The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.Caremark.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 844-910-3902 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network Deductible $1,600 / Individual $3,200/ Family Out of Network Deductible $3,200 / Individual $6,400/ Family	
Are there services covered before you meet your deductible?	Yes. Preventive Care and primary care services with copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. List can be found at: http://www.caremark.com/portal/asset/Generics_Only_Preventive_DL.pdf
Are there other deductibles for specific services?	No	
What is the out-of-pocket limit for this plan?	Annual Out-of-Pocket Limit in Network $3,200 / Individual $6,400 / Family Annual Out-of-Pocket Limit in Network	Combined with medical out-of-pocket limit.

	$6,400/ Individual $12,800 / Family	
What is not included in the out-of-pocket limit?	Premiums, penalties, balance-billed charges, prescriptions this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of the retail and mail-order pharmacies, visit www.Caremark.com and use the "Locate Nearby Pharmacy" tool. A list of specialty pharmacies is also available.	
Do you need a referral to see a specialist?	See Medical Plan Summary	

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	See Medical Plan Summary	See Medical Plan Summary	
	Specialist visit	See Medical Plan Summary	See Medical Plan Summary	
	Preventive care/screening/ immunization	See Medical Plan Summary	See Medical Plan Summary	
If you have a test	Diagnostic test (x-ray, blood work)	See Medical Plan Summary	See Medical Plan Summary	
	Imaging (CT/PET scans, MRIs)	See Medical Plan Summary	See Medical Plan Summary	

* For more information about limitations and exceptions, see the plan or policy document at www.Caremark.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Caremark.com	Generic drugs	Retail: $5.00 Mail-Order (Up to 90-day supply): $10.00	Reimbursed at contracted in-network rate less co-pay	You pay 100% of the cost for prescriptions until you reach your annual deductible. You will pay copays until you reach your annual out of pocket maximum.
	Preferred brand drugs (For Caremark's Preferred Drug List, please access: https://www.caremark.com/portal/asset/Advanced_Control_Specialty_Performance_Drug_List.pdf	Retail: You pay 35% ($100.00 max.) Mail-Order (Up to 90-day supply): You pay 35% ($200.00 max.)	Reimbursed at contracted in-network rate less co-pay	You pay 100% of the cost for prescriptions until you reach your annual deductible. You will pay copays until you reach your annual out of pocket maximum. When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name drug and the generic drug plus the generic copayment. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, visit the HR Benefits Prescription page, or call Caremark at **1-844-910-3902**
	Non-preferred brand drugs	You pay 100%	You pay 100%	You pay 100% of the cost for prescriptions until you reach your annual deductible. You will pay copays until you reach your annual out of pocket maximum. When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name drug and the generic drug plus the generic copayment. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, visit the HR Benefits Prescription page, or call Caremark at 1-844-910-3902
	Specialty drugs	*PrudentRx drugs: $0 cost (If enrolled in PrudentRx) or 30% if not enrolled in	N/A	You pay 100% of the cost for prescriptions until you reach your annual deductible. You will pay copays until you reach your annual out of pocket maximum.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		PrudentRx. Specialty drugs that are not part of PrudentRx are $100.		Specialty drugs must be filled through the CVS Specialty Pharmacy (www.cvsspecialty.com). Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, visit the HR Benefits Prescription page, or call Caremark at 1-844-910-3902. *If enrolled in the PrudentRx Specialty Drug co-pay program, your co-pay will be reduced to $0.00 once your Deductible portion has been met.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See Medical Plan Summary	See Medical Plan Summary	
	Physician/surgeon fees	See Medical Plan Summary	See Medical Plan Summary	
If you need immediate medical attention	Emergency room care	See Medical Plan Summary	See Medical Plan Summary	
	Emergency medical transportation	See Medical Plan Summary	See Medical Plan Summary	
	Urgent care	See Medical Plan Summary	See Medical Plan Summary	
If you have a hospital stay	Facility fee (e.g., hospital room)	See Medical Plan Summary	See Medical Plan Summary	
	Physician/surgeon fees	See Medical Plan Summary	See Medical Plan Summary	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	See Medical Plan Summary	See Medical Plan Summary	
	Inpatient services	See Medical Plan Summary	See Medical Plan Summary	
If you are pregnant	Office visits	See Medical Plan Summary	See Medical Plan Summary	
	Childbirth/delivery professional services	See Medical Plan Summary	See Medical Plan Summary	
	Childbirth/delivery facility	See Medical Plan	See Medical Plan	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	services	Summary	Summary	
If you need help recovering or have other special health needs	Home health care	See Medical Plan Summary	See Medical Plan Summary	
	Rehabilitation services	See Medical Plan Summary	See Medical Plan Summary	
	Habilitation services	See Medical Plan Summary	See Medical Plan Summary	
	Skilled nursing care	See Medical Plan Summary	See Medical Plan Summary	
	Durable medical equipment	See Medical Plan Summary	See Medical Plan Summary	
	Hospice services	See Medical Plan Summary	See Medical Plan Summary	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- To find covered drugs visit https://www.cmu.edu/hr/benefits/health-welfare/prescription/index.html and use the applicable "check drug cost" link. You can also call Caremark at 1-844-910-3902 for assistance.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Maintenance Choice Program.
- Living My Life® Self-Management Program for Diabetes.

PrudentRx Specialty Drug Copay Program
Generic Preventative Drug list

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-877-881-6388 for the state insurance department, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the insurer at 1-855-497-8762. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the US Department of Labor, Employee Benefits Social Security Administration at 1-866-444-3272 or www.dol.gov/ebs/healthreform. For questions about your rights, this notice, or assistance you can contact your State Insurance Department at 1-877-881-6388. Additionally, a consumer assistance program can help you file an appeal.

Does this plan provide Minimum Essential Coverage? **Yes.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-910-3902.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-910-3902.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-910-3902.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-910-3902.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.Caremark.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$ 350
■ Specialist copayment	$ 35
■ Hospital (facility) coinsurance	20 %
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$35
Coinsurance	$2,490
What isn't covered	
Limits or exclusions	$2,875
The total Peg would pay is	**$0**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$350
■ Specialist copayment	$35
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work)*
Prescription drugs
Durable medical equipment (*glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$35
Coinsurance	$1,410
What isn't covered	
Limits or exclusions	$1,795
The total Joe would pay is	**$0**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$350
■ Specialist copayment	$35
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic test (*x-ray)*
Durable medical equipment (*crutches)*
Rehabilitation services (*physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$35
Coinsurance	$310
What isn't covered	
Limits or exclusions	$695
The total Mia would pay is	**$0**

Note: These "Coverage Examples" reflect medical and pharmacy coverage. Medical coverage is listed as a limit or exclusion for the purposes of the Coverage Examples. You must elect pharmacy coverage if you elect medical coverage.
Note: These numbers assume the patient is participating in Living My Life® Self-Management Program for Diabetes. If you have diabetes and do not participate in the program, your costs may be higher.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.