Summary Plan Description for

Prescription Drug Benefit Plan
Managed by Express Scripts, Inc.

for

Washington University in St. Louis

Effective 1/1/2015
Washington University In St. Louis
Prescription Drug Benefit Plan

Table of Contents

Section 1 – Definitions  2
Section 2 – Benefit Highlights  5
Section 3 – Coverage Limits  9
Section 4 – Expenses Not Covered  10
Section 5 – Questions and Appeals  11
Section 6 – General Provisions  13
Prescription drug benefits, as described in this summary, are provided through Express Scripts, Inc. to faculty and staff employees, postdoctoral research appointees, and clinical fellows/trainees who are enrolled in group health insurance plans sponsored by Washington University in St. Louis (the “University”). Eligibility for coverage, effective dates of coverage, termination of coverage, and continuation of coverage for prescription drug benefits are as determined for health care coverage under the University’s group health insurance plans.

Section 1 - Definitions

**Brand-Name Drug**
A medication that is available only from its original manufacturer or from another manufacturer that has a licensing agreement to make the drug with the brand-name manufacturer. These medications are marketed under a recognized brand name. A brand-name drug may have a generic equivalent once the manufacturer is required to allow other manufacturers the opportunity to make the medication.

**Compound Drug**
A medication that consists of two or more ingredients that are weighed, measured, prepared or mixed according to a physician’s prescription order.

**Co-payment/Co-insurance**
A portion of the total plan cost of the drug that must be paid by the member. Co-insurance is stated as a percentage of the total plan cost of the drug.

**Date of Service**
Date on which a prescription is filled or dispensed.

**Days Supply**
The number of days payable by the plan for the dispensed drug.

**Direct Claim**
A reimbursement process whereby the member pays 100% of the prescription drug cost at the time of purchase and then submits a paper claim for reimbursement.

**Dispense-as-Written Rule**
A plan rule that requires a member to use a generic equivalent drug instead of a brand name drug. If the member purchases a brand name drug when a generic equivalent is available, the member will pay the brand drug co-payment plus the difference in cost between the brand name and generic drug.
Federal Legend Drug
A drug that requires a prescription. These drugs can be identified by the presence of “Federal Legend” on the label.

Formulary
A list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. An independent Pharmacy and Therapeutics Committee updates this list regularly based on continuous evaluation of medications. You can contact Express Scripts at 1-877-880-1877 to determine if the brand-name drug you are taking is on the formulary. You can also locate this information at www.express-scripts.com. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your physician or pharmacist. Using drugs on the formulary will keep your costs and Washington University's costs lower.

The plan formulary is subject to change from time-to-time. For example:
- A drug may be moved to a higher or lower co-payment tier
- Additional drugs may be excluded from the formulary
- A limitation may be added on coverage for a formulary-covered drug (e.g., prior authorization or step therapy requirements)
- A formulary-covered brand name drug may be replaced with a formulary-covered generic drug

Generic Drug
Medication that is therapeutically equivalent to a brand medication, but manufactured at a lower cost. The Food and Drug Administration (FDA) requires generic medications to meet the same standards as Multi Source (Brand) Drugs.

In-Network Retail Claims
Claims processed by pharmacies that are included in the member’s pharmacy network.

Maintenance Medication
Medications prescribed for long-term use, (e.g., the medication taken daily by high-blood pressure sufferers or diabetics).

Member
A faculty or staff employee, a postdoctoral research appointee, or an eligible dependent of a faculty or staff employee or postdoctoral research appointee who is enrolled in a group health insurance plans sponsored by the University.

Multi Source (Brand) Drug
Medication that has an FDA generic equivalent substitute available.
Network Pharmacy
A retail pharmacy that has an agreement currently in effect with Express Scripts for this Plan to dispense prescription drugs to members.

Non-Preferred Brand Name Drug
Drugs which are not recommended based on their relative (to other available products) poor performance in efficacy, safety or cost. A non-preferred drug will be dispensed but a higher co-pay will be paid.

Out-of-Pocket Maximum
The most that a member will pay out-of-pocket during the Plan Year in co-pays and co-insurance amounts for covered drugs.

Over-the-Counter (OTC) Products
Medications or products that are available without a prescription or physician intervention. Most of these products are not covered by the prescription benefit. Such medications are also known as non-legend drugs.

Plan
Washington University Welfare Benefit Plan.

Plan Year
The twelve (12) month period beginning each January 1.

Preferred Brand Name Drug
A Brand Name Drug that is not a Non-Preferred Brand Name Drug.

Prior Authorization
A plan rule that requires a member or the member’s physician to obtain prior authorization for the use of certain medications. Without prior authorization, the member may not receive coverage for the medication.

Specialty Drugs
High-cost drugs, including oral, topical, infused, and injectible drugs, that are used to treat rare or complex diseases. Such drugs usually require special handling, require close clinical monitoring and management, and may have limited access or distribution.

Step Therapy Rule
A plan rule that requires a member to first try one or more frontline (first step), clinically effective, lower-cost medications before the plan will cover a “step up” to a higher-cost medication that the member’s physician may have prescribed.
Section 2 - Benefit Highlights

Express Scripts, Inc. administers the prescription drug plan benefits that are available to you if you are enrolled in a University-sponsored group health insurance plan.

Co-payment or Co-insurance Requirements:

- If you are enrolled in any University health plan except the High Deductible Health Plan (HDHP), your co-payments or co-insurance requirements for covered drugs are:

<table>
<thead>
<tr>
<th>Retail Pharmacy (up to a 30-day supply)</th>
<th>Co-Payment/Co-Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Generic Drugs</td>
<td>$10*</td>
</tr>
<tr>
<td>Tier 2 - Preferred Brand Drugs</td>
<td>25% ($40 min - $80 max)</td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Brand Drugs</td>
<td>50% ($60 min - $120 max)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order Pharmacy (up to a 90-day supply)</th>
<th>Co-Payment/Co-Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Generic Drugs</td>
<td>$25*</td>
</tr>
<tr>
<td>Tier 2 - Preferred Brand Drugs</td>
<td>25% ($100 min - $200 max)</td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Brand Drugs</td>
<td>50% ($150 min - $300 max)</td>
</tr>
</tbody>
</table>

*For generic drugs used to treat diabetes and heart disease (high cholesterol and hypertension), the Tier One co-pay is $4 for retail and $10 for mail-order.

<table>
<thead>
<tr>
<th>Specialty Drugs</th>
<th></th>
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<tbody>
<tr>
<td>Generic Specialty Drugs</td>
<td>$10 per 30-day supply</td>
</tr>
<tr>
<td>Brand Specialty Drugs</td>
<td>$100 per 30-day supply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Out-of-Pocket Maximum</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,500 individual; $5,000 family</td>
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</tbody>
</table>

- If you are enrolled in the High Deductible Health Plan, you pay 100% of the plan cost for covered drugs until you have satisfied the calendar year deductible under the HDHP. Once your annual deductible has been satisfied, you pay 20% of the plan cost for covered drugs until the annual out-of-pocket maximum under the HDHP has been met.
Covered Expenses:
- Generic or Brand Name Drugs requiring a prescription under Federal law (or applicable state law) including compound medications of which at least one ingredient is a federal legend drug;
- Diabetic supplies such as test strips, lancets, syringes and needles;
- Preventive prescription and over-the-counter medications and products as required by the Patient Protection and Affordable Care Act (PPACA). See the Preventive Medications and Products section on page 7.

Direct Claims
Your plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. To request reimbursement, send your claim to Express Scripts, P. O. Box 14711, Lexington, KY 40512. This claim will be processed based on your plan benefit. If your claim is denied, you will receive a written notice within 30 days of receipt of the claim, as long as all needed information was provided with the claim. You will be notified within this 30-day period if additional information is need to process the claim, and a one-time extension not longer than 15 days may be requested and your claim pended until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all the needed is received within the 45-day time frame and the claim is denied, you will be notified of the denial within 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your claim will be deemed denied.

Express Scripts (Mail Order) Pharmacy
The Express Scripts Pharmacy mail order program is designed for plan members taking maintenance medications, or those medications taken on a regular basis, for the treatment of long-term conditions such as diabetes, arthritis or heart conditions. The program provides up to a 90-day supply of your maintenance medication, delivered directly to your home or other requested location, postage paid.

To fill your prescription through the Express Scripts Pharmacy, mail your 90-day prescription from your physician, your completed Express Scripts Pharmacy prescription order form, and payment to: Express Scripts Home Delivery Service, P. O. Box 66577, St. Louis, MO 63166-6577. To order online, sign in at www.StartHomeDelivery.com and follow the prompts. To order over the phone, call Patient Customer Service at 1-877-880-1877 to speak with a Member Services representative. If you’d like, Express Scripts can contact your physician to order your 90-day prescription.

To order refills, call Patient Customer Service at 1-877-880-1877 or visit the Order Center on www.express-scripts.com. Refills are normally processed and shipped within 3 to 5 days.

If you are a first-time visitor to the site please take a moment to register. Have your member ID and a prescription number available.
To ensure timely delivery, please place your orders at least two weeks in advance to allow for mail delays and other circumstances beyond our control. If you have any questions concerning your order, or if you do not receive your medication within the designated timeframe, please contact Patient Customer Service at 1-877-880-1877.

**Network Retail Pharmacies**
The Express Scripts pharmacy network is a national network comprised of more than 50,000 participating retail pharmacies. The network includes most major chains, discount, grocery and independent pharmacies, so there is a good chance that your local pharmacy is a participating member of the network. Use one of these Network Pharmacies to fill prescriptions for short-term medications, such as antibiotics. To find a local Network Pharmacy, visit [www.express-scripts.com](http://www.express-scripts.com) or contact Customer Service at 1-877-880-1877.

**Out-of Pocket Maximum**
An annual out-of-pocket maximum of $2,500 per individual or $5,000 per family limits the total amount of co-pays and co-insurance paid for covered drugs during the Plan Year by members enrolled in any University health plan other than the High Deductible Health Plan. Once the member has met the out-of-pocket maximum, the plan will pay 100% of the cost for covered drugs during the remainder of the Plan Year. Amounts a member may pay for non-covered drugs and products or in penalties assessed in connection with the Dispense-as-Written Rule or for Specialty Drugs purchased at pharmacies other than Accredo will not be applied to the member’s annual out-of-pocket maximum.

**Patient Customer Service**
Visit Express Scripts’ website, [www.express-scripts.com](http://www.express-scripts.com), to view your plan design and co-payment information, search for details on prescription medications, locate a Network Pharmacy near you, and manage your home delivery prescriptions. For additional plan inquiries, you may call Patient Customer Service directly at 1-877-880-1877. For future reference, this number is listed on the back of your Express Scripts ID card.

**Prescription Drug ID Cards**
Express Scripts will provide you a prescription drug ID card upon enrollment in the plan. Present your ID card when filling a prescription at a Network Pharmacy. Should you need additional or replacement ID cards, please contact Express Scripts at 1-877-880-1877 or visit [www.express-scripts.com](http://www.express-scripts.com) to either request a new card or print a temporary card.

**Preventive Medications and Products**
In accordance with the requirements of the PPACA, the following preventive and contraceptive prescription and over-the-counter (OTC) medications and products prescribed by your physician are covered at no cost sharing, subject to limitations such as those outlined below:

<table>
<thead>
<tr>
<th>Preventive Medications and Products</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>Limited to covered males age 45 through 79 and covered females age 55 through 79</td>
</tr>
<tr>
<td>Bowel Preps (Generic and OTC)</td>
<td>Limited to covered persons age 50 through 75</td>
</tr>
</tbody>
</table>
Breast Cancer Prevention Drugs (Tamoxifen and Raloxifene) | Limited to covered females age 35 and older and subject to co-pay review
---|---
Fluoride | Limited to covered persons through age 5
Folic Acid | Limited to covered females through age 50
Immunizations | As recommended by CDC Advisory Committee
Iron Supplements | Limited to covered persons birth through 12 months
Smoking Cessation Products | Limited to covered persons age 18 and older
Vitamin D | Limited to covered persons age 65 and older
Prescription and OTC Contraceptive drugs and products (Barrier; generic and single-source brand hormonal; implanted devices; and emergency contraceptives) | Limited to covered females through age 50

Please note: The above is not an all inclusive list of covered preventive medications and products or the limitations that may apply to such coverage. Please contact Express Scripts Customer Service to verify specific coverage.

**Specialty Drugs**
Due to the specialized nature and high cost of Specialty Drugs used to treat rare or complex medical conditions, such drugs may be subject to one or more coverage limits, such as Prior Authorization, Quantity/Duration Limits, or Step Therapy. Specialty Drugs must be obtained through Express Scripts’ specialty pharmacy Accredo Health Group, Inc.* (See Specialty Pharmacy Services section below.) If you have a prescription for a specialty drug filled at a pharmacy other than Accredo, you may be required to pay the entire cost of the medication, and that cost will not be applied to your annual out-of-pocket maximum.

You may be able to obtain up to a 90-day supply of certain specialty drugs through Accredo. Other specialty drugs, however, may be limited to less than a 90-day supply.

*A limited list of specialty oncology drugs will be available at Washington University pharmacies located at Siteman Cancer Centers.

**Specialty Pharmacy Services**
Express Scripts provides specialty pharmacy services for patients with certain complex and chronic conditions through Accredo Health Group, Inc.

Accredo’s website is [accredo.com](http://accredo.com). Accredo’s phone number is 1-800-501-7210. Accredo offers comprehensive therapy management solutions, including:
- Reimbursement services to review the patient’s coverage and coordinate payment from the health plan and/or patient, as appropriate.
- Confidential and convenient delivery with packaging and handling protocols designed so medication arrives with integrity intact.
- Clinical services to assist the patient—under the supervision of his/her physician—in implementing the prescribed course of treatment.
• Compliance programs to promote patient persistency and help the patient improve his/her quality of life.
• National Customer Support Center which provides patients with access to specialty-trained pharmacists and registered nurses 24 hours a day, 7 days a week

Accredo focuses on infused, injectable, and oral drugs that are very expensive and often have restrictions as determined by the FDA. These specialty drugs may be difficult to self-administer, have a potential for adverse reactions, and require temperature control or other specialized handling.

Section 3 - Coverage Limits

Your plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period. If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your physician a toll-free number to call. If you use the Express Scripts Pharmacy, your physician will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. Express Scripts will notify you and your physician in writing of the decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Dispense-As-Written Rule
You may be required to use a generic equivalent drug instead of a brand name drug. If the prescription written by your physician allows a generic equivalent and you choose to purchase the brand name drug, you will pay the brand drug co-payment plus the difference in cost between the brand name and generic drug. Only the amount of the co-pay for the generic equivalent will be applied to your annual out-of-pocket maximum.

Non-Covered Medications
Certain brand-name medications, as well as compound drugs that contain certain ingredients, may not be covered under the plan. If you fill a prescription for a non-covered brand-name or compound medication, you will be responsible for the full cost of the medication, and that cost will not be applied to your annual out-of-pocket maximum. The full cost will apply even if your physician writes “dispense as written” on the prescription. Talk with your physician about prescribing an alternative covered medication.

Drugs that are excluded under the plan may be covered if approved in advance through a formulary exception process, initiated by your physician and managed by Express Scripts, on the basis that the drug requested is (1) medically necessary and essential to your health and
safety and/or (2) all covered formulary drugs comparable to the excluded drug have previously been tried.

Prior Authorization
Certain classes of drugs may require Prior Authorization to be covered.

Quantity/Dose Duration Limits
A quantity or dose duration limitation may be placed on certain therapeutic classes of drugs.

Step Therapy Rule
Certain therapeutic classes of drugs may be subject to Step Therapy, which requires a member to first try one or more frontline (first step), clinically effective, lower-cost medications before the plan will cover a “step up” to a higher-cost medication that the member’s physician may have prescribed.

Section 4 - Expenses Not Covered
If any expense not covered is contrary to any law to which the plan is subject, the provision is hereby automatically changed to meet the law’s minimum requirement. No payment will be made under any portion of the plan for:

- Over-the-Counter (OTC) Products, except those listed under the Preventive Medications and Products section of this SPD
- Therapeutic devices or appliances, support garments and other non-medical devices
- Medication that is to be taken by or administered to a plan member, in whole or in part, while the plan member is a patient in a hospital, extended care facility, convalescent hospital, long term care facility, or similar institution that operates on its premises a facility for dispensing pharmaceuticals
- Investigational or experimental drugs; including compounded medications for non-FDA approved use; except for drugs covered under a Washington University sponsored clinical trial
- Prescriptions that a plan member is entitled to receive without charge under any Worker’s Compensation law or any municipal state or federal program
- Drugs used exclusively for cosmetic purposes
- Appetite suppressants or any drug used for weight loss
- Fertility medications
- Nutritional supplements
- Ostomy supplies
- Topical fluoride products
- Alcohol swabs
- Implantable, time-released medications
- Yohimbine
- Injectibles (contact Express Scripts for a list of exceptions)
- Charges for the administration or injection of any drug
- Biologicals/Vaccines/Immunization agents, except those covered under the Preventive Medications and Products provisions of the plan
- Plasma/blood products (Except hemophilia factors)

*Please note: The above is not meant to be an all inclusive list of covered or excluded benefits. Please contact Express Scripts customer service to verify specific coverage.*

**Section 5 - Questions and Appeals**

If you have a question or concern about a benefit determination, you may contact Express Scripts directly at 1-877-880-1877. If you are not satisfied with an adverse benefit determination, you may appeal it as described below.

**For non-urgent claims, including direct claims:**

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. A written appeal may be initiated by you or your authorized representative (such as your physician), and should be sent to Express Scripts, Inc., Attn: Pharmacy Appeals, 6625 West 78th Street, Mail Route BL0390, Bloomington, MN 55439. The following information should be included in your written request:

1. Your name and Express Scripts member ID number
2. Your telephone number
3. The provider’s name
4. The date of request for prescription drug
5. The prescription drug for which benefit coverage has been denied
6. The diagnosis code and treatment codes to which the prescription relates
7. Any documentation or additional information relevant to the appeal.

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal review processes, and contact information for an office of consumer assistance that might be available to assist you with the claims and appeals process and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

**Second Level Appeal**

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. The second level appeal may be initiated by you or your authorized representative (such as your physician),
and should be mailed to Express Scripts, Inc., Attn: Pharmacy Appeals, 6625 West 78th Street, Mail Route BL0390, Bloomington, MN 55439. The following information should be included in your formal written request:

1. Your name and Express Scripts member ID number
2. Your telephone number
3. The provider’s name
4. The date of request for prescription drug
5. The prescription drug for which benefit coverage has been denied
6. The diagnosis code and treatment codes to which the prescription relates
7. Any documentation or additional information relevant to the appeal.

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, any new or additional evidence considered by the plan in relation to your appeal, and the plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your second level appeal.

External Review
If your second level appeal is denied, you also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

If you are not satisfied with the final decision or your final adverse benefit determination notice does not contain all of the information required under the Employee Retirement Income Security Act of 1974 (ERISA), you also have the right to bring a civil action under section 502(a) of ERISA.

For Urgent Claims:
In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 24 hours of receipt of the claim. An urgent care claim is any claim for treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, would subject the claimant to severe pain that cannot be adequately managed. 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 of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don’t provide the needed information within the 48-hour period, your claim will be deemed denied.
You have the right to request an urgent appeal of an adverse benefit determination for urgent care claims. Urgent appeal requests may be sent by mail or fax. You or your physician may write to Express Scripts, Inc., Attn: Urgent Appeals, 6625 West 78th Street, Mail Route BL0390, Bloomington, MN 55439, or send a fax to 1-877-852-4070. For general urgent issues, you may also call Patient Customer Service at 1-877-880-1877. 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. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal.

External Review
You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function, you have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

You also have the right to bring a civil action under section 502(a) of ERISA if your final appeal is denied or the final adverse benefit determination notice does not contain all of the information required under ERISA.

Section 6 – General Provisions

AMENDMENTS

Any change or amendment to or termination of the Plan, its benefits or its terms or conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by the Plan Sponsor. Covered Persons will receive notice of any amendment to the Plan. No one has the authority to make any oral modification to the Plan or the Summary Plan Description.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (“PPACA”)

This plan is not a grandfathered plan based on the guidelines set forth under the Patient Protection and Affordable Care Act.
STATEMENT OF EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a member in Prescription Drug Benefit Program you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan members shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each member with a copy of this summary annual report.

Continue Group Health Plan Coverage

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 documents governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan members ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan members 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 (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until your receive the materials, unless the materials were not sent because of reason beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, 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 or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have 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 obtain 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 the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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.
WASHINGTON UNIVERSITY WELFARE BENEFIT PLAN

Name of Plan: Washington University Welfare Benefit Plan

Name and Address of Plan Sponsor and Named Fiduciary:

Washington University in St. Louis
1 Brookings Drive
St. Louis, MO  63130

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Employer Identification Number (EIN):  43-0653611

IRS Plan Number:  502

Effective Date of Plan:  January 1, 2013

Type of Plan:  Welfare benefit plan

Name and business address of Plan Administrator:

Plan Sponsor shown above.

Type of Administration of Plan:

The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor has contracted with Express Scripts, Inc., One Express Way, St. Louis, MO 63121 for the provision of other administrative services including claims processing services, coordination of benefit and subrogation; utilization management and complaint resolution assistance.

The named fiduciary of Plan is Washington University, the Plan Sponsor. The Plan Sponsor has also designated Express Scripts, Inc. as the claim fiduciary.

Express Scripts, Inc. 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. Express Scripts, Inc. shall not be responsible for fulfilling any duties or obligation of an employer with respect to the Plan Sponsor’s Plan.
Person designated as agent for service of legal process:

Plan Sponsor shown above.

Source of contribution under the Plan:

There are no contributions to the Plan. All benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required contributions are used to partially reimburse the Plan Sponsor for benefits under the Plan.

Method of calculating the amount of contribution:

Employee required contributions to the Plan Sponsor are the employee's share of costs as determined by the Plan Sponsor. From time to time the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purpose of maintaining Plan's fiscal records:

Plan year shall be a twelve month period ending December 31.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor including this Summary Plan Description.

Members' rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.