Benefit Summary

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

Effective: January 1, 2016

January 2016
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Introduction

Columbia University in the City of New York ("the University") is pleased to provide you with this Benefit Summary, 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 and the Columbia University Retiree Medical and Life Insurance Plan, whichever the case may be. As used in this Summary, the term "Plan" means either the Columbia University in the City of New York Group Benefits Plan or the Columbia University Retiree Medical and Life Insurance Plan, whichever the case may be as applicable to you. This Benefit Summary provides information about:

- Who is eligible
- Prescription drugs and supplies that are covered, called Covered Drugs
- Prescription drugs and supplies that are not covered, called Exclusions
- How benefits are paid

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

The rest of this summary 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, whoever the case may be.

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

How To Use This Benefit Summary

- Please read the entire Benefit Summary and share it with your family.
- Many of the sections of this Benefit Summary 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 Benefit Summary 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 Drug Health Benefits Coverage

The University offers choices of health coverage under the Plan so that you can select the option that best meets the needs of you and your family. The prescription drug health coverage is automatically provided to you when you elect any one of the health coverages offered under the Plan.

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1 The terms "you" and "your" as used in this Benefit Summary refer to an employee of the University who is otherwise eligible to participate in the Plan and is actually participating in the Plan pursuant to the applicable plan's terms. Your receipt of this Benefit Summary is not an indication that you are in fact a participant in the Plan.
After enrolling in a health coverage under the Plan, 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.

**What the Plan Covers**
The Plan covers medically necessary health care services, prescriptions and related supplies 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. The plan coverage is subject to conditions, limits and exceptions explained in the sections, “Covered Services” and “Exclusions”. The University and Express Scripts administer the prescription drug health benefits offered under the Plan and assume no responsibility for the outcome of any covered prescription.

The prescription drug health benefits under the Plan are not insured with Express Scripts or any of their affiliates but are paid from University 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. For a drug 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 drug or product or the fact that it may be the only treatment for a particular Injury, illness or Pregnancy does not mean that it is a medically necessary product or supply as defined above. The definition of “medically necessary” used in this Benefit Summary relates only to benefit coverage and may differ from the way you or your doctor define medical necessity.

**Express Scripts**

**Pre-Existing Conditions**
There are no pre-existing condition limits under the Plan.
Prior Authorization Requirements
Certain products and/or supplies require you to obtain prior authorization from Express Scripts for you to receive the maximum benefits under the Plan. You must get prior authorization for certain products and/or supplies before purchasing the products and/or supplies; otherwise, your benefits will be subject to a significant reduction in reimbursement. See the “Prior Authorization” section below.

Financial Penalty If You Do Not Get Prior Authorization
You must obtain prior authorization 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 “preauthorization.” If you do not obtain prior authorization 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 prior authorization. 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 Drug Health Coverage
You are automatically enrolled in the Express Scripts prescription drug health coverage when you elect medical coverage under the Plan. (With the exception of the Unitedhealthcare Medicare Advantage Plan). 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 drug health coverage allows you the flexibility to use non-participating pharmacies-at any time. However, your cost toward your healthcare expenses is significantly higher because there are no negotiated fees. In addition, the Plan limits the amount it will pay for any medical product and/or supplies 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.
Administrative and Legal Information about the Plan

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
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](http://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).

**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.

**Information and Records**

The Plan Administrator 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. The Plan Administrator and Express Scripts may request additional information from you to decide your claim for Benefits. The Plan Administrator and Express Scripts will keep this information confidential. The Plan Administrator and Express Scripts 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 The Plan Administrator and Express Scripts with all information or copies of records relating to the services provided to you. The Plan Administrator and 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. The Plan Administrator and Express Scripts agree that such information and records will be considered confidential.

The Plan Administrator 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 the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator 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 the Plan Administrator 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, the Plan Administrator 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 the University 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.
Eligibility for Benefit Coverage

You are generally eligible for prescription drug health benefit coverage under the Plan on the same terms and conditions that apply to your medical coverage under the Plan. For a detailed summary of those terms and conditions, including special enrollment rights and COBRA continuation coverage, please refer to your medical benefit coverage benefit summary and the wrap document for the Plan.

General Information About The Prescription Plan

Retail pharmacy (participating) for all Health Savings Plans and Choice Health Plans

Retail pharmacy (participating) for all Choice Plans and Non-Health Savings Plans (Non-HSP) – up to 30-day supply:

$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)

*For a list of the most common preventative drugs, please see the CU HR Benefit website, or call Express Scripts at 1-800-230-0508 or register at www.express-scripts.com

Mail Order for all Choice Plans non- Health Savings Plans (Non-HSP) – up to 90 day supply:

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

Retail pharmacy (participating) for all Health Savings Plans (HSP) – up to 30-day supply;

Preventive Drugs:

$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)

The co-pays bypass 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 Health Savings Plans (HSP) – up to a 90 day supply

**Preventive Drugs**
- $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%.

**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)

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 new prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 30 day supply. When a drug is dispensed, the system reviews current quantity limits, based on plan design, as well as prior claims to prevent coverage of excessive quantity of the drug within a defined 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, hematins, or folic acid
- Hemophilia factors
- Fertility medications (all dosage forms)

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
- Certain prescription vitamins
- Smoking deterrents
- Ostomy supplies
- Dental fluoride products
- Glucowatch/sensors
- Insulin Pumps
- Mifeprex
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums
- Biologics, 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(For a list of the most common preventative drugs, please see the CU HR Benefit website, or call Express Scripts at 1-800-230-0508 or register at www.expressscripts.com)
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 prescription drug coverage under the 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 prescription drug coverage under the 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

How does Step Therapy work?
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.

Prescription drugs are grouped according to copayment amounts.

- **Step 1 medications** — are generic drugs and some lower cost brand name 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 the 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.

Claims and Appeals Procedures

What this section includes:
- How Network and non-network claims work
- 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

In-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, 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.

Out-of-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 to the Claims Administrator for a covered product or drug under the 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 to the Claims Administrator for a covered product or drug under 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.

Please note that the Columbia Benefits Service Center cannot serve as your authorized representative for purposes of filing a claim or appeal under the Plan.
You or your enrolled Dependent may send a written request for an appeal to:

- Express Scripts
  PO Box 66588
  St. Louis, MO  63166-6588
  Attention:  Clinical Appeals Department

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.

You have the right to submit written comments, documents, records, and other information in connection with your appeal. Your authorized representative also may make such written submissions on your behalf. Please note that the Columbia Benefits Service Center cannot serve as your authorized representative for this purpose.

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, nor the subordinate of such individual; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process, if the adverse benefit determination which you are appealing is based in whole or in part on a medical judgment.

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 as well as a general explanation of your right to have the claims denial reviewed through the Plan’s external review program and/or by a court of competent jurisdiction.

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. You may request an independent review of the adverse benefit determination. Neither you
nor the University 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 the University. 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 Express Scripts in making a decision on the case; and
- all other information or evidence that you or your Physician has already submitted to Express Scripts.

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 the University 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>
</tbody>
</table>

* You do not need to submit Urgent Care claim appeals in writing. You should call Express Scripts 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>after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>15 days</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 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 the University 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 the University 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 the University or the Claims Administrator.

You cannot bring any legal action against the University 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 the University 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 the University 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 and any prescriptions the Physician prescribes.

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 you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. In all cases where a participant is Medicare eligible, the Medicare approved amount is the allowable expense for purposes of this Plan, and in no event will Medicare payments, combined with Plan Benefits, exceed 100% of the 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 the University 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 the University 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 the University made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount the University 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 the University 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, the University 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. The University may have other rights in addition to the right to reduce future Benefits.

**Subrogation and Reimbursement Provisions**

*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**

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;
- Express Scripts
- The University 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 you may have against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a 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.
• regardless of whether you have been fully compensated or made whole, the Plan may collect from you, your representative or a third-party payor the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.

• Benefits paid by the Plan may also be considered to be Benefits advanced.

• 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:
  ♦ complying with the terms of this section;
  ♦ providing any relevant information requested;
  ♦ signing and/or delivering documents at its request;
  ♦ notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  ♦ responding to requests for information about any accident or injuries;
  ♦ 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.

• upon the Plan's request, 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. Even if it files suit in your name, the Plan is not required to pay you part of any recovery it may obtain from a third party to the extent the recovery does not exceed the Benefits the Plan has provided for a Sickness or Injury caused by a third party and the costs the Plan incurs in obtaining the recovery. Notwithstanding anything to the contrary in this document, even if it files in your name, the Plan is not required to seek a recovery from the third-party in excess of the Benefits the Plan has provided for a Sickness or Injury caused by a third party and the costs the Plan incurs in obtaining the recovery.

• 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. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

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

if any claim is made that any part of the Plan’s subrogation, reimbursement and/or offset provisions are ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator has the sole authority and discretion to resolve all disputes regarding the interpretation of these provisions.

**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.

*It is a federal crime punishable by prison to defraud an ERISA-governed plan. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an ERISA-governed plan, submits an application or files a claim containing a false or deceptive statement is guilty of fraud.*

**Glossary**

**What this section includes:**
- Definitions of terms used throughout this Benefit Summary.

Many of the terms used throughout this Benefit Summary 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 Benefit Summary, 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 Benefit Summary and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and Benefit Summary and/or Amendments to the Benefit Summary, 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. Notwithstanding anything to the contrary in this Benefit Summary, the Plan Sponsor reserves the right, in its sole discretion, to amend, modify or terminate the terms of the Plan, including, but not limited to, the removal of a particular coverage or benefit provided under the Plan.

**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 Health Savings 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 Drugs, Covered Health Products, and Covered Health Services – those prescription drugs, medical products and 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 Benefit Summary 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>
<thead>
<tr>
<th>For Services Provided by a:</th>
<th>Eligible Expenses are Based On:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Pharmacy</td>
<td>Contracted rates with the Pharmacy</td>
</tr>
<tr>
<td>Out-of-Network Pharmacy</td>
<td>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.</td>
</tr>
</tbody>
</table>

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 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 Pharmacopoeia 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** – The Columbia University in the City of New York Group Benefits Plan or the Columbia University Retiree Medical and Life Insurance Plan, whichever the case may be as applicable to a particular participant.
**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 Benefit Summary 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.