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

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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
- Tuition Exemption for Support Staff
- Post-65 Benefits – Active Employees
- Forms, including medical claim forms
- Summary Plan Descriptions (SPDs)
- If you leave CU (including COBRA continuation coverage)

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

Important policy information is at www.hr.columbia.edu/policies.

Collective Bargaining Agreements are at www.hr.columbia.edu/union-contracts.

For information about other services and University programs, consult the Working at Columbia guide at www.hr.columbia.edu/wac.
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, your dependents will not have medical or dental coverage, and you will also miss the opportunity to enroll in 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

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.
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, 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 will be enrolled in individual medical and dental coverage. Any eligible dependents will not receive Medical, Prescription Drug, or Dental coverage, and you will not be able to elect Flexible Spending Accounts, or Optional Term Life Insurance. 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.
Who Is Eligible for Benefits

The online CU Benefits Enrollment System will show you the benefits and options you are eligible for, as well their monthly cost and the benefit effective date. Part-time employees must work 20 hours per week to be eligible for benefits.

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

If you do not enroll within 31 days and you are a full-time employee, you will be automatically enrolled for individual Choice In-Network medical coverage and individual GHI Dental coverage. You will not be able to enroll your eligible dependents—your spouse or same-sex domestic partner and your eligible children—in Medical, Prescription Drug, or Dental coverage, and you will not have Flexible Spending Accounts or Optional Term Life Insurance coverage from Columbia for the remainder of the calendar year. If you have questions, please contact the Columbia Benefits Service Center at 212-851-7000.

Waiting Periods for Benefits Coverage

<table>
<thead>
<tr>
<th></th>
<th>Full-Time</th>
<th>Part-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Coverage</td>
<td>2 months</td>
<td>2 months</td>
</tr>
<tr>
<td>Dental Coverage</td>
<td>2 months</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>2 months</td>
<td>2 months</td>
</tr>
<tr>
<td>Flexible Spending Account (FSA)</td>
<td>Hire date</td>
<td>Hire date</td>
</tr>
<tr>
<td>Transit/Parking Reimbursement Program</td>
<td>Hire date</td>
<td>Hire date</td>
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<tr>
<td>Columbia University Retirement Plan</td>
<td>Hire date</td>
<td>Hire date</td>
</tr>
<tr>
<td>Voluntary Retirement Savings Plan (VRSP)</td>
<td>Hire date</td>
<td>Hire date</td>
</tr>
</tbody>
</table>
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;
  - For GHI (EmblemHealth) dental coverage, until the end of the calendar year in which they turn 19;
  - 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) (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.

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Copy of legal marriage certificate</td>
</tr>
<tr>
<td>Same-Sex Domestic Partner</td>
<td><strong>Two</strong> of any of the following:</td>
</tr>
<tr>
<td></td>
<td>• Joint lease or mortgage</td>
</tr>
<tr>
<td></td>
<td>• Joint ownership of property</td>
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<tr>
<td></td>
<td>• Joint bank account statement</td>
</tr>
<tr>
<td></td>
<td>• Designation of the partner as primary beneficiary in your will or designation of the partner as beneficiary for your life insurance or retirement benefits</td>
</tr>
<tr>
<td></td>
<td>• Assignment of power of attorney to your partner</td>
</tr>
<tr>
<td>Child</td>
<td><strong>One</strong> of the following:</td>
</tr>
<tr>
<td></td>
<td>• Child's birth certificate</td>
</tr>
<tr>
<td></td>
<td>• Hospital record of birth (temporary, until birth certificate is received)</td>
</tr>
<tr>
<td></td>
<td>• Adoption certificate/court records</td>
</tr>
</tbody>
</table>
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 Employees Turning 65

Active employees and their spouses age 65 and over do not need to enroll in Medicare because they still have creditable coverage through the University.
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](http://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](tel: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](http://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.

- Choice In-Network Plan
- Choice Plus 100 Plan

The CU Benefits Enrollment System will show your monthly pre-tax contributions for each medical plan option. You can also view monthly contributions on page 21 of this booklet. The Medical Plan Comparison Chart on pages 16-17 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.

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 pages 16-17.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coinsurance</th>
<th>Out-of-Pocket Maximum</th>
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</table>
| • For the Choice Plus 100 Plan, if you have an out-of-network claim, the deductible is the amount you pay each year before the medical plan begins to pay for expenses. | • Once you have paid that deductible, the plan pays a percentage of the remaining covered medical services.  
• For example, the Choice Plus 100 Plan pays 60% for many out-of-network services. You pay the remaining 40%.  
• This 60%/40% cost-sharing is “coinsurance.” | • This feature protects you financially.  
• If you seek care from in-network medical providers, when your medical and prescription drug copays accumulate to the out-of-pocket maximum, the plan will pay 100% of covered charges for the remainder of the calendar year.  
• For the Choice Plus 100 Plan, if you go out-of-network, when your deductible plus coinsurance reaches your out-of-pocket maximum, the plan will pay 100% of covered charges for the remainder of the calendar year (within plan limits), but only up to 190% of Medicare’s maximum allowable charge. |
Medical and Prescription 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.

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.

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 pages 38-40, or online at www.hr.columbia.edu/benefits.
Choice Plans – UnitedHealthcare (UHC)

Columbia offers two different Choice medical plan options—the Choice In-Network plan and Choice Plus 100—so that you can choose the one that best suits your needs.

With the Choice Plus 100 plan only, 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 Choice In-Network plan and the Choice Plus 100 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. All medical and prescription copays accumulate toward your annual out-of-pocket maximum.

Choice In-Network Plan

The Choice In-Network plan has no deductible for all 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 In-Network plan pays 100% of covered medical charges for the remainder of the calendar year. Out-of-network services are not covered.

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”).

Choice Plus 100 — Pre 1/1/14 Hires

The Choice Plus 100 plan has no deductible for all 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.

*of 190% of the Medicare Maximum Allowable Charge. 70% for outpatient mental health/substance use disorder services.
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.

Out-of-Network Reimbursement (Choice Plus 100 Only)

For the Choice Plus 100 Plan, 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.

*70% for outpatient mental health/substance use disorder services
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.

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.

*70% for outpatient mental health/substance abuse services*
## 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 UHC 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 for you. 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](http://hr.columbia.edu/benefits/spds).

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Choice In-Network</th>
<th>Choice In-Network</th>
<th>Choice Plus 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (per person)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Individual)</td>
<td>$4,000</td>
<td>N/A</td>
<td>$4,000</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Family)</td>
<td>$8,000</td>
<td>N/A</td>
<td>$8,000</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100%</td>
<td>N/A</td>
<td>100%</td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>$30 copay</td>
<td>N/A</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Laboratory/Radiology Services</td>
<td>100% if non-hospital location; $150 copay if hospital**</td>
<td>N/A</td>
<td>100% if non-hospital location; $150 copay if hospital**</td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>$500 copay per admission</td>
<td>N/A</td>
<td>$500 copay per admission</td>
</tr>
<tr>
<td>Outpatient Hospital Care</td>
<td>$150 copay (including lab and radiology)</td>
<td>N/A</td>
<td>$150 copay (including lab and radiology)</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse — Inpatient care</td>
<td>$500 copay per admission</td>
<td>N/A</td>
<td>$500 copay per admission</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse — Outpatient programs</td>
<td>$150 copay per admission for facility based care, including intensive outpatient programs</td>
<td>N/A</td>
<td>$150 copay per admission for facility based care, including intensive outpatient programs</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse — Outpatient Counseling</td>
<td>$30 copay</td>
<td>N/A</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150 copay</td>
<td>$150 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Basic and Comprehensive Infertility Treatment</td>
<td>Unlimited benefit for diagnosis and basic medical treatment, including artificial insemination</td>
<td>N/A</td>
<td>Unlimited benefit for diagnosis and basic medical treatment, including artificial insemination</td>
</tr>
</tbody>
</table>

*Out-of-Network coinsurance reimbursement is indexed to 190% of the Medical Maximum Allowance 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 all plans, medical and prescription copays accumulate toward the in-network out-of-pocket maximum.

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*The above chart represents highlights of the Plan provisions. Clinical medical management restrictions and other limits may apply. See Summary Plan Descriptions (SPDs) at [www.hr.columbia.edu/benefits](http://hr.columbia.edu/benefits) for complete details.*
Vision Coverage

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

<table>
<thead>
<tr>
<th>Vision Benefits</th>
<th>Choice In-Network Only</th>
<th>Choice Plus Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Eye Exams</td>
<td>Adults: One exam every 12 months with a $10 copay</td>
<td>Adults: One exam every 12 months with a $10 copay</td>
</tr>
<tr>
<td></td>
<td>Children: One exam every 12 months with a $10 copay</td>
<td>Children: One exam every 12 months with a $10 copay</td>
</tr>
<tr>
<td>Lenses</td>
<td>Adults: Every 24 months, $20 allowance for single lenses, $30 for bifocal, $40 for trifocal and $75 for lenticular</td>
<td>Adults: Every 24 months, $20 allowance for single lenses, $30 for bifocal, $40 for trifocal and $75 for lenticular</td>
</tr>
<tr>
<td></td>
<td>Children: Lenses covered in full every 12 months (more frequently if medically necessary)</td>
<td>Children: Lenses covered in full every 12 months (more frequently if medically necessary)</td>
</tr>
<tr>
<td>Frames</td>
<td>Adults: $30 allowance every 24 months.</td>
<td>Adults: $30 allowance every 24 months.</td>
</tr>
<tr>
<td></td>
<td>Children: Up to $100 covered in full every 12 months (more frequently if medically necessary). Cost above $100 covered at 60%</td>
<td>Children: Up to $100 covered in full every 12 months (more frequently if medically necessary). Cost above $100 covered at 60%</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Adults: $75 allowance every 24 months.</td>
<td>Adults: $75 allowance every 24 months.</td>
</tr>
<tr>
<td></td>
<td>Children: Single purchase of a pair of contact lenses or 1 box of contact lenses per eye covered at 100% every 12 months</td>
<td>Children: Single purchase of a pair of contact lenses or 1 box of contact lenses per eye covered at 100% every 12 months</td>
</tr>
</tbody>
</table>

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.

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](http://www.express-scripts.com) or [1-800-230-0508](tel: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.
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.


- **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.
Cost of 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 Cost for Same-Sex Domestic Partner Coverage

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.

Monthly Contributions for 2015

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Yourself Only</th>
<th>Yourself &amp; Spouse or Same-Sex Domestic Partner</th>
<th>Yourself &amp; Child or Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice In-Network</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Choice Plus 100</td>
<td>$26</td>
<td>$53</td>
<td>$48</td>
<td>$80</td>
</tr>
<tr>
<td>Part-Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice In-Network</td>
<td>$281.41</td>
<td>$590.96</td>
<td>$534.67</td>
<td>$844.22</td>
</tr>
<tr>
<td>Choice Plus 100</td>
<td>$293.13</td>
<td>$615.58</td>
<td>$556.95</td>
<td>$879.40</td>
</tr>
</tbody>
</table>

Your Monthly Cost (Contributions) for GHI (EmblemHealth) Dental

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yourself</td>
<td>$0</td>
</tr>
<tr>
<td>You Plus One</td>
<td>N/A</td>
</tr>
<tr>
<td>Family</td>
<td>$0</td>
</tr>
</tbody>
</table>
The GHI (EmblemHealth) Dental Program

After the waiting period, full-time colleagues are enrolled in the GHI (EmblemHealth) Preferred Dental Program automatically, at no cost to you. **Note: If you have dependents, you must go online and enroll them within 31 days of your eligibility; otherwise, you will be automatically enrolled for yourself only.**

**GHI (EmblemHealth) Dental**

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

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

For a listing of GHI dentists, go to: [http://www.emblemhealth.com/find-a-doctor/directory](http://www.emblemhealth.com/find-a-doctor/directory) and select "Dental Preferred" from the menu. For more information, call GHI at **212-501-4443**.

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

<table>
<thead>
<tr>
<th>Plan Provisions</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive and Diagnostic Services</td>
<td>Covered 100%</td>
<td>Reimbursement is subject to established plan schedule</td>
</tr>
<tr>
<td>Examinations, cleanings, X-rays, flouride, treatments, space maintainers, mouth guards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>Covered 100%</td>
<td>Reimbursement is subject to established plan schedule</td>
</tr>
<tr>
<td>Extractions, root canals, gum disease, oral surgery, anesthesia, pain relief, denture repair, tests, and lab exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td>Covered 100%</td>
<td>Reimbursement is subject to established plan schedule</td>
</tr>
<tr>
<td>Dentures, crowns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Annual Benefit</td>
<td>$1,200</td>
<td></td>
</tr>
</tbody>
</table>
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.

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**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](http://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 Employee member.

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.

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 the Healthcare FSA 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.

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, enter “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 myuhc.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.

If your medical expenses exceed 7.5% of your adjusted gross income and you itemize deductions, you may be better off deducting your expenses from your income tax rather than using the Healthcare FSA. You may want to consult with a tax 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.
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
- Parking at or near your residence
- Amounts exceeding the maximum allowable monthly limit

### 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](http://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.”
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
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](http://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, or five times your Annual Benefits Salary up to a maximum of $1,000,000, 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](http://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:

<table>
<thead>
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<th>Age</th>
<th>Monthly cost per $1,000</th>
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<tbody>
<tr>
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<td>35 to 39</td>
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<tr>
<td>40 to 44</td>
<td>0.072</td>
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<tr>
<td>45 to 49</td>
<td>0.094</td>
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<table>
<thead>
<tr>
<th>Age</th>
<th>Monthly cost per $1,000</th>
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</thead>
<tbody>
<tr>
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<td>60 to 64</td>
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<td>0.668</td>
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<tr>
<td>70 to 74</td>
<td>0.888</td>
</tr>
<tr>
<td>75 or older</td>
<td>1.148</td>
</tr>
</tbody>
</table>
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).

\[
\begin{align*}
\text{Amount of Optional Term Life insurance} & \quad \text{$120,000} \\
\text{Divide by 1,000} & \quad 120 \\
\text{Rate \@ age 41, from table (page 32)} & \quad \times \quad 0.072 \\
\text{Your total monthly premium} & \quad = \quad $8.64
\end{align*}
\]

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 $500,000 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](http://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](tel: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](tel:888-264-3057) for an application and eligibility criteria.
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](http://www.frontiermedex.com/about-us/contact-us.html)

Or write an email to FrontierMEDEX directly at: [operations@frontiermedex.com](mailto: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.
Tuition Programs

Columbia University offers members of 1199 SEIU United Healthcare Workers East SSA area (Medical Center) 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 “Print Your Tuition Benefits Eligibility Form.”

Tuition Exemption for 1199 SEIU United Healthcare Workers East SSA area (Medical Center) and their Dependents

The Tuition Exemption Benefit Program pays for tuition for you at Columbia University, Barnard College and Teachers College. This is not a reimbursement or remission program; the tuition is simply exempt. There is a two semester waiting period (7 months) to be eligible for this benefit.

As a full-time member of 1199 SEIU United Healthcare Workers East SSA area (Medical Center), tuition for certain degree programs is covered at 100%, for a certain number of credits each term.

Your spouse or same-sex domestic partner may also be eligible for the unused portion of your Tuition Exemption Benefit toward a Bachelor’s or Master’s degree program at Columbia only. There is a two semester waiting period (7 months) to be eligible for this benefit.

Your children may be eligible for the unused portion of your Tuition Exemption Benefit toward a Bachelor’s or Master’s degree program at Columbia only, after you have completed two (2) years of continuous service.
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 Columbia University Retirement Plan for Supporting Staff Association at the College of Physicians and Surgeons. 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 Columbia University Retirement Plan for Supporting Staff Association at the College of Physicians and Surgeons (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.

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 or call the Columbia Benefits Service Center at 212-851-7000 to speak to a Specialist.

Detailed Information: For details on the Voluntary Retirement Savings Plan (VRSP) and the Columbia University Retirement Plan for Supporting Staff Association at the College of Physicians and Surgeons, 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.

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.

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.

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 continuous benefits eligible service with the University after age 45.

Note: A spouse or dependent is only eligible to enroll if the retiree is a participant, or if the retiree is deceased. Eligible children are covered up through age 26 only if they are full-time students. Qualifying events must be reported within 60 days of the event.
Benefits Glossary for Support Staff of Columbia University

**Annual Benefits Salary** – Used to determine employees’ Life Insurance 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 benefits require such evidence if the employee has not elected the plans within 31 days of their eligibility date.

**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.
Contact Information

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  I  HR website: www.hr.columbia.edu

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<td><a href="http://www.humana.com/eap">www.humana.com/eap</a>; username: Columbia, pw: eap</td>
<td>888-673-1153</td>
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<td><a href="mailto:operations@frontiermedex.com">operations@frontiermedex.com</a></td>
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<td><a href="http://www.humemlath.com/find-a-doctor/directory">www.humemlath.com/find-a-doctor/directory</a></td>
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<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
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