COLUMBIA UNIVERSITY
HR Benefits

2016 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 physician 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) and Summary Plan Description (SPD) available online at http://hr.columbia.edu/forms-docs/search.

Benefit	Choice Plus 80		Choice Plus 90		Choice Plus 100	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Annual Deductible Individual Family	$400 per person	$600 per person	$200 per person	$600 per person	None	$600 per person
Coinsurance	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100%	60% after deductible
Out-of-pocket Maximum Individual Family	$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
Physician Office Visits, including specialists	$30 copay	60% after deductible	$30 copay	60% after deductible	$30 copay	60% after deductible
Laboratory/Radiology Services, including services rendered in a physician's office	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	80% after deductible	60% after deductible; Precertification required	90% after deductible	60% after deductible; Precertification required	$500 copay	60% after deductible; Precertification required
Outpatient Hospital Care	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	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	$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	$30 copay	70% after deductible	$30 copay	70% after deductible	$30 copay	70% after deductible
Emergency Room	$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)
Basic and Comprehensive Infertility Treatment	*Unlimited benefit for diagnosis and basic medical treatment, including artificial insemination*					

Benefit	Choice Plus 80		Choice Plus 90		Choice Plus 100	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
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	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).
** 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, the in-network deductible, coinsurance and medical and prescription copays accumulate toward the in-network out-of-pocket maximum.

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	Choice Plus Plans
	Benefits Apply Both In-Network and Out-of-Network
Routine Eye Exams	**Adults:** One exam every 12 months with a $10 copay **Children*:** One exam every 12 months with a $10 copay
Lenses	**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% every 12 months.

**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 UHC for reimbursement.

For a listing of vision providers, log in to **www.myuhc.com** and click "Benefits & Coverage," "Vision"' and then "Vision benefit highlights." You will be taken to the UHC vision website where you can search for a vision provider under "Find a Provider."