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Summary Plan Description

**Columbia University in the City of New York
Optum Rx Prescription Drug Plan for Officers,
Support Staff, Post-Doctoral Fellows, Obama
Scholars, Pre and Post 65 Retirees**

Effective: January 1, 2022
Group Number: 712790

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SECTION 1 - WELCOME

Columbia University is pleased to provide you with this Summary Plan Description (SPD), which describes the pharmacy Benefits available to you and your covered family members under The Columbia University OptumRx Prescription Drug Plan. It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.
- Your rights and responsibilities under the 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.

IMPORTANT

A Prescription Drug Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 10, *Glossary*.) The fact that a Physician or other provider has performed or prescribed it, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the Prescription Drug Product is a Covered Health Service under the Plan.

Columbia University intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

OptumRx, Inc. is a private pharmacy claims administrator. OptumRx's goal is to give you the tools you need to make wise healthcare decisions. OptumRx also helps your employer to administer claims. Although OptumRx will assist you in many ways, it does not guarantee any Benefits. Columbia University is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Columbia University OptumRx Prescription Drug Plan works. If you have questions contact the number on the back of your ID card or call Benefits Department.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- 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 number on the back of your ID card.
- Capitalized words in the SPD have special meanings and are defined in Section 10, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 10, *Glossary*.
- Columbia University is also referred to as University.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

Eligibility

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 detailed summary of those terms and conditions, including special enrollment rights and COBRA continuation coverage, please refer to your medical benefit coverage summary and the wrap document of the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse/same-sex Domestic Partner, as defined in Section 10, *Glossary*.
- Your or your Spouse's/same-sex Domestic Partner's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under a Columbia University plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under a Columbia University plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 9, *Other Important Information*.

Cost of Coverage

Prescription drug coverage is included in the cost of the Medical Plan that you select. Please refer to your Medical Plan coverage for contribution amounts, if applicable. You may not elect Prescription drug coverage only. .

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Columbia University's cost in covering a same-sex Domestic Partner may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a same-sex Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and Columbia University reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by logging onto www.hr.columbia.edu.

How to Enroll

Active:

To enroll, you must log onto www.hr.columbia.edu within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections. When you enroll in a medical Plan you are automatically enrolled in the prescription drug coverage. You may not enroll in prescription drug coverage only. It is not a standalone benefit.

Retired:

To enroll you must properly complete the Health Plan Election Form for Retired Officers. If you separate from your position as an Officer and are otherwise eligible to participate in the Plan, you may enroll in a Columbia University retiree medical benefits effective as of the first day of the month following your retirement date.. If your retiree medical benefits commencement date is after age 65, you must enroll in Medicare parts A and B and your retiree medical plan offerings will be different from the pre-65 Retiree benefit offerings.

Please contact the Columbia Benefits Service Center at 212-851-7000 or hrbenefits@columbia.edu with any questions you have regarding enrollment under the Plan.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following birth, adoption of a child, placement for adoption of a child or other family status change, you must call the Columbia Benefits Service Center at 212 851-7000. within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once you enroll on CUBES in a medical plan both medical and prescription drug coverage will begin on your date of hire or if you are a retiree, coverage will begin on the first day of the month following your retirement date. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify the Benefits Department within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Columbia University HR Benefits at 212-851-7000 within 31 days of the birth, adoption, or placement. If you are a retiree you can enroll the Spouse/same-sex Domestic Partner that you were married to at your date of retirement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- Registering a same-sex Domestic Partner.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).
- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
- Termination of your or your Dependent's *Medicaid* or *Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility (you must contact OptumRx at the number on the back of your ID card within 60 days of termination).
- You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact OptumRx at the number on the back of your ID card within 60 days of the date of determination of subsidy eligibility).
- A strike or lockout involving you or your Spouse.
- A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must log onto CUBES at www.hr.columbia.edu within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all Plan coverage for the child will end when the

placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Columbia University's Benefits Plan, because her husband, Tom, has family coverage under his employer's plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for coverage. Due to this family status change, Jane can elect family coverage under Columbia University's Benefits plan outside of annual Open Enrollment.

SECTION 3 - OUTPATIENT PRESCRIPTION DRUGS

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either an In-Network Pharmacy or an Out-of-Network Pharmacy and are subject to Copayments or deductible or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 75% of the original retail Prescription Drug Product has been used (70% for Home Delivery)

What You Must Pay

You are responsible for paying the applicable Copayment and /or deductible described in the *Payment Terms and Features - Outpatient Prescription Drugs* table or *Schedule of Benefits - Outpatient Prescription Drugs*.

The amount you pay for any of the following under this section will not be included in calculating any Out-of-Pocket Maximum stated in your SPD:

- Certain coupons or offers from pharmaceutical manufacturers. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling the telephone number on your ID card.
- The difference between the Predominant Reimbursement Rate and an Out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Identification Card (ID Card) – In-Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at an In- Network Pharmacy or you must provide the In-Network Pharmacy with identifying information that can be verified by OptumRx during regular business hours.

If you don't show your ID card or provide verifiable information at an In-Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at the same level for tier-1, tier-2 and tier-3 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit www.myuhc.com or call OptumRx at the number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

For Prescription Drug Products at a retail In-Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Copay or deductible
- The In-Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order In-Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copay or deductible
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

Benefits are provided for Prescription Drug Products dispensed by a retail In-Network Pharmacy. The Plan has a network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about In-Network Pharmacies by contacting OptumRx at the number on your ID card or by logging onto www.myuhc.com.

Benefits are provided for Prescription Drug Products dispensed by a retail Out-of-Network Pharmacy. If the Prescription Drug Product is dispensed by a retail Out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with OptumRx, as described in your SPD, Section 6, *Claims Procedures*. The Plan will not reimburse you for the difference between the Predominant Reimbursement Rate and the Out-of-Network Pharmacy's Usual and

Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network Pharmacy.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay or meet the deductible first, if applicable. The following supply limits apply:

- As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- As written by the provider, a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed \$10 - \$20.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Copay for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copay that applies will reflect the number of days dispensed.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

Benefits are provided for certain Prescription Drug Products dispensed by a mail order In-Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach OptumRx at the number on your ID card.

The following supply limits apply: As written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order In-Network Pharmacy.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under Section 10, *Glossary*. You may determine whether a drug is a Preventive Care Medication at www.myuhc.com or by calling OptumRx at the number on your ID card.

Smart Fill Program - 90 Day Supply

Specialty medications are an important component to managing complex diseases and conditions, and sometimes it takes time for members to find the right dose and comfort level before they're able to follow their regimen. The Smart Fill program from OptumRx® specialty pharmacy, offers a strategy for dispensing specialty medications so that members get the medications they need, adhere to their therapy, and reduce waste due to intolerance. Our 90-day fill program provides refills every three months.

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The Smart Fill Program which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Covered Person who is stabilized on a Specialty Prescription Drug Product included in the Smart Fill Program. You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, at www.myuhc.com or by calling the telephone number on your ID card.

The 90-day program is a convenient option for members taking medications for HIV, rheumatoid arthritis, multiple sclerosis, and transplant. If members demonstrate regimen stability, they have the option of receiving three months of medication per refill. Regimen stability is defined as members stable and adherent to therapy for 6 months prior to program enrollment in or to become eligible for this option. Instead of 12 refills and 12 copays per year, members who take advantage of the 90-day fill program get four refills at the standard home delivery copays per refill. The program is voluntary and enables:

- Enhanced member convenience
- Adherence monitoring
- Improved member satisfaction

As a voluntary option, the conversion from 30-day to 90-day supplies is not automatic and needs to be requested. If interested, for your next fill after regimen stability has been satisfied, call the number on your ID card and ask to be transferred to Optum Specialty Pharmacy in order to request the 90-day supplies.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, the Specialty medications must be ordered through Optum Specialty Pharmacy.

Please see Section 10, *Glossary*, in this section, for a full description of Specialty Prescription Drug Product.

Refer to the *Schedule of Benefits - Outpatient Prescription Drug* for details on Specialty Prescription Drug Product supply limits.

Please see Section 10, *Glossary*, in this section for definitions of Specialty Prescription Drug Product and Designated Pharmacy.

Want to lower your out-of-pocket Prescription Drug Product costs?

Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drug Products to the Prescription Drug List (PDL)

OptumRx's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on OptumRx's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com or call the number on your ID card for the most up-to-date tier status.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)

The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

Limitation on Selection of Pharmacies

If OptumRx determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, OptumRx may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single In-Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, OptumRx will select a single In-Network Pharmacy for you.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading *Prescription Drug Product Coverage Highlights*. For a single Copayment and deductible, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to OptumRx's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and OptumRx have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, at www.myuhc.com or by calling the telephone number on your ID card.

Special Programs

Columbia University and OptumRx may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs at www.myuhc.com or by calling the number on the back of your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by calling the telephone number on your ID card.

Rebates and Other Discounts

OptumRx and Columbia University may, at times, receive rebates for certain drugs on the PDL. OptumRx does not pass these rebates on to you, nor are they taken into account in determining your Copays.

OptumRx and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. OptumRx is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, OptumRx may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-OptumRx entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition. The Plan Sponsor does not permit coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible or out-of-pocket maximum.

SECTION 4 – PLAN HIGHLIGHTS - OUTPATIENT PRESCRIPTION DRUGS

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Copay amounts that apply when you have a prescription filled at a Retail or Mail Order Pharmacy.

Schedule of Benefits - Outpatient Prescription Drugs

Benefit Information for Prescription Drug Products at either an In-Network Pharmacy or an Out-of-Network Pharmacy

Covered Health Services ^{1,2,3}	Percentage of Prescription Drug Charge Payable by the Plan (Per Prescription Order or Refill):	Percentage of Predominant Reimbursement Rate Payable by the Plan (Per Prescription Order or Refill):
	In-Network	Out-of-Network
Retail and Specialty - up to a 30-day supply ¹ .	100% after you pay a:	
■ Generic	\$10 Copay	Not Covered
■ Single-source brand	\$25 Copay	Not Covered
■ Multi-source brand	\$45 Copay	Not Covered
Mail Order In-Network Pharmacy - up to a 90-day supply	100% after you pay a:	
■ Generic	\$15 Copay	Not Covered
■ Single-source brand	\$50 Copay	Not Covered
■ Multi-source brand	\$90 Copay	Not Covered

¹The Plan pays Benefits for Specialty Prescription Drug Products as described in this table.

²For all Plans including the High Deductible Health Plan you are only responsible for paying a Copayment for Preventive Care Medications.

³Enrollment in the High Deductible Health Plan: Non-Preventative care drugs: If a non-preventative drug is filled, you will be required to meet the medical plan deductible first then the copayment will apply.

Note: there is a \$30,000 lifetime maximum for infertility Outpatient Prescription Drugs applicable to all members enrolled in the Columbia University Group Benefits Plan for active employees and the Pre-65 Retiree Plan. Members enrolled in the Post 65 Retiree Plan or the Indemnity Plan have a \$5,000 lifetime maximum for infertility Outpatient Prescription Drugs.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change. As a result, your Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug Product is assigned.

SECTION 5 - EXCLUSIONS AND LIMITATIONS: WHAT THE PLAN WILL NOT COVER

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

In addition to the exclusions below, please review all benefit and supply limits carefully, as the Plan will not pay Benefits for any of Prescription Drug Products that exceed those limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not OptumRx's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com or call the number on your ID card for information on which Prescription Drug Products are excluded.

1. For any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
2. Any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
3. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
4. Prescription Drug Products dispensed outside of the United States, except in an Emergency.
5. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *SPD*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
6. For growth hormone therapy.
7. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
8. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

9. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
10. Certain New Prescription Drug Products until they are reviewed and assigned to a tier by the PDL Management Committee.
11. Prescribed, dispensed or intended for use during an Inpatient Stay.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that OptumRx and Columbia University determine do not meet the definition of a Covered Health Service.
13. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
14. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
15. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by OptumRx. Such determinations may be made up to six times during a calendar year, and OptumRx may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
16. Certain unit dose packaging or re packagers of Prescription Drug Products.
17. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless OptumRx and Columbia University have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 10, *Glossary*.
18. Used for cosmetic purposes.
19. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
20. General vitamins, except for the following which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.

21. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.
22. A Prescription Drug Product that contains marijuana, including medical marijuana.
23. Dental products, including but not limited to prescription fluoride topicals.
24. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. Diagnostic kits and products.
26. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
27. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Experimental or Investigational or Unproven Services

Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except as described in Section 7, *Coordination of Benefits (COB)*.
2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you.
3. While on active military duty.
4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

All Other Exclusions

1. Charges for:
 - Completion of claim forms.
 - Record processing
 - Services, supplies or equipment that are advertised by the Provider as free.
2. Charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
3. Charges prohibited by federal anti-kickback or self-referral statutes.
4. Expenses for health services and supplies:
 - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
 - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
 - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
 - That exceed Usual and Customary Charges or any specified limitation in this SPD.
 - For which an Out-of-Network Pharmacy waives the Copay, Annual Deductible or amounts.
5. Prescription Drug Products that do not meet the definition of a Covered Health Service
 - see the definition in Section 10 *Glossary*. Covered Health Services are those Prescription Drug Products, which the Claims Administrator determines to be all of the following:
 - Medically Necessary.

- Described as a Covered Health Service in this SPD.
 - Not otherwise excluded in this SPD.
6. Prescription Drug Products related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition.

SECTION 6 - CLAIMS PROCEDURES

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

You may seek reimbursement from the Plan as described under the heading, *If Your Provider Does Not File Your Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card or contacting the Benefits Department. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the pharmacy who supplied the drug(s).
- The date the drug was dispensed.
- An itemized bill from the provider that includes:
 - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).
 - Pharmacy name and address.
 - Date of service.
 - Physician name or ID number.
 - NDC number (drug number).
 - Name of drug and strength.
 - Quantity and days' supply.
 - Prescription number.
 - Dispense-as-written instructions.
 - Amount paid.

Failure to provide all the information listed above may delay any reimbursement that may be due you.

When filing a claim for outpatient Prescription Drug Product Benefits. Submit your claim to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

After OptumRx has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Out-of-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to an Out-of-Network provider without OptumRx's consent. When you assign your Benefits under the Plan to an Out-of-Network provider with OptumRx's consent, and the Out-of-Network provider submits a claim for payment, you and the Out-of-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When OptumRx has not consented to an assignment, OptumRx will send the reimbursement directly to you (the Employee) for you to reimburse the Out-of-Network provider upon receipt of their bill. However, OptumRx reserves the right, in its discretion, to pay the Out-of-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, OptumRx may consider whether you have requested that payment of your Benefits be made directly to the Out-of-Network provider. Under no circumstances will OptumRx pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to an Out-of-Network provider shall not be deemed to constitute consent by OptumRx to an assignment or to waive the consent requirement. When OptumRx in its discretion directs payment to an Out-of-Network provider, you remain the sole beneficiary of the payment, and the Out-of-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although OptumRx may in its discretion send information concerning the Benefits to the Out-of-Network provider as well. If payment to an Out-of-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 7 *Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that OptumRx in its discretion determines to be adequate.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call OptumRx at the number on your ID card before requesting a formal appeal. If OptumRx 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 of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

OptumRx c/o Appeals Coordinator CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626
Fax 877-239-4565

For urgent care requests for Benefits that have been denied, you or your provider can call OptumRx 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 request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

OptumRx 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.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

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

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from OptumRx within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. The Claims Administrator will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by OptumRx, or if OptumRx fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of OptumRx's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received OptumRx's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.

- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). OptumRx has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by OptumRx of the request.
- A referral of the request by OptumRx to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, OptumRx will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that OptumRx may process the request.

After OptumRx completes the preliminary review, OptumRx will issue a notification in writing to you. If the request is eligible for external review, OptumRx will assign an IRO to conduct such review. OptumRx will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

OptumRx will provide to the assigned IRO the documents and information considered in making OptumRx's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by OptumRx.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and OptumRx will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by OptumRx. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the

request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and OptumRx, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing OptumRx determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, OptumRx will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that OptumRx may process the request.

After OptumRx completes the review, OptumRx will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, OptumRx will assign an IRO in the same manner OptumRx utilizes to assign standard external reviews to IROs. OptumRx will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by OptumRx. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to OptumRx.

You may contact OptumRx at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

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 request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify OptumRx before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and OptumRx are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, OptumRx must notify you within:	24 hours
You must then provide completed request for Benefits to OptumRx within:	48 hours after receiving notice of additional information required
OptumRx must notify you of the benefit determination within:	72 hours
If OptumRx denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
OptumRx must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call OptumRx as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, OptumRx must notify you within:	5 days
If your request for Benefits is incomplete, OptumRx must notify you within:	15 days
You must then provide completed request for Benefits information to OptumRx within:	45 days
OptumRx must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	15 days
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
OptumRx must notify you of the appeal decision within:	30 days after receiving the first level appeal

*OptumRx may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, OptumRx must notify you within:	30 days
You must then provide completed claim information to OptumRx within:	45 days
OptumRx must notify you of the benefit determination:	
■ if the initial claim is complete, within:	30 days
■ after receiving the completed claim (if the initial claim is incomplete), within:	30 days

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
OptumRx must notify you of the appeal decision within:	60 days after receiving the appeal

Limitation of Action

You cannot bring any legal action against Columbia 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 Columbia 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 Columbia University or the Claims Administrator.

You cannot bring any legal action against Columbia 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 Columbia University or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Columbia University or the Claims Administrator.

SECTION 7 - COORDINATION OF BENEFITS (COB)

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.
- 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. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Determining Which Plan is Primary

Order of Benefit Determination Rules

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 pharmacy payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more pharmacy 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.
 - 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.
- 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.

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 allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

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 the provider is an In-Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's In-Network rate. When the provider is an In-Network provider for the primary plan and an Out-of-Network provider for this Plan, the allowable expense is the primary plan's In-Network rate. When the provider is an Out-of-Network provider for the primary plan and an In-Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is an Out-of-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As 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 (however, same-sex Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

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 (as opposed to a provider who does not accept assignment of Medicare benefits), 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.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience OptumRx will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

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. OptumRx 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.

OptumRx does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give OptumRx any facts needed to apply those rules and determine benefits payable. If you do not provide OptumRx 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 the Plan 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 University may recover the amount in the form of salary, wages, or benefits payable under any University-sponsored benefit plans, including this Plan. The University also reserves the right to recover any overpayment by legal action or offset payments on future Benefits.

If the Plan overpays a health care provider, OptumRx reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan 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 Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but 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 Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 8 - WHEN COVERAGE ENDS

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

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

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

- 21 days after your employment ends or the end of the month, whichever is greater
- If retiring, coverage ends end of the month, unless you retire on the first of a month, in which case coverage ends on the first of the month
- The date the Plan ends.
- The date you stop making the required contributions.
- The date you are no longer eligible.
- The date OptumRx receives written notice from Columbia University to end your coverage, or the date requested in the notice, if later.
- The date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

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

- 21 days after the employee's coverage ends or the end of the month, whichever is greater
- If dependent of retiree, coverage ends the end of the month.
- The last day of the month you stop making the required contributions.
- The last day of the month OptumRx receives written notice from Columbia University to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior 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, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If OptumRx and Columbia University find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Columbia University has the right to demand that you pay back all Benefits Columbia University paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to Columbia University proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon Columbia University's request, that the child continues to meet these conditions.

The proof might include medical examinations at Columbia University's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 10, *Glossary*.

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

Continuation Coverage under Federal Law (COBRA)

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

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

- An Employee.
- An Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law.
- An Employee's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

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

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

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

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

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

How Your Medicare Eligibility Affects Dependent COBRA Coverage

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

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

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

Getting Started

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

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

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

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

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

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

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.
- 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 Department with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 11, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

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

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

When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date 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.

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.
- 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.

SECTION 9 - OTHER IMPORTANT INFORMATION

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with OptumRx and Columbia University

In order to make choices about your health care coverage and treatment, Columbia University believes that it is important for you to understand how OptumRx interacts with the Plan Sponsor's benefit Plan and how it may affect you. OptumRx helps administer the Plan Sponsor's benefit plan in which you are enrolled. OptumRx does not provide medical services or make treatment decisions. This means:

- OptumRx communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Columbia University and OptumRx may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Columbia University and OptumRx will use individually identifiable information about you as permitted or required by law, including in operations and in research. Columbia University and OptumRx will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Columbia University, OptumRx and In-Network providers are solely contractual relationships between independent contractors.

Although In-Network providers may be Columbia University's agents or employees that does not change the relationship for the purposes of the benefit plan.

In-Network Providers are not agents or employees of OptumRx.

Columbia University and any of its employees are not agents or employees of In-Network providers. Although they may be employees of Columbia University, that does not change the relationship for the purposes of the benefit plan.

OptumRx and any of its employees are not agents or employees of In-Network providers.

Although Columbia University does provide health care services or supplies and practice medicine through their onsite clinic, that does not change the relationship for purposes of the benefit plan.

OptumRx does not provide health care services or supplies, nor do they practice medicine.

Instead, Columbia University and OptumRx arrange for health care providers to participate in a network and administer payment of Benefits. OptumRx's credentialing process confirms public information about the pharmacies' licenses and other credentials, but does not assure the quality of the services provided.

Although In-Network Providers may be Columbia University's employees, that does not change the relationship for the purposes of the benefit plan.

In-Network Providers are not employees of OptumRx.

Columbia University and OptumRx are not liable for any act or omission of any pharmacy.

OptumRx is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Columbia University is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to OptumRx.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

Relationship with Providers

The relationships between Columbia University, OptumRx and In-Network providers are solely contractual relationships between independent contractors. In-Network providers are not Columbia University's agents or employees, nor are they agents or employees of OptumRx. Columbia University and any of its employees are not agents or employees of In-Network providers, nor are OptumRx and any of its employees agents or employees of In-Network providers.

Columbia University and OptumRx do not provide health care services or supplies, nor do they practice medicine. Instead, Columbia University and OptumRx arrange for health care providers to participate in a network and administer payment of Benefits. OptumRx's credentialing process confirms public information about the pharmacies' licenses and other credentials, but does not assure the quality of the services provided. They are not Columbia University's employees nor are they employees of OptumRx. Columbia University and OptumRx are not liable for any act or omission of any pharmacy.

OptumRx is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Columbia University is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to OptumRx.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

Interpretation of Benefits

Columbia University and OptumRx have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Columbia University and OptumRx may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Columbia University may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Columbia University does so in any particular case shall not in any way be deemed to require Columbia University to do so in other similar cases.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Usual and Customary Charges.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes In-Network providers you choose and providers to whom you have been referred.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Columbia University is that of employer and employee, Dependent or other classification as defined in the SPD.

Information and Records

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

Columbia University and OptumRx 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 is required to do by law or regulation. During and after the term of the Plan, Columbia University and OptumRx 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 pharmacy records or billing statements Columbia University 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 pharmacy forms or records from OptumRx, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, Columbia University and OptumRx will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. OptumRx's 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 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 your ID card if you have any questions.

The Plan Sponsor does not permit coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible or out-of-pocket maximum.

Workers' 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 University 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 University'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 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 University 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 University 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 University 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. A copy of the plan document is 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 this document by written request to the Plan Administrator, for a nominal charge.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 7, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling the telephone number on your ID card.

SECTION 10 - GLOSSARY

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 Deductible is shown in the first table in Section 4, *Plan Highlights*. If you are enrolled in the Health Savings Plan, the deductible must be met first for prescription drugs that are consider non-preventative than copayments apply.

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

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that OptumRx identifies as a Brand-name product, based on available data resources including, but not limited to, Medi-Span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by OptumRx.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Claims Administrator – OptumRx, Inc. and its affiliates, who provide certain claim administration services for the Plan.

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

Coinsurance - Coinsurance for a Prescription Drug Product at an In-Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug Product at an Out-of-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.

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) - Copayment for a Prescription Drug Product at an In-Network or Out-of-Network Pharmacy is a specific dollar amount.

Covered Health Services - those health services, including services, supplies or Prescription Drug Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this SPD.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 5, *Exclusions and Limitations*.

Covered Person - either the Employee or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Domestic Partner - a person of the same sex with whom the Employee has established a Domestic Partnership.

Domestic Partnership - a relationship between an Employee and one other person of the same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a same-sex Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent
- They must have power of attorney.

The Employee and same-sex Domestic Partner must jointly sign an affidavit of domestic partnership provided by the Benefits Department upon your request.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.

- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Employee - an Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. 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 –The Trustees of Columbia University,om the City of New York

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator 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.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials.
- If you are not a participant in a qualifying clinical trial and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator 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, the Claims Administrator must determine that, although

unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that OptumRx identifies as a Generic product based on available data resources including, but not limited to, Medi-Span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by OptumRx.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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

In-Network Pharmacy (or In-Network provider) - a pharmacy that has:

- Entered into an agreement with OptumRx or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by OptumRx as an In-Network Pharmacy.

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.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card.

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 Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by OptumRx's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

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

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount.

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 OptumRx Prescription Drug Plan.

Plan Administrator - The Trustees of Columbia University in the City of New York or its designee.

Plan Sponsor - Columbia University.

Predominant Reimbursement Rate - the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at an Out-of-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at an Out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax. OptumRx calculates the Predominant Reimbursement Rate using its Prescription Drug Product Charge that applies for that particular Prescription Drug Product at most In-Network Pharmacies.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Prescription Drug Charge - the rate the Plan has agreed to pay OptumRx on behalf of its In-Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at an In-Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to OptumRx's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting OptumRx at the number on your ID card or by logging onto www.myuhc.com.

Prescription Drug List (PDL) Management Committee - the committee that OptumRx designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - Standard insulin syringes with needles.
 - Blood-testing strips - glucose.
 - Urine-testing strips - glucose.

- Ketone-testing strips and tablets.
- Lancets and lancet devices.
- Glucose meters, including continuous glucose monitors.
- Certain vaccines/immunizations administered in a Network Pharmacy.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications (PPACA Zero Cost Share) - the medications that are obtained at an In-Network Pharmacy and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives at www.myuhc.com or by calling OptumRx at the number on your ID card.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. You may access a complete list of Specialty Prescription Drug Products at www.myuhc.com or by calling the number on your ID card.

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

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted

randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

OptumRx has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, OptumRx issues drug policies that describe the clinical evidence available with respect to specific health care services. These drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), OptumRx may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, OptumRx must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at OptumRx's discretion. Other apparently similar promising but unproven services may not qualify.

University – Columbia University

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 11 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA**What this section includes:**

- Plan administrative information, including your rights under *ERISA*.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by *ERISA* as defined in Section 10, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

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

Plan Administrator - Medical Plan
Trustees of the Columbia University in the City of New York
615 West 131st Street
4th Floor
New York, NY 10027
(212) 851-7000

Claims Administrator

OptumRx is the Plan's Claims Administrator. 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.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

OptumRx.
2950 Expressway Drive South
Suite 240
Islandia, NY 11749-1412
ATTN: Claims Department
P.O. Box 29077
Hot Springs, AR 71903

Agent for Service of Legal Process

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

Agent for Legal Process - Medical Plan
The Trustees of Columbia University In the City of New York
615 West 131st Street
4th Floor
New York, NY 10027
(212) 851-7000

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a welfare Plan that for Actives is self-funded and for Retirees is funded by a Trust and the administration is provided through one or more third party administrators.

Actives:

Plan Name:	Columbia University in the City of New York Group Benefits Plan
Plan Number:	515
Employer ID:	13-5598093
Plan Type:	Welfare benefits plan
Plan Year:	January 1 - December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Columbia University
Source of Benefits:	Assets of the University

Retirees:

Plan Name:	Columbia University Retiree Medical and Life Insurance Benefits Plan
Plan Number:	517
Employer ID:	13-5598093
Plan Type:	Welfare benefits plan
Plan Year:	July 1 – June 30
Plan Administration:	Trust
Source of Plan Contributions:	Retired Employees and the Plan Sponsor
Source of Benefits:	The Trust

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.

- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided under *How to Appeal a Denied Claim* in Section 6, *Claims Procedures*.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, *ERISA* imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under *ERISA*.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 6, *Claims Procedures*, for details.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it 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 for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the

nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor*, listed in your telephone directory, or write to the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publications hotline of the *Employee Benefits Security Administration* at 1-866-444-3272.

The Plan's Benefits are administered by Columbia University, the Plan Administrator. OptumRx is the Claims Administrator and processes claims for the Plan and provides appeal services; however, OptumRx and Columbia University are not responsible for any decision you or your Dependents make to receive Prescription Drug Products, whether provided by an In-Network Pharmacy or Out-of-Network Pharmacy. OptumRx and Columbia University are neither liable nor responsible for the Prescription Drug Products provided by In-Network Pharmacy or Out-of-Network Pharmacy.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's In-Network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's In-Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to UnitedHealthcare Service LLC, on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
UnitedHealthcare Service LLC Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

