

Columbia University Officer Medical Summary Plan Description

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Columbia University Officers' Health Care Program

Each of the medical options available to you under the Columbia University Officers' Health Care Program offers a wide range of health care services and supplies, including annual exams, office visits, hospitalization, prescription drugs, and mental health and substance abuse treatment. Two major differences among the plans are:

- **How you access care.** Depending on the option you choose, you can access care through a network of health care providers or you can choose to go to any health care provider you want.
- **How much you pay for your care.** When you receive care from a network provider, you will generally have lower out-of-pocket costs than you would if you receive care from a provider outside the network. That's because you have no annual deductible and a higher level of reimbursement. When you receive care outside the network, you have an annual deductible to meet before the plan begins to share in the cost of care. And, if expenses exceed the reasonable and customary (R&C) charge for the expense, you're responsible for paying the amount that exceeds the R&C limit.

This booklet summarizes your benefits under the following health plans under the Columbia University Officers' Health Care Program as of January 1, 2002.

- The CIGNA Point-of-Service Plan
- The Oxford Point-of-Service Plan
- Modified Indemnity Plan

Columbia University also offers medical coverage through Health Maintenance Organizations (HMOs). Detailed benefits information can be found in the HMO's Member Handbook, which is available from the HMO.

Please note that this information is only a summary of the health plans. The plan described in this booklet is governed by its plan documents. If there are any discrepancies between the information included in this booklet and the plan documents, the plan documents will govern.

About your Participation

Selecting Your Coverage Level

When you enroll, you may choose from one of the following coverage levels:

- Yourself only
- Yourself and spouse/same-sex domestic partner
- Yourself and your child(ren) or your spouse/same-sex domestic partner's child(ren)
- Family (including your unmarried dependent children, your spouse/same-sex domestic partner, and your spouse's or same-sex domestic partner's unmarried dependent children).

- If you decide to waive coverage, you'll receive a monthly credit, which you can take as salary or apply to your Medical/Dental University Spending Account.

Who Is Eligible

Officers of Columbia University

You are generally eligible to participate in the Columbia University Officers' Health Care Program if you are a full-time Officer of Administration, Officer of Research, Officer of Libraries, or Officer of Instruction (faculty member). If you are a new officer, you are eligible to participate in the plan on the first day of the month coincident with or following your date of hire.

Dependents

You may elect coverage for your eligible dependents, including your:

- Legal spouse
- Child(ren)
 - Your or your spouse's/same-sex domestic partner's unmarried dependent children under age 19, including adopted children, foster children, stepchildren, and children placed with you for adoption
 - Your or your spouse's/same-sex domestic partner's unmarried dependent children under age 26, if they are full-time students at an accredited college or university
 - Your or your spouse's/same-sex domestic partner's unmarried children of any age who have a physical or mental disability, are unable to provide for themselves, and rely on you for support, provided that when they became disabled they were covered dependents under the plan and under age 20.

Note: Some HMOs have different rules about covering dependent children, so be sure to check with your HMO about dependent eligibility.

- Same-sex domestic partner provided he/she meets the following requirements:
 - Your partner must not be a blood relation who is close enough to bar marriage in the state you reside
 - Your partner must not be eligible for coverage through Columbia University as an employee
 - You and your partner have lived together in a committed personal relationship for at least six consecutive months before applying for coverage, and you expect to continue living together in a personal relationship in which you have joint and reciprocal financial responsibilities
 - You and your partner are not married nor have other domestic partners.

In addition, you must present two forms of documentation showing your shared financial responsibilities, such as:

- A joint lease or mortgage
- A joint bank account statement

- Joint ownership of a motor vehicle
- Designation of your partner as the primary beneficiary of your will, life insurance or retirement benefits.

Under Internal Revenue Service (IRS) regulations, you must pay the monthly payroll contributions for your same-sex domestic partner's portion of the coverage on an after-tax basis. In addition, under federal law, the amount that the University pays for your same-sex domestic partner's coverage will be included as taxable income to you.

When Coverage Begins

If you are a new officer enrolling during the year, coverage for you and your eligible dependents will begin as of the first day of the month coincident with or following the date you start work, provided you have elected coverage within 60 days of your start date. If you do not enroll when you are first eligible, restrictions may apply for health plan elections.

If you enroll or change coverage during the open enrollment period each year, coverage for you and your dependents will begin on January 1 and remain in effect through December 31 of that year as long as you are still eligible for coverage.

Making Changes

According to IRS rules, you may make changes to your medical coverage once each year during annual enrollment or when you experience a qualified life status change. The IRS defines a life status change as a change in your job or family status that justifies a change in your medical elections during the plan year (January 1 – December 31). Qualified changes in job or family status include:

- Marriage, divorce, legal separation, annulment or the beginning of eligibility or end of a same-sex domestic partnership
- A change in the number of dependents either through birth, death, adoption, or placement for adoption
- Employment or termination of employment for your spouse/same-sex domestic partner or dependent
- A change in employment status, including a switch from full-time to part-time status or vice versa, a strike or lockout, or the beginning or end of an unpaid leave of absence for you, your spouse/same-sex domestic partner, or dependent
- A significant change in medical coverage under your spouse's/same-sex domestic partner's health plan for you or your spouse/same-sex domestic partner
- Your spouse/same-sex domestic partner or dependent satisfying or failing to satisfy a medical plan's coverage requirements due to age, student status, or similar circumstances
- A change in residence or work site for you, your spouse/same-sex domestic partner, or dependent

- You or one of your covered dependents becomes entitled to Medicare or Medicaid (you may cancel coverage under the University medical plans for that individual)
- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) is issued requiring health coverage for your child.

Please note that even with a qualified life status change you can only make changes to your benefit election that are consistent with your life status change. For example, if you have a child, you can add the child to your medical plan, but you would not be able to change from one medical plan to another. Changes must be made within 30 days of the life status change. After your request is received, the benefit change you request will go into effect as of the date the qualified event occurred.

When Coverage Ends

Your benefits coverage ends on the last day of the month in which you terminate your employment with the University. Coverage under this plan also ends if:

- Columbia University terminates the plan
- You are no longer eligible for benefits
- You fail to make any required contribution.

Your dependent's coverage ends if:

- Columbia University terminates all dependent coverage under the plan
- Your dependent becomes covered as an employee
- Your dependent is no longer eligible for benefits
- You fail to make any required contributions
- Your coverage terminates.

You may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You may also be able to continue coverage if you are on an approved leave.

Your Medical Options

Depending on where you live, you can choose to enroll in one of the following options:

- CIGNA Point-of-Service (POS) Plan
- Oxford POS Plan
- CIGNA Modified Indemnity Plan
- Oxford Health Maintenance Organization (HMO)
- HIP HMO
- Aetna HMO

Your personalized enrollment worksheet, which you receive during the annual enrollment period, shows the HMOs available. For more information about a specific HMO, contact the HMO directly.

Terms you should know

Deductible

Under the Modified Indemnity Plan and the out-of-network feature of the POS Plans, you have a deductible to meet. A deductible is the amount of covered expenses that you pay before a plan begins paying any benefits.

Out-of-Pocket Limit

Under the Modified Indemnity Plan and the out-of-network feature of the POS Plans, there's a limit on the amount you pay for covered expenses each year. This limit represents the most you have to pay out of your own pocket for covered expenses. Once you reach the out-of-pocket limit, the plan will pay 100% of any covered expenses that you incur during the year. However, you will be responsible for any amounts that exceed the reasonable and customary (R&C) charge for an expense. (See the definition of "Reasonable and Customary Limit" in this section.)

Note: Copays, out-of-network prescription drug expenses, and services covered at 50% do not count toward the out-of-pocket maximum.

Primary Care Physician

A Primary Care Physician (PCP) coordinates all your network care through an HMO or POS Plan. In general, a PCP is an internist, family or general practitioner or pediatrician.

Reasonable and Customary Limit

Under the Modified Indemnity Plan and the out-of-network feature of the POS Plans, reimbursement is based on the reasonable and customary (R&C) charge for the expense. R&C is the typical charge made by most providers for similar care in a geographic area. If the charge for care exceeds the R&C limit, you may be responsible for the amount above the limit. Amounts that exceed the R&C limit do not apply to the out-of-pocket limit or annual deductible.

About Health Maintenance Organizations (HMOs)

With HMOs, you must choose a PCP within the HMO's network to provide your routine services and coordinate your health care needs or refer you to a specialist.

When your PCP coordinates your care, the plan typically covers 100% of eligible expenses after your copay. In general, the plan will not pay benefits if your PCP does not coordinate your care, or you use a doctor who is not in the HMO network (unless your PCP refers you).

Your copays will vary based on the HMO you choose and the service you receive.

How to Reach the HMOs

- Oxford: 1-800-760-4566, www.oxhp.com
- HIP: 1-800-HIP-TALK, www.hipusa.com
- Aetna: 1-800-433-8531, www.aetna.com

Point-of-Service (POS) Plan

The POS Plan option lets you choose between receiving care from doctors, hospitals, and facilities that are part of the plan's network of providers (in-network care) or from providers that are not part of the plan's network (out-of-network care).

In-Network Care

To receive in-network benefits, you must choose a Primary Care Physician (PCP) who is responsible for providing or coordinating your care within the POS Plan's network. When you choose to receive in-network care, you must contact your PCP first. Your PCP will treat you or refer you to a specialist, hospital or other health care provider. You do not need a PCP referral to visit an OB/GYN or to receive mental health/substance abuse care.

For in-network care, the plan pays 100% of the cost of your eligible expenses after you pay a fixed fee (copay). **You do not have to meet an annual deductible for in-network care, nor do you need to complete any claim forms.** When you receive care from a network provider, your out-of-pocket costs are generally less than they would be if you received care from a provider outside the network.

Out-of-Network Care

To receive out-of-network benefits, you may see any provider you want—you do not have to coordinate with your PCP. If you use out-of-network doctors and facilities or go to a network provider without a referral from your PCP, you have an annual deductible to meet before the plan begins to share in the cost of coverage. After meeting the deductible, the plan pays a percentage of your covered medical expenses, up to an out-of-pocket limit. After you meet the out-of-pocket limit, the plan pays 100% of covered reasonable and customary medical expenses for the remainder of that year.

You may need to pay the full cost of coverage up front and file a claim for reimbursement.

POS Plan Key Features

In-Network

- Select a PCP/contact PCP when you seek care
- Request a referral from your PCP if you need to see a specialist
- No annual deductible
- Copays
- Network provider is responsible for seeking precertification
- No claim forms to file

Out-of-Network

- See any provider you choose
- Do not need referral from PCP
- Annual deductible based on salary and coverage level (before any reimbursement is made)
- Coinsurance based on R&C charges
- You're responsible for seeking pre-certification
- Claim forms to file

Choosing a PCP

With the POS Plans, you need to choose a PCP to coordinate your in-network care. To choose a PCP, review the plan's provider directory, which includes a list of doctors, hospitals, and other facilities that are part of the plan's network. Provider directories are available from the plan's Member Services department; in most cases, directories are also

available online via the plan's web site. You can also access provider directories for all plans through the Columbia University Human Resources website

You can change your PCP at any time by calling the plan's Member Services department. In some cases, you may be able to select a PCP through a plan's web site.

Changing Your PCP

You may change your PCP at any time. To change your PCP, you can call the plan's Member Services department or access the plan's web site. For the Oxford POS Plan, the change will become effective immediately; for the CIGNA POS Plan, the change will become effective on the first day of the month following the month in which the plan completes the processing of the change request.

In addition, if at any time a PCP drops out of the plan's network, you or your dependent will be notified by the plan and you'll need to select a new PCP.

OB/GYN Self-Referral

If you're a woman, you have direct access to an OB/GYN network. You do not need to obtain authorization from your PCP for visits to a network OB/GYN. However, under the Oxford POS Plan, you must elect a network OB/GYN when you enroll in the plan; otherwise, your care may not be covered

In an Emergency...

If you have an emergency, seek care immediately. You should notify the plan within 48 hours of being treated or admitted to the hospital, or as soon as is practicable.

If You Need Urgent Care While You're Traveling

If you need to receive urgent care while you're traveling, you'll be covered at the in-network level of benefits, as long as you call the plan's Member Services department when you need care. If you don't call Member Services, you may be covered at the out-of-network level of benefits.

If Your Dependents Live Outside the Network Service Area

Under the CIGNA POS Plan, if your dependent lives outside of metropolitan New York—such as a child who attends college outside the state—special "guest services" may be available. (CIGNA has a national network of doctors, hospitals, and other providers.) That means your eligible dependent can enroll as a "guest" of another CIGNA POS network and continue to receive in-network benefits. All you need to do is call CIGNA and find out if a CIGNA network is available where your dependent lives.

Under the Oxford POS Plan, routine care is paid at the out-of-network level (generally 80% of R&C charges after the annual deductible is met) for care received outside the network service area.

How to Reach the POS Plans

- CIGNA: 1-800-832-3211, www.cigna.com
- Oxford, 1-800-879-2399, www.oxhp.com

Precertifying Care

If you need to be hospitalized or have a surgical procedure, you may need to obtain precertification before services can be performed. Precertification is also required for in-network care under the POS Plans or HMOs; however, your network doctor obtains precertification for you. Precertification assures that the treatment you receive is

appropriate for your needs and is delivered in the most cost-effective way.

When And How To Seek Precertification

<i>Plan</i>	<i>Services that require precertification</i>	<i>When you or your network provider needs to seek precertification</i>	<i>Whom to call</i>	<i>If you or your network provider doesn't seek precertification</i>
<i>CIGNA POS Plan</i>	Inpatient hospitalization, surgery, and certain outpatient procedures	As soon as you learn of the need for an elective procedure	1-800-832-3211	You are responsible for the first \$500 in inpatient hospital charges, as well as bed and board charges you incur during your hospital stay
<i>Oxford POS Plan</i>	Inpatient hospitalization, surgery, and certain outpatient procedures	At least 14 days in advance of procedure	1-800-666-1353	You are responsible for a \$500 penalty charge

Modified Indemnity Plan

The Modified Indemnity Plan allows you to receive care from any covered health care provider you choose. However, the annual deductible for this plan is \$3,000 (individual)/\$6,000 (family), so it's possible that you won't receive any reimbursement under this plan for medical services. After you meet your deductible, the plan pays 100% of your covered reasonable and customary (R&C) medical expenses. However, if the expense exceeds the R&C limit for the expense, you're responsible for paying the amount that exceeds the R&C limit.

Modified Indemnity Plan Key Features

- See any provider you choose
- Annual deductible based on salary and coverage level (before any reimbursement is made)
- Coinsurance based on R&C charges
- Claim forms to file
- No precertification for hospital stays
- No prescription drug card

Please note that certain services that are covered under the POS Plans and HMOs are not covered under the Modified Indemnity Plan, including preventive care. In addition, precertification is not required for care received under the plan. See "Comparison of Medical Options" for benefits covered under the plan.

Case Management

Case management is a free service offered by CIGNA under the Modified Indemnity Plan that assists with treatment needs that extend beyond the acute care setting. With Case Management, a case manager works with you, your family, and a doctor to determine the needs of the patient and to identify what alternate treatment programs may be available. (For example, in-home medical care, rather than an extended hospital convalescence.) You, your dependents, or your doctor can request case management services at any time by calling the toll-free phone number shown on the back of your health plan ID card. The goal of case management is to ensure that appropriate care is provided in the most effective setting possible, whether at home, or as an outpatient, or an inpatient in a hospital or specialized facility.

Case managers include registered nurses and other credentialed health care professionals, each trained in a clinical specialty area. In addition, case managers are supported by a panel of doctors' advisors who offer guidance on up-to-date treatment programs, as well as medical technology. If you request case management services, a case manager trained in the appropriate clinical specialty areas will be assigned to you or your dependent.

While participation in case management is strictly voluntary, case management professionals can offer quality, cost-effective treatment alternatives. In addition, they can provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

How to Reach the Modified Indemnity Plan

- CIGNA Modified Indemnity, 1-800-462-7486, www.cigna.com

Filing a Claim

When you or your dependents receive care under the Modified Indemnity Plan or from an out-of-network provider under the POS Plans, you must file a claim form. Otherwise, there are no claim forms to file—your provider does it for you.

Claim forms are available online via the Columbia University Human Resources web site. Simply follow the instructions on the form.

You may also need to include the original, itemized bill(s) with your claim form. Only original bills will be considered. Generally, itemized bills should contain:

- Patient's name
- Type of service
- Name and address of provider making the charge
- Description of service
- Date of service
- Individual charge for each service
- Diagnosis or symptoms.

Be sure to keep a copy of your claim form and bills for your records.

All claims should be submitted promptly. You have one year from the date of service to submit your claims. You should contact your medical plan if you have any problems with your claim.

Comparison of Medical Options

Here is a comparison of benefits provided under each medical option. This summary also shows how you and the plan share in the cost of coverage. Please note that benefits paid under the Modified Indemnity Plan or for out-of-network care under the POS Plans are based on the reasonable and customary (R&C) charge for the expense. You are responsible for paying any amounts that exceed the R&C limit.

Comparison of Medical Plans

	CIGNA POS Plan		Oxford POS Plan		Modified Indemnity Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	
In the doctor's office					
Office visit (excluding routine physical exams)	\$10 copay	You pay 20% after deductible	\$10 copay	You pay 20% after deductible	You pay nothing after deductible
Adult routine physical exams (including immunizations, hearing and vision exams)	You pay nothing	Not covered	You pay nothing	Not covered	Not covered
Child routine physical exams (for children through age 19)	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
Annual OB/GYN exam	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
In the hospital					
Room and board	\$150 per admission (waived if readmitted within 30 days)	You pay 20% after deductible***	\$50 per day copay, up to \$250 maximum per admission	You pay 20% after deductible***	You pay nothing after deductible
Surgeon, doctor, anesthesiologist; drugs and medications; rehabilitation services (including physical,	You pay nothing	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible

speech, and occupational); and intensive care services					
In the outpatient department					
Outpatient surgery	You pay nothing	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
Radiation therapy and chemotherapy	You pay nothing	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
Oxygen and equipment for administration	You pay nothing	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
Laboratory tests and X-rays	You pay nothing	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
Anesthesia services	You pay nothing	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
Endoscopic procedures	You pay nothing	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
Routine mammograms (one baseline for women ages 35 through 39, every other year for women ages 40 through 49 and annually for women 50 and older)	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
One routine prostate cancer test per year for males age 40 and older	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
In your home					
Intermittent skilled nursing	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible

care					
Home care services	You pay nothing	You pay 20% after deductible (200 visit annual maximum)	You pay nothing (200 visit annual maximum)	You pay 20% after deductible (200 visit annual maximum)	You pay nothing after deductible
For maternity care					
Prenatal and postpartum care	\$10 copay for initial visit; you pay nothing for all other visits	You pay 20% after deductible	\$10 copay for initial visit; you pay nothing for all other visits	You pay 20% after deductible	You pay nothing after deductible
Hospital services for mother and child	\$150 per admission (applicable to mother only)	You pay 20% after deductible***	\$50 per day copay, up to \$250 maximum per admission (applicable to mother only)	You pay 20% after deductible***	You pay nothing after deductible
For reconstructive and corrective surgery					
Injury to sound natural teeth	You pay nothing for outpatient surgical facility and physician services; \$10 copay for doctor's office visit	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
To correct a congenital birth defect of an infant who was born while covered under the plan	You pay nothing	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
Correction of an anatomical dysfunction that is the result of disease, or injury that occurred while covered under the plan	You pay nothing	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
In an emergency					
Emergency	\$50 copay	\$50 copay	\$50 copay	\$50 copay	You pay nothing after

room	(waived if admitted)†	(waived if admitted)†	(waived if admitted)†	(waived if admitted)†	deductible
Ambulance transport for <i>emergency</i> care	You pay nothing	You pay nothing	You pay nothing	You pay nothing	You pay nothing after deductible
For non-routine podiatry care					
Treatment for fractures or dislocations	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
Diagnostic lab tests and X-rays	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
Surgery and medical care services	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
For treatment in a skilled nursing facility					
Skilled nursing facility, room and board	\$150 per admission (waived if readmitted within 30 days); 120-day annual maximum	You pay 20% after deductible***; 120-day annual maximum	You pay nothing; 120-day annual maximum	You pay 20% after deductible***; 120-day annual maximum	You pay nothing after deductible
Inpatient rehabilitation	\$150 per admission (waived if readmitted within 30 days)	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
For child dental (children under age 12)					
Prophylaxis	Not covered	Not covered	You pay nothing; limit one per year	You pay nothing; limit one per year	Not covered
For approved organ transplant services					
Immunosuppressive medication	You pay nothing	Not covered unless approved by health plan	You pay nothing	Not covered unless approved by health plan	You pay nothing after deductible
Organ procurement costs	You pay nothing	Not covered unless approved by health plan	You pay nothing	Not covered unless approved by health plan	You pay nothing after deductible

For other specialized care					
Hospice care	\$150 per admission (waived if following hospital admission or if readmitted within 30 days)	You pay 20% after deductible***	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
Chiropractic care	\$10 copay	You pay 20% after deductible	\$10 copay	You pay 20% after deductible	You pay nothing after deductible
Acupuncture (must receive care from a medical doctor who is a licensed acupuncturist)	\$10 copay	You pay 20% after deductible	You pay the full cost of care at a 10% to 15% discount	Not covered	You pay nothing after deductible
For other health services					
Purchase and fitting of external prosthetic device (replacement is covered due to normal body growth)	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible***	You pay nothing after deductible
Breast prostheses and reconstruction incidental to mastectomy	You pay nothing (subject to hospital and office visit copays)	You pay 20% after deductible	You pay nothing (subject to hospital and office visit copays)	You pay 20% after deductible***	You pay nothing after deductible
Blood transfusions and blood not donated or replaced	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
Cardiac rehabilitation	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
Dialysis	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
Dressings	You pay nothing	You pay 20% after deductible	You pay nothing	You pay 20% after deductible	You pay nothing after deductible
Durable	You pay	You pay 20%	You pay	You pay 20%	You pay nothing after

medical equipment (i.e. wheelchairs, crutches and hospital beds)	nothing	after deductible	nothing	after deductible	deductible
Family planning services (counseling on contraceptives and related topics)	\$10 copay	You pay 20% after deductible	\$10 copay	You pay 20% after deductible	You pay nothing after deductible
Temporo-mandibular joint syndrome	\$10 copay (limited benefit provided on case by case basis; always excludes appliances and orthodontic treatment)	You pay 20% after deductible (limited benefit provided on case by case basis; always excludes appliances and orthodontic treatment)	Covered per an authorized treatment plan	Covered per an authorized treatment plan	You pay nothing after deductible (limited benefit provided on case by case basis; always excludes appliances and orthodontic treatment)

* For all reasonable and customary costs.

** Copays, out-of-network prescription drug expenses, and services covered at 50% do not count toward out-of-pocket maximum.

*** Precertification required.

† In the case of an emergency, health plan must be notified within 48 hours.

Out-of-Pocket Expenses

	CIGNA POS Plan		Oxford POS Plan		Modified Indemnity Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	
deductible	none	salary-based (see chart below)	none	salary-based (see chart below)	\$3,000 single; \$6,000 per family
coinsurance (% paid by plan)	100% after copay	80%‡	100% after copay	80%‡	100%‡
out-of-pocket limit	not applicable	salary-based (see chart below)	not applicable	salary-based (see chart below)	\$3,000 single; \$6,000 per family

‡ For all reasonable and customary costs.

Deductibles for POS Plan Out-of-Network Benefits

Annual Benefits Salary	Annual Deductible	
	Individual	Family
less than \$30,000	\$250	\$750
\$30,000–39,999	\$300	\$900
\$40,000–59,999	\$475	\$1,425
\$60,000–74,999	\$675	\$2,025
\$75,000 or more	\$750	\$2,250

Out-of-Pocket Limits for POS Plan Out-of-Network Benefits (Includes Deductible)

Annual Benefits Salary	Annual Deductible	
	Individual	Family
less than \$30,000	\$1,000	\$2,000
\$30,000–39,999	\$1,200	\$2,400
\$40,000–59,999	\$1,900	\$3,800
\$60,000–74,999	\$2,700	\$5,400
\$75,000 or more	\$3,000	\$6,000

Prescription Drug Benefits

The Columbia University medical plans cover generic and brand-name prescription drugs. You can fill prescriptions through a retail pharmacy or through a mail order program.

- **Retail Pharmacy**—up to a 30-day supply
 - *Under the POS Plans and HMOs*, you can fill your prescription at a participating network pharmacy and have a small copay. The amount of your copay varies according to whether your prescription is filled with a generic or a brand-name drug. There may be a supply limit for certain prescription drugs. *Note:* Under the POS Plans, you can fill your prescription at a non-participating pharmacy. You'll pay the full cost of the drug up front and file a claim for reimbursement.
 - *Under the Modified Indemnity Plan*, you can go to any pharmacy you want to have your prescription filled. You'll pay the full cost of the drug up front and file a claim for reimbursement. You'll be reimbursed for the full amount of the R&C charge for that drug (after you meet your annual deductible).
- **Mail Order**—31- to 90-day supply

When you order your prescription drugs through the mail, you can receive a larger supply, at a lower price than you would pay at a pharmacy. You may want to consider the mail order program if you have a chronic condition that requires longer-term prescriptions. The CIGNA POS Plan, Oxford POS Plan, and Modified Indemnity Plan offer a mail order service.

Prescription Drug Benefits

	CIGNA POS Plan		Oxford POS Plan		CIGNA Modified Indemnity Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Retail (30-day supply)	\$5 (generic) \$15 (brand-name)	You pay 75% of R&C charges with no deductible	\$5 (generic) \$15 (brand-name)	You pay 75% of R&C charges with no deductible	You pay nothing after deductible (generic and brand-name)
Mail Order (90-day supply)	\$5 (generic) \$15 (brand-name)	Not covered	\$5 (generic) \$15 (brand-name)	Not covered	\$5 (generic) \$15 (brand-name)

About Certain Types of Drugs

Infertility Drugs

Certain prescription drugs for the treatment of infertility may be covered under the plans.

- The CIGNA POS Plan covers both oral—i.e., Clomid, Clomiphene, and Serophene—and injectable infertility drugs.
- The Modified Indemnity Plan covers only injectable infertility drugs.
- The Oxford POS Plan covers only oral infertility drugs

Existing and New Drugs

Under the plans, existing and new drugs are covered once they are FDA-approved, released for distribution, and become federal legends—that means they require a prescription. Certain prescriptions may be reviewed for medical necessity or to determine if alternative medical treatments are available.

Mental Health And Substance Abuse Coverage

The Columbia University medical plans provide coverage for inpatient and outpatient mental health and substance abuse treatment. Benefits vary depending on the plan you choose and whether you receive care through the network or outside the network. In addition, precertification may be required.

- Under the POS Plans, precertification is required for all in-network inpatient and outpatient mental health and substance abuse care.
 - Under the CIGNA POS Plan, precertification is not required for care received outside the network
 - Under the Oxford POS Plan, there is no coverage for outpatient mental health and substance abuse care received outside the network.

- Under the Modified Indemnity Plan, precertification is not required; however, for outpatient care, you must be hospitalized for 15 consecutive days for care to be covered.

For in-network mental health and substance abuse care under the POS Plans, simply call the toll-free number shown below to get a referral to a network mental health and substance abuse provider, as well as to obtain pre-certification.

Mental Health and Substance Abuse Coverage

	CIGNA POS Plan		Oxford POS Plan		CIGNA Modified Indemnity
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Inpatient mental health	\$150 per admission* (up to 60 days per year†)	80% after deductible* (up to 60 days per year†)	\$50 per day copay*; maximum \$250 per admission (up to 60 days per year†)	80% after deductible* (up to 60 days per year†)	100% after deductible (up to 60 days per year)
Outpatient mental health	\$10 copay, for visits 1 – 10*; \$25 copay for visits 11 – 60* (maximum 60 visits per year); Group therapy; \$10 copay, no visit limit	50% after deductible, maximum 20 visits per calendar year, individual and group therapy combined	\$10 copay, for visits 1 – 10*; \$25 copay for visits 11 – 60* (maximum 60 visits per year)	Not covered	Not covered unless following 15 consecutive days of inpatient care, then 100% after deductible (up to 60 visits per year)
Inpatient substance abuse	Same as inpatient mental health * †	Same as inpatient mental health * †	Same as inpatient mental health * †	Same as inpatient mental health * †	100% after deductible (up to 60 visits per year)
Outpatient substance abuse	Same as outpatient mental health *	Same as outpatient mental health	Same as outpatient mental health *	not covered	100% after deductible (up to 60 visits per year)

* Precertification required.

† Combined 60-day maximum for inpatient mental health and substance abuse care.

Medical Rules That Apply To All Plans

Breast Reconstruction Benefits

The medical options provide benefits related to breast reconstruction in compliance with the Women’s Health and Cancer Rights Act of 1998. This federal law states that group health plans that provide medical and surgical benefits for mastectomy must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the medical plans will provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications of mastectomy, including lymphedemas.

Benefits will be provided as they would for any other surgical expense.

Maternity Admissions

Under federal law, group health plans and health insurance issuers generally may not restrict benefits for hospital care in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Coordination of Benefits

Coordination of benefits is a method of paying benefits when more than one medical plan covers you or a family member. It determines how much each plan pays toward expenses.

The Columbia University POS Plan and Modified Indemnity Plan will coordinate benefits with any other group insurance plan that provides coverage for you and your family to ensure benefits that are paid from the Columbia plan does not exceed the total covered expenses. This means the amounts normally payable to you under the plan may be reduced to account for payments made by other plans.

The Columbia University medical plan you elect is your primary coverage. This means it pays for your eligible expenses first. Your spouse/same-sex domestic partner's employer-sponsored plan is your spouse/same-sex domestic partner's primary coverage if he/she is enrolled in that plan.

If your spouse/same-sex domestic partner is covered under either one of the Columbia University POS Plan options or the Modified Indemnity Plan and another medical plan, such as his or her employer's medical plan, the Columbia University plan will coordinate benefits with the other medical plan. The Columbia University plan will assume that the other plan will pay benefits first and the Columbia University plan will pay second. The two plans combined will pay up to the amount you'd normally receive if the Columbia University plan was your only plan. Once you reach the out-of-pocket maximum under the Columbia University plan, the two plans combined will pay the amount you'd normally receive if the Columbia University plan was your only plan and you reached the out-of-pocket maximum.

If your dependent child is covered under your and your spouse's/same-sex domestic partner's plans, the plan of the parent whose birthday falls earlier in the calendar year pays first, regardless of the year of birth. This is called the "birthday rule." For example, if your birthday is April 1 and your spouse/same-sex domestic partner's is October 1, your plan is primary for your child.

If the Columbia University plan is secondary, you should file a claim for benefits under your primary plan, then submit a claim to your Columbia University plan. The Columbia University plan will determine how to pay benefits based on the coordination of benefits rules described in this section.

Medicare

You and your dependents may be eligible for Medicare at age 65, or after 24 months of receiving Social Security Disability Income benefits, whichever comes first.

Medicare consists of hospital insurance benefits (Part A) and Supplemental Medical Insurance benefits (Part B). Generally, you do not have to pay a premium for Part A; however, you're required to pay a premium for Part B coverage. About three months before your 65th birthday, you'll receive an Initial Enrollment Package from the federal government, which includes information about Medicare, a questionnaire, and your Medicare card. At this time, you can choose whether you want to participate in Medicare Part B. For more information, visit the Medicare web site at www.medicare.gov or call the Social Security Administration at 1-800-772-1213.

Coordination of Benefits with Medicare

If you are an active officer or the spouse/same-sex domestic partner or dependent of an active officer and are also covered under Medicare, your Columbia plan will be primary. Medicare coverage will be secondary. In general, the plan determines benefits by taking the difference between what you are charged and what Medicare covers, then applying the deductible and coinsurance. For example, if you have met your deductible and incur a \$1,000 expense for which Medicare pays \$800, you will be reimbursed \$160 (\$200 × 80%).

Pre-Existing Medical Conditions

There are no pre-existing medical condition exclusions under the Columbia University medical plans. After you enroll in the plan, you will be covered for all eligible medical expenses.

Qualified Medical Child Support Order (QMCSO)

The Columbia University medical plans will comply with all the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or judgment from a court or administrative body, which directs the plan to cover a child as a participant under the health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a Qualified Medical Child Support Order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid. Coverage under the plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the Benefits Office.

Coverage will be retroactive to the date of the court order, provided you make a written request for such coverage within 31 days of the court order. If you fail to make the request within the 31-day period, coverage for the child will be subject to the terms of the plan.

Subrogation and Right of Reimbursement

The purpose of your Columbia University medical plan is to provide medical coverage for qualified medical expenses that are not covered by a third party. If the Columbia University medical plan pays benefits for any claim you incur as the result of negligence or willful misconduct of a third party, the plan will be subrogated to all your rights of recovery. You'll be required to reimburse the plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition, you may be required to assist the Plan Administrator in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the plan.

The plan is entitled to reimbursement of any claim paid for which you receive compensation from a third party, other than a family member, for medical expenses that have been paid by the plan.

What's Not Covered

The POS and Modified Indemnity plans will not cover the following services and supplies. Please note that this is only a partial list of ineligible expenses. For a more complete list, contact the health plan directly.

Surgical Procedures

- Surgical or medical treatments, procedures, drugs, and research studies that are considered experimental, investigational, or are not expected to result in medical improvement. These include, but are not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice, and any such services where federal or other governmental agency approval is required but has not been granted.
- Infertility treatment and supplies, including but not limited to: artificial insemination, in vitro fertilization, in vivo fertilization, embryo or ovum transfer procedures, sperm collection or sperm preservation, and maternity services for a surrogate mother who is not a plan member
- Blood, blood plasma and blood derivatives if participation in a volunteer blood replacement program is available to the plan participant
- Transplant services when the plan participant serves as an organ donor (unless the recipient is a member of the same health plan)
- Organ procurement costs that are not directly related to procurement of an organ from a cadaver or a donor who has a blood relationship with the recipient
- Charges made by a doctor for or in connection with surgery, which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures
- Charges made by an assistant surgeon in excess of 20% of the surgeon's allowable charge; or for charges made by a cosurgeon in excess of the surgeon's allowable charge plus 20% (for purposes of this limitation, allowable charge means that amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts)

Dental Care

- Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth and gums
- Treatment of the teeth or periodontium, unless such expenses are incurred for:
 - Charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth
 - Charges made by a hospital for bed and board or necessary services and supplies
 - Charges made by a free-standing surgical facility or the outpatient department of a hospital in connection with surgery.

Vision Care

- Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn
- Vision correction services and supplies including, but not limited to: eyeglasses, all manner of contact lenses or corrective lenses, refractions, eye exercises, visual training. (The CIGNA POS Plan and Modified Indemnity Plan will cover the purchase of the first pair of eyeglasses or contact lenses that follows cataract surgery.)

Podiatry

- Routine foot care, including nail trimming, corn and callous removal, cleaning and soaking
- Charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails, unless medically necessary

Non-Essential Care

- Charges for supplies, care, treatment or surgery, which are not considered essential for the necessary care and treatment of an injury or sickness
- Cosmetic surgery, plastic or reconstructive surgery, which is performed primarily to improve the appearance of any portion of the body, including but not limited to: surgery for sagging of extra skin, any augmentation or reduction procedure, liposuction, keloids, rhinoplasty and associated surgery
- Physical examinations, diagnostic services and immunizations not required for health reasons, such as: obtaining or continuing employment, obtaining insurance coverage, foreign travel and school admissions
- Sex transformations (including hormonal therapy)
- Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies
- Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse
- Outpatient medical supplies including, but not limited to: syringes (except for hemophiliacs) and elastic stockings
- Private or special duty nursing, unless approved in advance by the health plan
- Recreational, educational or sleep therapy and related diagnostic testing
- Rehabilitation services or physical therapy on a long-term basis—speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed
- Sex, marital or religious counseling
- Special medical reports not directly related to treatment
- Weight control programs, meals, and counseling
- Therapy to improve general physical condition, including but not limited to: cardiac rehabilitation and pulmonary rehabilitation

- Services for or in connection with speech therapy, if such therapy is:
 - Used to improve speech skills that have not fully developed
 - Can be considered custodial or educational, or
 - Is intended to maintain speech communication; speech therapy that is not restorative in nature will not be covered.

Hospice Care

- The following charges for hospice care services:
 - For the services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house
 - For any period when you or your dependent is not under the care of a doctor
 - For services or supplies not listed in the hospice care program
 - For any curative or life-prolonging procedures
 - For services or supplies that are primarily to aid you or your dependent in daily living
 - For bereavement counseling sessions.

Miscellaneous

- Charges made by a hospital owned or operated by or which provides care or performs services for the United States government, if such charges are directly related to a military-service-connected sickness or injury
- Inpatient private duty nursing
- Military service-related conditions
- Occupational conditions, ailments, or injuries arising out of, and in the course of, employment
- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitment for mental illness
- Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be covered if the plan determines that the services are medically necessary
- Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. The plan does not cover room, board, nursing care or personal care that is rendered to assist a member who, in its opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement
- Non-eligible institutions
- No-show charges
- Penile prostheses

- Replacement of external prostheses due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices
- Charges when the person is not legally required to pay
- Charges made by any covered provider who is a member of your family or your dependent's family
- Service to the extent that payment is unlawful where the person resides when the expenses are incurred
- Services to the extent that you or any one of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- A period when a person is not under the continuing care of a doctor
- Services performed by a non-licensed practitioner