdiction or the IRS to be a common law employee or a leased employee.
- An employee who is a non-resident alien who received no earned income from the University that constitutes income from sources within the United States (as defined by the IRS).
- Temporary employees.

**You Are Responsible for Covering Only Eligible Dependents**

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

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

Report Changes in Dependent Eligibility
When a dependent is no longer eligible, it is your responsibility to report any changes in the status of your dependents within 31 days of the change. Examples of changes include, but are not limited to, divorce, child reaching the limiting age under the Plan, etc. Go to the CU Benefits Enrollment System at www.hr.columbia.edu/benefits and update any changes in the status of your Dependents online. If you need assistance, call the Columbia Benefits Service Center at 212-851-7000.

Proof of Eligibility
Columbia University in the City of New York has a responsibility to ensure that only Eligible Expenses are paid from the benefit Plans. This is a requirement of the Internal Revenue Service (IRS) regulations that govern qualified benefit plans.

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

You Choose Who to Cover Under Your Benefits
You must select from one of the following coverage options to ensure your dependents have medical and dental Benefits:

- Yourself and your legal Spouse or yourself and your same-sex Domestic Partner
- Yourself and a child or children
- Family

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

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

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

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

- The order recognizes or creates a child’s right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child’s name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child’s mailing address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

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

Payment of Benefits

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

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

If you and your Spouse or same-sex Domestic Partner work for the University and are eligible for medical coverage, you may choose your coverage in either of the following ways:

- One Spouse or same-sex Domestic Partner makes the medical choice for the entire family, including eligible Dependent children, if any. In this case, the other Spouse or same-sex Domestic Partner must select “No Coverage.”
- Each spouse or same-sex Domestic Partner can make his or her own medical choice. In this case, all eligible Dependent children must be covered by employee or the other Spouse or same-sex Domestic Partner.

Enrollment

How to Enroll

Newly Eligible Employee

*If you are newly hired, you must enroll for benefits within 31 days of your date of hire.* If you do not make your benefit elections during your first 31 days of employment, you and any eligible dependents will
You will be notified of your benefits on-line enrollment opportunity via email. If you do not receive this notice within 3 weeks of your date of hire, please contact the Columbia Benefits Service Center at 212-851-7000.

**Annual Enrollment Opportunities**

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

**Making Changes to Your Benefits During the Year**

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

Examples of a qualified life status change include:

- Marriage, divorce
- Beginning or end of a same-sex Domestic Partnership
- Birth, adoption, or placement for adoption
- Death of a Dependent
- Dependent loses eligibility for coverage (child reaches maximum age, spouse/domestic partner loses non-University coverage from their employer)
- Change in home address that changes your provider Network access
- A permanent change in the way you commute to work (applies to the Transit/Parking program)
- Spouse or eligible Dependent called to military duty in the United States armed forces.
- Job promotions and/or transfers that change the benefit offerings within job grade and/or bargained benefits.

If you experience a qualified life status change, you must report it within 31 days of the event on the CU Benefits Enrollment System at [www.hr.columbia.edu/benefits](http://www.hr.columbia.edu/benefits). If you need assistance, call the Columbia Benefits Service Center at 212-851-7000. You may be required to provide proof (e.g., marriage certificate, birth certificate) in order to make changes to your benefit selections. Your benefit changes must be consistent with the nature of your qualified life status change.

**Adding Your Newborn Child**

For a newborn’s Hospital and medical expenses to be eligible for reimbursement, you must add your child by reporting a qualified life status change online through the CU Benefits enrollment system at [www.hr.columbia.edu/benefits](http://www.hr.columbia.edu/benefits) within 31 days of the child’s birth. If you need assistance, please contact the Columbia Benefits Service Center at 212-851-7000. Please remember that because these benefits must comply with IRS regulations, you must provide proper documentation for your change, such as a birth certificate.
Your Cost

Your Cost for Benefit Coverage

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

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

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

- The plan you select
- The coverage level you select (individual vs. family, etc.)
- Your Annual Benefits Salary

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

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

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

Your contributions toward the cost of coverage are regularly deducted from your University paycheck on a pre-tax basis as allowed under the Internal Revenue Section 125. Your “premium” for healthcare coverage is based on the plan you select and the coverage level you select (individual vs. family, etc.)

Your Cost for Same-Sex Domestic Partner/Civil Union Partner
Federal income tax rules require that your contributions toward the coverage of a same-sex Domestic Partner or civil union partner be deducted from your pay on an after-tax basis unless your domestic or civil union partner is your legal spouse or your federal tax dependent for group health plan purposes. In addition, University contributions toward premiums for covering your domestic or civil union partner are taxable to you unless your domestic or civil union partner is your legal spouse or your federal tax dependent for group health plan purposes. Effective October 1, 2013, Officers who are legally married to their same-sex partner, and who live in one of the states or DC that recognize same-sex marriage, are eligible to have their payroll contributions made to the Columbia medical plan deducted on a pre-tax basis and not subject to imputed income on the employer-sponsored portion of the costs of medical plan coverage. You must contact the Columbia Benefits Service Center at 212-851-7000 to provide a
marriage certificate or to request recognition of your same-sex domestic partner as a federal tax dependent for group health plan purposes.

**When Coverage Ends**

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

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

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

**When Your Employment Ends**

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

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

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

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

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

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

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

However, you may continue the medical coverage in effect for you and your eligible dependents for up to 18 months under COBRA provisions. Under COBRA, the same plans are available as under the Columbia University in the City of New York Group Benefits Plan and the same rules apply for eligible dependents and qualifying changes in status. See the section, COBRA Continuation Rights.
When Your Employment Ends: Are You Eligible for Retiree Medical Benefits?

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

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

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

If You Become Disabled

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

- If you receive salary continuance: Any “premium” contributions you make for Columbia University in the City of New York benefits will continue on a before-tax basis. Your coverage continues without change under the medical plan in effect when your disability began.
- If you are placed on unpaid leave, you may continue your medical and prescription drug coverage on direct billing. Any contributions you make for Columbia University in the City of New York benefits will be on an after-tax basis.
- If you receive Long Term Disability benefits: Any “premium” contributions you make for Columbia University in the City of New York will be on an after-tax basis.

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

If You Take a Leave of Absence

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

Please note that for certain coverage’s to remain in effect during your leave of absence, you must pay the monthly premium costs associated with them. You will be billed separately for these coverage’s by Employee Benefit Plan Administrators (EBPA), an outside vendor. The Columbia Benefits Service Center
will notify EBPA of your leave of absence status who will calculate the monthly costs for those coverages that will require payment during your leave. You will be charged your regular monthly contribution rate for 6 months. After 6 months of leave, you will be charged the full premium rate, that is, your regular contribution plus the Columbia portion of the premium.

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

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

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

**Coverage While on Military Duty in the United States Armed Forces**

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

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

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

**If You Die**

If you die, your surviving Dependents who are covered under the Columbia University in the City of New York Group Benefits Plan at the time of your death will receive:

- Medical, Vision and prescription coverage for 1 year following the date of your death, free of charge.
- COBRA benefits will then be offered following the one year period of free coverage.

If you were eligible for Retiree Medical benefits at the time of your death, your surviving Dependents will be given the choice between COBRA or Retiree Medical coverage as per the requirements and regulations.
If Your Eligible Dependent Dies

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

Other Events Ending Your Coverage

The Plan will provide written notice to you that your coverage will end on the date identified in the notice if:

- You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person’s eligibility or status as a Dependent; or
- You commit an act of physical or verbal use that imposes a threat to Columbia University in the City of New York’s staff, the staff of your selected healthcare plan, or a provider.

Uniformed Services Employment and Reemployment Rights Act

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

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

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

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

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

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

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.
When Coverage Ends for Your Dependents

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

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

Same-Sex Domestic Partner
End of the month or 21 days (whichever is greater) following the dissolution of the partnership or commencement of other medical coverage (through partner’s employer).

Child
Coverage ends at the end of the calendar month in which your child turns age 26.

Handicapped Dependent Children
Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a Dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental disorders or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to UnitedHealthcare no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

UnitedHealthcare will have the right to require proof of the continuation of the handicap. UnitedHealthcare also has the right to examine your child as often as needed while the handicap continues at its own expense.

COBRA Continuation Rights

Continuing Coverage Through COBRA
If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in the Glossary.
Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Columbia University in the City of New York is subject to the provisions of COBRA.

**Continuation Coverage under Federal Law (COBRA)**

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

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

- an Employee;
- an Employee’s enrolled Dependent, including with respect to the Employee’s children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee’s former Spouse, same-sex domestic or civil union partner

**Qualifying Events for Continuation Coverage under COBRA**

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

<table>
<thead>
<tr>
<th>If Coverage Ends Because of the Following Qualifying Events:</th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For Yourself</td>
</tr>
<tr>
<td>Your work hours are reduced</td>
<td>18 months</td>
</tr>
<tr>
<td>Your employment terminates for any reason (other than gross misconduct)</td>
<td>18 months</td>
</tr>
<tr>
<td>You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage¹</td>
<td>29 months</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
</tr>
<tr>
<td>You divorce (or legally separate)</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child is no longer an eligible family member (e.g., reaches the maximum age limit)</td>
<td>N/A</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>N/A</td>
</tr>
</tbody>
</table>

¹ The 60-day period begins on the date the Plan “ loses” coverage, even if a Qualifying Event for COBRA coverage has not yet occurred, but the employee’s eligibility for COBRA coverage has been lost. The 60-day period is extended if it overlaps with, or follows a Qualifying Event for the same or a new Plan. In the event that Medicare coverage overlaps with COBRA coverage, Medicare is primary and COBRA coverage is secondary. Therefore, Medicare will always be the first source of coverage after a Qualifying Event for COBRA coverage has occurred.
If Coverage Ends Because of the Following Qualifying Events:

<table>
<thead>
<tr>
<th></th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For Yourself</td>
</tr>
<tr>
<td></td>
<td>For Your Spouse or your Same-Sex Domestic Partner</td>
</tr>
<tr>
<td></td>
<td>For Your Child(ren)</td>
</tr>
</tbody>
</table>

Columbia University in the City of New York files for bankruptcy under Title 11, United States Code.  

|                                    | 36 months | 36 months³ | 36 months³ |

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

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

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

### How Your Medicare Eligibility Affects Dependent COBRA Coverage

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

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

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

### Getting Started

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

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

During the 60-day election period, the Plan will, only in response to a request from a Provider, inform that Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

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

- during Open Enrollment; and
- following a change in family status, as described under Making Changes to Your Benefits During the Year, in the Enrollment Section.

Notification Requirements

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

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

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

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

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

Notification Requirements for Disability Determination

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

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Administrative and Legal Information About the Plan: Your ERISA Rights. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.
Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or ‘alternative trade adjustment assistance’ under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

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

When COBRA Ends

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

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

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

GENERAL INFORMATION ABOUT THE PRESCRIPTION PLAN

Retail pharmacy (participating) for all High Deductible Health Plans and non High Deductible Health Plans
Retail pharmacy (participating) for all non High Deductible Health Plans (non-HDHP) – up to 30-day supply:

- $10 co-pay for generic
- $25 co-pay for single source brand (brand name drugs that have a generic equivalent)
- $45 co-pay for multi-source brand (brand name drugs that do not have a generic equivalent)

Mail Order for all non High Deductible Health Plans (non-HDHP) – up to 90 day supply:

- $15 co-pay for generic
- $50 co-pay for single source brand (brand name drugs that have a generic equivalent)
- $90 co-pay for multi-source brand (brand name drugs that do not have a generic equivalent)

Retail pharmacy (participating) for all High Deductible Health Plans (-HDHP) – up to 30-day supply;

**Preventive Drugs:**

- $10 co-pay for generic
- $25 co-pay for single source brand (brand name drugs that have a generic equivalent)
- $45 co-pay for multi-source brand (brand name drugs that do not have a generic equivalent)

The co-pays by pass the deductible and accumulate towards the out-of-pocket maximum. Once the out-of-pocket maximum is met, the plan pays 100% for preventive drugs

**Non-Preventive Drugs:**

Member pays 100% until the deductible is met. After the deductible is met the plan copays are:

- $10 co-pay for generic
- $25 co-pay for single source brand (brand name drugs that do not have a generic equivalent)
- $45 co-pay for multi-source brand (brand name drugs that have a generic equivalent)

Mail Order for all High Deductible Health Plans (HDHP) – up to a 90 day supply

**Preventive Drugs-Mail Order**

- $15 co-pay for generic
- $50 co-pay for single source brand (brand name drugs that do not have a generic equivalent)
- $90 co-pay for multi-source brand (brand name drugs that have a generic equivalent)
  - The co-pays bypass the deductible and accumulate toward the out-of-pocket maximum. Once the out-of-pocket is met, the plan pays 100%
**Non-Preventive Drugs**

Member pays 100% of cost until the deductible is met. Once the deductible is met the following co-pays apply:

- $15 co-pay for generic
- $50 co-pay for single source brand (brand name drugs that do not have a generic equivalent)
- $90 co-pay for multi-source brand (brand name drugs that have a generic equivalent)
  - Deductible and co-pays accumulate towards out-of-pocket maximum. Once the out-of-pocket maximum is met the plan pays 100%.

When you enroll in any Columbia University Medical Plan as an active employee, you are also covered under the Columbia University in the City of New York Prescription Drug Plan through Express Scripts. You will receive a prescription drug card from Express Scripts which you need to present to your pharmacist when filling a prescription. In the event you lose or need a card for a covered dependent, you should contact Express Scripts at 1-800-230-0508 or register at [www.express-scripts.com](http://www.express-scripts.com).

**DISPENSING AND REIMBURSEMENT LIMITS**

Dispensing limits:

- Up to a 30-day supply if filled at your pharmacy; up to a 90-day supply if mail service is used
- One-year period after prescription is written
- You have up to 12 months from the date of disbursement or date of prescription written to submit a claim for reimbursement

Reimbursement limits:

- 12 months after a prescription is written
- Only the number of refills authorized by your doctor

**COVERED DRUGS FOR PHARMACY**

**COVERED DRUGS**

The following are covered benefits unless listed as an exclusion below:

- Federal Legend Drugs
- State Restricted Drugs
- Legend Bulk Powders are covered unless specifically coded to be excluded and listed as such in the excluded section
- Insulin
- Needles and Syringes
- OTC diabetic supplies (except Glucowatch/sensors, Insulin Pumps)
- Yohimbine
- Contraceptive Injections
- Inhaler assisting devices
- Legend prenatal or pediatric fluoride vitamins, hematinics, or folic acid
- Hemophilia factors
- Fertility medications (all dosage forms)
- Self injectable list F8Y
QUANTITY LEVEL LIMITS

- Oral, Transdermal, or Intravaginal Contraceptives for females only, limited to 30 days supply or 1 cycle, whichever is less per claim.
- Drugs used to treat impotency (all dosage forms except Yohimbine) for males only, age 18 and older limited to 30 days supply or 8 units, whichever is less per claim.
- Cialis 2.5mg and 5mg for males only, age 18 and older limited to 30 days supply or 15 units, whichever is less per claim.
- Stadol NS limited to a 30 day supply or 4 units of 2.5ml (10ml) whichever is less per claim.

DISPENSING LIMITS

- The amount of drug which is to be dispensed per prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 30 day supply. The quantities will be subject to Dispensing Quantity edits based on the Dispensing Event as well as a Quantity Duration edit which prevents coverage of excessive quantities of the drug within a defined time interval. Thus the quantity of drug in an incoming claim is evaluated in conjunction with prior claims submitted within a specified period of time.

COVERED DRUGS FOR MAIL ORDER

COVERED DRUGS

The following are covered benefits unless listed as an exclusion below:

- Federal Legend Drugs
- State Restricted Drugs
- Legend Bulk Powders are covered unless specifically coded to be excluded and listed as such in the excluded section
- Insulin
- Needles and Syringes
- OTC diabetic supplies (except Glucowatch/sensors, Insulin Pumps)
- Contraceptive injections
- Inhaler assisting devices
- Legend prenatal or pediatric fluoride vitamins, hematinics, or folic acid
- Hemophilia factors
- Fertility medications (all dosage forms)
- Self injectable list F8Y

QUANTITY LEVEL LIMITS

- Oral (except Emergency Contraceptives), Transdermal, or Intravaginal Contraceptives for females only, limited to 90 days supply or 3 cycles, whichever is less per claim.
- Seasonale 91 day supply
- Drugs used to treat impotency (all dosage forms except Yohimbine) for males only, age 18 and older limited to 90 days supply or 24 units, whichever is less per claim.
- Cialis 2.5mg and 5mg for males only, age 18 and older limited to 90 days supply or 30 units, whichever is less per claim.
- Stadol NS limited to a 90 day supply or 12 units of 2.5ml (30ml) whichever is less per claim.

**DISPENSING LIMITS**

- The amount of drug which is to be dispensed per prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 90 day supply. The quantities will be subject to Dispensing Quantity edits based on the Dispensing Event as well as a Quantity Duration edit which prevents coverage of excessive quantities of the drug within a defined time interval. Thus the quantity of drug in an incoming claim is evaluated in conjunction with prior claims submitted within a specified period of time.

**TRADITIONAL PRIOR AUTHORIZATION (for both retail and mail order)**

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

**EXCLUSIONS: (for both retail and mail order)**

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

- Non-Federal Legend Drugs
- Non systemic contraceptives, devices, or implants
- Injectable medications (except as listed)
- Emergency Contraceptives
- Relenza, Tamiflu
- All other vitamins
- Smoking deterrents
- Ostomy supplies
- Dental fluoride products
- Glucowatch/sensors
- Insulin Pumps
- Mifeprax
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers’ Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is taken by or administered to an individual, in whole or part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug
- Drugs that are most commonly prescribed for cosmetic or non-medically necessary treatment are excluded by the plan. However, they may be covered if they are prescribed for medically necessary treatment.

EXCLUSIONS: (mail order only)
- Emergency Contraceptives
- Relenza, Tamiflu

Express Scripts Formulary List
Express Scripts manages your prescription benefit. A national panel of physicians and pharmacists, regularly review the plan’s prescription drug list. Some medications may be removed from coverage when safe and effective alternatives are available. You will be notified if any of your medications are taken off the covered prescription drug list, so your doctor can prescribe another covered medication that is proven to be effective for conditions like yours.

**Woman’s Preventive Coverage under the Affordable Care Act (ACA)**

**Pharmaceutical Contraceptives**
The Columbia prescription drug plan covers female contraceptive methods with no copay, provided it is generic or single-source brand contraception:

- Approved by the Food and Drug Administration (FDA), and
- Filled at an in-network pharmacy

**Immunizations (dose, recommended ages, and recommended populations vary)**
The Columbia prescription drug plan covers the following female immunizations with no copay:
- Diphtheria, pertussis, tetanus (DPT)
- Hepatitis
- Herpes zoster
- Human papillomavirus (HPV)
- Influenza
- Measles, mumps, rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chicken pox)

Step Therapy

Step Therapy is a program designed especially for people who take prescription drugs regularly for ongoing conditions like arthritis, asthma and high blood pressure. It helps you get an effective medication to treat your condition while keeping your costs as low as possible.

How does Step Therapy work?

Prescription drugs are grouped according to copayment amounts.

- **Step 1 medications** — are generic drugs proven safe, effective and affordable. These medications should be tried first because they can provide the same health benefit as more expensive medications, at a lower cost.

- **Step 2 and Step 3 medications** — are brand-name drugs such as those you see advertised on TV. There are lower-cost brand-name drugs (Step 2) and higher-cost brand-name drugs (Step 3). Step 2 and Step 3 medications usually cost more than Step 1 medications.

Prior Authorization

The program monitors certain prescription drugs and their costs so that you can get the right medication at the right cost.

When your doctor prescribes one of these medications, he or she simply needs to contact Express Scripts. An Express Scripts representative will see if your plan can cover your prescription drug.

- If your prescription drug is covered, you'll pay the applicable copayment.
- If the prescription drug isn't covered and you still want to take it, you need to pay the full cost.

Prior Authorization helps you get a prescription drug that works well for you and that is also covered by your plan.

Drug Quantity Management
Drug quantity management reduces wasteful spending in the pharmacy benefit by aligning the dispensed quantity of prescription medication with dosage guidelines approved by the Food and Drug Administration. This supports safe, effective, and efficient use of drugs while giving patients access to quality care. In addition, dosing consolidation ensures that the pharmacy dispenses the most cost-effective product strength. For example, when appropriate, our Drug Quantity Management program guides a member to take one 40 mg tablet instead of two 20 mg tablets.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare’s discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person’s medical condition occurs sooner than the two year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the two year timeline for replacement.

Please remember for Non-Network Benefits, you must notify Personal Health Support. To receive Network Benefits, you must purchase or rent the DME from the vendor Personal Health Support identifies or purchase it directly from the prescribing Network Physician. If Personal Health Support is not notified, Benefits will be subject to a $500 reduction.

Claims and Appeals Procedures

What this section includes:

- How Network and non-network claims work; and
- What to do if your claim is denied, in whole or in part.
- Claim Filing Deadline
- Explanation of Benefits (EOB)
- If Your Claim is Denied
- How to Appeal a Denied Claim

Network Benefits

In general, if you receive Covered Health Products or Drugs from a Network Pharmacy, Express Scripts will pay the Pharmacy directly. If a Participating Pharmacy bills you for any Covered Health Product or Drug other than your Copay o, please contact the Pharmacy or call Express Scripts at the phone number on the back of your ID card for assistance.

Keep in mind, you are responsible for paying any Copay owed to a Participating Pharmacy at the time of sale, or when you receive a bill from the Pharmacy.
Non-Network Benefits

If you receive a bill for Covered Health Products or Drugs from a non-network Pharmacy, you (or the Pharmacy if they prefer) must send the bill to Express Scripts for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to Express Scripts at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.Express-scripts.com or calling the toll-free number on your ID card. You can also contact the Columbia Benefits Service Center at (212) 851-7000 or go to www.hr.columbia.edu/benefits. Claim Filing Deadline

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

You have 12 months to submit a claim for a covered product or drug to your prescription plan. While most in-network Pharmacies automatically submit claims on behalf of the patient, there are many situations when this does not occur. If you receive a product or drug from an out-of-network Pharmacy, you are responsible for submitting your claim for a covered service within the 12 months from the date the prescription is written or dispensed.

Explanation of Benefits (EOB)

You may request that Express Scripts send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call Express Scripts at the number on your ID card before requesting a formal appeal. If Express Scripts cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
the date the prescription dispensed; 
the reason you disagree with the denial; and
any documentation or other written information to support your request.

You or your enrolled Dependent may send a written request for an appeal to:

- Express Scripts – Appeals Unit

For Urgent Care claims that have been denied, you or your Provider can call Express Scripts at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care;
- pre-service; or
- post-service claim.

Review of an Appeal
Express Scripts will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if Express Scripts upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

External Review Program
If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services; or
- as otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Columbia University in the City of New York fails to respond to your appeal within the time lines stated below.

You may request an independent review of the adverse benefit determination. Neither you nor Columbia University in the City of New York will have an opportunity to meet with the reviewer or otherwise participate in the reviewer’s decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You, your treating Physician or an authorized designated representative
may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by Express Scripts and has no material affiliation or interest with Express Scripts or Columbia University in the City of New York. Express Scripts will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of Express Scripts’ receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by Columbia University in the City of New York in making a decision on the case; and
- all other information or evidence that you or your Physician has already submitted to Columbia University in the City of New York.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and Express Scripts will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer’s decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and Columbia University in the City of New York with the reviewer’s decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact Express Scripts at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

Timing of Appeals Determinations
Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care - a claim for Benefits provided in connection with Urgent Care services, as defined in the Glossary;
- Pre-Service - a claim for Benefits which the Plan must approve or in which you must notify Express Scripts before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.
The tables below describe the time frames which you and Express Scripts are required to follow.

### Urgent Care Claims*

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, Express Scripts must notify you within:</td>
<td>24 hours</td>
</tr>
<tr>
<td>You must then provide completed claim information to Express Scripts within:</td>
<td>48 hours after receiving notice</td>
</tr>
<tr>
<td>If Express Scripts denies your initial claim, they must notify you of the denial:</td>
<td></td>
</tr>
<tr>
<td>• if the initial claim is complete, within:</td>
<td>72 hours</td>
</tr>
<tr>
<td>• after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>48 hours</td>
</tr>
<tr>
<td>You must appeal the claim denial no later than:</td>
<td>180 days after receiving the denial</td>
</tr>
<tr>
<td>Express Scripts must notify you of the appeal decision within:</td>
<td>72 hours after receiving the appeal</td>
</tr>
</tbody>
</table>

### Pre-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is filed improperly, Express Scripts must notify you within:</td>
<td>5 days</td>
</tr>
<tr>
<td>If your claim is incomplete, Express Scripts must notify you within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to Express Scripts within:</td>
<td>45 days after receiving an extension notice**</td>
</tr>
<tr>
<td>If Express Scripts denies your initial claim, they must notify you of the denial:</td>
<td></td>
</tr>
<tr>
<td>• if the initial claim is complete, within:</td>
<td>15 days</td>
</tr>
<tr>
<td>• after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>15 days</td>
</tr>
</tbody>
</table>

* You do not need to submit Urgent Care claim appeals in writing. You should call UnitedHealth care, Aetna or Cigna as soon as possible to appeal an Urgent Care claim.

** Express Scripts may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.
## Pre-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must appeal the claim denial no later than:</td>
<td>180 days after receiving the denial</td>
</tr>
<tr>
<td>Express Scripts must notify you of the first level appeal decision within:</td>
<td>15 days after receiving the first level appeal</td>
</tr>
</tbody>
</table>

## Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, Express Scripts must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to Express Scripts within:</td>
<td>45 days after receiving an extension notice***</td>
</tr>
<tr>
<td>If Express Scripts denies your initial claim, they must notify you of the denial:</td>
<td></td>
</tr>
<tr>
<td>• if the initial claim is complete, within:</td>
<td>30 days</td>
</tr>
<tr>
<td>• after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must appeal the claim denial no later than:</td>
<td>180 days after receiving the denial</td>
</tr>
</tbody>
</table>

## Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Express Scripts will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

*** Express Scripts may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.
Limitation of Action

You cannot bring any legal action against Columbia University in the City of New York or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Columbia University in the City of New York or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Columbia University in the City of New York or the Claims Administrator.

You cannot bring any legal action against Columbia University in the City of New York or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Columbia University in the City of New York or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against Columbia University in the City of New York or the Claims Administrator.

Coordination of Benefits (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal Injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
• a plan that covers a person as an Employee pays benefits before a plan that covers the person as a Dependent;
• if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
• your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  ♦ the parents are married or living together whether or not they have ever been married and not legally separated; or
  ♦ a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
• if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  ♦ the parent with custody of the child; then
  ♦ the Spouse of the parent with custody of the child; then
  ♦ the parent not having custody of the child; then
  ♦ the Spouse of the parent not having custody of the child;
• plans for active Employees pay before plans covering laid-off or retired Employees;
• the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
• finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

**Determining Primary and Secondary Plan – Examples**

Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

**When This Plan is Secondary**

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

• the Plan determines the amount it would have paid based on the primary plan's allowable expense.
• if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
• if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.
The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

**Determining the Allowable Expense When This Plan is Secondary**

When this Plan is secondary, the allowable expense is the primary plan's Participating Pharmacy rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

**What is an allowable expense?**

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

**When a Covered Person Qualifies for Medicare**

**Determining Which Plan is Primary**

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

**Determining the Allowable Expense When This Plan is Secondary**

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

**Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Plan Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Express Scripts any facts needed to apply those rules and determine benefits payable. If you do not provide Express Scripts the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

**Overpayment and Underpayment of Benefits**

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that Express Scripts should have paid. If this occurs, the Plan may pay the other plan the amount owed.
If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or Benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care Provider, Express Scripts reserves the right to recover the excess amount, by legal action if necessary.

**Refund of Overpayments**

If Columbia University in the City of New York pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to Columbia University in the City of New York if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment Columbia University in the City of New York made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount Columbia University in the City of New York paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help Columbia University in the City of New York get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, Columbia University in the City of New York may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. Columbia University in the City of New York may have other rights in addition to the right to reduce future Benefits.

**Subrogation and Reimbursement**

**What this section includes:**

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

**Right of Recovery**

The Plan has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.
If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

**Right to Subrogation**

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid. Subrogation applies when the Plan has paid on your behalf Benefits for a Sickness or Injury for which a third party is considered responsible, e.g., an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

**Right to Reimbursement**

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

**Third Parties**

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- Columbia University in the City of New York in workers’ compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers’ compensation coverage; or
  - any other insurance carrier or third party administrator.

**Subrogation and Reimbursement Provisions**

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
• the Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys’ fees. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right.

• the Plan may enforce its subrogation and reimbursement rights regardless of whether you have been “made whole” (fully compensated for your injuries and damages).

• you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

  ♦ complying with the terms of this section;
  ♦ providing any relevant information requested;
  ♦ signing and/or delivering documents at its request;
  ♦ appearing at medical examinations and legal proceedings, such as depositions or hearings; and

  ♦ obtaining the Plan’s consent before releasing any party from liability or payment of medical expenses.

• if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney’s trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

• if the Plan incurs attorneys’ fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.

• you may not accept any settlement that does not fully reimburse the Plan, without its written approval.

• you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.

• the Plan’s rights will not be reduced due to your own negligence.

• the Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.

• the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party.

• in case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.

• your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

• if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

• the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

Glossary

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the Amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The High Deductible Health Plan has a deductible that must be met before non-preventive prescription drugs will be reimbursed and copay will apply.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Express Scripts Claims Administrator – Express Scripts (also known as Express Scripts Service LLC.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Company – Columbia University in the City of New York.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in How the Plan Works.
**Cosmetic Procedures** – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

**Covered Health Services** – those health services, including medications or supplies, which Express Scripts determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility*; and
- not identified the *Exclusions*.

**Covered Person** – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

**Deductible** – see Annual Deductible.

**Dependent** – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

**Dependent Child(ren)** – legally dependent children, including adopted children, foster and stepchildren of your spouse or same-sex Domestic Partner.

**Domestic Partner** – an individual of the same sex with whom you have established a Domestic Partnership as described below.

A Domestic Partnership is a relationship between an Employee and one other person of the same sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent.

The Employee and Domestic Partner must jointly sign an affidavit of Domestic Partnership. Contact Human Resources for more information.

**Domiciliary Care** – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

**Eligible Expenses** – charges for Covered medications or products that are provided while the Plan is in effect, determined as follows:
<table>
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<th>For Services Provided by a:</th>
<th>Eligible Expenses are Based On:</th>
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<td>Participating Pharmacy</td>
<td>Contracted rates with the Pharmacy</td>
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| Non-Network Pharmacy     | • Negotiated rates agreed to by the non-participating pharmacy and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator.  
  • if rates have not been negotiated, then one of the following amounts:  
  ◦ 190 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or  
  ◦ When a rate is not published by CMS for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:  
  For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the Claims Administrator based on an internally developed pharmaceutical pricing resource. |

**Emergency** – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and  
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

**Emergency Health Services** – Medications or products necessary for the treatment of an Emergency.

**Employee** – a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility*. An Employee must live and/or work in the United States.

**Employee Retirement Income Security Act of 1974 (ERISA)** – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

**Employer** – Columbia University in the City of New York.

**EOB** – see Explanation of Benefits (EOB).


**Experimental or Investigational Services** – drug therapies, medications, at the time Express Scripts Express Scripts makes a determination regarding coverage in a particular case, are determined to be any of the following:
• not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use;
• subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
• the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

• If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), Express Scripts may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, Express Scripts must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Explanation of Benefits (EOB)** – a statement provided by Express Scripts to you, your Physician, or another health care professional that explains:

• the Benefits provided (if any);
• the allowable reimbursement amounts;
• Deductibles;
• Coinsurance;
• any other reductions taken;
• the net amount paid by the Plan; and
• the reason(s) why the service or supply was not covered by the Plan.

**Health Statement(s)** – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

**Home Health Agency** – a program or organization authorized by law to provide health care services in the home.

**Hospital** – an institution, operated as required by law, which is:

• primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
• has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

**Injury** – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Medicaid** – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.
Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by Columbia University in the City of New York who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless they are listed in Exclusions.

Open Enrollment – the period of time, determined by Columbia University in the City of New York, during which eligible Employees may enroll themselves and their Dependents under the Plan. Columbia University in the City of New York determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Plan Highlights for the Out-of-Pocket Maximum amount. See How the Plan Works for a description of how the Out-of-Pocket Maximum works.

Express Scripts Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription Pharmaceutical Products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.


Plan Administrator – Columbia University in the City of New York or its designee.

Plan Sponsor – Columbia University in the City of New York.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance use disorder, regardless of the cause or origin of the Mental Illness or substance use disorder.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.