Benefits in Brief

2011

TWU

Effective January 1, 2011

About This Communication

Benefits in Brief provides highlights of the benefits programs that are available to Columbia University members of TWU.

This communication is intended to be a Summary of Material Modifications (SMM) to the Medical and Life Insurance Plans and other benefit programs. It explains the changes being made to these plans effective January 1, 2011. Full details regarding coverage, eligibility and limitations can be found in the official Plan documents. If there are any discrepancies between the information in this publication, verbal representations, and the Plan documents, the Plan documents will always govern. Columbia University reserves the right to change or terminate these Plans at any time. This publication is in no way intended to imply a contract of employment.

You are entitled to receive this SMM under the Employee Retirement Income Security Act of 1974 (ERISA). You also have other important rights and protections under ERISA. These are explained in more detail in the Summary Plan Descriptions. You can find them online at **www.hr.columbia.edu/benefits/spds**.

Introducing Your Benefits for 2011

This *Benefits in Brief* booklet is designed to help you during annual Benefits Open Enrollment, and as a reference for newly hired colleagues. It highlights the following:

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- This *Benefits in Brief* is also posted online at **www.hr.columbia.edu/benefits**. In addition, there you can find **benefits-related information** about:
  - Your current benefits enrollment (in the CU Benefits Enrollment System)
  - Frequently Asked Questions
  - Links to health plan websites and network doctors
  - University holidays and personal days
  - Tuition Exemption for Support Staff
  - Forms, including medical claim forms
  - Post-65 Benefits – Active Employees
  - If you leave CU (including COBRA continuation coverage)
  - Summary Plan Descriptions (SPDs)

  If you do not have easy access to a computer, feel free to call the Columbia University HR Benefits Service Center at 212-851-7000.

- Important policy information is at **www.hr.columbia.edu/policies**.
- Collective Bargaining Agreements at **www.hr.columbia.edu/union-contracts**.
- For information about other services and University programs, consult the *Working at Columbia* guide at **www.hr.columbia.edu/wac**.

What's New for 2011

Medical and Dental Plan Changes

- Medical and Prescription Drug coverage for your **adult children up to age 26**:
  - Beginning January 1, 2011, your adult children up to age 26 can be covered by your medical plan regardless of their student or marital status, their access to other health coverage or whether you claim them as dependents on your income taxes.
  - However, your child's spouse, their domestic partner and your child's children will not be eligible for coverage.
  - When your child reaches age 26, he or she will no longer be eligible to be covered as your dependent.
  - The above also applies to the Aetna Columbia Dental Plan. For the GHI Preferred Dental Program, however, children are eligible until the end of the calendar year in which they reach age 19.
- **For the POS 100 medical plans:**
  - New out-of-network annual deductible will be $575/individual and $1,725/family
  - New out-of-network annual out-of-pocket maximum of $3,500/individual and $7,000/family
  - This means if you choose to go out of the network, you will pay more than in 2010. There is no similar increase if you stay in the network. (These benefit terms are explained in the Medical Coverage section of this booklet.)
- **Prescription Drugs:** Copayments for brand-name prescriptions are increasing. Read about this and related changes to the plan's design in the Prescription Drug Coverage section.

Healthcare Flexible Spending Account (FSA) Change

- **Over-the-counter medications:** The 2010 Patient Protection and Affordable Care Act (PPACA) says you may no longer be reimbursed through the Healthcare FSA for over-the-counter medications and similar supplies (except when prescribed). This is effective January 1, 2011.

Look Again

One of the most important benefits the University offers is sometimes overlooked. It's the Voluntary Retirement Savings Plan (VRSP). Increasing numbers of your University colleagues are taking advantage of it. Make sure you are contributing.

Important Reminders

To continue participating in the following benefits in 2011, you must re-enroll:

- Healthcare FSA
- Dependent Care FSA
- Transit Reimbursement Program
- Parking Reimbursement Program

If you are enrolled in any of the above benefits in 2010 and you do not re-enroll for 2011, your deductions will be $0 on January 1, 2011, and you will not be covered in any of these programs.

Choose Your Coverage Carefully

The elections you make within 31 days of your hire date will be in effect for the rest of the calendar year. You will have an opportunity to change your benefit coverage selection during annual Benefits Open Enrollment, held each fall. Changes you make during annual Benefits Open Enrollment take effect the following January.

Healthcare Reform

The full impact of the 2010 Patient Protection and Affordable Care Act (PPACA) on our benefits is still being evaluated by CU. It will be an important focus of the newly formed Task Force on Fringe Benefits. In the meantime, here are a few things that may be helpful to you.

First, most of the significant benefit-related items you hear about, such as the "exchanges," do not go into effect until 2014 for those who have private coverage (as you do through CU).

- On the opposite page, you see the changes for 2011. Many CU colleagues will be most interested in how the new law opens up coverage to children until they turn age 26—even if they are not in school.
- In 2012, a Presidential election year, almost no changes occur.
- In 2013, the maximum deposit to a Healthcare FSA will be $2,500.
- Also in 2013, payroll taxes to the Medicare program are scheduled to increase to 2.35% (versus 1.45% today) for those earning over $200,000/individual taxpayers or $250,000/married couples.

As the Federal government issues more clarifying regulations and notices about PPACA, the University will share the information that affects you.

Who is Eligible for Benefits

The online CU Benefits Enrollment System will show you the benefits you are eligible for and your options (plus their monthly cost) based on your personal situation. The benefits of eligible full-time and part-time members of TWU are effective the first day of the month following the completion of the applicable waiting period. Part-time employees must work 20 hours per week to be eligible for benefits.

Newly Hired? You must enroll for benefits within 31 days of your date of hire.

If you do not enroll within 31 days, you and any eligible dependents will not receive Medical, Prescription Drug, Dental, Flexible Spending Accounts, Transit/Parking Reimbursement or Optional Term Life Insurance coverage from Columbia University for the remainder of the calendar year. If you have questions, please contact the **HR Benefits Service Center at (212) 851-7000**.

Waiting Periods for Benefits Coverage

	Full-Time	Part-Time
Medical Coverage	3 months*	3 months
Dental Coverage	4 months*	Not eligible
Life Insurance	6 months	6 months
Flexible Spending Account (FSA)	Hire date	3 months
Transit/Parking Reimbursement Program	Hire date	Hire date
Columbia University Retirement Plan	Hire date	Hire date
Voluntary Retirement Savings Plan (VRSP)	Hire date	Hire date

* Upon reaching eligibility, you are automatically enrolled for individual **CIGNA POS** and **GHI Dental** coverage. To add dependents, you must enroll online by accessing the CU Benefits Enrollment System at **www.hr.columbia.edu/benefits** within **31** days of your eligibility date.

Eligible Dependents

For most CU benefits, including medical and dental, your dependents can be covered if they meet the following requirements:

- Legal spouse
- Same-sex domestic partner or civil union partner, provided your partner is:
  - At least 18 years old;
  - Not related to you by blood;
  - Not legally married to another person;
  - In the case of a civil union partnership, is entered into a certified civil union under applicable state law that recognizes a relationship between people of the same gender or treats a relationship between people of the same gender as a marriage.

  And meets two or more of the following requirements:

  - Shares the same principal residence with you full-time and continuously for the past 12 months;
  - Shares financial responsibilities with you, such as co-ownership of property, joint financial accounts, etc.;
  - Has power of attorney for medical purposes.
- Legally dependent children, including adopted children, foster children and stepchildren of your spouse or same-sex domestic partner. Dependent children are covered:
  - Until the end of the month they turn age 26;
  - At any age if they have a physical or mental disability, provided that when they were diagnosed, they were covered dependents and it was prior to the end of the calendar year in which they turned 26;
  - If a court has appointed you legal guardian, for any child from birth to age 26.

Please note that eligible children are defined differently for the FSAs.

Reporting Changes to Dependent Eligibility

There are two ways you can report a change in dependent eligibility:

1. Go to the CU Benefits Enrollment System at **www.hr.columbia.edu/benefits** and update any changes in the status of your dependents online.
2. Call the Columbia University HR Benefits Service Center at (212) 851-7000.

Dependent no longer eligible, e.g., divorce: It is your responsibility to report this change to the Columbia University HR Benefits Service Center within **31 days** of the change.

Proof of Dependent Eligibility

Columbia University has a responsibility to ensure that only eligible expenses are paid from its plans. This requirement is consistent with Internal Revenue Service (IRS) regulations that govern the operation of a qualified benefits plan.

You must be prepared to provide satisfactory proof that each of your covered dependents meet the eligibility requirements. Audits are conducted periodically each year to ensure that all dependents continue to meet the eligibility requirements of the benefit plans. If you are selected for this audit, you will receive a letter detailing the audit process and you will be asked to provide dependent verification documents (listed in the chart below).

If you are not able to provide proof that your dependent is eligible for coverage, your dependent will not have coverage. If you previously provided satisfactory proof of dependent eligibility, you will not be selected for this audit.

Dependent	Documentation
Spouse	Copy of marriage certificate
Same-Sex Domestic Partner	**Two** of any of the following: • Joint Lease or Mortgage • Joint ownership of property • Joint bank account statement • Designation of the partner as primary beneficiary in your will or designation of the partner as beneficiary for your life insurance or retirement benefits • Assignment of power of attorney to your partner • Registration in the New York City's Domestic Partnership Registration Program • Marriage license/civil union from state/country (e.g., CT, NH, MA, Canada, etc.)
Child	**One** of the following: • Child's birth certificate • Hospital record of birth (temporary, until birth certificate is received) • Adoption certificate/court records

Submit copies of your documents, plus the "Verification Request Form" (from your online benefits enrollment session), to the Columbia University HR Benefits Service Center by either:

- Scan and email to **hrbenefits@columbia.edu**, or
- Fax (secure) to (212) 851-7025

Or, if you do not have access to email or a fax, call Columbia University HR Benefits Service Center at 212-851-7000.

For questions on how to obtain duplicate documents, such as a marriage or birth certificate, please contact the appropriate entity or government office.

Important: Send copies only. Omit all Social Security Numbers.

Verifying Dependent Eligibility

Having a baby? Covering a dependent under your medical or dental coverage? If adding a dependent (spouse, same-sex domestic partner or child) to your coverage, you are required to provide documentation before the dependent's coverage is effective. You will be guided through this process on the CU Benefits Enrollment System. (If you do not have easy access to a computer, feel free to call the Columbia University HR Benefits Service Center at 212-851-7000.)

- **New hires:** Add your dependent at the time you enroll in your own benefits:
  1. Follow instructions on the CU Benefits Enrollment System (or by calling Columbia University HR Benefits Service Center at 212-851-7000). The system will take you to the "Dependent Required Documentation" page.
  2. On that page, print the "Verification Request Form." Submit it as instructed within 30 days, along with the valid documentation for approval. (See list of documentation in previous chart.)
  3. Once proper verification is received, coverage for your dependent will be retroactive to the date of your own election.
- **Qualified life status change (e.g., birth, marriage):** Add your dependent within **31** days of the qualified life status event:
  1. Follow instructions on the CU Benefits Enrollment System (or by calling Columbia University HR Benefits Service Center at 212-851-7000). The system will take you to the "Dependent Required Documentation" page.
  2. On that page, print the "Verification Request Form." Submit it as instructed within 30 days, along with the valid documentation for approval. (See list of documentation in previous chart.)
  3. Once proper verification is received, coverage for your dependent is effective on the date of the qualified event (date of birth or marriage, etc.).

Medical and Dental ID Cards

If you make any changes to your medical and/or dental coverage, you will receive an ID card. These cards are mailed to your home and you can expect them by January 10, 2011. (If you need your ID card sooner, go to the carrier website. These are available January 1.)

Newly hired? After you enroll in medical or dental benefits, you will receive an ID card directly from the insurance carrier. It takes approximately four weeks for you to receive your ID card. If you need an ID card sooner, go to your selected carrier's website two weeks after you complete your benefits enrollment.

Who You Can Cover for Medical and Dental

You do not have to cover the same people for both the medical and dental plans. For each plan, you have the choice of covering:

- Yourself only;
- Yourself and your spouse, or yourself and your same-sex domestic partner;
- Yourself and a child or children; or
- Family—you, your spouse or same-sex domestic partner, plus children.

As you will see in the CU Benefits Enrollment System, Social Security Numbers are required for all dependents to be covered by our medical plan.

Both Work for the University?

If you and your spouse both work for the University and are eligible for coverage, you may choose your coverage in either of the following ways:

- One spouse makes the choice for the entire family, including eligible dependent children, if any. In this case, the other spouse must select "No Coverage."
- Each spouse can make his or her own choice. In this case, all eligible dependent children must be covered by one spouse or the other.

Are You Throwing Money Away?

Not using the Healthcare FSA? For most people, that's like throwing money away.

Think about how much you have to earn to pay for a $300 expense. Most people lose at least one third of their pay to federal, state and Social Security taxes. Here's an example of the math:

You need to earn:	$450
Then subtract 1/3 for taxes:	- $150
You have left for expenses:	$300

You could be throwing away $100 for every $300 if you do not use the FSA. Those in higher tax brackets are losing even more by not taking advantage of the Healthcare FSA.

Making Changes to Your Benefits

Limited Changes During the Year

The Internal Revenue Service (IRS) limits when you can add coverage for a dependent or make changes to your healthcare benefits and FSA elections during the year.

After new hire initial enrollment, or after annual Benefits Open Enrollment, you will only be able to change most benefits for the remainder of the calendar year if you experience a "qualified life status change."

Examples of a qualified life status change include:

- Marriage, divorce or the beginning or end of a same-sex domestic partnership;
- Birth, adoption, placement for adoption;
- Death of a dependent (spouse, same-sex domestic partner, child);
- A dependent losing eligibility for coverage (child reaches maximum age, spouse/partner loses non-University coverage);
- Change in home address that makes you ineligible for your current plan option;
- Spouse or eligible dependent called to military duty in the U.S. armed forces;
- Job promotions and/or transfers that change the benefit offerings.

If you experience a qualified life status change, you must go to www.hr.columbia.edu/benefits and make your changes within 31 days of the event. If you need assistance, please contact the HR Benefits Service Center at (212) 851-7000 and a representative will help you with your changes. Please remember that because these benefits must comply with IRS regulations, you must provide proper documentation for your change, such as a birth certificate or divorce decree. Your benefit changes must be consistent with the nature of your qualified life status change.

Changes Permitted

Transit/Parking Reimbursement Plans

You can make changes to your account any time during the year. You can change your deposit amount if:

- You change your work location or residence;
- You change the way you commute;
- There is a fare increase for bus, subway or rail service; or
- There is an increase in the amount you pay for parking.

Retirement Savings Plan

As explained later in this booklet, you can enroll in or change your election for the Voluntary Retirement Savings Plan (VRSP) at any time during the year.

Medical Coverage

Overview of Medical Coverage

Columbia University offers two medical plan options for you to choose from, through two different insurance carriers. The level of coverage they provide is the same but there is a difference in your cost. The easiest way to consider both the plan features and cost is to use the online "Medical Plan Comparison Tool" on the CU Benefits Enrollment System.

Both options cover the same comprehensive set of services — from lab work to transplants. They also both offer preventive care such as annual physicals, immunizations and well-baby visits at no cost to you. Both enable you to receive the same level of prescription drug coverage.

Our medical carriers all use information technology to facilitate quality of care and patient safety. For some serious health situations, they may contact you to help you receive best practice care.

Additionally, they both only cover **medically necessary** services and supplies for the purpose of preventing, diagnosing or treating an acute sickness, injury, mental illness, substance abuse or symptoms. For more about the definition of "medically necessary," see the Summary Plan Descriptions on the HR website.

Key Differences Between Your Medical Options

Their Network

"Network" is short for "network of participating providers." It is the group of physicians, hospitals and other providers who agree to offer services to a medical plan at lower-priced, "negotiated rates."

- **In-network**—When care is given by a participating provider, it is considered "in-network." Staying in-network means you will be given the lower negotiated fees for services.
- **Out-of-network**—When care is given by a provider who is outside the plan option network, it is considered "out-of-network." You will not receive the network negotiated rate and your share of the cost—the percentage you pay of "coinsurance"—will be much higher than for in-network services.

Important difference: If you have a strong preference for certain physicians or a certain hospital, you should take time to determine if that care provider is in-network for your option. To do this, you will want to contact the medical carriers listed at the end of this booklet.

The UHC POS 100 has the least restricted network—it is national. The CIGNA POS network applies only to the tri-state area (New York, New Jersey and Connecticut); if you receive medical treatment outside of the tri-state area, those services would be reimbursed at the out-of-network level.

For both plans: During the year, you must keep this in-network issue in mind if a physician refers you for lab tests, X-rays or other services. **It is your responsibility to check that a provider is in the network**—otherwise you will pay the higher deductible and coinsurance of the out-of-network benefits.

Is a “PCP” Required?

Another key difference between the plan options is whether or not a Primary Care Physician (PCP) is required. A PCP is your first point of contact when you need care. Your PCP also coordinates other care — for example, if you need a specialist.

No PCP is required for the UHC POS 100 option. **The CIGNA POS 100 option requires you and each covered dependent to have a PCP.** If you want the CIGNA POS 100 option, you will need to visit the CIGNA website to determine the code for the PCPs for you and each covered dependent and have them handy when you begin using the CU Benefits Enrollment System. Those codes are required in order to complete your online enrollment. In the CIGNA website, under “Provider Directory,” our plan is called “Seamless Network (Tristate).”

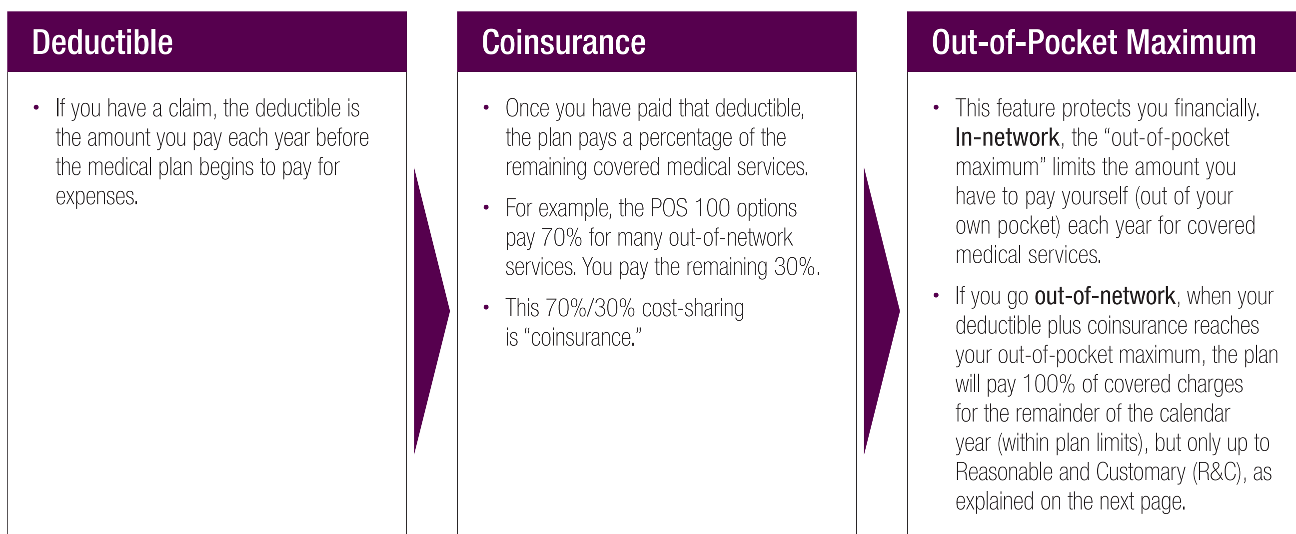
With **any POS plan**, you have the flexibility to use either in-network or out-of-network providers each time you seek care. You receive much greater benefit coverage when you choose in-network providers.

Learn the Lingo

To make the right choice, and understand the Medical Plan Comparison Chart on the following pages, it is helpful to learn just a few more benefit terms:

Copay is the fixed amount you pay directly to the provider when you receive some in-network services. For example, the $20 you often pay for a physician’s office visit. That flat fee of $20 is all you pay—Columbia University pays the rest of the cost.

For services that do not have a copay, the following three terms are used:



The most important thing to remember is how these three work together when you study the Comparison Chart on page 13.

More about Reasonable and Customary (R&C). R&C is the most that is reimbursed for out-of-network services. For example, your coinsurance is a percentage of R&C charges for out-of-network services. Once the amounts you've paid reach the out-of-pocket maximum, your selected plan pays 100% of covered expenses, but only up to the R&C limits (called the Maximum Allowable Charge). **Providers can bill you for any unpaid balance (for amounts above R&C) and you are solely responsible for these payments.**

Precertification: On the Medical Plan Comparison chart, you will see the phrase **precertification required**. That means those services require you to obtain authorization from your selected medical plan before you receive them. If you are receiving services from an in-network provider, your physician will obtain this authorization on your behalf. If you go out-of-network, however, it is your responsibility to obtain precertification.

HR Benefits is Here to Help!

Have you called your selected medical insurance carrier several times about a claim problem and not received a satisfactory response? Did you know the Columbia University HR Benefits Service Center is available to help you with medical, prescription drug or dental claim problems? You can reach us at (212) 851-7000 or email hrbenefits@columbia.edu and describe your issue.

The Benefits Service Center can also help you resolve billing problems with in-network providers. For example, your coinsurance is a percentage of the negotiated rates when you stay in the network. Once the amounts you've paid reach the out-of-pocket maximum, your selected plan pays 100% of covered charges for the remainder of the calendar year. Your network providers should not bill you for any balances.

Medical Plan Comparison Chart*

	CIGNA POS 100		UHC POS 100	
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****
Network	Tri-State only	N/A	National	N/A
PCP	Required	N/A	Not required	N/A
Preventive Care	100%	Not covered	100%	Not covered
Physician Office Visits	$20 copay	70% after deductible	$20 copay	70% after deductible
Annual Deductible				
Individual	N/A	$575	N/A	$575
Family	N/A	$1,725	N/A	$1,725
Coinsurance (% paid by CU)	100%	70% after deductible	100%	70% after deductible
Out-of-Pocket Maximum				
Individual	N/A	$3,500	N/A	$3,500
Family	N/A	$7,000	N/A	$7,000
Hospital Services				
Inpatient Care	$250 copay per admission *Precertification required*	70% after deductible *Precertification required*	$250 copay per admission *Precertification required*	70% after deductible *Precertification required*
Outpatient Care	100% *Precertification required*	70% after deductible *Precertification required*	100% *Precertification required*	70% after deductible *Precertification required*
Emergency Room Copay (Waived if admitted)	$100 copay	$100 copay	$100 copay	$100 copay
Mental Health & Substance Abuse				
Inpatient Care	$250 copay per admission *Precertification required*	70% after deductible *Precertification required*	$250 per admission Combined annual limit of 60 days *Precertification required*	70% after deductible *Precertification required*
Outpatient Care	$20 copay Annual maximum of 60 visits *Precertification required*	70% after deductible Combined annual limit of 60 visits *Precertification required*	$20 copay Annual maximum of 60 visits *Precertification required*	70% after deductible Combined annual limit of 60 visits *Precertification required*
Infertility Treatment				
ART, IVF, GIFT, ZIFT	Annual benefit limit: $5,000		Annual benefit limit: $5,000	

* The above chart represents highlights of Plan provisions. Clinical medical management restrictions and other limits apply. See Summary Plan Descriptions (SPDs).
** Percentages are of Reasonable and Customary (R&C).

Prescription Drug Coverage

When you enroll in any University medical plan, you are automatically enrolled in the Prescription Drug Plan. The Plan's design and copays for brand-name prescription drugs are changing for 2011, as shown in the chart below.

	Prescription Drug Copays
Retail pharmacy (up to 30-day supply)	• $10 generic • $25 single-source brand (product not available in generic) • $45 multi-source brand (choice between generic and brand available)
Home delivery: mail-order (up to 90-day supply)	• $15 generic • $50 single-source brand (product not available in generic) • $90 multi-source brand (choice between generic and brand available)
Infertility coverage (oral and injectable medication)	Same as above, up to $15,000 lifetime maximum

Note: If the patient cannot use the generic version of a multi-source drug, the brand-name drug will be covered at the $25 retail or $50 mail-order single-source copay.

Using Your Prescription Drug Benefit

Medco administers the prescription drug benefit plan. You will receive a prescription drug ID card around the same time you receive your medical card.

Retail – Here is a summary of how it works in a pharmacy:

- You will need to present your Medco ID card at the pharmacy the first time you fill a prescription.
- If both generic and brand-name are available for your prescription, you have a multi-source drug.
  - In New York, New Jersey and certain other states, the pharmacy is required by law to substitute a generic for a brand-name drug—so if a generic is available, you will have the lowest copay: $10.
  - If you choose the brand-name drug instead of the generic, then you will pay the highest copay: $45.
- If no generic is available for your prescription, then your drug is a single-source prescription. Your copay will be: $25.

The copays above are for up to a 30-day supply.

You may find participating pharmacies at **www.medcohealth.com** or by calling 800-230-0508.

Mail-Order Pharmacy – Mail-order copays are for up to a 90-day supply. So if you take medication on a regular basis for conditions such as high blood pressure or asthma, the mail-order option will be more affordable than the retail option.

- Your first step is to enroll in the mail-order program. Go to **www.medcohealth.com** or call 800-230-0508.

- Once you have enrolled in Medco's mail-order program, you can refill prescriptions easily, either online or over the phone.
- If both generic and brand-name are available for your prescription, you have a multi-source drug.
  - If a generic is available, you will have the lowest copay: $15.
  - If you choose the brand-name drug instead of the generic, then you will pay the highest copay: $90.
- If no generic is available for your prescription, then your drug is a single-source prescription. Your copay will be: $50.

Appeals Process

If your medical condition prevents you from taking the generic form of a brand name drug (a multi-source brand drug), you and your physician may complete a Medco Appeals form to request having it covered at the lower copay level. This form is available online at **www.hr.columbia.edu/benefits** under "Forms." Submit your completed "Benefits Coverage Request Form" directly to Medco at the address listed on the bottom of the form. If you do not have easy access to a computer, call and ask Medco for the Appeals form at 800-230-0508 and they will send it to you.

How to Find Out if a Drug is "Single-Source" or "Multi-Source"

First, your pharmacist can tell you. Second, starting January 1, 2011, you can go to **www.medcohealth.com** or call 800-230-0508. Keep in mind that your prescription may move from "single-source" to "multi-source" during the year, if the Federal Drug Administration approves a generic equivalent drug.

Vision Care

All employees and their covered dependents who participate in the UHC POS or CIGNA POS Plans are also covered by a vision benefit.

Vision Expense	UHC*	CIGNA** (VSP Network)
Vision Exam	$50 allowance once every 12 months	$10 copay (1 exam per year)
Hardware (Lenses and Frames) and Contact Lenses		
Single lenses	$70 allowance for all hardware and contact lenses once every 24 months.	$20 for single lenses
Bifocal lenses		$30 for bifocal lenses
Trifocal lenses		$40 for trifocal lenses
Lenticular lenses		$75 for lenticular lenses
Frames		$30 frames allowance; 1x every 24 months
Contact lenses: cosmetic		Cosmetic contacts are not covered
Contact lenses: Medically necessary		$75 for medically necessary contacts

* UHC provides a total cumulative benefit for all hardware (lenses, contacts, frames) of $70 every 24 months.

** Benefits for hardware under the CIGNA POS Plan are per item. To receive vision benefits from the CIGNA POS plan, you must select a CIGNA provider from the network directory who is specifically designated "VSP."

Your Cost for Medical Coverage (Contributions)

The Columbia University medical and prescription benefits are "self-insured." That is, Columbia University does not pay "premiums" to each of the insurance carriers. Columbia University pays your healthcare claims plus an administrative expense to the insurance carriers.

Contributions are the amount you pay toward the cost of your medical and prescription coverage through your payroll deductions. Your contributions are deducted from your pay **before any taxes are taken**.

Your pre-tax contribution for medical and prescription coverage is based on two factors:

1. Which plan you select, and
2. Who you cover, e.g., Yourself Only versus Family

Your Cost for Same-Sex Domestic Partner

Federal income tax rules require that your contributions toward the coverage of a same-sex domestic partner or civil union partner be deducted from your pay on an **after-tax basis**. In addition, University contributions toward the total cost of coverage for your domestic or civil union partner are taxable to you.

2011 Monthly Pre-Tax Contributions for Medical & Rx Coverage

Health Plan	Yourself Only	Yourself & Spouse or Same-Sex Domestic Partner	Yourself & Child or Children	Family
Full-Time				
CIGNA POS	$0	$0	$0	$0
UHC POS	$25	$50	$50	$75
Part-Time*				
CIGNA POS	$321	$674	$610	$963
UHC POS	$422	$886	$802	$1,266

* Part-time employees must work at least 20 hours per week to be eligible for benefits.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a network of services, including short-term counseling, to help you and your household members cope with issues that you experience in everyday life. You do not have to be covered by our medical plan to take advantage of the EAP. You, or a member of your household, can receive assistance with a wide variety of issues and concerns including:

- Stress, anxiety
- Depression
- Alcoholism and drug abuse
- Sleeping difficulties
- Eating disorders
- Elder care
- Adult day care and assisted living facilities
- Pet care (e.g., finding a dog walker)
- Loss of a loved one
- Career concerns
- Travel planning

Free to you: Columbia University assumes all costs for initial assessment and counseling sessions through the EAP, for up to three counseling sessions per subject. If additional assistance is necessary, the counselor will give you referrals, taking into account your preferences, medical plan and financial circumstances.

Licensed professionals: Harris, Rothenberg International (HRI) provides confidential short-term counseling 24 hours a day, 7 days a week. Phones are answered by licensed Master's or Ph.D.-level mental health professionals and, if needed, refer you to a network of more than 20,000 counselors available nationwide.

Stressed Out? Financial Worries? Elder Care Issues?

These are just a few of the reasons to call the Employee Assistance Program (EAP). Free, confidential help and support is available 24 hours, 7 days a week.

Call **(888) 673-1153**; TTY: **(800) 256-1604**
Or log on to: **www.harrisrothenberg.com**
Username: **Columbia**; Password: **eap**

Aetna Columbia Dental Plan

The Aetna Columbia Dental Plan provides you with the flexibility to see Columbia University College of Dental Medicine faculty and alumni (called Columbia Preferred Dental Network), along with the national Aetna network of dentists, all under one comprehensive program. You may also see a dentist outside of the network, although your cost will be significantly higher whenever you use out-of-network dentists.

The University contributes towards the cost of dental coverage.

Aetna Columbia Dental Plan Overview

Benefit	Columbia Preferred Dental Network	Aetna Dental Network	Out-of-Network*
Preventive Care Includes routine cleanings,routine exams and X-rays	100%	100%	100%
Basic Restorative Care Includes fillings and extractions	100%	80%	80%
Major Restorative Care Includes crowns, root canals, bridges and dentures	60%	50%	50%
Orthodontia for Adults & Children	50%	50%	50%
Annual Deductible (per Person)	none	$25	$25
Annual Maximum Benefit (per Person)	$1,500	$1,250	$1,250
Orthodontic Lifetime Maximum (per Person)	$1,500	$1,250	$1,250

*The percentage paid by Aetna Dental will be limited to the network-negotiated fees. This means if you use an out-of-network dentist, your reimbursement will be based on the network fees for the services provided. For example, if your dentist bills you $800 for a crown, but the network-negotiated fee is $400, you will be reimbursed for 50% of the $400 (the network-negotiated fee) totaling $200. You are responsible for paying the balance of $600 to your out-of-network dentist.

Your Monthly Cost (Contributions) for Dental	
Yourself	$19
You Plus One	$62
Family	$105

Using the Columbia Preferred Dental Network

When you use a dentist who participates in the Columbia University network, you receive a higher level of reimbursement for services. To locate a Columbia Preferred dentist, go to **www.aetna.com/docfind/custom/columbia**.

Columbia Preferred dentists accept reimbursement for services covered at 100% as payment in full. You are not responsible for paying any fees that exceed the network-negotiated fees. You also **do not have to submit any claim forms** when you use a network participating dentist.

Columbia Preferred Dental Plan Facilities

Columbia Dental Associates
Morningside Associates
1244 Amsterdam Avenue (near 121st Street)
New York, NY 10027
(212) 961-1266

and

430 West 116th Street
New York, NY 10027
(212) 662-4887

Columbia Dental Associates
100 Haven Avenue
New York, NY 10032
(212) 342-0107

Columbia-Presbyterian
Eastside Dental Faculty Practice
16 East 60th Street
New York, NY 10021
(212) 326-8520

Columbia Oral & Maxillofacial Surgery
630 West 168th Street
Vanderbuilt Clinic, 7th Floor
New York, NY 10032
(212) 305-4552

Using the Aetna Dental Network

If you see an Aetna participating dentist, the amount you pay is applied toward fees that have been negotiated by Aetna. Dentists who participate in Aetna's network will not bill you for any fees that exceed the negotiated amount. To locate an Aetna participating dentist, go to **www.aetna.com/docfind/custom/columbia**.

The GHI Preferred Dental Program

The GHI Preferred Dental Program covers preventive, basic and major services. You may choose to use participating GHI Preferred Program dentists or go to a nonparticipating dentist.

When you receive care from a nonparticipating dentist, you pay the provider up front, and then file a claim for reimbursement. You'll be reimbursed up to the allowance shown on the GHI Dental fee schedule for covered services, which is available from GHI. If you use a participating dentist, no forms are required.

For a listing of GHI dentists, go to: **www.ghi.com/Prov_search** and select Dentists from the menu. Click the link to Dentist Directories and enter your location. Choose Dental from the first drop-down menu. Choose Your Network and select Dental Preferred under the Select Provider Network pull-down menu. For more information, call GHI at **212-501-GHID (4443)**.

If you use a nonparticipating dentist, you may have to pay the difference between the total cost and the amount the plan pays.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow you to save money on a wide variety of healthcare and dependent day care expenses. ***You must re-enroll during Benefits Open Enrollment each year to take advantage of FSAs.*** If you work full-time or part-time for the University, you may participate. Columbia University offers two types of FSAs:

Healthcare FSA for eligible healthcare expenses, including medical, prescription drug or dental copayments and deductibles, as well as vision or hearing services.

Dependent Care FSA for eligible child or adult care expenses for your dependents, such as licensed day care centers and nursery schools, before-school or after-school programs and home attendants. (Note: For dependents' health-related expenses, use the Healthcare FSA.)

Don't Lose Out

The Healthcare FSA can save you money. Consider it for 2011.

How FSAs Work

FSAs allow you to set aside pre-tax money to reimburse yourself for eligible expenses. Since your FSA contributions reduce your gross taxable income, **you pay lower taxes and take home more money**.

If you elect an FSA, you contribute to it in equal installments each pay period throughout the year. You cannot change your deposit amount during the calendar year unless you have a qualifying life status change.

When you have eligible expenses, you submit a claim form to receive money from your FSA to repay yourself. For forms, go to **www.hr.columbia.edu/forms-docs**. You will not owe taxes on the money you take from your account.

Forfeiture Rule: The IRS has strict rules regarding FSAs. Any money left in your FSA account(s) must be forfeited the following year. So, it is important to estimate your expenses carefully, and make sure that your claims are received by the FSA administrator (EBPA) no later than March 31 of the following year. We recommend using the Decision Support Tools in the CU Benefits Enrollment System at **www.hr.columbia.edu/benefits** to plan.

Healthcare FSA

You can deposit between $120 and $3,000 in this account to cover unreimbursed healthcare expenses for yourself and your spouse and children, even if you elected not to cover them under Columbia University benefit plans.

Children must be your dependents for income tax purposes. Same-sex domestic partners and their children are not eligible for this plan due to IRS rules, unless they qualify under Section 152.

You can use your Healthcare FSA for many of your healthcare expenses, such as:

- Medical and dental plan deductibles
- Contact lenses and solutions
- Acupuncture and chiropractor visits
- Copayments for prescription drugs, office visits, hospital stays and other medical services
- Weight-loss programs to treat obesity
- Prescription eyeglasses, sunglasses and LASIK surgery
- Medical and dental expenses that exceed benefit plan limits

For more complete information on eligible expenses go to: www.ebpabenefits.com/members/reimbursement-accounts.aspx.

Keep in Mind

If your medical expenses exceed 7.5% of your adjusted gross income and you itemize deductions, you may be better off deducting your expenses from your income tax rather than using the Healthcare FSA. You may want to consult with a tax advisor or financial professional to determine which works best for you.

Dependent Care FSA

The Dependent Care FSA helps you pay the cost of dependent day care services for an adult or child because you work or attend school. If you are married, your spouse must also work or go to school while you are at work. You can be reimbursed for the cost of services provided for:

- Dependent children under age 13. (If your child will turn 13 during the coming year, you can submit claims only for expenses incurred up to the child's birthday.)
- Other dependents, including a parent, spouse or spouse's child who is physically or mentally unable to care for him or herself

IRS regulations do not allow you to use money from this account for expenses incurred by or on behalf of same-sex domestic partners and their children unless they qualify as your legal tax dependents. Please refer to IRS Publication 503 for further guidance.

How Much You Can Deposit

You can deposit between $120 and $5,000 a year. However, if you are married, the IRS has several guidelines that might affect how much you can deposit. For example, **if your spouse also has a Dependent Care FSA at work and you file a joint tax return, your combined deposits cannot exceed $5,000**. If you are married and file separate income tax returns, the most you can contribute is $2,500.

You must be able to identify the name, address and Social Security number of the person who provides the dependent care. If you use a child or adult care center, you simply provide the Taxpayer Identification Number.

Covered dependent care providers include:

- Qualified child or adult day care centers, including senior centers
- Summer day camps
- Babysitters
- Nursery schools, pre-schools, before-school and after-school programs
- Person who cares for an elderly or disabled person that you claim as a dependent on your tax return

Keep in Mind

- You can use the Dependent Care FSA for day care expenses only. Do not deposit money in this account for your dependents' healthcare expenses.
- You may use the Dependent Care FSA, the federal tax credit or a combination of both for your eligible expenses. Your choice will depend on your family income and the number of dependents you have in eligible day care programs. Generally, if your family's adjusted gross income exceeds $40,000, you may save more in taxes using the Dependent Care FSA. You can also go to **www.irs.gov/taxtopics/tc602.html** or consult your tax advisor or financial professional.

Term Life Insurance

Life insurance can provide valuable financial protection and Columbia University offers you the choice of different levels of coverage to help meet your needs. Columbia University offers two Term Life Insurance Plans: the Basic Term Life Insurance Plan and the Optional Term Life Insurance Plan. The Life Insurance Plans are insured and administered by The Standard Life Insurance Company (The Standard).

Basic Term Life Insurance Plan

The Basic Term Life Insurance Plan is provided automatically by Columbia University at no cost to you and without providing evidence of insurability. You'll automatically receive Basic Term Life Insurance of one times your salary, up to $50,000. For more information, visit **www.hr.columbia.edu/benefits/spds**.

The Life Insurance Plan pays a lump sum benefit to your beneficiary in the event of your death while actively employed by Columbia University. The Plan can also pay a living benefit. If you become terminally ill, you may elect to have the Plan pay out a benefit while you are still living. Any amount you receive will reduce the benefit paid to your beneficiary.

Optional Term Life Insurance Plan

You may elect additional amounts of coverage of one, two, three, four or five times your annual benefits salary up to a maximum of $1,000,000. The benefit will be determined using your pay as of July 1 each year, rounded to the next highest $1,000. You will see your personal monthly premiums on the CU Benefits Enrollment System based on your age as of January 1. There you can also add or update beneficiaries.

Evidence of Insurability

You must provide Evidence of Insurability and be approved by The Standard if:

- You are **newly hired** and elect Optional Term Life Insurance coverage in excess of three times pay or $500,000, including Columbia University's Basic Life insurance coverage and your own additional Optional Life insurance coverage;
- You did not elect Optional Term Life previously and want to elect this coverage during Benefits Open Enrollment; or
- You wish to increase the level of your coverage during Benefits Open Enrollment.

If Evidence of Insurability applies to you, the CU Benefits Enrollment System will guide you through what to do next.

Travel Emergency Assistance

When you are covered under our Basic Term Life Insurance Plan (from The Standard), you and your dependent children are also covered for emergency travel assistance. This assistance can be for situations as serious as needing to be evacuated from a foreign country to things as simple as information on visas. This program is called MEDEX Travel Assist. It can help you with travel emergencies in the U.S. and internationally. See the Contact Information on inside back cover.

Transit/Parking Reimbursement Program

Transit/Parking Reimbursement Program (T/PRP)

The Transit/Parking Reimbursement Program (T/PRP) is a convenient way to pay commuting expenses using pre-tax dollars. If you work full-time or part-time for the University, you may participate in T/PRP. Remember, **each year during Benefits Open Enrollment you must make your election for T/PRP**. This is the one benefit, however, that is easy to add or change during the year.

Newly hired? Your election goes into effect the month following your enrollment.

Transit Reimbursement Program

You may elect a monthly deposit amount from $10 to $230. The amount will be deducted from your paycheck before taxes are taken out.

What's Covered/Not Covered—Transit

Under IRS regulations, you can use the money in your transit account for commuting expenses on any public transit commuter system, including:

- Amtrak
- Long Island Railroad (LIRR)
- New Jersey Transit (NJT)
- Staten Island Rapid Transit (SIRT)
- Port Authority Trans-Hudson Corp. (PATH)
- Metro North Commuter Railroad
- Commuter and suburban express bus services
- Certain ferry and registered vanpool services
- New York City Transit Authority buses and subways

The following commuting expenses are not eligible:

- Airfare
- Taxi and limo services
- Amounts that exceed the monthly limit
- Transit expenses of your family members
- Bridge, tunnel, and highway tolls, including E-Z Pass

Parking Reimbursement Program

You may elect a monthly deposit amount from $10 to $230. The amount will be deducted from your paycheck before taxes are taken out.

Keep in mind if you commute and park in a University-owned lot or at New York-Presbyterian Hospital, you are already paying for parking through a pre-tax deduction. Therefore, you should not sign up for a Parking account unless you also commute to a lot that the University does not own. In that case, your Parking deduction plus your monthly University parking bill cannot exceed the $230 monthly parking limit.

What's Covered/Not Covered—Parking

Under IRS regulations, you can use the money in your parking account for the cost of parking at any:

- Commercial parking lot near your work location
- Parking at a train station where you board mass transit

If you pay to park at locations where you board mass transit, you can participate in both transit and parking accounts, up to the maximum of each account.

The following parking expenses are not covered:

- Parking expenses of your family members
- Amounts exceeding the maximum allowable monthly limit
- Parking at or near your residence

How the Program Works

You may participate in either the Transit or Parking Reimbursement Program—or both. The T/PRP allows you to set aside pre-tax dollars each paycheck to pay for commuting expenses. As you incur eligible expenses during the year, money is taken from your account by the Program's debit card (or you can file claims for reimbursement).

Under IRS regulations, you must use the entire amount of each monthly deposit. The unused amount from one month will not be available to you in the next month. So, for example, if you take a vacation during August, the unused August balance does not get added to the amount you have available for September. However, any unused balance left in a T/PRP account at the end of the year will roll over to the next year. The rollover takes place after the annual claim period ends (March 31 each year).

You Can Make Changes During the Year

If there is an increase or decrease in the amount you pay for transit or parking expenses, you can make changes to your account anytime during the year. You can also change your deposit amount if you:

- Change your work location or residence.
- Change the way you commute (for example, you stop driving and begin to take public transit).

Just go online to **www.hr.columbia.edu/benefits** and log in with your UNI and password to the CU Benefits Enrollment System. Click on Update 2011 Transit and Parking Elections.

When will my changes take effect? This depends if the change to your benefit election is before or after the 20th of the month. To illustrate:

- **A change made January 10:** because this is before the 20th of the month, your change will be effective February 1
- **A change made January 21:** because this falls after the 20th of the month, your change will be effective March 1

The EBPA Debit Card for Transit and Parking

If you participate in T/PRP, you will receive a debit card from EBPA. The EBPA debit card can be used for both Transit and Parking accounts.

This card allows you to pay for your transit or parking expenses through any vendor that sells commuter tickets or Metro-Cards and accepts MasterCard. When you use the card to pay for your monthly commute, please be sure to select "credit."

If You Do Not Use the EBPA Debit Card

You may also submit your Transit and/or Parking benefit expenses with a paper claim form. To obtain a claim form, go to **www.hr.columbia.edu/forms-docs/forms**.

Then you can arrange to have your reimbursements deposited directly into the bank account of your choice. If you would like to authorize this, the form is also available at **www.hr.columbia.edu/benefits/forms-docs/forms**. Please contact EBPA if you have any questions regarding direct deposit service.

EBPA
P.O. Box 1140
Exeter, NH 03833-1140
(888) 456-4576
Monday – Friday, 8:00 a.m. – 7:00 p.m.
www.ebpabenefits.com

Columbia University Retirement Plan – Local 241 Transport Workers Union of America

You receive a pension in retirement that is calculated on whichever of the following two formulas gives you the greatest benefit.

Formulas

- If you retire on or after July 1, 2008, the Career Pay Formula is:
  - 2.0% of your pay for the first 10 years of service (including year 10) that you are covered by the Plan
  - 2.2% of your pay for the next 20 years of service (years 11— and including 30) that you are covered by the Plan
  - 2.3% of your pay for years of service in excess of 30 that you are covered by the Plan
- The Final Pay Formula is 1.2% of your base earnings for the last five years of your employment at Columbia, multiplied by your total years of credited benefits service covered under the Plan with the University.

Vesting

This benefit is 100% vested after five years of service with the University.

Unreduced Pension

To receive an unreduced pension, you must a) retire with at least 20 years of service and be at least age 62 or b) retire on or after age 65. Retirements may only occur on the first day of a calendar month.

Please see the *Columbia University Summary Plan Description (SPD) – Retirement Benefits for Local 241 Transport Workers Union of America* at **www.hr.columbia.edu/benefits/spds** for detailed information.

Lessons Learned About VRSP

The majority of Columbia University colleagues take advantage of pre-tax savings with our Voluntary Retirement Savings Plan. But the one thing we hear most of them say is: “I just wish I’d started earlier.”

This is your opportunity to learn more about the VRSP. It is one of the most important benefits the University offers. Take advantage of it. And take the advice of your fellow colleagues: Save early and save more.

You may enroll at **www.hr.columbia.edu/benefits**.

Voluntary Retirement Savings Plan (VRSP)

Eligibility and Participation

You are eligible to participate in the VRSP as long as you receive W-2 income from the University. Eligibility begins on your date of hire. **You must enroll if you wish to contribute** to the VRSP. You may enroll and designate an investment carrier at any time during the year online in the CU Benefits Enrollment System at **www.hr.columbia.edu/benefits**. Your benefit is 100% vested at all times.

Pre-Tax Contributions

Standard Contributions: You may elect either a flat dollar amount per paycheck or the annual maximum contribution allowed under the IRS regulations. If you elect the annual maximum, the CU Benefits Enrollment System will calculate the amount for you and divide it equally per paycheck.

You can reach the annual maximum contribution as early in the year as you choose by electing a large flat dollar amount. Deductions will automatically stop from your pay when you reach the IRS limits.

The IRS limits the amount you can contribute to your VRSP each year. For example, in 2010, the limit was $16,500.

Catch-Up Contributions: If you are age 50 or older, you may contribute an additional $5,500, the 2010 limiit, on a pre-tax basis to your VRSP once you have met the maximum standard contribution limit. You are eligible on January 1 of the year you turn age 50. This election is available to you online.

Newly Hired: You are responsible for ensuring your annual contributions do not exceed the IRS limit. If you contributed to another pre-tax retirement plan during the calendar year, please be careful to elect the appropriate per paycheck amount.

Investing Your VRSP Account

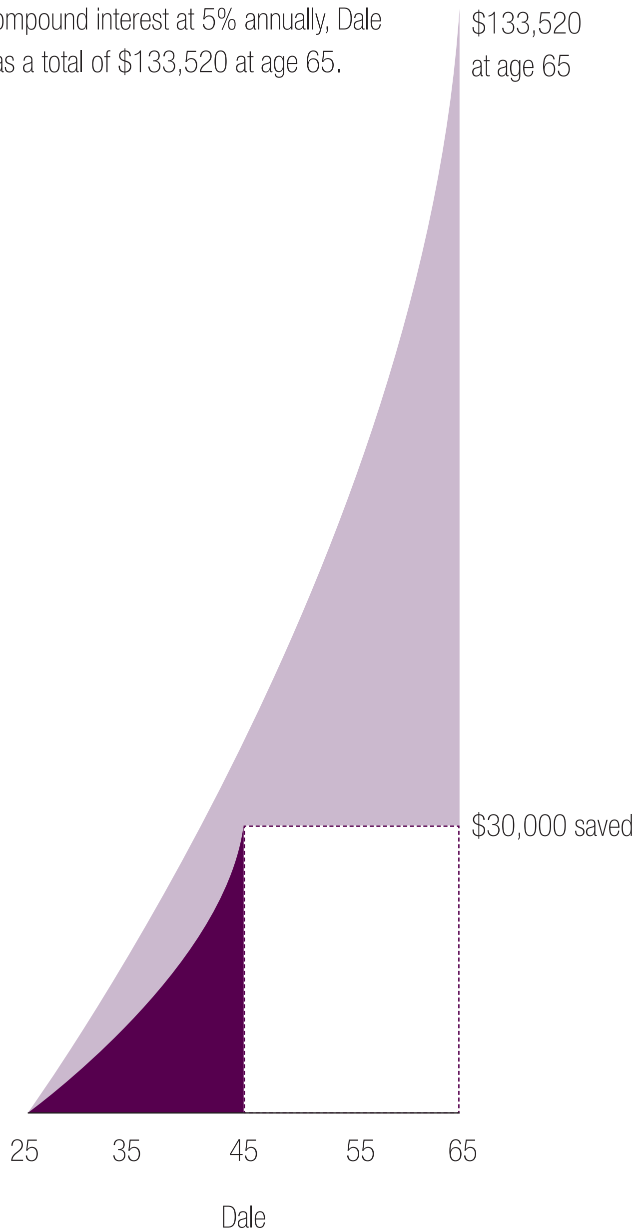
You may direct the investment of the contributions to your VRSP account using one, two or three investment carriers. Please review the investment choices available to you by contacting the carriers directly.

You may select how your funds are invested at the carrier website or by completing a form available from the investment carrier.

Columbia University VRSP Carriers		
Calvert	www.calvert.com/investor-workplace-columbia.html	(800) 368-2745
The Vanguard Group	www.vanguard.com	(800) 523-1188
TIAA-CREF	www.tiaa-cref.org	(800) 842-2776

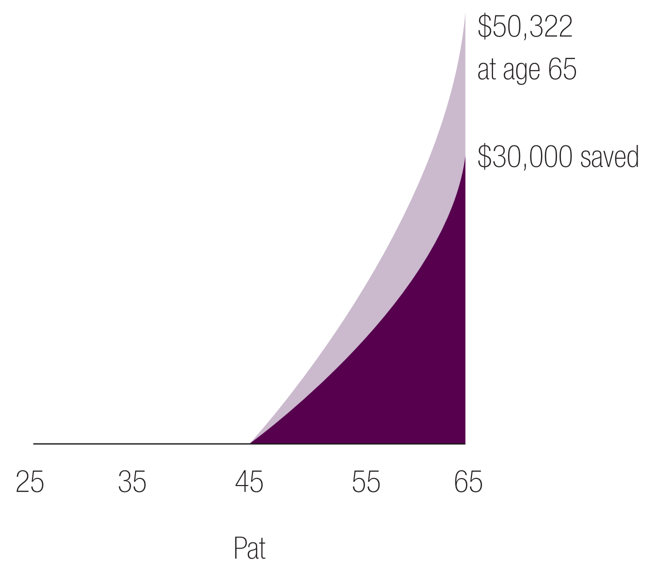
Time is Money

Dale started saving at age 25 and saved a total of $30,000 through age 44 making annual contributions. With the effect of compound interest at 5% annually, Dale has a total of $133,520 at age 65.



Pat started saving at age 45. Pat saved the same amount, $30,000, making annual contributions to age 64, and had a total of $50,322 at age 65. This assumes Pat also has 5% compound interest annually.

To have the same amount at age 65 as Dale, $133,520, Pat would have needed to contribute almost $6,000 each year from age 45 to age 54.



Save early and save more.
Any dollar you save right now will be worth much more in 20 years than a dollar saved next year.

Default Investment

If you designate an investment carrier online but **do not enroll in specific funds** with the carrier, your contributions will be directed to a ***Retirement Target Date Fund***. These funds actively manage a portfolio of investments that change over time. These funds are intended to match the appropriate diversification of investments needed for someone at different life stages and assumes your retirement will be at age 65. If you would like details about these funds or to change your fund selection, contact the investment carrier directly by phone or website.

Withdrawing Money from Your VRSP Account Early

You may request a loan or a hardship withdrawal (subject to specific IRS requirements) from your VRSP account.

TIAA-CREF administers all requests for loans and hardship withdrawals. This means that if you use Calvert or Vanguard, you must transfer assets to TIAA-CREF before you can apply for a loan or hardship withdrawal. Please be advised that this type of request may take three to six weeks to process.

For more information about loans and hardship withdrawals, please see the *Columbia University Summary Plan Description – Voluntary Retirement Savings Plan (VRSP) Benefits* at **www.hr.columbia.edu/benefits/spds** for detailed information.

Financial Planning and Retirement Education Resources

Representatives from Calvert, TIAA-CREF and Vanguard visit the University on-site throughout the year to discuss personal financial planning, investment strategies, portfolio reviews and retirement education.

The dates and locations for all sessions are posted at the carrier websites so you can select the date and time that works best for you. **Please note: You need to register for these sessions by contacting the carriers directly.**

Retirement Planning Session Registration Information		
Calvert	www.calvert.com/investor-workplace-columbia.html	Online registration only
The Vanguard Group	www.meetvanguard.com	(800) 662-0106, ext. 14500
TIAA-CREF	www.tiaa-cref.org/moc	(800) 842-2776, ext. 234217

Retiree Medical and Life Insurance Coverage

You are eligible for this coverage if you leave the University on or after age 55 and you complete at least 10 years of continuous benefit-eligible service with the University after age 45.

Notices Required Under the Patient Protection and Affordable Care Act of 2010

Grandfathered Status Under Healthcare Reform Law

Columbia University believes that all medical benefit options under the Columbia University Group Benefits Plan (the "Plan") are "grandfathered health plans" under the Patient Protection and Affordable Care Act of 2010 (more commonly known as Health Care Reform). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when Health Care Reform was enacted. Being a grandfathered health plan means that the medical coverage that you have elected under the Plan may not include certain consumer protections of Health Care Reform that apply to other group health plans, for example, the requirement for the provision of preventive health services without any cost sharing (i.e., copayments, coinsurance, deductibles). However, grandfathered health plans must comply with certain other consumer protections in Health Care Reform, for example, the elimination of lifetime limits on benefits and extension of coverage to dependents until age 26.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 212-851-7000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Contact the Plan Administrator for more information.

Note: Heath Care Reform applies only to the medical and prescription drug benefits that are being offered under the Plan.

Lifetime Limits Repealed

The lifetime limit on the dollar value of benefits under the Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the Plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Plan Administrator at 212-851-7000.

Annual Dollar Limits

In accordance with applicable law, the annual dollar limits (except to the extent they exceed $750,000 in 2011) set forth in this booklet shall not apply to "essential health benefits," as such term is defined under Section 1302(b) of the Patient Protection and Affordable Care Act of 2010 or any regulations related thereto. For this purpose, a determination as to whether a benefit constitutes an "essential health benefit" shall be based on a good faith interpretation by the Plan Administrator of the applicable guidance available as of the date on which the determination is made.

Dependent Coverage to Age 26

Effective January 1, 2011, you may enroll your child who has not attained age 26 in the Plan without regard to your child's financial dependency, residency or student status.

Subject to the eligibility requirements of the applicable benefit options, an individual whose coverage ended, or who was denied coverage (or was not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 is eligible to be enrolled or reenrolled in the Plan if currently under the age of 26, unless the individual is eligible to enroll in other employer-provided group health coverage (other than coverage through a plan of the other parent's employer). However, you must request the enrollment or reenrollment of your child who meets these criteria within 30 days of this notice. Enrollment will be effective January 1, 2011. For more information contact the Plan Administrator at 212-851-7000.

OTC Notice

Effective January 1, 2011, expenses for non-prescription drugs that constitute "medical care" under Section 213 of the Code (i.e., over-the-counter drugs) are not eligible for reimbursement from your Flexible Savings Account.

Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation

The University reserves the right to terminate coverage for you and/or your Dependent(s) prospectively without notice for cause or if you and/or your Dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or your covered Dependent(s) commits fraud or intentional misrepresentation in an application for coverage under the Plan, in a claim or appeal for benefits, or in response to any request for information by the Plan Administrator, a Claims Administrator, an Appeals Administrator, or Columbia University, the Plan Administrator may terminate your coverage retroactively to the date of the fraud or misrepresentation upon 30 days notice. Failure to inform the Plan Administrator, a Claims Administrator, an Appeals Administrator, or Columbia University, as applicable, that you or your Dependent is covered under another plan constitutes fraud under the Plan. Failure to inform the Plan Administrator, a Claims Administrator, an Appeals Administrator, or Columbia University, as applicable, that your Dependent child is eligible for coverage under another employer sponsored plan (other than coverage through the other parent's employer) constitutes fraud under the Plan.

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under the Columbia University Group Benefits Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse or same-sex domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or same-sex domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse or same-sex domestic partner dies;
- Your spouse's or same-sex domestic partner's hours of employment are reduced;
- Your spouse's or same-sex domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse or same-sex domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or your domestic partnership ends.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Columbia University, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Employee Benefit Plan Administration
Attn: COBRA Department
P.O. Box 1140
Exeter, NH 03833-1140
888-456-4576
www.ebpabenefits.com

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide written proof of the disability to Employee Benefit Plan Administration at P.O. Box 1140, Exeter, NH 03833-1140 within 60 days of receiving a Social Security disability determination and before the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact the Plan's COBRA Administrator using the below contact information if you have any questions regarding COBRA continuation coverage.

Employee Benefit Plan Administration
Attn: COBRA Department
P.O. Box 1140
Exeter, NH 03833-1140
888-456-4576
www.ebpabenefits.com

Health Insurance Portability & Accountability Act (HIPAA)

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

Disclosure Limitations

The Columbia University Health Plan – which includes Aetna POS, CIGNA POS, UHC POS, CIGNA Modified Indemnity, CIGNA International, Medco Rx, the Aetna Columbia Dental Plan, Aetna HMO, HIP HMO and the Healthcare Flexible Spending Account – has always maintained the strictest privacy and confidentiality standards in the use and handling of your health insurance information.

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

- To make or obtain payments
- To conduct healthcare operations
- To recommend treatment alternatives
- To provide information about health related benefits and services
- To communicate with an individual – that is, a friend or family member – involved in your care or the payment for your care (if authorized by you)
- To comply with a federal, state, or local legal requirement
- To comply with a court order or administrative proceeding
- To conduct health oversight activities
- To counter serious threats to your health or safety

- For law-enforcement purposes
- For specified government functions
- For worker's compensation

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

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

Your rights regarding your health information include:

- The right to request restrictions beyond those outlined above
- The right to receive confidential communications (for example) at only a specified phone number or email address
- The right to inspect and copy your private health information
- The right to amend your private health information
- The right to an accounting of instances when your private health information has been disclosed

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

Privacy Officer

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

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

Authorization Forms

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

The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009

Special Enrollment Extension and Expansion Rule for CHIP under HIPAA

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility.

Alabama – Medicaid

Website: www.medicaid.alabama.gov

Phone: 800-362-1504

Alaska – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529

Arizona – CHIP

Website: www.azahcccs.gov/applicants/default.aspx

Phone: 877-764-5437

Arkansas – CHIP

Website: www.arkidsfirst.com

Phone: 888-474-8275

California – Medicaid

Website: www.dhcs.ca.gov/services/pages/tplrd_cau_cont.aspx

Phone: 866-298-8443

Colorado – Medicaid and CHIP

Medicaid Website: www.colorado.gov

Medicaid Phone: 800-866-3513

CHIP Website: www.chpplus.org

CHIP Phone: 303-866-3243

Florida – Medicaid

Website: www.fdhc.state.fl.us/medicaid/index.shtml

Phone: 866-762-2237

Georgia – Medicaid

Website: http://dch.georgia.gov
Click on Programs, then Medicaid

Phone: 800-869-1150

Idaho – Medicaid and CHIP

Medicaid Website: www.accesstohealthinsurance.idaho.gov

Medicaid Phone: 800-926-2588

CHIP Website: www.medicaid.idaho.gov

CHIP Phone: 800-926-2588

Indiana – Medicaid

Website: www.in.gov/fssa/2408.htm

Phone: 877-438-4479

Iowa – Medicaid

Website: www.dhs.state.ia.us/hipp

Phone: 888-346-9562

Kansas – Medicaid

Website: https://www.khpa.ks.gov

Phone: 800-766-9012

Kentucky – Medicaid

Website: http://chfs.ky.gov/dms/default.htm

Phone: 800-635-2570

Louisiana – Medicaid

Website: www.lahipp.dhh.louisiana.gov

Phone: 888-342-6207

Maine – Medicaid

Website: www.maine.gov/dhhs/oms

Phone: 800-321-5557

Massachusetts – Medicaid and CHIP

Medicaid & CHIP Website: www.mass.gov/masshealth

Medicaid & CHIP Phone: 800-462-1120

Minnesota – Medicaid

Website: www.dhs.state.mn.us
Click on Health Care, then Medical Assistance

Phone (Outside of Twin City area): 800-657-3739

Phone (Twin City area): 651-431-2670

Missouri – Medicaid

Website: www.dss.mo.gov/mhd/index.htm

Phone: 573-751-6944

Montana – Medicaid

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml

Phone: 800-694-3084

Nebraska – Medicaid

Website: www.dhhs.ne.gov/med/medindex.htm

Phone: 877-255-3092

Nevada – Medicaid and CHIP

Medicaid Website: http://dwss.nv.gov

Medicaid Phone: 800-992-0900

CHIP Website: www.nevadacheckup.nv.org

CHIP Phone: 877-543-7669

New Hampshire – Medicaid

Website: www.dhhs.state.nh.us/dhhs/medicaidprogram/default.htm

Phone: 800-852-3345 x 5254

New Jersey – Medicaid and CHIP

Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid

Medicaid Phone: 800-356-1561

CHIP Website: www.njfamilycare.org/index.html

CHIP Phone: 800-701-0710

New Mexico – Medicaid and CHIP

Medicaid Website: www.hsd.state.nm.us/mad/index.html

Medicaid Phone: 888-997-2583

CHIP Website: www.hsd.state.nm.us/mad/index.html
Click on Insure New Mexico

CHIP Phone: 888-997-2583

New York – Medicaid

Website: www.nyhealth.gov/health_care/medicaid

Phone: 800-541-2831

North Carolina – Medicaid

Website: www.nc.gov

Phone: 919-855-4100

North Dakota – Medicaid

Website: www.nd.gov/dhs/services/medicalserv/medicaid

Phone: 800-755-2604

Oklahoma – Medicaid

Website: www.insureoklahoma.org

Phone: 888-365-3742

Oregon – Medicaid and CHIP

Medicaid & CHIP Website: www.oregonhealthykids.gov

Medicaid & CHIP Phone: 877-314-5678

Pennsylvania – Medicaid

Website: www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm

Phone: 800-644-7730

Rhode Island – Medicaid

Website: www.dhs.ri.gov

Phone: 401-462-5300

South Carolina – Medicaid

Website: www.scdhhs.gov

Phone: 888-549-0820

Texas – Medicaid

Website: https://www.gethipptexas.com

Phone: 800-440-0493

Utah – Medicaid

Website: http://health.utah.gov/medicaid

Phone: 866-435-7414

Vermont – Medicaid

Website: http://ovha.vermont.gov

Phone: 800-250-8427

Virginia – Medicaid and CHIP

Medicaid Website: www.dmas.virginia.gov/rcp-HIPP.htm

Medicaid Phone: 800-432-5924

CHIP Website: www.famis.org

CHIP Phone: 866-873-2647

Washington – Medicaid

Website: http://hrsa.dshs.wa.gov/premiumpymt/apply.shtm

Phone: 877-543-7669

West Virginia – Medicaid

Website: www.wvrecovery.com/hipp.htm

Phone: 304-342-1604

Wisconsin – Medicaid

Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm

Phone: 800-362-3002

Wyoming – Medicaid

Website: www.health.wyo.gov/healthcarefin/index.html

Phone: 307-777-7531

Workers' Compensation

All Support Staff are covered by the provisions of the New York State Workers' Compensation Law. Benefits are provided under this law for job-related illnesses or accidents. For additional information please review the website: **http://hr.columbia.edu/wac/workplace/workers-comp**.

Medical Leave of Absence for Disability

The University has established medical leave of absence policies for its employees to use as needed and when appropriate and in compliance with applicable law. Please review information on the HR website at **www.hr.columbia.edu**.

Contact Information

	Website	Phone
Employee Assistance Program (EAP)	www.harrisrothenberg.com	(888) 673-1153
Travel Emergencies (including international) MEDEX	www.medexassist.com/Groups/ContactUs/CorporateInfo.aspx or write email to: operations@medexassist.com	North America: (800) 527-0218 Worldwide, call collect: (410) 453-6330
Medical		
UHC Medical UHC Behavioral Health	www.myuhc.com/groups/columbiauniversity	(800) 232-9357 (888) 265-9945
CIGNA	www.cigna.com	(800) 244-6224
Dental		
Aetna Columbia Dental Plan	www.aetna.com/docfind/custom/columbia	(800) 773-9326
GHI Dental	www.ghi.com	(212) 501-GHID (4443)
Prescriptions		
Medco Rx	www.medcohealth.com	(800) 230-0508
Life Insurance		
The Standard Life Insurance	www.standard.com	(888) 264-3057
FSAs, Transit/Parking		
EBPA	www.ebpabenefits.com	(888) 456-4576
Retirement Plans		
Calvert	www.calvert.com/investor-workplace-columbia.html	(800) 368-2745
The Vanguard Group	www.vanguard.com	(800) 523-1188
TIAA-CREF	www.tiaa-cref.org	(800) 842-2776

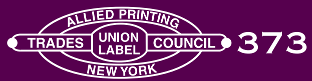
Columbia University HR Benefits Contacts

For all Benefits-related questions, contact:

Columbia University HR Benefits Service Center
Studebaker 4th Floor, MC 8703
615 West 131st Street
New York, NY 10027
Phone: (212) 851-7000
Secure fax: (212) 851-7025
Email: **hrbenefits@columbia.edu** or **hr-retirement@columbia.edu**

For updates, forms, tuition exemption and information about other HR programs:

www.hr.columbia.edu



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