Addendum to Summary Plan Description
for the Davidson College Group Health Plan – High
Deductible HSA Plan

Prescription Drug Coverage – Administered by Express Scripts
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PRESCRIPTION DRUG COVERAGE

As a Participant in the High Deductible HSA Plan, you are eligible for the prescription drug coverage described on the following pages. This coverage is provided by Davidson College and administered by Express Scripts. With your prescription drug coverage, you may purchase Prescription Drugs through a network retail pharmacy, Express Scripts’ Home Delivery Pharmacy and Accredo Specialty Pharmacy. Specialty medications must be obtained thru Accredo, Express Scripts specialty pharmacy. See Specialty Pharmacy section for additional details. Some exceptions apply.

COVERAGE STATEMENT

The prescription drug coverage described in this booklet is effective January 1, 2018 and is administered by Express Scripts. The coverage information applies to Participants in the High Deductible HSA Plan. Like all other coverage sponsored by Davidson College, prescription drug coverage is not guaranteed. Davidson College hopes to continue the High Deductible HSA Plan, but reserves the right to change or discontinue all or part of the medical plan or this prescription drug coverage at any time. Premiums, copayments/co-insurance and all other charges or fees paid by a participant may change from year to year.

This booklet states the terms and conditions under which prescription drug coverage is available through the High Deductible HSA Plan. The terms and conditions stated in this booklet shall control in the case of any question or dispute concerning such coverage.

The prescription drug coverage is not insured by Express Scripts; it is paid from Davidson College funds. Express Scripts provides certain administrative services under the program. The program is an ERISA-covered plan.
**DEFINITIONS**

**Accredo Specialty Pharmacy Services:** A pharmacy that dispenses specialty medications (e.g., injectables and supplies) and provides care management services to assist with therapy.

**Brand-Name Drug:** A Prescription Drug that is protected by a patent, supplied by a single company and marketed under the manufacturer’s brand name.

**Co-insurance:** The percentage of charges a Participant is required to pay for Formulary Brand-Name and Generic Drugs.

**Copayment (Copay):** The specified charge you are required to pay for a Covered Drug.

**Covered Drug:** Prescription Drugs and certain supplies that are covered.

**Eligible Dependent:** One of the following:

- Your Spouse or Domestic Partner
- Your, your Spouse’s, or your 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

**Formulary:** A list of Federal Drug Administration (FDA) approved Prescription Drugs and supplies developed by a Pharmacy and Therapeutics Committee, and/or customized by Davidson College. This list reflects the current clinical judgment of practicing health care practitioners—based on a review of current data, medical journals, and research information. In your prescription drug coverage, the Formulary Drug list is used as a guide for determining your costs for each prescription. Drugs not listed on the Formulary are not covered.

**Formulary Drug:** A Brand-Name Drug that is listed on your Formulary. It is also referred to as a “preferred brand drug.”

**Generic Drug:** A Prescription Drug that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and is approved by the FDA.

**Generic Policy:**
If your doctor writes a prescription stating that a Generic may be dispensed, and you choose the Brand name drug, you will pay the Brand co-pay plus the difference in cost between the Generic and Brand name drug. This expense does not apply to the deductible or the out of pocket maximum.

**Health Plan Subscriber:** An individual who is a subscriber under the High Deductible HSA Plan and is properly enrolled in the High Deductible HSA Plan, as determined by Davidson College. The term “you” or “your” refers to the Health Plan Subscriber.

**Home Delivery Pharmacy:** An Express Scripts’ mail-order pharmacy that is under contract with Davidson College to fill prescriptions by mail for Participants under this coverage.
**Maintenance Drug:** A medication that is used for chronic health conditions on an ongoing or long-term basis (e.g., antihypertensive medication taken daily to control high blood pressure).

**Maximum Out-of-Pocket:** The maximum amount a Participant pays for covered prescription drug expenses per calendar year. Once the maximum expense limit is met, the Participant pays nothing for Covered Drugs for the remainder of the year.

**Preferred Retail Pharmacy (Network):** A retail pharmacy that is under contract with Express Scripts that provides lower copays and/or co-insurance.

**Not covered/Non-Formulary Drug:** A Brand-Name drug that is not included on the Formulary and the Participant is responsible for paying 100% of the drug cost. Covered Generic and/or Preferred Brand-Name Drug therapeutic alternatives are available for Non-Formulary Drugs.

**Non-preferred Retail Pharmacy (Network):** A retail pharmacy that is under contract with Express Scripts but features higher copays and/or co-insurance.

**Over-the-Counter Drug (OTC):** Any medical substance that can be purchased without a prescription.

**Participant:** A Health Plan Subscriber or Eligible Dependent, as determined by Davidson College, who has met all conditions of eligibility and has successfully enrolled under this program.

**Prescription Drug:** Any medication, which by federal or state law, may not be dispensed without a prescription from a licensed health care professional authorized to prescribe drugs.

**Prior Authorization:** Verification that must be obtained before a medication is dispensed to ensure it is being used for a medically-approved indication.

**Proton Pump Inhibitor (PPI):** A class of drugs primarily used to treat conditions such as frequent heartburn and Gastro Esophageal Reflux Disease (GERD).

**Quantity Level Limit (QLL):** Specific maximum quantity per dispensing, allowed for a drug.

**Step Therapy:** The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails.
ENROLLMENT PROVISIONS

The prescription drug coverage provided by Davidson College is combined with a medical plan. To be enrolled in Davidson College prescription drug coverage, you must be enrolled in the High Deductible HSA Plan. Enrollment eligibility is defined in accordance with the terms of the High Deductible HSA Plan.

COVERED DRUGS AND SUPPLIES*

The following Covered Drugs and supplies are available at Network Retail Pharmacies and through Express Scripts’ Home Delivery Pharmacy and Accredo Specialty Pharmacy:

- FDA-approved pharmaceuticals requiring a written prescription, issued by a licensed physician, dentist, osteopath, podiatrist, optometrist (licensed professionals) or licensed advance practice certified nurse and dispensed by a licensed pharmacist. Exceptions: See Exclusion list below and Formulary list

- Insulin and diabetic testing supplies including:
  - Insulin
  - Blood test strips
  - Alcohol prep pads
  - Lancets
  - Insulin needles and syringes
  - Insulin injectors
  - Glucagon emergency kits
  - Blood glucose meter testing solutions

  To obtain coverage for the items listed above, a written prescription from your doctor indicating that the medication or supply item is prescribed for the diagnosis or treatment of your diabetes is required.

- Prescription contraceptives, including oral, transdermal, intravaginal, implantable devices, injectable, diaphragms, IUD’s and extended cycle products.

- ADD/ADHD Medications

- Androgens and Anabolic Steroids (prior authorization required)

- Topical Acne Medications

- Impotency Medications (quantity limits apply)

- Narcolepsy Medications (prior authorization required)
• Growth Hormones (prior authorization required)
• Migraine medications (quantity limits apply)
• Hypnotics (quantity limits apply)
• Pain/Narcotics (quantity limits apply)
• Gastrointestinal-Antiemetics (quantity limits apply)
• Topical Analgesic Pain Patches (quantity limits apply)
• Prescription Vitamins
• Prescription and OTC smoking cessation (two 12 week programs per plan year); OTC requires prescription

*This is not an inclusive list but is a representation of the most commonly used medications. Contact member services for specific drug coverage information. To view the ESI formulary now, please access the Express Scripts website at www.express-scripts.com/NATPLSNATPREF14
COVERAGE FEATURES AND FINANCIAL RESPONSIBILITIES

Copayments/Co-insurance

Copayments/Co-insurance must be paid at the time the prescription order is submitted. Note: If the cost of the drug is less than the Copayment, you will pay the lower amount. Copayment and Co-insurance amounts are based on the type of medication. Generic and Brand-Name medication types are established and updated periodically by a nationally recognized drug pricing and classification source. Medication Formulary status may change without advance notice. You will be required to pay the applicable Copayment/Co-insurance for the Covered Drug when the Formulary status of a medication changes until your Maximum Out-of-Pocket is met. To confirm a Copayment/Co-insurance amount before you have a prescription filled, sign in at express-scripts.com or call Express Scripts toll-free at 1-866-727-5873.

Retail Pharmacies

With the appropriate prescription, you can obtain up to a maximum 30-day supply of brand medication. Up to a 90-day supply of generic medications is available at a retail pharmacy at 2.5 times the retail Copay.

Preferred Network Retail Pharmacies — The preferred network includes more than 59,000 independent and chain pharmacies nationwide. The network currently includes, but is not limited to, large chain pharmacies like CVS, Target, Rite-Aid, Giant Eagle, Wal-Mart and Kröger. You only pay what the coverage requires for covered medications when your pharmacy participates in the network. The network is subject to change.

For a list of network pharmacies, call Express Scripts toll-free at 1-866-727-5873 or visit www.express-scripts.com. The retail pharmacy network includes more than 59,000 preferred and 10,000 non-preferred independent and chain pharmacies nationwide.

When you have your prescriptions filled at a Network Retail Pharmacy, your Copayment/Co-insurance amounts are as follows:

<table>
<thead>
<tr>
<th>2018 Retail Pharmacy Coverage (30 day supply)</th>
<th>Preferred Retail</th>
<th>Non-Preferred Retail Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$2,700 individual / $5,400 family</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>20% Coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Formulary Brand</strong></td>
<td>30% Coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Non-Formulary Brand</strong></td>
<td>40% Coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>Combined with Medical</td>
<td>Combined with Medical</td>
</tr>
</tbody>
</table>
Out-of-Network U.S. Retail Pharmacy — If you obtain your prescriptions from an Out-of-Network Retail Pharmacy, you will pay the full price of the medication at the time of purchase. Out-of-Network Retail Pharmacies have not agreed to discount pricing, so your costs will usually be higher.

Foreign Pharmacies — If you obtain your prescriptions from a pharmacy outside of the United States or Puerto Rico, you will pay the full price of the medication at the time of purchase. If you are visiting for an extended period of time, you can fill your prescription using Express Scripts Home Delivery Pharmacy before you go. You can request a vacation override to receive up to six month supply of medication in this situation.

Home Delivery Pharmacy — With the appropriate prescription, you can obtain up to a maximum 90-day supply of medication through Express Scripts’ Home Delivery Pharmacy. Copayments/Co-insurance must be paid at the time the order is submitted. Medications will generally be delivered to your home within two weeks from the date Express Scripts receives your prescription order. You are responsible for any applicable postage when mailing prescriptions to Express Scripts.

When you have your prescriptions filled through the Home Delivery Pharmacy, your Copayment/Co-insurance amounts are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2018 Home Delivery Pharmacy (90 day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$2,700 individual / $5,400 family</td>
</tr>
<tr>
<td>Generic</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Formulary Brand</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>Non-Formulary Brand</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>Combined with Medical</td>
</tr>
</tbody>
</table>
SPECIALITY PHARMACY / DRUG

Specialty Medications – Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through Accredo, Express Scripts’ specialty pharmacy. Some exceptions apply. These medications are limited to a 30-day supply. Specialty medications largely fall into the formulary brand category, but could also fall into the biosimilar or generic specialty drug category. These medications are subject to the appropriate co-insurance as listed below. Accredo Specialty Pharmacy also offers pharmaceutical care management services designed to provide you with assistance throughout your treatment.

Specialty medications must be dispensed by Accredo Specialty Pharmacy. With the appropriate prescription, you can obtain up to a maximum 30-day supply of medication. Medications will be shipped to your home within 24–72 hours of receiving your order. If you obtain a prescription for a specialty medication from a retail pharmacy, beginning with your second fill, you will be required to fill the specialty medication through Accredo Specialty Pharmacy. Starting January 1, 2018 copayments for certain specialty medications may be set to the maximum available from the manufacturer-funded copay assistance. Prescriptions filled through Accredo Specialty Pharmacy provider are subject to the following Copayments/Co-insurance for up to a 30-day supply:

<table>
<thead>
<tr>
<th>2018 Specialty Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
</tr>
<tr>
<td>Specialty Medications</td>
</tr>
</tbody>
</table>
COVERAGE LIMITATIONS

- Up to a maximum 30-day supply of brand medication per original prescription or refill, as prescribed by your doctor, may be obtained at one time from a Network Retail Pharmacy (excludes Over-the-Counter PPIs). May not be filled more than once in a 30-day period.

- Up to a maximum 90-day supply of medication per original prescription or refill, as prescribed by your doctor, may be obtained through Express Scripts’ Home Delivery Pharmacy.

- Prescribed medications, especially certain controlled substances, may be subject by law to dispensing limitations and to the professional judgment of the pharmacist.
  - Through Express Scripts’ Home Delivery Pharmacy or specialty pharmacy, if your doctor prescribes a drug that is available as both a Generic Drug and a Brand-Name Drug, the Generic Drug will be dispensed if allowed by state law unless you or your doctor specifically indicates otherwise.
  - Drug manufacturer coupons cannot be used toward Copayment/Co-insurance costs when using Express Scripts’ Home Delivery Pharmacy.

COVERAGE EXCLUSIONS*

Coverage is not provided for:

- Biologicals, Vaccines, Immunization Agents
- Blood Products and Serums
- Cosmetic agents: Anti-wrinkle agents, Pigmenting & De-Pigmenting, Hair growth stimulants and hair removal products
- Compounded prescriptions that use ingredients such as bulk chemicals and powders
- Anti-obesity/Appetite Suppression medications
- Infertility Medications
- Nutritional Supplements
- Formulary Exclusion List
- OTC Products unless notes above
- Therapeutic devices or appliances unless listed as a covered product.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a physician’s office, licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a
facility for dispensing pharmaceuticals. (These medications are covered under the medical benefit
• Charges you are not required to pay or charges made only because health care coverage exists (subject to the right, if any, of the U.S. government to recover reasonable and customary charges for care provided in a military or veterans’ hospital);
• Medication for which coverage is payable under workers’ compensation or any occupational disease or similar law, whether such coverage is insured or self-insured;
• Durable medical equipment (DME) and other therapeutic devices or appliances;
• Drugs whose FDA-approved indication is to promote or stimulate hair growth regardless of the prescriber’s intended use;
• Drugs whose FDA-approved indication is for cosmetic purposes regardless of the prescriber’s intended use;
• Drugs or medicines lawfully obtainable without a prescription order of a licensed authorized prescriber, except insulin;
• Any charge for the administration or injection of any drug;
• Any diagnostic or testing supply(e.g., contrast dyes);
• Any amount of brand-name medicine that is more than a 30-day supply filled at the Network Retail Pharmacy or more than a 90-day supply filled through Express Scripts’ Home Delivery Pharmacy;
• Drugs that may be received by a Health Plan Subscriber or an Eligible Dependent at no charge under local, state or federal programs;
• Any prescription or refill in excess of the number specified by the licensed professional or applicable law or any refill dispensed after one year from the licensed professional’s original order;
• Drugs prescribed for sickness or injury resulting from war or acts of war;
• Experimental, investigational or unproven drugs, or drugs used for a treatment not approved by the FDA, even though a charge is made to the covered person;
• Compounded preparations that: include components not approved by the FDA (e.g., bioidentical hormones); are not approved by the FDA (e.g., transdermal verapamil); or are deemed experimental, investigational or unproven by the FDA;
• Depigmentation Agents;
• Homeopathic Drugs;
• Legend Medical Foods;
• Allergens;
• OTC PPIs

*This is not an inclusive list but is a representation of the most commonly used medications. Contact member services for specific drug coverage information. To view the ESI formulary now, please access the Express Scripts website at www.express-scripts.com/NATPLSNATPREF14
COMPOUND DRUGS

For compound drugs to be covered, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. That list may be obtained from Express Scripts. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable (e.g. if the cost of any ingredient has increased more than 5% every other week or more than 10% annually), the cost will not be considered reasonable. Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under this coverage.

PRIOR AUTHORIZATION

Certain Prescription Drugs are subject to Prior Authorization or need to be preapproved by Express Scripts before they will be a Covered Drug. Drugs subject to Prior Authorization may cause potentially serious side effects and/or have a high potential for inappropriate use. Physicians now have access to EPA (electronic prior authorization), which is a process that allows the prescriber to request and complete a Prior Authorization (PA) with Express Scripts electronically from the electronic medical record (EMR) used in their normal daily workflow.

Your doctor may initiate the Prior Authorization process by calling Express Scripts toll-free at 1-800- 417- 8164 or by fax at 1-800-357-9577. They can also initiate using the ExpressPAth web-based portal at www.Express-PAth.com after completing the registration process. If you plan to have your prescription for a Prior Authorization drug filled at a Network Retail Pharmacy, consider working with your provider and completing the Prior Authorization process before you go to the Network Retail Pharmacy. A registered pharmacist working at the Network Retail Pharmacy may also initiate or assist in the process. If you pay out of pocket waiting for a Prior Authorization approval, be aware that reimbursement will only be for 90 days from the approval date.

If approved, your prescription will be filled within any stated coverage limits. If the medication is not approved for coverage, you will be responsible for paying the full cost of the drug. However, rejection of coverage may be appealed. To appeal, you or your doctor must follow the procedure outlined in the Appeals section on page 18.
COVERED DRUG LIMITATIONS

Certain Prescription Drugs are covered up to preset limits. These limits are based upon standard FDA approved dosing for the medications. If you request that a prescription be filled for a drug that is subject to quantity limitations, the prescription will be filled up to the preset limits. In some cases, it may be medically necessary for you to exceed the preset limits. In those instances, Prior Authorization is required. In such cases your doctor may initiate Prior Authorization by calling Express Scripts’ Prior Authorization Department toll-free at 1-800-417-8164. Several hundred drugs are subject to quantity limitations for patient safety based on FDA guidelines. The following are the top ten drug categories based on Davidson College Participant utilization that reach Quantity Level Limits (QLL):

- Sleep
- Nausea/Vomiting
- Infection
- Migraine Headache
- Fungal Infection
- Osteoporosis Medications
- Pain Medications
- Cholesterol Medications
- Pain and Inflammation Medications
- Viral Infection Medications

For more information about specific drugs subject to coverage limitations, please call Express Scripts.

STEP THERAPY

Certain Prescription Drugs are subject to Step Therapy review. Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails. If Step Therapy criteria are not met, Prior Authorization will be required. Your doctor may initiate the Prior Authorization process by calling Express Scripts’ Prior Authorization Department toll-free at 1-800-417-8164. If you pay out-of-pocket waiting for a prior authorization to be approved, please be aware that reimbursement will only be for 90 days from the approval date.

If approved, your prescription will be filled within any stated coverage limits. If the medication is not approved for coverage, you will be responsible for paying the full cost of the drug. However,
rejection of coverage may be appealed. To appeal, you or your doctor must follow the procedure outlined in the Appeals section on page 18.

**MAKING A COMPLAINT**

This section explains how to use the process for filing a complaint with Express Scripts. The complaint process is used for problems related to quality of care, waiting times, and the customer service you receive from Express Scripts. Here are examples of the kinds of problems handled by the complaint process. If you have any of these problems you can file a complaint:

- Disrespect, poor customer service, or other negative behaviors
- Unhappy about how Customer Service has dealt with you
- Kept waiting too long by a pharmacist or Customer Service
- Unhappy with the cleanliness or condition of a pharmacy
- Believe the written information Express Scripts has given you is too hard to understand
- Believe Express Scripts has not given you the notice they are required to give
- Right to privacy was not respected

Reasons for possible complaints may also be related to the timeliness of Express Scripts’ actions in respect to the coverage decisions and appeals process. If you have already asked for a coverage decision or made an appeal, and you think Express Scripts is not responding quickly enough, you can also make a complaint about their response time:

- You asked Express Scripts to give you a ‘fast response’ and they have said they will not.
- You believe Express Scripts is not meeting the deadlines for giving you a coverage decision or answer to an appeal.
- You believe Express Scripts is not meeting the deadlines for covering or reimbursing you for an approved coverage decision or appeal.
- Express Scripts does not give you a decision on time, and fails to forward your case to the Independent Review Entity within the required time limit.

**Who Can File a Complaint?**

You can file a grievance yourself, or you can have someone act for you. If you want a friend, relative, your doctor, or other person to be your representative, call Express Scripts Customer
Service and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give Express Scripts a copy of the signed form.

**Contact Express Scripts to File a Complaint**

Call Express Scripts at the number on the back of your prescription ID card for filing a grievance. If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to Express Scripts. The complaint must be made within 60 calendar days after you had the problem you want to complain about.

If you are making a complaint because Express Scripts denied your request for a fast response to a coverage decision or appeal, Express Scripts will automatically give you a fast complaint. If you have a “fast” complaint, it means Express Scripts will give you an answer within 24 hours.

**Express Scripts Reviews Your Complaint and Gives you an Answer**

If possible, Express Scripts will answer you right away. If you call Express Scripts with a complaint, they may be able to give you an answer on the same phone call. If your health condition requires Express Scripts to answer quickly, Express Scripts will do that.

Most complaints are answered in 30 calendar days. If Express Scripts needs more information and the delay is in your best interest or if you ask for more time, they can take up to 14 more days to answer your complaint. In some cases, you can get a fast grievance, and they will respond within 24 hours.

If Express Scripts does not agree with some or all of your complaint or doesn’t take responsibility for the problem you are complaining about, they will let you know. Express Scripts’ response will include reasons for this answer. Express Scripts must respond whether they agree with the complaint or not.
CLAIMS PROCEDURE

You must use and exhaust the administrative claims and appeals procedure set forth below before bringing a suit in either state or federal court. Similarly, failure to follow the prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

A pre-service claim is a request for coverage of a medication when your coverage requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided you have submitted sufficient information to decide your claim. A post-service claim is a request for coverage or reimbursement when you have already received the medication. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, you will be notified that the claim is missing information within 15 days from receipt of your pre-service claim and 30 days from receipt of your post-service claim. You will have 45 days to provide the information. Hall of the needed information is received within the 45-day time-frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don’t provide the needed information within the 45-day period, your claim is considered “deemed” denied and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call 1-800-753-2851. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Urgent Claims (Expedited Reviews)

An urgent care claim is defined as a request for treatment when, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. In the case of a claim for coverage involving urgent care, you will be
notified of the benefit determination within 72 hours of receipt of the claim provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If you don’t provide the needed information within the 48-hour period, your claim is considered “deemed” denied and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call 1-800-753-2851. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Non-Urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered “deemed” denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

Your name

Member ID

Phone number

The prescription drug for which benefit coverage has been denied, and

Any additional information that may be relevant to your appeal.

This information should be mailed to Express Scripts, P.O. Box 631850, Irving, TX 75063-0030

Attn: Appeals. A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If your appeal is denied, the denial notice will include information to identify the
claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call 1-800-753-2851. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If you are not satisfied with the coverage decision made on your appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing:

- Your name
- Member ID
- Phone number
- The prescription drug for which benefit coverage has been denied, and
- Any additional information that may be relevant to your appeal.

This information should be mailed to Express Scripts, PO Box 631850, Irving, TX 75063-0030 Attn: Appeals. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered in relation to your appeal, the provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call 1-800-753-2851. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where
notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your final adverse benefit determination') or your initial benefit denial notice or any appeal denial notice (i.e., any ‘adverse benefit determination notice’ or “final adverse benefit determination’) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (‘ERISA’), you have the right to bring a civil action under ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under ERISA, you have the right to an independent review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the prescription drug coverage (e.g., prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

**Urgent Appeal (Expedited Review)**

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. To initiate an urgent claim or appeal request, you or your physician (or other authorized representative) must call 1-800-753-2851 or fax the request to 1-888-235-8551. Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your claim or appeal be considered for urgent processing. In the case of an urgent appeal (for coverage involving urgent care), you will be notified of the benefit determination within 72 hours of receipt of the claim. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered in relation to your appeal, the provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal You also have the right to request the diagnosis code and treatment code and their
corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call 1-800-753-2851. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

If your appeal is denied and you are not satisfied with the decision of the appeal (i.e., your “final adverse benefit determination”) or any appeal denial notice (i.e., “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under ERISA, you have the right to bring a civil action under ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if your appeal is denied and you are not satisfied with the decision (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., your “adverse benefit determination” or “final adverse benefit determination”) does not contain all of the information required under ERISA, you have the right to an independent external review by an external review organization.

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize your life or health or your ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. If you are not satisfied or you do not agree with the determination of the external review organization, you have the right to bring a civil action under ERISA section 502(a).

Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the prescription drug coverage (e.g., prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

**External Review Procedures**

The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the prescription drug coverage (e.g., prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be
eligible for an independent external review, you must exhaust the internal claim review process
described above, unless your claim and appeals were not reviewed in accordance with all of the
legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the
case of an urgent appeal, you can submit your appeal in accordance with the above process and
also request an external independent review at the same time, or alternatively you can submit your
urgent appeal for the external independent review after you have completed the internal appeal
process.

To file for an independent external review, your external review request must be received within
4 months of the date of the adverse benefit determination (If the date that is 4 months from that
date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should
be mailed or faxed to: Express Scripts, Attn: External Review Requests, P.O. Box 631850, Irving
TX 75063-0030. Phone: 1-800-753-2851. Fax: 1-888-235-8551.

Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5
business days to determine if it is eligible to be forwarded to an Independent Review Organization
(IRO) and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an
IRO and your appeal information will be compiled and sent to the IRO within 5 business days.
The IRO will notify you in writing that it has received the request for an external review and if the
IRO has determined that your claim involves medical judgment or rescission, the letter will
describe your right to submit additional information within 10 business days for consideration to
the IRO. Any additional information you submit to the IRO will also be sent back to the claims
administrator for reconsideration. The IRO will review your claim within 45 calendar days and
send you, the prescription drug coverage sponsor, and Express Scripts written notice of its
decision. If you are not satisfied or you do not agree with the decision, you have the right to bring
civil action under ERISA section 502(a). If the IRO has determined that your claim does not
involve medical judgment or rescission, the IRO will notify you in writing that your claim is
ineligible for a full external review and you have the right to bring civil action under ERISA section
502(a).

Urgent External Review

Once you have submitted your urgent external review request, your claim will immediately be
reviewed to determine if you are eligible for an urgent external review. An urgent situation is one
where in the opinion of your attending provider, the application of the time periods for making
non-urgent care determinations could seriously jeopardize your life or health or your ability to
regain maximum function or would subject you to severe pain that cannot be adequately managed
without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will immediately be reviewed to determine if
your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If
your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an
IRO and your appeal information will be compiled and sent to the IRO. The IRO will review
your claim within 72 hours and send you, the prescription drug coverage sponsor, and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA’s

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA
This section includes information on the administration of the Prescription Drug Plan, as well as information required of all Summary Plan Descriptions by ERISA.

Plan Sponsor and Administrator
Davidson College is the Plan Sponsor and Plan Administrator of the Davidson College Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:
Plan Administrator
Davidson College
Box Number: 7163
209 Ridge Road
Davidson, NC 28035
(704) 894-2000

Claims Administrator
Express Scripts 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 College. 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 or mail at the number on your ID card.

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:

Davidson College
Box Number: 7163
209 Ridge Road
Davidson, NC 28035
(704) 894-2000

Legal process may also be served on the Plan Administrator.

Type of Administration

<table>
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<tr>
<th><strong>Plan Name:</strong></th>
<th>Davidson College Welfare Benefit Plan</th>
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<td><strong>Plan Number:</strong></td>
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<tr>
<td><strong>Plan Year:</strong></td>
<td>January 1 - December 31</td>
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<tr>
<td><strong>Plan Administration:</strong></td>
<td>Self-Insured</td>
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Source of Plan Contributions:  Employee and College
Source of Benefits:            Assets of the College

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 above.

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.