COLUMBIA UNIVERSITY
HR Benefits

2015 Benefits Highlights

Officers

Effective January 1, 2015

About This Communication

Benefits Highlights summarizes the benefits programs that are available to benefits-eligible employees of Columbia University. It does not include important information about exclusions and limitations. For additional details of benefits coverage, eligibility, limitations and exclusions, you must reference the Summary Plan Description (SPD), the Summary of Benefits and Coverage (SBC), and the ***Guide to What's New for Open Enrollment 2015*** (Summary of Material Modifications – SMM). You are entitled to receive these Plan documents under the Employee Retirement Income Security Act of 1974 (ERISA). You also have other important rights and protections under ERISA, which are explained in more detail in the Summary Plan Descriptions. You can find the documents online at **www.hr.columbia.edu/benefits/spds**. 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 benefits Plans at any time. This publication is in no way intended to imply a contract of employment.

Your Benefits for 2015

Benefits Highlights is primarily a reference for newly hired colleagues and to help you during annual Benefits Open Enrollment. It summarizes the following:

Benefits Highlights is also posted online at **www.hr.columbia.edu/benefits**. In addition, 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
- Adoption Assistance Program
- Post-65 Benefits – Active Employees
- Forms, including medical claim forms
- Summary Plan Descriptions (SPDs)
- If you leave CU (including COBRA continuation coverage)

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

Welcome to Columbia

We are pleased to share with you important information about the benefits options available to you and your eligible dependents.

Please keep in mind that, in order to enroll in any of these benefits programs, ***you must enroll online within 31 days of your date of hire.*** **If you miss the deadline, neither you nor your eligible dependents will have medical coverage or other important benefits.**

So that you can make informed decisions, we encourage you to review this **Benefits Highlights**, the **Summary Plan Descriptions**, and the **New Hire checklist** online at: **http://hr.columbia.edu/wac/welcome.**

If you have any questions, please call the Columbia Benefits Service Center at **212-851-7000**, Monday through Friday, 9 a.m. to 4 p.m. You also may contact us via email at **hrbenefits@columbia.edu**. We are always pleased to help.

Newly hired or newly eligible? You must enroll for benefits within 31 days of your date of hire or date of eligibility. The elections you make will be in effect for the calendar year in which you enroll.

Choose Your Coverage Carefully

The elections you make will be in effect for the 2015 calendar year. Unless you have a Qualified Life Status Change, you will not have another opportunity to change your benefits coverage selection until the annual Benefits Open Enrollment held each fall. Changes you make during Benefits Open Enrollment take effect the following January 1.

Online Tools to Help You Compare

In the Tools and Estimators section of the CU Benefits Enrollment System, you will find online tools including "Estimate My Medical Costs for In-Network Services" that will help you compare the different medical plan options based on your personal needs and health.

In the Retirement section of the CU Benefits Enrollment System, you will find a Voluntary Retirement Savings Plan calculator that will allow you to estimate your contributions based on a percentage election, an annual dollar amount and a per-pay-period dollar amount.

How to Enroll

If you are newly hired or newly eligible, you can enroll online when you receive the confirmation email from **hrbenefits@columbia.edu**. You have until the date indicated in your email to enroll. If you do not receive this email 3 weeks from your date of hire or date of eligibility, please contact the Columbia Benefits Service Center at **212-851-7000** or via email at **hrbenefits@columbia.edu**.

Step 1 Please know your UNI and password before you start the online enrollment process.

- If you do not know your UNI, you can look it up at **http://uni.columbia.edu**.
- If you do not know your password, you can change it by visiting **http://uni.columbia.edu** and clicking the link to "Forgot Password?"

For further assistance with your UNI and password, you can also contact:

CUIT Service Desk: 212-854-1919 or askcuit@columbia.edu

Step 2 Go to **www.hr.columbia.edu/benefits**. Click on the **"CU Benefits Enrollment System."** You will be prompted to log in using your UNI and password.

Step 3 Select **"New Hire Enrollment or Newly Eligible Benefits Enrollment."** Then, follow the instructions to make your benefits choices. Please be sure to click **"Continue"** to finish the enrollment process and go to your **"Benefits Enrollment Confirmation."**

Step 4 Print your **"Benefits Enrollment Confirmation."** Check it carefully before exiting the system. If you see a problem or want to make a change, simply go back into the online system and modify your election. A paper Enrollment Confirmation will not be mailed to you.

Step 5 Now is also a good time to review your retirement investments. Select **"Update your Retirement Elections."** Please be sure to **"Save and Continue."**

Step 6 Print your Benefits Confirmation Statement.

If you have questions, contact:

Columbia Benefits Service Center: 212-851-7000 or hrbenefits@columbia.edu

You Must Enroll Within 31 Days

You must enroll for benefits within 31 days of your date of hire. Your first enrollment is very important because:

- As a new hire, you have a one-time opportunity to elect Optional Life Insurance and Optional Long-Term Disability, up to certain limits, without providing Evidence of Good Health.
- Most of the elections you make now will be in effect for the rest of the calendar year. Read the next section about **"Making Changes to Your Benefits"** for the rules.
- As a new hire, you can log in to the CU Benefits Enrollment System as often as you wish until the date indicated in your email.
- **If you do not enroll within 31 days,** you and any eligible dependents will not receive Medical, Prescription, Dental, Optional Long-Term Disability Insurance, Flexible Spending Accounts, Optional Term Life Insurance, or Dependent Term Life Insurance from Columbia University for the remainder of the calendar year. If you have questions, please contact the **Columbia Benefits Service Center** at **hrbenefits@columbia.edu** or **212-851-7000**.

You will have an opportunity to change your benefits elections during the annual Benefits Open Enrollment held each fall. Changes you make during the annual Benefits Open Enrollment take effect the following January 1. You can make changes at any time during the year for the Voluntary Retirement Savings Plan (VRSP) and the Transit/Parking Reimbursement Program.

Please note that if you enroll for Long-Term Care Insurance within 60 days of your date of hire, you can take advantage of being accepted for coverage without providing Evidence of Good Health. Refer to page 50 for enrollment information.

Who Is Eligible for Benefits

The online CU Benefits Enrollment System will show you the benefits and options you are eligible for, as well as their monthly cost, and the benefit effective date.

- **Full-Time Officer**

  As a regular full-time, salaried, active Columbia University Officer, you and your family are eligible for various benefits programs described in this booklet. You and your eligible dependents—your spouse or same-sex domestic partner and your eligible children—are eligible for benefits on your date of hire.

- **Part-Time Officer of Administration**

  As a regular part-time Officer of Administration, you are eligible to participate in the Columbia University medical plan options, Basic Life Insurance, Optional Term Life Insurance for yourself and/or your eligible dependent(s), Flexible Spending Accounts and Transit/Parking Reimbursement Accounts, provided you meet the following requirements:

  - You are a regular salaried Officer of Administration scheduled to work at least 20 hours per week; and less than 35 hours per week, **and**
  - You are a Grade 10 position or higher at Morningside, Lamont, or Nevis; **or**
  - You are a Grade 103 or higher at Columbia University Medical Center.

  Part-Time Officers of Administration do not have coverage for Dental benefits, Long-Term Care, Tuition benefits or Basic Long-Term Disability, nor are they eligible to elect Optional Long-Term Disability or the Child Care Benefit.

- **Temporary Officers**

  "Temporary" positions are those approved for a period of four months or more with **a specific end date**. Temporary full-time Officers are eligible for Medical, Dental, Basic Life Insurance, Optional Life Insurance, Basic and Optional LTD, Flexible Spending Accounts, the Child Care Benefit and Transit/Parking Reimbursement accounts only, upon date of hire. Temporary part-time Officers are not eligible for benefits.

Ineligible Officers

The following are not eligible for coverage under Columbia University benefits:

- Temporary part-time Officers
- Officers whose appointments are incidental to their educational program at the University
- Adjunct professors
- Officers who are classified as non-benefits eligible
- Casual employees
- Officers whose terms of employment are subject to a collective bargaining agreement, unless the agreement specifically provides for their participation in the Benefit Plan

Eligible Dependents

For most Columbia benefits, including Medical and Dental benefits, your dependents—your spouse or same-sex domestic partner and your eligible children—can be covered if you verify that they meet the following requirements:

- Legal spouse
  - Marriage Certificate
- Same-sex domestic partner, provided your partner is:
  - At least 18 years old;
  - Not related to you by blood;
  - Not legally married to another person;

  And meets two or more of the following requirements:
  - Shares the same principal residence with you full-time and has done so 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 in which 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 month in which they turned 26;
    - If you're a newly eligible employee and your disabled child is older than age 26 when you are electing coverage, you may apply to cover your child when your coverage begins;
    - If you're an eligible employee when your child meets this definition, you must apply for continued coverage before the end of the month in which he or she turns age 26.
  - If a court has appointed you as the legal guardian for any child from birth to age 26.

Please note that eligible children are defined differently for the Flexible Spending Accounts (FSAs), Health Savings Account (HSA) and Dependent Life Insurance (see eligibility details under each plan description). Also, dependent medical and dental coverage will be in a "pending" status until eligibility is verified by the Columbia Benefits Service Center.

Making Changes to Dependent Eligibility

There are two ways to make a change in dependent eligibility:

1. Go to the CU Benefits Enrollment System at **www.hr.columbia.edu/benefits** and make changes to the status of your dependents online, or
2. Call the Columbia Benefits Service Center at **212-851-7000**.

When your dependent is no longer eligible, e.g., divorce: It is your responsibility to report this change to the Columbia 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 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 meets the eligibility requirements. Audits are conducted periodically to ensure that all dependents continue to meet the eligibility requirements of the benefit plans. If you are selected for one of these audits, you will receive a letter detailing the audit process and you will be asked to provide the documentation listed in the chart on the next page of this booklet.

If you are not able to provide proof that your dependent is eligible for coverage, your dependent will not have coverage.

Submit copies of your documents, plus the **"Dependent Verification Request Form"** from your online benefits enrollment session, to the **Columbia Benefits Service Center**. To submit documentation, you may either:

- Scan and email to **hrbenefits@columbia.edu**, or
- Fax to **212-851-7025**; this is a secure fax.

Or, if you do not have access to scan documents and send them via email or fax, call the Columbia Benefits Service Center at **212-851-7000**.

For questions about 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 from paperwork—you should enter Social Security Numbers directly into the CU Benefits Enrollment System by selecting "Add a Dependent Child or Update Dependent SSN" under "Actions."

Verifying Dependent Eligibility

If you are 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 Benefits Service Center at **212-851-7000**.

- To add your dependent at the time you enroll in your own benefits, or to make changes due to a Qualified Life Status Change, please refer to "Making Changes to your Benefits." Follow the instructions on the CU Benefits Enrollment System (or call the **Columbia Benefits Service Center** at **212-851-7000**). The system will take you to the "Dependent Required Documentation" page.

  1. On that page, print the "Dependent Verification Request Form." Submit it as instructed by the deadline on the form, along with the valid documentation for approval. (See the list of documentation in the chart below.)

  2. Once proper verification is received, coverage for your dependent will be retroactive to the date of your own election, or the date of the Qualified Life Status Change.

Note: You must make your changes within 31 days of your Qualified Life Status Change.

Dependent	Documentation
Spouse	Copy of legal 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
Child	**One** of the following: • Child's birth certificate • Hospital record of birth (temporary, until birth certificate is received) • Adoption certificate/court records

Who You Can Cover for Medical and Dental

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

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

Social Security Numbers are required for all dependents to be covered by our benefit plans. If you have dependents who do not have Social Security Numbers, please call the Columbia Benefits Service Center at 212-851-7000.

Both Work for the University?

If you and your spouse both work for the University and are eligible for coverage, you **must** 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.

Active Officers Turning 65

Active Officers and their spouses age 65 and over do not need to enroll in Medicare because they still have creditable coverage through the University.

Making Changes to Your Benefits

Limited Changes During the Year—Qualified Life Status Changes

The IRS restricts when you can add coverage for a dependent or make changes to your healthcare benefits and Flexible Spending Account (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 or placement for adoption or foster care;
- Death of a dependent (spouse, same-sex domestic partner, child);
- A dependent losing eligibility for coverage, such as a child reaching maximum age; or losing coverage under another plan, such as a spouse/partner losing coverage from his or her employer;
- A spouse or eligible dependent being 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 **Columbia Benefits Service Center** at **212-851-7000** and a specialist 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, marriage certificate or divorce decree. Your benefit changes must be consistent with the nature of your Qualified Life Status Change. **If you make a Qualified Life Status Change election after mid-November, you may not be able to make changes to certain benefits for the remainder of the current calendar year.**

Changes Permitted At Any Time

Transit/Parking Reimbursement Plans

You can make changes to your account at any time during the year. For example, you can change your deposit amount if you change your work location or residence; you change the way you commute; if there is a change in cost for bus, subway or rail service; or there is a change in the amount you pay for parking.

Voluntary Retirement Savings Plan (VRSP)

You can enroll in or change your elections for the Voluntary Retirement Savings Plan (VRSP) at any time during the year. For details on the VRSP, including investment options, educational information and planning resources, please see the brochure, ***Your Columbia University Retirement Savings Program*** at **www.hr.columbia.edu/benefits**.

Overview of Medical Coverage

Columbia University offers comprehensive medical plan options through UnitedHealthcare (UHC). Please review the following important information before making an election. For more detailed information about your medical plan options, you can visit the CU Benefits Enrollment System and review the Summary Plan Descriptions.

- Health Savings Plan (HSP), which can be paired with the tax-advantaged Health Savings Account (HSA).
- Choice Plus 80
- Choice Plus 90
- Choice Plus 100

The CU Benefits Enrollment System will show your monthly pre-tax contributions for each medical plan option. You can also view monthly contributions on pages 28 through 29 of this booklet. The Medical Plan Comparison Chart on page 22 summarizes the key differences in the level of coverage provided by our medical plan options. There is an online version called the "Compare CU Medical Plans" tool in the CU Benefits Enrollment System, which allows you to customize your comparison view of plan options. Once you receive the confirmation email from HR Benefits to enroll, you can access this online tool.

Please review the Medical Plan Comparison Chart and/or the online chart carefully before enrolling in your medical plan option.

All medical plan options cover the same comprehensive set of services—from lab work to transplants—and cover in-network preventive care, such as annual physicals, immunizations and well-baby visits, at 100%. All medical plan options include prescription drug and vision coverage.

Evaluate which Medical Plan Option Might Be Right for You

To get a better idea of which medical plan option might be best for you, try the online tool called "Estimate My Medical Costs for In-Network Services."

1. Go to the Tools and Estimators section of the CU Benefits Enrollment System at **www.hr.columbia.edu/benefits**.
2. Answer a few questions to personalize the results.
3. See which options are most valuable to you. It calculates:

\+ Your **monthly contributions** for the year

What you can expect to spend during the year on **in-network copays, deductibles, coinsurance and similar expenses**

= **Your total estimated cost for the year**

All University medical plan options cover only 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 Benefits website at **www.hr.columbia.edu/benefits/spds**.

Understanding the Terms

To make the right choices and understand the Medical Plan Comparison Chart, it is helpful to know the following benefits terms:

Network 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 the network for care means services will be provided at the lower negotiated fees. You will therefore pay lower out-of-pocket expenses than for out-of-network services.
- **Out-of-network:** When care is given by a provider who is outside the plan option network, it is considered "out-of-network." Services will not be provided at the network negotiated rate. Therefore, your share of the cost for out-of-network services will be much higher than for in-network services.

Copay is the fixed amount you pay directly to the provider when you receive certain in-network services—for example, the $30 you pay for a doctor's office visit. The $30 is all you pay—the medical plan pays the balance of the cost. Your in-network medical copays for the Choice Plus plans accumulate toward your in-network out-of-pocket maximum.

For health services, the following three terms are used. The most important thing to remember is **how these three work together** when you study the Medical Plan Comparison Chart on page 22.

Deductible

- If you have a claim, the deductible is the amount you pay each year before the medical plan begins to pay for expenses.

Coinsurance

- Once you have paid that deductible, the plan pays a percentage of the remaining covered medical services.
- For example, the Choice Plus 90 option pays 90% for many in-network services. You pay the remaining 10%.

Out-of-Pocket Maximum

- This feature protects you financially. The "out-of-pocket maximum" limits the amount you pay out of your own pocket each year for covered medical services.
- If you seek care from in-network medical providers, when your medical and prescription copays, deductible and coinsurance accumulate to the Choice Plus out-of-pocket maximum, the plan will pay 100% of covered charges for the remainder of the calendar year.
  See pages 13-15 for details regarding the HSP.

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

For other terms, please see the **"Benefits Glossary"** on page 55, or online at **www.hr.columbia.edu/benefits**.

Comparing the Health Savings Plan and Choice Plus Plans At a Glance

Plan Provision	Health Savings Plan	Choice Plus Plans
Payroll Contributions	Lower than Choice Plus Plans	Higher than Health Savings Plan
Preventive Care (In-Network)	Covered at 100% with no deductible	Covered at 100% with no deductible
Deductible	Higher than Choice Plus Plans	Lower than Health Savings Plan
Physician Office Visits	Covered at 90% after deductible	$30 Copay
Preventive Prescription Drugs	$10/$25/$45 Copay, no deductible	$10/$25/$45 Copay, no deductible
Non-Preventive Prescription Drugs	$10/$25/$45, after deductible	$10/$25/$45 Copay, no deductible
Health Savings Account (HSA)	Save up to $3,350 single/$6,650 family on a pre-tax basis to pay for healthcare expenses now or in the future (no expiration date). Rolls over from year to year.	Not Available (per IRS regulations)
Healthcare Flexible Spending Account (FSA)	Set aside up to $2,500 per year on a pre-tax basis to pay for healthcare expenses during a single calendar year. Roll over up to $500 from one year to the next. Cannot elect an HSA and an FSA in the same calendar year.	Set aside up to $2,500 pre-tax per year on a pre-tax basis to pay for healthcare expenses during a single calendar year. Roll over up to $500 from one year to the next. Cannot elect an HSA and an FSA in the same calendar year.

The Health Savings Plan (HSP)

The Health Savings Plan (HSP) provides comprehensive coverage with low monthly contributions. In exchange for lower contributions, the HSP deductible and out-of-pocket maximum are higher. Plus, the HSP can be paired with a Health Savings Account (HSA) that gives you the opportunity to save pre-tax dollars. If you elect both the HSP and the HSA, you can use the account to pay for qualified medical expenses now or in the future.

What You Need to Know About the HSP: In-Network

- ***You must first meet a deductible of $1,300 individual/$2,600 family for your medical and prescription expenses before the HSP starts to pay for covered services.***
- The individual deductible of $1,300 only applies if you elect HSP coverage for yourself only.
- If one or more family members are covered in addition to yourself, you reach the family deductible when total expenses reach $2,600, no matter how the expenses are spread across the family. The entire $2,600 family deductible must be met, even if only one family member has claims. **There is no individual deductible when you elect family coverage.**
- After you reach the deductible, any additional medical expenses are shared between the Plan and you as "coinsurance." The Plan's coinsurance is 90% and your coinsurance is 10%.
- When your coinsurance plus deductible and prescription copays reach the out-of-pocket maximum, the Plan pays 100% of your remaining covered medical services, including prescription drug costs, for the rest of the calendar year. The “out-of-pocket maximum” for in-network expenses is $2,800 for individual coverage or $5,600 for family coverage. For family coverage, the entire $5,600 out-of-pocket maximum must be met, even if only one family member has claims.
- Preventive medical care is covered at 100% when you use an in-network provider.
- For non-preventive care—and non-preventive drugs—you pay for your expenses until you reach your deductible: $1,300 for individual coverage or $2,600 for family coverage.
- You have access to UHC’s network of providers for your care.

Prescription Drug Coverage Under the HSP

Prescription drug coverage is integrated with the HSP medical coverage. This means you pay for your non-preventive prescription drugs until you meet the HSP deductible. Once the deductible is met, the prescription copay applies.

If you use an Express Scripts participating pharmacy, you will receive a discount on the cost of your prescription drugs.

Drugs that bypass the deductible: Prescription drugs that are categorized as "preventive" under federal guidelines are not subject to the HSP deductible, so you are only responsible for paying the appropriate copay, which accumulates toward the HSP out-of-pocket maximum.

The following list, which is subject to change, provides the therapeutic classes of prescription drugs, and the conditions for which drugs may be prescribed, that are considered "preventive" under federal guidelines.

- Anticoagulants
- Antihypertensive Agents (High Blood Pressure)
- Asthma/COPD
- Cholesterol Lowering Agents
- Diabetes
- Heart Disease
- Hepatitis C
- Immunosuppressant Agents
- Mental Health/ Substance Abuse Agents
- Osteoporosis
- Prenatal Vitamins
- Thyroid Disease

The chart below summarizes the prescription drug coverage under the HSP:

	Certain Preventive Drugs	Non-Preventive Drugs
Retail pharmacy (up to 30-day supply)	• **$10 generic** • **$25 single-source brand** • **$45 multi-source brand**	Subject to HSP deductible; then Rx copays apply
Home delivery: mail-order (up to 90-day supply)	• **$15 generic** • **$50 single-source brand** • **$90 multi-source brand**	Subject to HSP deductible; then Rx copays apply
Infertility coverage (oral and injectable medication)	N/A	Subject to HSP deductible; then Rx copays apply

Note: Prescription drug copays **and** the deductible accumulate toward the HSP's out-of-pocket maximum. Therefore, once you reach the annual out-of-pocket maximum, the plan pays 100% of the cost of prescription drugs (preventive and non-preventive), in addition to paying 100% of the cost of in-network medical services.

Health Savings Account (HSA)

If you elect coverage under the HSP, you may also elect a Health Savings Account (HSA). It is important to keep in mind that you can only use HSA funds after you have contributed them.

You can contribute money to your HSA on a pre-tax basis through payroll deductions. Each year, you can contribute up to $3,350 (2015) for ***Yourself Only*** coverage and $6,650 (2015) for ***Yourself and Spouse/Same-Sex Domestic Partner/ Child or Family*** coverage. Any unused balance accumulates year over year. You can manage both your HSP and your HSA at **www.myuhc.com**.

Qualified medical expenses that may be paid through your HSA on a tax-free basis include: most medical care and services; dental and vision care; prescription drugs; and premiums paid for COBRA, long-term care, and medical and prescription drug expenses as a retiree, including Medicare premiums. You can see a complete list of eligible expenses at **www.irs.gov** (Publications 969 and 502).

- Optum Bank is the administrator of the HSA.
- You can reach Optum Bank by calling UnitedHealthcare customer service at **800-791-9361** or at **www.optumbank.com**.
- You can change your HSA elections at any time during the year.
- The HSA is your account even if you change health plans, leave Columbia or retire.
- You do not pay taxes on the money you withdraw to pay for current and/or future eligible qualified healthcare expenses, including deductibles and coinsurance.
    - However, if you withdraw money from your HSA and do not have enough qualified expenses to cover the withdrawal, you'll pay taxes on the ineligible expenses distribution and an additional 20% penalty if you're under age 65.
    - You should keep careful records of your healthcare expenses and the corresponding withdrawals from your HSA, in case you need to provide proof to the IRS of your account distributions.
- If you have an account balance of at least $2,000, you can choose to invest among nine investment options. Any earnings are automatically reinvested and grow tax-free.

Restrictions on Electing an HSA

- Under IRS regulations, if you enroll in the HSA, you cannot participate in any healthcare Flexible Spending Account (FSA) because you can use your HSA to pay for eligible healthcare expenses.
  - In addition, if your spouse participates in a Healthcare FSA that permits reimbursement of your unreimbursed medical expenses, then you will not be eligible to establish or contribute to an HSA until you are no longer covered by your spouse's Healthcare FSA.
  - You will not be eligible to establish or contribute to an HSA if you are covered by another medical plan option that is not an HSA-qualified HSP (e.g., a spouse's employer's non-HSP coverage).
- Important for same-sex domestic partners: IRS rules do not allow you to use your HSA to reimburse yourself for the expenses of your same-sex domestic partner or his/her children.
- You can contribute to the HSA if you are over 65, but only if you are not enrolled in any Medicare benefits (including Part A).

Funding Your HSA

Here's how you can save using your HSA:

- **Pre-tax contributions.** You can elect automatic payroll deductions on a pre-tax basis to fund your account. You can change the amount of your contributions at any time. Keep in mind that the total amount of your contributions cannot exceed $3,350 for ***Yourself Only*** coverage and $6,650 for ***Yourself and Spouse/Same-Sex Domestic Partner/Child or Family*** coverage.
- **Catch-up contributions.** If you are at least age 55 and are not enrolled in Medicare, you can make "catch-up" contributions to your HSA. The maximum catch-up contribution is $1,000.

Note: If you are considering after-tax HSA contributions, you may want to consult with a tax adviser or financial professional.

How to Access Your HSA Funds

You can choose to pay your bills out of your own pocket or through your HSA. If you choose to pay through your HSA, you can use:

- Your Optum Bank HSA Debit Mastercard;
- Online Bill Payment Service available on **www.myuhc.com**.

For example, you could use your HSA debit card to pay for prescription drugs at the pharmacy.

Important: You cannot access funds in your HSA until you have contributed them. You need to build up your HSA contributions—made through your payroll deductions—***before*** taking money out of your HSA for qualified expenses. Your HSA funds will be available as soon as administratively possible after Columbia has sent your semi-monthly payroll deductions to Optum Bank.

Always check your balance on the UHC website before you use your account. A small service charge will apply if you check your balance at any ATM machine, but checking it on ***UHC's website is free***. You will also incur a fee if your card is declined for insufficient balance, so checking your balance before you use your HSA debit card is important.

Health Savings Account (HSA) vs. Healthcare Flexible Spending Account (FSA)

- If you enroll in the HSP, you're eligible to contribute to the HSA, provided you are not enrolled in Medicare.
- If you enroll in Medicare, you cannot make new contributions to the HSA; however, you can use any accumulated HSA funds to pay for qualified medical expenses. If you are in the HSP, you can enroll in the HSA or Healthcare FSA, but not both.
- Both the HSA and Healthcare FSA allow you to save money on taxes by contributing pre-tax earnings to a healthcare account.
  - You can roll over any remaining balance in your HSA from year to year and earn tax-free interest.
  - In the FSA, you must use the money by December 31 each year, or any balance over $500 will be forfeited. Balances of $500 or less roll over to the next calendar year.

Medical, Prescription and Dental ID Cards

After you enroll in medical benefits, you will receive an ID card directly from the insurance carrier. It takes approximately four weeks for new hires to receive an ID card. If you need a temporary ID card sooner, go to **www.myuhc.com** or **www.express-scripts.com** two weeks after you complete your benefits enrollment to download and print your temporary card.

For dental, Aetna will not mail you an ID card. Instead, they will mail you a letter confirming your enrollment. When you go to the dentist, you can show the office a copy of that letter, or tell the office your name, date of birth, and Member ID# (or your social security number). If you still prefer to have an ID card, sign up on Aetna's member website to print out a card for you and your dependents.

Choice Plus Plans – UnitedHealthcare (UHC)

Columbia offers three different Choice Plus medical plan options—80, 90 and 100—so that you can choose the one that best suits your needs.

With any of these plans, you have the flexibility to use in-network or out-of-network providers each time you seek care. However, you can minimize your out-of-pocket expenses when you use in-network providers.

In-Network Coverage: For the 80, 90 and 100 medical plan options, when you use UnitedHealthcare network providers, you pay a $30 copay for physician office visits (including specialists). Preventive care is covered at 100% for in-network services. The deductible, coinsurance and all medical and prescription copays accumulate toward your annual out-of-pocket maximum.

Health4Me "YOUR Family's health care resources, in your hands."

UnitedHealthcare's **Health4Me**™ app provides instant access to your family's critical health information – anytime and anywhere. Whether you want to find a physician near you, check the status of a claim or speak directly with a health care professional, Health4Me is your go-to resource. Key features include:

- Search for physicians or facilities by location or specialty
- View claims
- Check status of deductible and out-of-pocket spending
- Check health-related financial account balance
- Have Easy Connect representatives contact you to answer any questions
- Locate convenience clinics, urgent care facilities and emergency rooms
- Store favorite physicians or facilities by location or specialty
- Contact an experienced registered nurse 24/7

The Health4Me app is available from the Apple iTunes App Store as a free download for the iPhone, iPod Touch and iPad. It is also available as a free download in the Android marketplace for Android phones.

Choice Plus 80

Preventive care is covered at 100%. Other than preventive care, for most in-network medical services you must meet an annual deductible of $400 per member before the Choice Plus 80 plan pays the coinsurance of 80% of the negotiated fee; you are responsible for the remaining 20% of the coinsurance. After you reach the out-of-pocket maximum of $3,000 for an individual and $6,000 for a family, the Choice Plus 80 plan pays 100% of covered medical charges for the remainder of the calendar year. Most out-of-network services are covered at 60%* after the annual deductible of $600 per member.

Choice Plus 90

Preventive care is covered at 100%. Other than preventive care, for most in-network medical services you must meet the annual deductible of $200 per member before the Choice Plus 90 plan pays the coinsurance of 90% of the negotiated fee; you are responsible for the remaining 10% of the coinsurance. After you reach the in-network out-of-pocket maximum of $2,500 for an individual and $5,000 for a family, the Choice Plus 90 plan pays 100% of covered medical charges for the remainder of the calendar year. Most out-of-network services are covered at 60%* after the annual deductible of $600 per member.

Choice Plus 100

The Choice Plus 100 plan has no deductible for most in-network services. Copays apply for certain services and in some cases are dependent on where the service is received. For example, inpatient hospital services require a $500 per admission copay; outpatient hospital services, including lab and radiology, require a $150 copay. In addition, after you reach the in-network out-of-pocket maximum of $4,000 for an individual and $8,000 for a family, the Choice Plus 100 plan pays 100% of covered medical charges for the remainder of the calendar year. Most out-of-network services are covered at 60%* after the annual deductible of $600 per member.

The $150 outpatient hospital copay does not apply if you obtain your lab and/or radiology at certain New York Presbyterian (NYP) locations. See the list of NYP participating locations at **www.hr.columbia.edu/benefits** (under "Contacts").

Whenever you are having diagnostic or preventive tests, be sure to ask your physician if he/she is referring you to a provider who is in-network.

Condition Management and UnitedHealthcare Outreach

If you participate in the medical plan options, you are eligible to participate in a condition management program. This program will help you and/or your family members become more knowledgeable and active in managing a medical condition. Participation in the program is voluntary and there is no cost to participate. You will receive a call from a UHC representative to discuss your condition, and partner with you on your road to recovery (or managing your condition). We highly recommend speaking with this representative regarding your care when they call you.

For example, UHC offers a Cancer Resource program that provides numerous services to help cancer patients through their treatment. UHC's Cancer Resource program can provide access to experimental treatment and/or clinical trials where indicated.

*of 190% of the Medicare Maximum Allowable Charge

Out-of-Network Reimbursement

For the Choice Plus 80, 90 and 100 medical plans, the out-of-network expenses are always handled the same way, as outlined below:

- You are responsible for obtaining pre-authorizations from UHC before treatment begins (unless it is an emergency). If you do not request precertification before having inpatient or outpatient surgery and/or certain treatment, you will be subject to a $500 penalty. If you are having trouble finding providers and/or services in the network, please call UHC at **800-232-9357**. In an emergency, if you or your covered dependent is admitted to a non-network hospital, you must contact UHC **within 48 hours of admission** or you will be subject to a $500 penalty.
- Before the plan starts to pay anything for out-of-network services, you must meet your deductible.
- Then the plan pays coinsurance of 60%* of remaining covered charges. **That does not mean, however, that the plan will pay 60%* no matter how much you were charged.** Columbia's plans pay no more than 60%* of 190% of the Medicare Maximum Allowable Charge (MAC).
- **If you reach the out-of-network out-of-pocket maximum, the plan will pay 190% of the Medicare Maximum Allowable Charge.**

Medicare Maximum Allowable Charge Example

Out-of-network services in the healthcare plans are indexed to 190% of the Medicare Maximum Allowable Charge (MAC). Out-of-network services for all medical plan options will therefore be reimbursed at 60%* of 190% of the Medicare MAC.

Here's an example: Your out-of-network doctor charges you $200 for an office visit. The claim submitted to the medical carrier has a billing code of 99212 (office visit for an established patient in ZIP code 10010 in New York City). 190% of the Medicare Maximum Allowable Charge for this billing code is $94.16. Therefore, $94.16 (not $200) is the basis for the out-of-network reimbursement.

- **If you had not met the out-of-network annual deductible,** you would be responsible to pay the full $200, and $94.16 would be applied to the deductible.
- **If you had already met the out-of-network annual deductible,** the plan would pay the coinsurance of 60% of $94.16, which is $56.50. Your share of the coinsurance is 40% of $94.16, which is $37.66. You are also responsible to pay the amount in excess of the 190% of the Medicare Maximum Allowable Charge; that is $200 - $94.16 = $105.84. In total, therefore, you would pay $37.66 plus $105.84, which is $143.50. The amount counted toward your out-of-network out-of-pocket maximum would be $37.66.
- **If you had met the out-of-network annual out-of-pocket maximum,** the medical carrier would pay the 190% of the Medicare Maximum Allowable Charge ($94.16), and you would be responsible for the balance ($105.84).

Please note that the charges in excess of 190% of the Medicare Maximum Allowable Charge (in this example, $105.84) do not count toward the out-of-network out-of-pocket maximum.

*70% for outpatient mental health/substance abuse services

For information on specific Medicare Maximum Allowable Charge(s) talk to your doctor or his/her office staff.

- **Providers can bill you for any unpaid balance for amounts above these limits, and you are solely responsible for these payments.**

  - Any charges exceeding plan limits do not count toward the out-of-pocket maximum, including any changes exceeding 190% of Medicare Maximum Allowable Charges (MAC).
  - You can find out how much you will be reimbursed for out-of-network services before you seek treatment by first asking your doctor for the medical "procedure code" along with the associated fee. Then, call UHC's member services to request an estimate of their reimbursement.

The Columbia Benefits Service Center Is Here to Help

Did you know the Columbia Benefits Service Center is available to help you with medical, prescription drug and dental claims, or billing problems?

For assistance, please call us at **212-851-7000**, or email us at **hrbenefits@columbia.edu**. Be sure to provide as much detail as possible when you contact us.

Medical Plan Comparison Chart

Important notes: UnitedHealthcare (UHC) has a national provider network and does not require a primary care physician or referrals to see specialists. UHC requires precertification for some services. If you use an in-network provider, your participating network doctor or hospital generally handles the precertification process. However, it is your responsibility to confirm that your provider has obtained the necessary authorizations from UHC. If you see a provider who is out-of-network, you are responsible for obtaining precertification for most services except routine office visits. Check your Summary of Benefits and Coverage (SBC) available online at **http://hr.columbia.edu/benefits/spds**.

Benefit	HSP		Choice Plus 80		Choice Plus 90		Choice Plus 100	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Annual Deductible Individual Family	$1,300 $2,600	$2,500 per person	$400 per person	$600 per person	$200 per person	$600 per person	None	$600 per person
Coinsurance	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100%	60% after deductible
Out-of-pocket Maximum Individual Family	$2,800 $5,600	$6,000 $12,000	$3,000 $6,000	$4,500 $9,000	$2,500 $5,000	$4,500 $9,000	$4,000 $8,000	$4,500 $9,000
Preventive Care	100%	Not covered	100%	Not covered	100%	Not covered	100%	Not covered
Physician Office Visits	90% after deductible	60% after deductible	$30 copay	60% after deductible	$30 copay	60% after deductible	$30 copay	60% after deductible
Laboratory/ Radiology Services	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100% if non-hospital location $150 copay if hospital	60% after deductible
Inpatient Hospital Care	90% after deductible	60% after deductible; Precertification required	80% after deductible	60% after deductible; Precertification may be required	90% after deductible	60% after deductible; Precertification required	$500 copay per admission	60% after deductible; Precertification required
Outpatient Hospital Care	90% after deductible	60% after deductible; Precertification may be required	80% after deductible	60% after deductible; Precertification required	90% after deductible	60% after deductible; Precertification required	$150 copay (including lab and radiology)**	60% after deductible; Precertification required
Mental Health and Substance Abuse – Inpatient care	90% after deductible	60% after deductible; Precertification required	80% after deductible	60% after deductible; Precertification required	90% after deductible	60% after deductible; Precertification required	$500 copay per admission	60% after deductible; Precertification required
Mental Health and Substance Abuse – Outpatient programs	90% after deductible for facility based care including intensive outpatient programs	70% after deductible for facility based care including intensive outpatient programs; Precertification required	$30 copay	70% after deductible for facility based care including intensive outpatient programs; Precertification required	$30 copay	70% after deductible for facility based care including intensive outpatient programs; Precertification required	$30 copay	70% after deductible for facility based care including intensive outpatient programs; Precertification required
Mental Health and Substance Abuse – Outpatient counseling	90% after deductible	70% after deductible	$30 copay	70% after deductible	$30 copay	70% after deductible	$30 copay	70% after deductible
Emergency Room	90% after in-network deductible	90% after in-network deductible	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)

* Out-of-network coinsurance reimbursement is indexed to 190% of the Medicare Maximum Allowable Charge (MAC).

** No copay for Lab and Radiology at certain designated NYP locations. See the list of NYP participating locations at **www.hr.columbia.edu/benefits** (under "Contacts").

Note: In the Choice Plus plans, in-network deductible, coinsurance and medical and prescription copays accumulate toward the in-network out-of-pocket maximum. In the HSP, the in-network deductible, coinsurance and prescription copays accumulate toward the in-network out-of-pocket maximum.

Benefit	HSP		Choice Plus 80		Choice Plus 90		Choice Plus 100	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Basic and Comprehensive Infertility Treatment	Unlimited benefit for diagnosis and basic medical treatment, including artificial insemination							
Advanced Infertility Treatment	$30,000 lifetime maximum for advanced treatments and Assisted Reproductive Technology including IVF, GIFT and ZIFT							
Prescription Drug coverage with Express Scripts	Some prescription drugs are subject to annual deductible. Copays apply up to the annual out-of-pocket maximum.		Retail (30-days) • Generic: $10 copay • Single-source brand: $25 copay • Multi-source brand: $45 copay		Mail-order (90-days) • Generic: $15 copay • Single-source brand: $50 copay • Multi-source brand: $90 copay			

* Out-of-network coinsurance reimbursement is indexed to 190% of the Medicare Maximum Allowable Charge (MAC).

Vision Coverage

All employees and their covered dependents who participate in any of Columbia's medical plan options are covered by a vision benefit.

Vision Benefits	UHC Health Savings Plan	Choice Plus Plans
	Benefits Apply Both In-Network and Out-of-Network	
Routine Eye Exams	**Adults:** One exam every 12 months, plan pays 90% after deductible, no copay **Children:** One exam every 12 months, plan pays 90% after deductible, no copay	**Adults:** One exam every 12 months with a $10 copay **Children:** One exam every 12 months with a $10 copay
Lenses	**Adults:** $100 allowance every 12 months (combined for lenses, frames and contact lenses) **Children:** One pair of eyeglasses (lenses and frames) OR one pair of contact lenses (or a 12 month supply) every 12 months with a $75 copay. More frequently if medically necessary.	**Adults:** Every 24 months, $20 allowance for single lenses, $30 for bifocal, $40 for trifocal and $75 for lenticular **Children:** Lenses covered in full every 12 months (more frequently if medically necessary)
Frames		**Adults:** $30 allowance every 24 months. **Children:** Up to $100 covered in full every 12 months (more frequently if medically necessary). Cost above $100 covered at 60%.
Contact Lenses		**Adults:** $75 allowance every 24 months **Children:** Single purchase of a pair of contact lenses or 1 box of contact lenses per eye covered at 100%

Child is defined as a member less than age 19.
Provider might require payment in full at the time of service. The patient then submits a claim to UnitedHealthcare for reimbursement.

For a listing of vision providers, please visit **www.myuhc.com**.

ID Card

Please present your medical ID card at participating providers to obtain vision services.

Prescription Drug Coverage

When you enroll in any Columbia medical plan option, you are automatically enrolled in the following Express Scripts Prescription Drug Plan. If you enroll in the HSP, be sure to read "Prescription Drug Coverage" on page 14.

Is a Drug "Single-Source" or "Multi-Source"?

- If both a generic and brand name prescription are available, this is a multi-source drug
- If no generic is available, this is a single-source drug

To find out if a drug is single-source or multi-source, ask your pharmacist or contact Express Scripts at **www.express-scripts.com** or **1-800-230-0508**. Keep in mind that your prescription may move from "single-source" to "multi-source" during the year if the U.S. Food and Drug Administration (FDA) approves a generic equivalent drug.

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** (generic and brand both available)
Mail-order (up to 90-day supply)	• **$15 generic** • **$50 single-source brand** (product not available in generic) • **$90 multi-source brand** (generic and brand both available)

Using Your Prescription Drug Benefit

Express Scripts administers the prescription drug benefit plan. You will receive a Prescription Drug ID card in the mail about the same time you receive your medical card.

Retail

You will need to present your Prescription Drug ID card at the pharmacy the first time you fill a prescription. You can have up to a 30-day supply of your prescription when filled at a retail pharmacy.

- In New York, New Jersey and certain other states, the pharmacy is required by law to substitute a brand name drug with a generic. If a generic is available, you will have the lowest copay: $10.
- If your physician prescribes the brand-name drug instead of the generic, then you will pay the highest copay: $45. Your physician must request the pharmacist "Dispense as Written."
- If no generic is available for your prescription, then your drug is a single-source prescription. Your copay will be: $25.

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

Mail-Order

Mail-order copays are for up to a 90-day supply. If you take medication on a regular basis for conditions such as high blood pressure or asthma, the mail-order option will be less expensive than the retail option. To use mail-order, go to **www.express-scripts.com** or call **800-230-0508**.

After you have enrolled in the Express Scripts mail-order program, you can refill prescriptions easily, either online or over the phone.

Wellness Programs

There is nothing more important than your health. Becoming fit and healthy can be a challenge. Wellness programs are about inspiring you to care about your health, to find time in your schedule, choose the right activity to meet your goals, and then maintain your motivation to stay on track. To help you find your good path to health, UHC has wellness resources to help you to eat right, exercise more, stop smoking or just relax. The following UHC programs are provided at no cost to you.

- **Members can register at http://welcometouhc.com/columbia for the UHC wellness portal – http://columbia.welcometouhc.com/tools/programs**. It gives you access to self-care goals, and includes a health assessment, personal health record, online coaching, and health and wellness information.
- **NurseLine – 800-232-9357**. This 24/7 toll-free telephone line gives you access to registered nurses who can help you with symptom and condition support, provider referrals, medication information, an audio information library and many more services.
- **Healthy Pregnancy Program.** This prenatal wellness program provides screening of maternity cases, patient education and management of high-risk cases.

International Medical Coverage

Cigna International Plan

The Cigna International Plan is a medical plan option for which you may be eligible, if you are out of the U.S. for an extended period of time (6 months or more) provided you receive pay through Columbia University's U.S. payroll.

If you are enrolled in one of the Columbia University medical plan options (the Choice Plus plans or the HSP with UnitedHealthcare), it is important to know that these plans provide overseas coverage for emergencies only, while the Cigna International Plan provides comprehensive coverage while you are outside of the U.S.

Some of the benefits of this coverage:

- Easy access to comprehensive, quality healthcare around the world
- Around-the-clock support, regardless of your time-zone
- Connection to the right doctor or hospital in your area 24 hours a day, 7 days a week
- When you need assistance, contact Cigna anytime by phone or fax. Collect calls are accepted anytime

If you believe you are eligible for this medical plan option, please contact the Columbia Benefits Service Center at **212-851-7000** for more information.

If you travel over 100+ miles from home or abroad and need emergency travel assistance, refer to "Emergency Travel Assistance" on page 49.

Cost of Medical Coverage: Your Contributions

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

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

- Which plan you select; and
- Who you cover – Yourself Only, Yourself & Spouse/Same-Sex Domestic Partner, Yourself & Child(ren) or Family
- Your Annual Benefits Salary. This is calculated as of July 1 each year and is the greater of (a) your base salary or (b) your prior 12 months' compensation from the University as of June 30 each year, including certain approved additional and private practice compensation, and excluding any Housing Allowance.

Same-Sex Domestic Partner Tax Credit

Federal income tax rules require that your contributions toward the coverage of a same-sex domestic partner be deducted from your pay on an **after-tax** basis. In addition, University contributions toward the total cost of coverage for your same-sex domestic partner are taxable to you. **To assist with this tax burden, if you elect same-sex domestic partner medical coverage, Columbia will provide a credit of $1,000 per year ($41.67 per pay period) beginning the pay period following the effective date of your election.**

2015 Monthly Pre-Tax Contributions for Medical & Rx Coverage (Full-Time)

Salary Tier	Yourself Only	Yourself & Spouse or Same-Sex Domestic Partner	Yourself & Child(ren)	Family
$0 - $44,999				
Health Savings Plan (HSP)*	$3	$11	$5	$13
Choice Plus 80	$15	$51	$26	$62
Choice Plus 90	$21	$73	$38	$90
Choice Plus 100	$73	$205	$132	$264
$45,000 - $79,999				
Health Savings Plan (HSP)*	$11	$39	$20	$47
Choice Plus 80	$53	$187	$96	$229
Choice Plus 90	$77	$269	$139	$331
Choice Plus 100	$270	$755	$485	$970

* Formerly Aetna HDHP

2015 Monthly Pre-Tax Contributions for Medical & Rx Coverage (Full-Time)

Salary Tier	Yourself Only	Yourself & Spouse or Same-Sex Domestic Partner	Yourself & Child(ren)	Family
$80,000 - $134,999				
Health Savings Plan (HSP)*	$12	$42	$22	$52
Choice Plus 80	$58	$203	$104	$249
Choice Plus 90	$84	$293	$151	$360
Choice Plus 100	$293	$820	$527	$1,055
$135,000 - $174,999				
Health Savings Plan (HSP)*	$13	$44	$23	$54
Choice Plus 80	$61	$213	$110	$262
Choice Plus 90	$88	$307	$158	$378
Choice Plus 100	$308	$861	$554	$1,107
$175,000 - $224,999				
Health Savings Plan (HSP)*	$17	$61	$31	$75
Choice Plus 80	$84	$294	$151	$362
Choice Plus 90	$121	$424	$218	$521
Choice Plus 100	$425	$1,189	$765	$1,529
$225,000+				
Health Savings Plan (HSP)*	$18	$64	$33	$79
Choice Plus 80	$89	$311	$160	$382
Choice Plus 90	$128	$448	$230	$550
Choice Plus 100	$448	$1,255	$807	$1,614

2015 Monthly Pre-Tax Contributions for Medical & Rx Coverage (Part-Time Officers of Administration)

Plan	Yourself Only	Yourself & Spouse or Same-Sex Domestic Partner	Yourself & Child(ren)	Family
REGULAR PART-TIME SALARIED OFFICERS OF ADMINISTRATION				
UHC HSP	$237	$497	$450	$709
Choice Plus 80	$256	$537	$486	$766
Choice Plus 90	$266	$559	$506	$798
Choice Plus 100	$390	$820	$742	$1,169

* Formerly Aetna HDHP

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 the Columbia Preferred Dental Network, along with the national Aetna PPO 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.

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

Important Information About Out-of-Network Reimbursement

*The percentage paid by Aetna Dental is 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 greater benefit for services. To locate a Columbia Preferred dentist, go to **www.aetna.com/docfind/custom/columbia**. Columbia Preferred dentists are located throughout the Tri-State area.

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
cudentalassociates.columbia.edu

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
Medical Center Practice
100 Haven Avenue
New York, NY 10032
212-342-0107

Columbia-Presbyterian
Eastside Dental Faculty Practice
51 West 51st Street
Suite 350
New York, NY 10019
212-326-8520

Columbia Oral & Maxillofacial Surgery
622 West 168th Street
Vanderbilt Clinic, 7th Floor
New York, NY 10032
212-305-4552

Using the Aetna Dental Network

If you see an Aetna participating dentist, you will not be billed for any fees that exceed the Aetna negotiated amount. To locate an Aetna participating dentist, go to **www.aetna.com/docfind/custom/columbia**.

Dental ID Cards

Aetna will not mail you an ID card after you enroll. Instead, they will mail you a letter confirming your enrollment. When you go to the dentist, you can show the office a copy of that letter, or tell the office your name, date of birth, and Member ID# (or your social security number). If you still prefer to have an ID card, sign up on Aetna's member website at **www.aetna.com** to print out a card for you and your dependents.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a network of services, including short-term confidential 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 options to take advantage of the EAP. You, or a member of your household, can receive confidential 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
- Loss of a loved one
- Pet care, e.g., finding a dog walker
- Concierge services: from theatre tickets to travel planning

Free to you: Columbia University assumes all costs for initial assessment and confidential 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: Humana 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/substance abuse professionals and, if needed, they will 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: **711**
Or log on to: **www.humana.com/eap**
Username: **Columbia** Password: **eap**

Flexible Spending Accounts (FSAs)

Flexible Spending Account Administration

Flexible Spending Accounts (FSAs) allow you to save money on a variety of eligible healthcare and dependent day care expenses. You must enroll during Benefits Open Enrollment each year to take advantage of FSAs. Columbia University offers two types of FSAs that are administered by UnitedHealthcare:

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 day 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.)

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 can contribute to it in equal installments each pay period throughout the year.

You cannot change your election amount during the calendar year unless you have a Qualified Life Status Change. Please refer to "Making Changes to Your Benefits" for more details.

After you elect the FSA, UnitedHealthcare will send two Health Care Spending cards to your home mailing address. These cards are linked to any Healthcare and Dependent Care FSA accounts you elect. Both cards will be in the name of the Officer member.

When you incur an eligible healthcare or dependent care expense you can use your Health Care Spending Card to pay for the expense at participating locations. The spending card can be used for eligible expenses, such as prescription drugs, or office visit copays. If you are unable to use your card at the time of purchase, keep your receipts as you will need to substantiate your expenses with UnitedHealthcare, the Plan Administrator, by submitting a form to receive reimbursement from your FSA. For forms, go to **www.hr.columbia.edu/forms-docs/forms#fsa**. You can also opt to submit claims for reimbursement directly online via **www.myuhc.com**. Your out-of-network healthcare expenses, and dental expenses will not be eligible to be charged on your Health Care Spending Card. If a claim is filed and processed with UHC for a healthcare expense, the claim will automatically be rolled over to the FSA for payment. Dental FSA claims must be filed on line or manually with UHC.

When you submit a claim, you will receive a check at your home mailing address or you can sign up for direct deposit of your FSA claims by visiting **www.myuhc.com** and enrolling via the secure website.

Forfeiture Rule: The IRS has strict rules regarding FSAs. A balance of up to $500 in your **Healthcare FSA** can be rolled over to the next plan year. Any money left in your **Dependent Care FSA** account will be forfeited the following year. So, it is more important to estimate your expenses carefully, incur your claims by December 31, and make sure that your claims for the calendar year are received by the FSA administrator (UnitedHealthcare) no later than March 31 of the following year. If you leave the University or become ineligible for benefits, you can only be reimbursed for expenses incurred prior to your employment end date or the date you became benefits-ineligible. Any remaining funds are forfeited.

Don't Lose Out on Tax Savings

Using either the Healthcare FSA or the HSA could save you hundreds or thousands of dollars on uncovered healthcare expenses, such as deductibles and orthodontia. Use the tool "Estimate HSA or FSA Tax Savings" in the CU Benefits Enrollment System at **www.hr.columbia.edu/benefits** to see this on a personal basis.

Healthcare FSA

The 2015 IRS limit for the Healthcare FSA is $2,500. You can deposit between $120 and $2,500 in this account to cover out-of-pocket eligible healthcare expenses for yourself, your spouse and children, even if you did not elect to cover them under Columbia University benefits 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
- Coinsurance and 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 information on eligible expenses see the "UHC Healthcare FSA Expenses" document at **www.hr.columbia.edu/forms-docs/forms#fsa**.

Make the most of your FSA with myuhc.com®

1. Go to **myuhc.com** and click on Register Now.
   Your health plan ID card includes information you will need to register. Or, you can register using your Social Security Number and date of birth.

2. Click on View Account Balances. Then select Flexible Spending Account(s).

Don't have a health plan with UnitedHealthcare?

You can register using your Social Security Number and date of birth. Under group/account number "902784".

You will find everything you need on **myuhc.com** to manage your FSA. Select Claims & Accounts and you will see your account balance and a list of all your claims. You can even submit claims online for reimbursement and much more.

1. **Most expenses may be paid automatically.**
   Once your UHC Health Claim is processed, it will be electronically submitted to the UHC FSA department. Any out-of-pocket amounts not charged on your Health Care Spending Card will generate an FSA payment. This auto-rollover of health claims can be turned "off" or back "on" via **myuhc.com**.

2. **Turn on direct deposit to get your money faster.**
   Don't wait for a reimbursement check in the mail. With direct deposit, your money will be reimbursed directly into your personal checking or savings account. See the UHC document "Your money could be in the bank" on **www.hr.columbia.edu/forms-docs/forms#fsa**.

3. **Submit your eligible expenses (claims) such as dental, vision and dependent care, online at myhuc.com.**
   Claims submitted online are processed in three days or less, which can mean faster reimbursement. You can even submit multiple expenses and receipts for different members of the family all at once. See the UHC document "Online Claim Submission" on **www.hr.columbia.edu/forms-docs/forms#fsa**. You may also mail or fax a form to receive reimbursement from your FSA. For forms go to **www.hr.columbia.edu/forms-docs/forms#fsa**.

Estimate tax savings and look up eligible expenses.

Use the FSA Savings Calculator on **myuhc.com** to estimate your tax savings, and view a list of common eligible expenses.

Healthcare Flexible Spending Account (FSA) vs. Health Savings Account (HSA)

Important: Keep in mind that the IRS does not permit you to elect both a Healthcare FSA and a Health Savings Account (HSA). If your spouse has one of the two—for example, through another employer—you cannot elect the other type of tax-advantaged account. This rule does not apply to domestic partners because the IRS does not allow use of an HSA for expenses of a domestic partner.

Here is a summary of the key similarities and differences between the two accounts:

Feature	Healthcare FSA	HSA (Available with the HSP)
Pre-tax contributions	Yes	Yes
Unused funds roll over from year to year	Yes*	Yes
Investment options with tax-free earnings	No	Yes
Tax-free withdrawal—for eligible expenses	Yes	Yes
Can use for medical, mental health/substance abuse, Rx, vision, dental, orthodontia and hearing expenses	Yes	Yes
Portable—can take with you when leave Columbia	No	Yes
Helps you pay for retiree medical expenses	No	Yes
Annual elected amount available at beginning of year	Yes	No**
Can contribute if in HDHP	Yes	Yes***

* A balance of up to $500 will roll over to the following plan year.

** You cannot access funds in the HSA until you have contributed money to your account. Only your funded balance (this means your year-to-date pre-tax contributions) can be used to pay eligible medical expenses.

*** If you are enrolled in the HSP, you can choose either the FSA or the HSA, but you cannot elect both.

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 either the Healthcare FSA or the HSA. You may want to consult with a tax adviser or financial professional to determine which works best for you.

If you are enrolled in Medicare, you are still eligible to elect a Healthcare FSA.

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 in order to qualify for this coverage.

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 himself or herself.

Your reimbursement for dependent care cannot exceed the balance in your account at the time of your claim. If the money in your account is insufficient to pay your claim, the balance will be paid later as your pre-tax payroll contributions accumulate in your account.

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

Same-sex domestic partners: IRS regulations do not allow you to use money from FSAs for expenses incurred by or on behalf of same-sex domestic partners, or 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 in a Dependent Care FSA. 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. If your prior year W-2 wages exceed $115,000, Columbia Benefits may contact you before June 30, 2015 to inform you whether your contributions must be capped as a result of mandatory IRS testing.

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

Child Care Benefit

Eligible Officers can elect to receive up to a $2,000 contribution from Columbia to a Dependent Care FSA. If you elect this benefit during the year, you will receive a **prorated** portion of the benefit.

To be eligible for this benefit, you must meet *all* of the eligibility criteria below:

- Be a full-time, benefits-eligible Officer with an Annual Benefits Salary of less than $115,000 in 2015; **and**
- Have a dependent child under the age of 5 and not yet attending kindergarten; **and**
- Have a child who has been verified by the Columbia Benefits Service Center as an eligible dependent; **and**
- Have a child who meets the IRS definition of a tax dependent; **and**
- Elect to participate in the Child Care Benefit during the annual Open Enrollment period or Qualified Life Status Change; **and**
- The invoice or documentation of your child's care-taker or facility must include the Taxpayer Identification Number or the care-taker's SSN in order to receive reimbursement for this benefit.

There is a limit of a single benefit per family regardless of the number of eligible children, and regardless of whether both parents are eligible Officers. Officers who receive the $2,000 contribution can also contribute up to $3,000 in personal pre-tax payroll contributions to their Dependent Care FSA. Aside from the $2,000 Child Care Benefit contribution from Columbia, Officers can use remaining funds in their Dependent Care FSA to pay for other eligible Dependent Care FSA expenses.

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 adviser or financial professional.

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. Remember, each year during Benefits Open Enrollment you must make your election for T/PRP. This benefit, however, is easy to change during the year.

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.
- **If you make changes after November 20, 2015**, your changes will be effective January 1, 2016.

Transit Reimbursement Program

You may elect a monthly deposit amount from $10 to $130. 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 van pool services
- New York City Transit Authority buses and subways

The following commuting expenses are not eligible:

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

Parking Reimbursement Program

You may elect a monthly deposit amount from $10 to $250. The amount will be deducted from your paycheck before taxes are taken out.

If you participate in the Parking Reimbursement Program and you drive to work and park in a University-owned lot or at New York-Presbyterian Hospital, your combined pre-tax monthly deductions cannot exceed the $250 IRS monthly maximum.

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 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 eligible:

- 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. You can use the program's Benefits Card for eligible transit expenses—or you can file paper claims for reimbursement. Receipts are required for Parking Reimbursement.

Any unused funds will roll over from month to month. Please remember the IRS only allows you to use the limit of $250 per month for parking. For example, if you take a vacation during the month of August, the unused August balance will roll over to the following month, September. The funds are available as long as the expenses are not greater than the IRS allowable amounts. If you do not submit calendar year claims by March 31 of the following year, any unused funds will roll over and can only be used for expenses in the new calendar year. The roll over takes place on January 1 each year. If you leave the University or become ineligible for benefits, you can only be reimbursed for expenses incurred prior to your termination date or the date you became benefits-ineligible. Any remaining funds are forfeited.

You Can Make Changes During the Year

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).
- If there is an increase or decrease in the amount you pay for transit or parking expenses.

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 2015 Transit and Parking Elections."**

EBPA Benefits Card

If you elect to participate in the **Transit/Parking Reimbursement Program (T/PRP)**, you will receive a Benefits Card at your home mailing address from EBPA, the administrator of this benefit. This card is linked to all T/PRP accounts.

If you are a current employee and already have a Benefits Card you will not receive a new card. The Benefits Card will be automatically loaded with your new election.

Personal Identification Numbers (PINs) are available to you for use with your Benefits Card. It is not required that you use the PIN; however, individual merchants, such as parking garages, can decide if they will require a PIN for debit card purchases, or if they will let transactions go through as credit card purchases. You can obtain your PIN by logging in to your EBPA account and clicking "Card Status" under "My Cards" on the left side of the screen. Click "to view your PIN click here"; you will need to log in again and complete authentication information as requested to retrieve your PIN.

T/PRP

The Benefits Card allows you to pay for transit or parking expenses through any vendor that sells commuter tickets or Metrocards and accepts MasterCard.

If You Do Not Use the Benefits Card

You may also submit claims with a paper form. Please note that if you use a paper form, you must include receipts.

You can arrange to have your reimbursements deposited directly into the bank account of your choice. If you would like to authorize this, the EBPA direct deposit form is available on the HR website. Please contact EBPA if you have any questions regarding direct deposit service.

To obtain either a claim form or a direct deposit form, go to **www.hr.columbia.edu/forms-docs/forms**.

Manage your T/PRP Account with EBPA

To create an EBPA online account:

1. Go to **http://select.ebpabenefits.com/columbia/**
2. At the "Columbia University Portal," click "Transit/Parking Reimbursement"
3. Click on the EBPA Benefits Card image, then click continue
4. Click on Register on the upper right-hand corner of the page

Contact EBPA if you need assistance:

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

Disability Insurance

Columbia's Salary Continuation Plan and Long-Term Disability (LTD) Insurance Plan can replace all or some of your income if you become ill or injured and cannot work. You are automatically covered under the Salary Continuation Plan and the Basic LTD Insurance Plan at no cost to you. You may elect to buy additional coverage under the Optional LTD Plan, and the University recommends you seriously consider this valuable coverage. All of the LTD Plans are insured and administered by MetLife.

As a new hire, take advantage of the one-time opportunity to enroll in Optional LTD **without** providing Evidence of Good Health.

Disability Option	Coverage	Your Cost of Coverage
Salary Continuation Plan* For first six months	Full-time Officers receive 100% of regular compensation for up to six months of disability during any rolling 12-month period. To receive disability benefits, you must be able to provide proof of your disability and must be under a doctor's care consistent with your medical condition.	$0
Basic Long-Term Disability After six months	Basic LTD begins after you have been disabled for 6 months. For the first 6 months, your LTD benefit payment is 66⅔% of your Annual Benefits Salary** and it is reduced to 60% thereafter. • Coverage applies to a maximum Annual Benefits Salary of $100,000. • The maximum monthly benefit is $5,000. • There is no cost-of-living adjustment. • Contributions to the Officers' Retirement Plan continue if you become Totally and Permanently disabled.	$0
Optional Long-Term Disability Also after six months	The same benefit provisions as for the Basic LTD apply, with the following enhancements: • Coverage applies to a maximum Annual Benefits Salary of $300,000. • The maximum monthly benefit is $15,000. • You receive an annual 3% cost-of-living adjustment (COLA). • Contributions to the Officers' Retirement Plan continue if you become Totally and Permanently disabled.	$0.216 per $100 of your monthly covered Annual Benefits Salary.

* Faculty should review their appointment letters for specific information relative to salary continuation payments.

** Annual Benefits Salary is calculated as of July 1 each year and is the greater of (a) your base salary or (b) your prior 12 months' compensation from the University as of June 30 each year, including certain approved additional and private practice compensation, and excluding any housing allowance.

The LTD benefits are reduced by other disability income you receive, such as Social Security or Workers' Compensation. Any payments made to your dependents because of your disability will also reduce your LTD benefit amount.

Here's an example of how Basic LTD benefit payments are calculated:

After your first 6 months on Basic LTD benefits, the percentage reimbursement of your Annual Benefits Salary is reduced to 60%:

Basic LTD covered earnings	$60,000
Basic LTD % of salary benefit 60%	x 0.60
Your Basic LTD Benefit	= $36,000 annually or $3,000 per month

The Basic LTD benefit payment is fully taxable because Columbia pays the premium.

LTD Insurance Maximum Benefit Period

If you remain disabled (as defined by MetLife), you will continue to receive LTD benefits for a maximum benefit period based on your age on the date you become disabled. Benefits continue as long as you remain totally disabled throughout the Maximum Benefit Period as defined by MetLife. These benefits may be taxable.

Age on Date of Disability	Maximum Benefit Period for Basic and Optional LTD
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Optional LTD Insurance Plan

Statistically, your chance of becoming disabled is greater than your chance of dying during most of your working years. Please consider electing Optional LTD coverage to provide additional income protection in the event of disability.

The Optional LTD Plan pays 66⅔% of the first $300,000 of your Annual Benefits Salary for the first six months, and 60% thereafter, up to $15,000 per month.

There are important benefits from Optional LTD, including:

- Contributions to the Officers' Retirement Plan commence when you become permanently and totally disabled and unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.
- A 3% annual cost-of-living increase in the disability benefit payment.
- A 3% annual cost-of-living increase in the Officers' Retirement Plan contributions.

You make the Optional LTD election when you are hired or during annual Benefits Open Enrollment. You pay for this coverage with after-tax dollars, so that your **Optional LTD benefits are only partially taxable if you become disabled**.

Here's an example of how Optional LTD payments are calculated if you become disabled. After your first six months on Optional LTD Benefits, the percentage reimbursement of your Annual Benefits Salary is reduced to 60%.

Optional LTD Example: $150,000 Annual Benefits Salary

LTD covered earnings	$150,000
Optional LTD % of salary benefit 60%	x 0.60
Your total benefit	= $90,000 annually or $7,500 per month

Benefit is 50% taxable because Columbia subsidizes the premium for Optional LTD.

How to Calculate Your Optional LTD Monthly Premium Cost

Monthly covered earnings	$12,500
Divide by 100	$125
Rate	x 0.216
Your total monthly premium cost	= $27.00

Additional Benefit Coverage Information

Medical and Dental: For the first six months you are on a paid or unpaid leave of absence, you will be charged the same medical and dental insurance contributions as you were charged when not on a leave of absence.

Should your leave of absence extend beyond six months, your cost for medical and dental insurance will increase. If you are approved for Long-Term Disability, you will have the opportunity to continue medical and dental coverage. For information about coverage and rates, contact the Columbia Benefits Service Center at **212-851-7000**.

Life Insurance: If you become disabled before age 60, you may be eligible for a waiver of life insurance premium. To apply for a waiver of premium, please contact the Columbia Benefits Service Center at **212-851-7000** and choose the Disability Benefits option. You may not have to pay for your life insurance coverage if you qualify under the Plan's definition of disability.

Keep in Mind

- **As a new hire, please note that this is your opportunity to easily elect this valuable coverage—without Evidence of Good Health.**
- **If you did not select Optional LTD coverage when you first became eligible**, you'll need to be approved for coverage by MetLife after submitting Evidence of Good Health. Your coverage, as well as your payroll deductions, will not begin until MetLife has approved your application.
- If you leave the University (for a reason other than Retirement), you may be able to continue LTD coverage by applying to MetLife for conversion to an individual policy. Call the Columbia Benefits Service Center to request the conversion form.

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 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. You will automatically receive Basic Term Life Insurance of one times your Annual Benefits 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 also can 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, five or six times your Annual Benefits Salary up to a maximum of $1,750,000, including your Basic Term Life Insurance coverage amount. The additional amounts of coverage are paid with post-tax dollars.

The benefit will be determined using your Annual Benefits Salary 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.

We encourage you to use the tool called "Determine My Life Insurance Needs" in the CU Benefits Enrollment System at **www.hr.columbia.edu/benefits**.

Monthly Cost of Coverage

You pay a monthly premium for each $1,000 of coverage. Your premium is based on your age as of January 1:

Age	Monthly cost per $1,000
Less than 25	0.031
25 to 29	0.040
30 to 34	0.051
35 to 39	0.063
40 to 44	0.072
45 to 49	0.094

Age	Monthly cost per $1,000
50 to 54	0.146
55 to 59	0.250
60 to 64	0.417
65 to 69	0.668
70 to 74	0.888
75 or older	1.148

How to Calculate Your Optional Term Life Monthly Premium Cost

Example: An employee, age 41, with an Annual Benefits Salary of $40,000, elects Optional Term Life Insurance of 3x salary ($120,000).

Amount of Optional Term Life insurance	$120,000
Divide by 1,000	120
Rate @ age 41, from table (page 46)	x 0.072
Your total monthly premium	= $ 8.64

Evidence of Good Health

You must provide Evidence of Good Health (EOI) and be approved by The Standard if:

- You are **newly hired** and elect Optional Term Life Insurance coverage in excess of 3x your Annual Benefits Salary or $1,000,000 Guaranteed Issue Amount, whichever is less;
- You did not elect Optional Term Life previously and want to elect this coverage during Benefits Open Enrollment;
- You wish to increase the level of your coverage by more than 1x your salary or beyond the Guaranteed Issue amount during Benefits Open Enrollment.

If Evidence of Good Health applies to you, the CU Benefits Enrollment System will guide you through what to do next. To obtain Evidence of Good Health forms, go to **www.hr.columbia.edu/forms-docs/forms**. The forms can be printed using the link in the CU Benefits Enrollment System once the election has been made.

Waiver of Premium

If you become disabled before age 60, you may be eligible for a waiver of life insurance premium. To apply for a waiver of premium, please contact the Columbia Benefits Service Center at **212-851-7000** and choose the Disability Benefits option. You may not have to pay for your life insurance coverage if you qualify under the Plan's definition of long-term disability.

If You Leave the University

If you leave the University, you may be able to continue some life insurance coverage by applying to The Standard Life Insurance Company for conversion or portability to an individual policy. The Standard Life Insurance Company will automatically send a conversion packet to you. If you don't receive the packet, contact The Standard Life Insurance Company at **888-264-3057** for an application and eligibility criteria.

Dependent Life Insurance

Dependent Life Insurance provides a benefit to you in the case of the death of your spouse, your same-sex domestic partner or your dependent children up to age 26. You pay the full cost of this benefit.

Coverage choices:

- Spouse/Same-Sex Domestic Partner Life Insurance – $10,000, $30,000, $50,000 or $100,000 of coverage.

  Note: You cannot elect dependent life insurance greater than your own total life insurance value.

- You must provide Evidence of Good Health if you elect spouse/same-sex domestic partner coverage of $100,000.
- Child Life Insurance – $10,000 for each dependent child; you pay one premium rate, regardless of the number of children in your family. For the definition of "child" for this benefit, see **www.hr.columbia.edu/benefits**.

Coverage	$10,000	$30,000	$50,000	$100,000
Spouse/Same-Sex Domestic Partner Life Insurance	$1.50 per month	$4.50 per month	$7.50 per month	$15.00 per month
Child Life Insurance	$0.50 per month	N/A	N/A	N/A

Emergency Travel Assistance

When you are covered under our Basic Term Life Insurance Plan (from The Standard), you and your eligible dependents are also covered for emergency travel assistance when traveling 100+ miles from home or when traveling in a foreign country for trips up to 180 days. 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 FrontierMEDEX. It can help you with travel emergencies both in the U.S. and internationally. In an emergency, you may call:

North America: **800-527-0218**

Worldwide, call collect: **410-453-6330**

Please reference Group Number 9061 when you contact FrontierMEDEX.

Or use the Contact section of the FrontierMEDEX website: **www.frontiermedex.com/about-us/contact-us.html**

Or write an email to FrontierMEDEX directly at: **operations@frontiermedex.com**

Here is a summary of the range of services FrontierMEDEX offers:

- Pre-trip assistance
- Medical and prescription drug assistance
  - Locating medical care
  - Translation/interpreter
  - Medical insurance coordination
- Emergency transportation
  - Emergency evacuation when adequate medical facilities are not available locally
  - Family or friend travel arrangements
- Travel assistance
  - Provide assistance with emergency credit card and ticket replacement
  - Provide assistance with emergency passport replacement
  - Locating legal services
- Personal security
  - Latest information on social or political unrest
  - Weather or health hazards
  - Security evacuation services

Services are only covered if coordinated by FrontierMEDEX.

Long-Term Care (LTC) Insurance

Long-Term Care (LTC) insurance offered by Genworth can help you and your family pay some of the costs associated with long-term nursing home or home healthcare services that are not covered by traditional medical insurance or Medicare. Due to New York State insurance and licensure laws, residents of the following states ***only*** are eligible to participate in the Genworth LTC plan at this time: Alabama, Colorado, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Michigan, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Virginia, West Virginia and Wyoming.

LTC insurance is available to you, your spouse, your same-sex domestic partner, your parents/parents-in-law, grandparents/grandparents-in-law and adult children. You do not need to be enrolled in LTC in order for a family member to apply for this coverage. Once you or a family member are approved for the LTC benefit, coverage is guaranteed as long as the premiums are paid.

How LTC Insurance Works

LTC pays part of the daily cost of services designed to help a person perform certain activities of daily living such as bathing, eating and dressing. The covered person will receive a percentage of the daily maximum benefit, depending on the type of care he or she receives.

For example:

- Nursing home or alternative care facility—100% of daily maximum benefit.
- Home healthcare or adult care services—75% of daily maximum benefit.
- Informal care such as light housekeeping or shopping—25% of daily maximum benefit, up to 30-day annual maximum.

You can elect a daily maximum benefit of $150, $200, $250, $300 or $350.

Evidence of Good Health

Newly hired or newly eligible? Please consider your unique opportunity to elect LTC within 60 days of your date of hire without providing Evidence of Good Health.

You do not need to provide Evidence of Good Health if you elect LTC insurance coverage within 60 days after you become eligible and are under age 66. If you are age 66-69, you can apply with a shortened enrollment form within the first 60 days of eligibility. If you are age 70 or older, you must provide Evidence of Good Health.

Similarly, if your spouse or same-sex domestic partner enrolls within 60 days after you become eligible, he or she may complete a shortened enrollment form. Other eligible family members and anyone who enrolls after the 60-day period, must provide Evidence of Good Health and be approved by the insurance company.

Contact Genworth Life Insurance Company of New York (Genworth Life) for Premium Costs and How to Enroll

The cost of LTC coverage depends on the level of coverage you choose and your age when your application is signed. The younger you are when you enroll, the lower your premium cost. You pay the full cost of LTC directly to Genworth. You and other eligible family members who enroll, can have Genworth Life deduct the premium payment directly from your bank account or Genworth can bill you directly. To enroll in the LTC Insurance Plan, please coordinate directly with Genworth Life. For more information, call Genworth Life at **800-416-3624** or go to its website at **www.genworth.com/columbia**.

Tuition Programs

Columbia University offers three tuition benefit programs to support the education of you and your family. Complete policy information is online at **http://hr.columbia.edu/benefits/tuition**. You can review your Tuition eligibility by logging in to the CU Benefits Enrollment System and choosing "Tuition Programs, Print Your Eligibility Form."

Tuition Exemption Benefit for Officers and their Children

The Tuition Exemption Benefit Program pays tuition for you and your eligible children, for programs at Columbia University, Barnard College and Teachers College. This is not a reimbursement or remission program; when you submit your eligibility form to your school's Student Financial Services office, your tuition is simply exempted.

As a newly hired or newly eligible Officer, you must complete two (2) years of regular full-time continuous service before you are eligible. Once you become eligible, Tuition Exemption will pay 100% of the tuition for a pre-defined number of courses each term; see the policy for details.

If you want to take courses toward a degree before you meet the service requirements, you are eligible for a 35% reduction in tuition costs, at Columbia only.

Your children may also be eligible for a 100% Tuition Exemption benefit for undergraduate degrees at Columbia and Barnard College. For Columbia University Officers' children who attend Barnard College, the Tuition Exemption benefit is limited to eight (8) Fall and Spring terms. Officers are eligible for this benefit after completing four (4) years of regular full-time continuous service. Your child must matriculate into their degree program by the end of the month in which they turn age 26.

College Tuition Scholarship (CTS) Benefit for Officers' Children

For your college-aged children, the College Tuition Scholarship benefit pays for up to 50% of the undergraduate tuition at accredited institutions outside of Columbia (up to an annually defined limit) for up to eight semesters. You are eligible for this benefit after completing four (4) years of regular full-time continuous service. Your child must matriculate into their degree program by the end of the month in which they turn age 26.

Primary Tuition Scholarships (PTS) Benefit for Officers' Children

The Primary Tuition Scholarship benefit program provides tuition support for your primary-school-aged child to attend a private school, grades K-8, located within the five boroughs of New York City. You are eligible to receive PTS as soon as you are eligible for benefits. You and your child must live within the five boroughs of New York City. This benefit covers between 10% and 35% of the tuition, depending on your family income, or 50% of the tuition at The School at Columbia University. You may receive as many scholarships as you have eligible children.

Work/Life Programs

Columbia University's Office of Work/Life fosters the well-being of the Columbia community and its people in their pursuit of meaningful and productive academic, personal and work lives.

Work/Life offers a number of services and programs. For more information on the range of programs and workshops Work/Life offers, please go to **http://worklife.columbia.edu**, or **email worklife@columbia.edu**, or call **212-854-8019**.

- **Affiliated Child Care Centers** are independent centers, located on or near Columbia campuses, which provide quality care and greater access for Columbia families.
- **Affinity Lending Program** includes preferred lenders that can help you refinance your current mortgage, consolidate debt or purchase a new home.
- **Backup Care** is for the care of adults/elders, children, or yourself for those situations when normal care arrangements are interrupted or when short-term care is required but you still need to attend to your work responsibilities. Coverage is available 24 hours / 7 days per week, nationwide and in some international locations.
- **Breastfeeding Support Program** provides a variety of support and resources for nursing mothers, including private lactation rooms equipped with hospital-grade breast pumps, on all Columbia campuses, for nursing mothers to express milk. Breast pump attachments are available for purchase below retail cost, and there are breastfeeding workshops each semester.
- **Faculty Spouse/Partner Dual Career Service** is for faculty spouses/partners who are new to the NYC metropolitan area and wish to explore employment opportunities.
- **Housing Information and Referral Service** provides individual consultation and information resources for renting or purchasing apartments or homes in the New York metropolitan area.
- **School and Child Care Search Service** assists families exploring child care and school options including public, parochial, independent and special needs schools; it also provides information about after-school, summer/holiday and gap year programs. Free subscriptions to an online school finder and a Pre-K and Kindergarten newsletter are also available.
- **Wellness Program** includes Walk to Wellness, Healthy Lifestyle Challenge, Weight Watchers at Work, wellness discounts, Stress Reduction classes and a CU Wellness listserv.

Go to **http://worklife.columbia.edu** for workshops, programs, events calendar and the online bulletin board.

Retirement Programs

Columbia University's retirement savings program is designed to provide retirement income that will add to your other savings and investments, as well as your Social Security benefits. The program consists of two retirement plans: The **Voluntary Retirement Savings Plan (VRSP)** and **The Officers' Retirement Plan**. Outlined below is an overview of each plan.

The **Voluntary Retirement Savings Program (VRSP)—** The VRSP is a defined contribution 403(b) plan that lets you contribute from 1% to 80% of your eligible pay on a pre-tax and/or Roth basis, in whole percentages through convenient payroll deductions. **The most you can contribute to the VRSP in 2014 is $17,500 or, if you are age 50 or over, an additional $5,500 to an annual total of $23,000. This IRS limit applies to your combined contributions, pre-tax and Roth.** Eligibility begins on your date of hire.

The **Retirement Plan for Officers of Columbia University (the "Plan")—** The University makes contributions to the Plan for you as soon as you become eligible.

Please keep in mind: **If you do not select your investment funds** for these plans, your contributions will be invested in the appropriate Qualified Default Investment Alternative (QDIA) ***with TIAA-CREF and Vanguard***. You may change your investment fund options at any time.

Your Contributions

Pre-tax contributions: Contributions deducted from your pay before federal income taxes (and, in most areas, state and local income taxes) are applied. Your pre-tax contributions and their investment earnings will not be subject to taxes as long as they remain in your VRSP account.

Roth contributions: After-tax contributions, which means you pay taxes on Roth contributions along with the rest of your current pay. Because you pay taxes on your Roth contributions when they go into the VRSP, you'll pay no taxes on Roth contributions when they are paid out to you from the plan, subject to certain rules.

Automatic Enrollment: If you are an Officer who is hired after July 1, 2013, and you do not make an election to contribute on a pre-tax and/or Roth basis to the VRSP, you will automatically be enrolled to contribute 3% of your eligible pay on a pre-tax basis 60 days following your hire date.

Matching Contributions: For those Officers hired after July 1, 2013, the University will match your pre-tax and Roth contributions to the VRSP, up to a maximum of 3% of eligible pay, when you become eligible for University contributions to the Officers' Retirement Plan. If you are a full-time Senior Officer, the University's contributions begin on your date of hire. If you are a full-time or part-time Junior Officer, the University's contributions begin after you complete 2 years of eligible service.

Catch-Up Contributions: If you are age 50 or older, you may contribute an **additional** amount—up to $5,500 in 2014—on a pre-tax and/or Roth basis to your VRSP. You become eligible for catch-up contributions on January 1st of the year you turn 50.

Log on to the CU Benefits Enrollment System at **www.hr.columbia.edu/benefits** to make this election.

Make Sure You are Signed Up

Not sure if you are participating in the VRSP today? The simplest way to check is to look at your payroll statement.

Detailed Information: For details on the Voluntary Retirement Savings Plan (VRSP) and the Officers' Retirement Plan, including your contributions, investment options, educational information and planning resources, please see the brochure, ***Your Columbia University Retirement Savings Program***, at **www.hr.columbia.edu/benefits/bib**. Be sure to refer to the appropriate version, either for Officers hired on or after July 1, 2013, or for Officers hired prior to July 1, 2013.

For complete details we encourage you to read the Summary Plan Descriptions (SPD) which are online at **www.hr.columbia.edu/benefits/spds**.

Newly Hired: It is your responsibility to ensure that your annual contributions do not exceed the IRS limit for the calendar year. If you have already contributed to another qualified pre-tax retirement plan this year, please be sure to review those contributions so you can elect the appropriate per-paycheck percentage.

Financial Planning and Retirement Education Resources

Representatives from TIAA-CREF and Vanguard visit the University throughout the year to discuss personal financial planning, investment strategies, portfolio reviews and retirement education at no cost to you. These individual counseling sessions are personalized to meet your goals and objectives and your spouse or partner is welcome to attend.

You can register for these sessions by contacting the carriers directly.

The Vanguard Group	**www.meetvanguard.com**	**800-662-0106, ext. 14500**
TIAA-CREF	**www.tiaa-cref.org/moc**	**800-732-8353**

Retiree Medical Insurance

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

The University provides a fixed-dollar subsidy to help retirees pay for the cost of retiree medical insurance. Retirees pay the balance of the cost.

- The monthly subsidy—i.e., the University contribution—for retiree medical insurance is:
  - $72 for a retiree—both under and over age 65
  - $36 for a spouse or eligible dependents—both under and over age 65

Benefits Glossary for Officers of Columbia University

Annual Benefits Salary – Used to determine employees' medical contributions, Child Care Benefit eligibility, Life Insurance coverage and Long-Term Disability (LTD) coverage amounts. Annual Benefits Salary is calculated as of July 1 each year and is the greater of a) the base salary in effect on each July 1 or b) the prior 12 months' gross compensation, plus additional and private practice compensation, to June 30.

Annual Deductible – The amount you pay for ***Covered Health Services*** each year before the Plan begins to pay for expenses.

Appeal of Claim – If you have a claim for a benefit which is denied in whole or in part, you must receive a written explanation of the reason for the denial. Under ERISA, you have the right to appeal the denial of a claim and have the denial decision reconsidered.

Coinsurance – Cost-Sharing between you and the Plan for ***Eligible Expenses*** for certain ***Covered Health Services***, where you are required to pay a percentage of the cost. For example, a 90/10 coinsurance plan with a $200 deductible requires you to pay 10% of the covered costs after the ***Annual Deductible*** has been met, while the Plan will be responsible for the remaining 90%.

Copayment – A fixed amount you pay when you receive a healthcare service. The amount can vary by the type of ***Covered Health Service***. Typically you pay a copay for a visit to an in-network provider's office.

Cost of Living Adjustment (COLA) – An adjustment made to income in order to adjust benefits to reflect the effects of inflation.

Cost Sharing – The share of plan costs that you pay out of your own pocket. This generally includes ***Annual Deductibles, Coinsurance*** and ***Copayments***, but does not include premiums or the cost of non-covered services.

Covered Health Services – Health services, including supplies, which are determined by the Plan to be provided for the purpose of preventing, diagnosing or treating sickness, injury, mental illness, substance use disorders, or their symptoms. Covered services are listed in the Summary Plan Description.

Eligible Expenses – Charges for ***Covered Health Services*** rendered, or supplies furnished by a certified health professional under the Plan. Eligible Expenses may be subject to ***Cost Sharing*** and/or annual or lifetime maximums as specified by the terms of the plan. Eligible Expenses for services rendered by ***In-Network*** providers are limited to the network negotiated charge. For ***Out-of-Network*** providers, ***Eligible Expenses*** are limited to 190% of the Medicare Maximum Allowable Charge.

Evidence of Good Health – Documentation of good health by an applicant for insurance. Usually this requires completing a form with your medical history. Enrollment in Optional Term Life and Optional Long-Term Disability benefits require such evidence if the employee has not elected the plans within 31 days of their eligibility date and, for Long-Term Care, if elected 60 days after date of hire.

Exclusion(s) – A health condition or service not eligible for coverage under the healthcare plan.

Explanation of Benefits (EOB) – A statement provided by a health insurer to the plan participant that explains how their claim was paid. The EOB typically includes the date of service, type of service rendered, ***Eligible Expense***, amount paid by the Plan and the balance to be paid by the plan participant. If applicable, it will also provide any reason(s) the service or supply was not covered by the Plan.

Guaranteed Issue – A feature of certain insured benefits that permits you to enroll regardless of health status, age, gender, or other factors that might predict the use of the benefit.

Imputed Income – The value of an employer-sponsored benefit or service that is considered by the IRS as compensation and added to an employee's taxable wages in order to properly withhold income and employment taxes from the wages. Examples of Imputed Income include:

- Educational assistance above the excluded amount.
- Employer contributions to the coverage of same-sex domestic partners and their children.

In-Network – Refers to providers or facilities that are part of a health plan carrier's network with which it has negotiated and contracted, to provide a discount for services rendered. Individuals pay less when using an ***In-Network*** provider.

Medically Necessary – Healthcare services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Multi-Source Brand – Prescription drugs that are available in both the brand name and generic form.

Network – The group of physicians, hospitals and other providers who are contracted with the health plan carrier to provide services to health plan participants at lower-priced, negotiated rates.

Non-Duplication – A provision in health plans specifying that benefits will not be paid for amounts reimbursed by other plans. This typically applies to a plan participant who is eligible for benefits under more than one plan (e.g., covered under spouse's plan).

Non-Preventive Drugs – Prescription medications that are designed and intended to treat a specific condition. If either a therapeutic class or specific drug is not defined as a Preventive Drug, then it is considered a Non-Preventive drug.

Open Enrollment – The annual period in which employees can select from a choice of benefits programs with an effective date of January 1 of the following year.

Out-Of-Network Benefits – ***Covered Health Services*** provided by non-network Providers. Individuals usually are responsible for additional ***Out-of-Pocket Costs*** if they use an out-of-network provider. ***Eligible Expenses*** for out-of-network services are indexed to 190% of the Medicare Maximum Allowable Charge.

Out-of-Pocket Costs – Expenses for medical services that are not reimbursed by the plan. ***Out-of-Pocket Costs*** include deductibles, coinsurance, copayments for ***Covered Health Services***, costs above the ***Eligible Expense*** and costs for services that are not covered under the Plan.

Out-of-Pocket (OOP) Maximum – The maximum amount a patient must pay for ***Covered Health Services*** during a plan year. The in-network ***Out-of-Pocket Maximum*** includes the ***Annual Deductible,*** medical and prescription drug ***Copayments*** and ***Coinsurance***. The out-of-network maximum does not include medical or prescription drug ***Copayments***. The OOP maximum does not include premiums, payments made for non-covered services or charges above ***Eligible Expenses***.

Precertification – A process where the health plan carrier is contacted before certain services are provided, to determine if it is a ***Covered Health Service***. Precertification is not a guarantee your health plan will cover the cost of the services. Also called prior authorization, preauthorization or prior approval.

Pre-Tax Contribution – A contribution which is made before federal and/or state taxes are withheld.

Preventive Care – Medical care that focuses on health maintenance such as annual physicals, certain screening tests and child immunization programs.

Preventive Drugs – Prescription medications that are designed to prevent individuals from developing a health condition.

Qualified Life Status Change – A change to benefits eligibility that is recognized by the IRS and allows an employee to make a change in certain benefits during the calendar year. After the initial enrollment as a new hire, or after annual Benefits Open Enrollment, employees are only able to change benefits for the remainder of the calendar year if they experience a Qualified Life Status Change.

Self-Insured Plan – Columbia University's medical and prescription benefits are "self-insured." Columbia University does not pay "premiums" to each of the insurance carriers. Columbia University pays employee healthcare claims plus an administrative fee to the health plan carriers.

Single-Source Brand – Drugs that do not have a generic equivalent.

Summary Plan Description (SPD) – A document that explains the fundamental features of an employer's retirement or medical plan including eligibility requirements and the schedule of benefits.

University Network ID (UNI) – Your UNI, consisting of your initials plus an arbitrary number, is the key to accessing computer services and electronic resources at Columbia. You will use it to gain access to benefits information.

Vesting – A term that means a permanent right of ownership. You are always 100% vested in your Voluntary Retirement Savings Plan contributions.

Notes

Notes

Contact Information

	Website	Phone
Employee Assistance Program (EAP)	www.humana.com/eap; username: Columbia, pw: eap	888-673-1153
Travel Emergencies (including international) FrontierMEDEX	https://members.medexassist.com/Default.aspx Group Number: 9061 or write email to: operations@frontiermedex.com	North America: 800-527-0218 Worldwide, call collect: 410-453-6330
Medical		
UHC Medical UHC Behavioral Health	http://columbia.welcometouhc.com/home	800-232-9357 888-265-9945
Dental		
Aetna Columbia Dental Plan	www.aetna.com/docfind/custom/columbia	800-773-9326
Prescriptions		
Express Scripts	www.express-scripts.com	800-230-0508
Long-Term Disability		
MetLife	www.metlife.com/mybenefits	800-858-6515
Life Insurance		
The Standard Life Insurance	www.standard.com	888-264-3057
FSA		
UHC	www.myuhc.com	800-232-9357
Transit/Parking		
EBPA	http://select.ebpabenefits.com/columbia/	888-456-4576
Long-Term Care		
Genworth	www.genworth.com/columbia	800-416-3624
Retirement Plans		
The Vanguard Group	http://columbia.vanguard-education.com/ekit/	800-523-1188
TIAA-CREF	www.tiaa-cref.org/columbia	800-842-2252

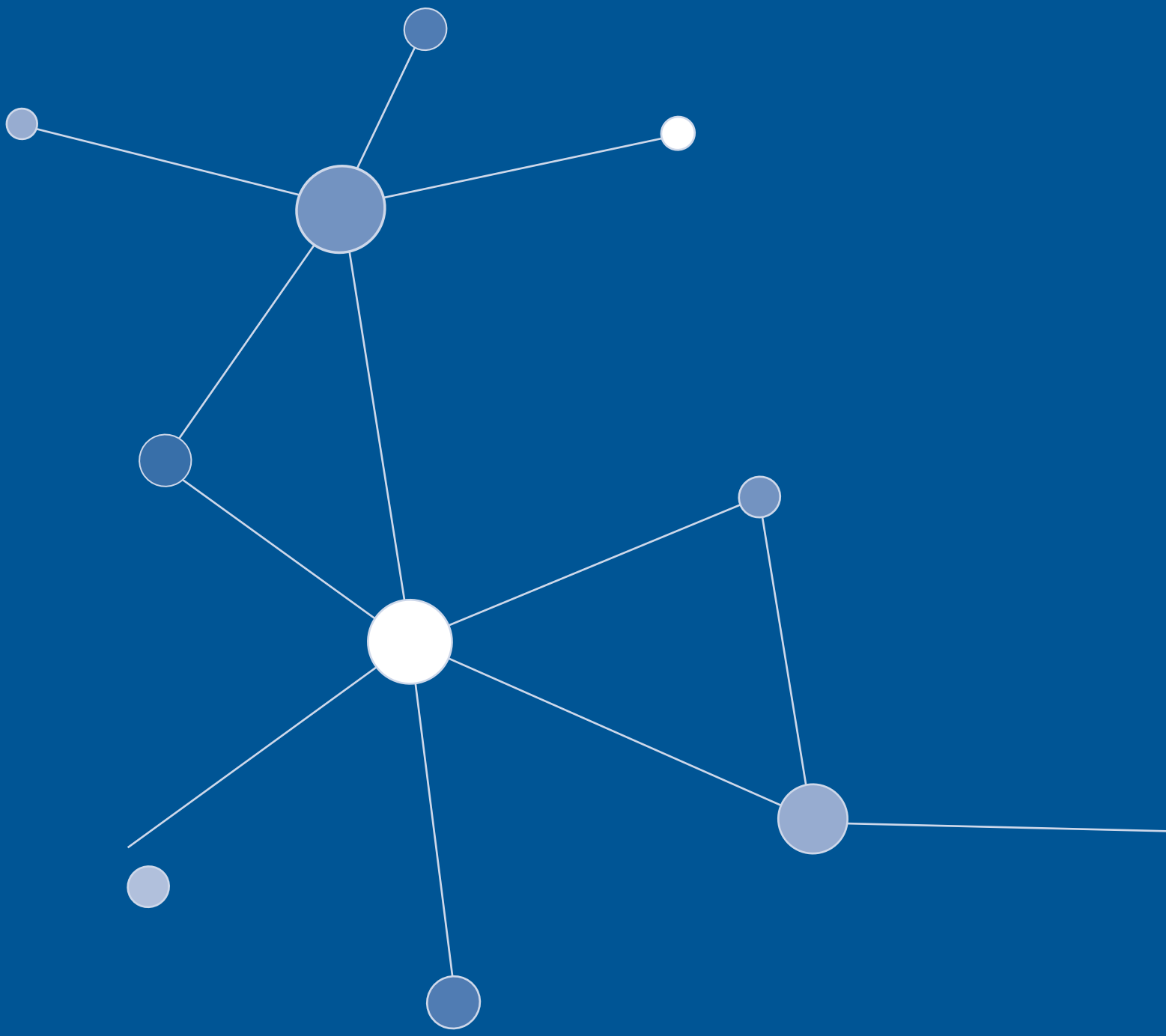
Columbia Benefits Contacts

For all benefits-related questions, contact:

Columbia 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

For updates, forms, Tuition Exemption and information about other HR programs:

Benefits website: www.hr.columbia.edu/benefits | HR website: www.hr.columbia.edu



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