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2012 BENEFITS WORKBOOK

FOR DOMESTIC FULL-TIME EMPLOYEES

TAKE CHARGE OF YOUR BENEFITS

ENROLL ONLINE IN HR CONNECTION

http://www.cmu.edu/hr/benefits/hr_connection.html

For more information about 2012 benefits, go online to http://www.cmu.edu/hr/benefits.

Carnegie Mellon
HUMAN RESOURCES

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Need Assistance Understanding Your Benefits?

The Human Resources Benefits Office is available to assist you in understanding your benefit options and to help you enroll. To reach the Benefits Office:

- Send an e-mail to hrhelp@andrew.cmu.edu.
- Call the HR Benefits Office at 412-268-2047 Monday through Friday, from 8:30 a.m. to 5:00 p.m. for telephone assistance.
- Schedule a one-on-one enrollment session (20 minutes) with a Benefits Specialist. Call 412-268-2047 to schedule.
- View our website resources at http://www.cmu.edu/hr/benefits.
- Come to the Benefits & Fitness Fair during Open Enrollment. It is traditionally held on the first Wednesday of November in the University Center.

Coordination of Benefits

Individuals who are covered under another medical plan will have their Carnegie Mellon benefits coordinated with the benefits payable under the other plan. The benefits offered through one's employer take precedence over those in which they are covered as a dependent. No charges will be covered under more than one plan.

Make Elections Online Through HR Connection

To enroll in or change your benefits, use the online HR Connection self-service system. HR Connection is designed to be user-friendly. Follow the instructions and read all of the information on each screen. Note that rate information will be displayed PER PAY (biweekly or monthly). You may change the display (using the buttons in the upper right corner of the tables) to view annual rates.

HR Connection
Connect Now

1. Go to http://www.cmu.edu/hr/benefits/hr_connection.html and click on the HRC logo (see right).
2. You will need your Andrew user name and password, HR Connection password, Primary Care Physician codes (if enrolling in an HMO plan) and dependent data.

   If you forget or do not have an HR Connection password, please follow the online instructions.
3. Click on the name of the module that corresponds to the action you wish to complete: New Employee Enrollment, Open Enrollment, or Life Changes.
4. Contact the HR Systems Help Desk at hrit@andrew.cmu.edu with any technical problems.
5. If you exit the system in the middle of the module or are inactive for more than 20 minutes, your elections will be lost and you will need to start over.
6. **You must re-enter your HR Connection password to save your changes. If you exit without doing so, your changes will be lost.**

This is a Summary

This workbook contains summaries of the options provided in each benefit category. It is intended to help you choose among the available options. You may obtain additional information from the HR web site at http://www.cmu.edu/hr/. The web site also provides links to the carriers and plan booklets.

This booklet and our web resources are not intended to take the place of plan documents.

If there is a conflict between this workbook and the plan documents, the plan documents will govern. The Benefits Office maintains the Summary Plan Description (SPD), which contains more detailed information.

The SPD can be found online on the HR web site at http://www.cmu.edu/hr/benefits/benefit_admin/plans. Contact the Benefits Office at 412-268-2047 or by email to hrhelp@andrew.cmu.edu to obtain a hard copy of the SPD.

Carnegie Mellon reserves the right to modify, amend, or terminate any or all of the provisions of these benefits or the plan documents at any time for any reason upon appropriate action by the university. Notwithstanding any of the prior statements, in all cases, university policies will govern.

Healthy Solutions Benefits

Carnegie Mellon offers a broad range of benefit options under the Healthy Solutions umbrella. You can choose to participate in the medical, prescription drug, dental, and vision plans, as well as life and accidental death and dismemberment insurance, life insurance for dependents, and long-term disability insurance.

In addition, eligible employees can contribute to a health care flexible spending account and/or a dependent care reimbursement account to assist in managing eligible health care and dependent care costs.

The contributions for all of these benefits (except dependent life insurance) are deducted from your pay before taxes are assessed, saving you money!

Work-Life and Retirement Benefits

The university also provides many benefits for eligible faculty and staff that do not need to be selected during Open Enrollment.

Full-Time Work-Life Benefits That Do Not Require Open Enrollment Elections Include:

- Carnegie Mellon contributions into a 403(b) retirement account
- Employee supplemental retirement contributions into a tax-deferred or Roth retirement account
- Tuition benefits for employees and their children
- Paid time off, paid holidays and leaves of absence
- Child Care benefits (Cyert Center benefits and Child Care Search tool)
- Free use of the Allegheny County Port Authority Transit (PAT) system
- Discounts on Ford Motor Company and General Motors makes and models
- Ceridian LifeWorks employee assistance plan and life management resources
- Learning and Development programs
- Carnegie Mellon ID card (and the access and discounts associated with it)
- Financial benefits (WorkPlace Banking through PNC Bank and Citizens Bank, real estate services through Howard Hanna, wireless telephone services)

To learn more about these benefits and their eligibility requirements, go to the Human Resources web site at http://www.cmu.edu/hr/benefits.

Enrollment in Work-Life Benefit Programs

Enrollment in Work-Life Benefits is not necessarily automatic. You should apply for the benefit at the time you wish to take advantage of it, according to the procedures for that particular benefit program.

See the HR web site at http://www.cmu.edu/hr for more information on other benefit programs and their enrollment processes.

Who Is Full-Time Benefits Eligible

Full-time, benefits eligibility is granted to faculty, staff, Campus Police Association, or Teamsters Local 249 employees who:

- work at least 37.5 hours per week or 100% of a full-time schedule
- are in an active appointment of at least 4 consecutive months (serial appointments of less than four months each do not satisfy this requirement)

Eligible employees may also cover their eligible dependents under certain benefits. Eligible dependents include your:

- your spouse or registered domestic partner
- your children up to their 26th birthday
- your unmarried, dependent children of any age who, upon attainment of age 19, were covered under the particular benefit and were disabled as defined in the information provided by the third party administrator or insurance company

Part-time employees and those on an international assignment are eligible for different benefits, and should refer to the Benefits Workbook for their employment status.

New Employee Benefits Enrollment

New employees must enroll in benefits within 30 days of their hire date using HR Connection's New Employee module. Your choices will be in effect for the remainder of the calendar year, unless you experience a qualified life or family status change (see below).

Benefits Effective Date

If your hire date is the 1st of the month, your benefits effective date is the same. If your hire date is after the 1st, your benefits effective date is the 1st of the following month.

Default Benefits for New Hires

New hires who do not submit their benefit choices or "opt-out" decision within 30 days of their hire date are automatically enrolled in a default benefit plan. (See right.) In addition, until you complete the retirement plan application, university retirement contributions will be invested into an age-appropriate TIAA-CREF LifeCycle Account.

Default Benefits

The default benefit plan costs $33 per month and covers the employee only:

- Medical: UPMC PPO Option 2
- Prescription: Caremark Option B
- Life and AD&D Insurance: Basic
- Long-Term Disability Insurance: Basic

You will not be enrolled in dental, vision, supplemental life, dependent life, or either spending account.

New eligible employees will also be defaulted to a TIAA-CREF LifeCycle Fund for their university retirement contributions, with no employee supplemental contributions.

Enrolling In Benefits at Open Enrollment

Each year, Open Enrollment (OE) provides you the opportunity to review your benefits coverage and make new elections, if desired, for the upcoming calendar year.

If you do not actively select your benefits for the upcoming year, you will be enrolled in the same benefit plans at the same level of participation that you have in the current year, with the exception of either flexible spending account. (You must actively enroll in the spending accounts each year to participate.)

Elections made during Open Enrollment will become effective the following January 1 and will remain in effect for the entire calendar year. **Unless you experience a qualified life or family status change (see below), Open Enrollment is the only time during the year when you may change your benefit elections.**

Life/Family Status Changes During the Year

Family or life changes sometimes require you to change your benefits. Following IRS regulations, you can make changes consistent with your status change within 30 days of the date the status change occurred.

- In most circumstances, you may not change the benefit carrier or option (e.g. UPMC to Highmark, or PPO Option 2 to PPO Option 1), but you may modify the level of your coverage (e.g. employee and spouse to family coverage).
- Changes must be made within 30 days of the status change. If you miss the 30 day period, you must wait until the next Open Enrollment to make changes.
- Changes should be made using HR Connection's Life Changes module (see page 3).
- Supporting documentation - such as a birth certificate, marriage license, or proof of new coverage - is required to verify a status change.

See page 20 for a list of qualifying life or family status changes that permit you to make benefit changes mid-year.

Medical

You can select medical plans offered by UPMC, Highmark or HealthAmerica. To be sure your current provider is in a particular carrier's network, contact the carrier or provider directly or look online.

Preferred Provider Organization (PPO) Plans

(Available from UPMC and Highmark)

PPO plans give you the flexibility to use in- or out-of-network providers without referrals. A higher level of benefits is provided when in-network providers are used, resulting in lower out-of-pocket costs for you.

High-Deductible PPO with HRA Plans

(Available from UPMC and Highmark)

Carnegie Mellon funds a Health Reimbursement Account that you can use to help pay for eligible health care expenses. Once your health care expenses for the year exceed your deductible, the PPO plan begins paying benefits. You will pay out-of-pocket for any charges that exceed your HRA balance before the deductible is satisfied. Unused HRA funds can be rolled over to the following year, up to a maximum of three years' accumulation.

Health Maintenance Organization (HMO) Plan

(Available from HealthAmerica)

HMOs have low out-of-pocket expenses, but do not provide benefits if you use out-of-network providers. You will select a primary care physician (PCP) who will help coordinate your care, although referrals are not required in most circumstances.

Comprehensive (Indemnity) Plan

(Available from Highmark)

This plan makes no distinction between in-network and out-of-network providers – the plan pays the same for all services. However, non-participating providers have not agreed to accept the insurance reimbursement as payment in full and can bill you for their additional charges.

Opting Out of Coverage

You can opt out of Carnegie Mellon medical coverage. Individuals are strongly encouraged to enroll in one of our plans if they are not covered under another policy.

Preventive Care Benefits

Our plans pay 100% of in-network adult and pediatric preventive care services, according to the carriers' preventive care schedule. No copay, deductible or coinsurance is required.

Couples Working for Carnegie Mellon

Individuals can only be covered under one Carnegie Mellon plan at a time. Each person may have their own coverage and cover different dependents.

Residing Outside of Western PA

Highmark and UPMC have affiliated U.S. networks outside of the Pittsburgh area. Employees located outside of Western PA may not select the HealthAmerica HMO. Employees on an international appointment are eligible for coverage through our international benefits plan.

Medical Insurance Terms and Features to Understand

Network: The providers (doctors, hospitals, facilities) that have contracted with an insurance carrier to accept that insurance plan's rates as payment-in-full.

Deductible: The amount you must pay each year before coinsurance payments will be made by the plan. Deductibles vary. Plans with out-of-network coverage have separate deductibles for in-network and out-of-network services, except for the Comprehensive plan.

Copay: An amount you must pay up front for in-network office visits. The copay does not count toward the deductible or out-of-pocket maximum.

Coinsurance: The percentage of covered expenses that the plan will pay, after you have met your deductible. You pay the rest, up to an annual out-of-pocket maximum.

Out-of-Pocket Maximum: The amount you would pay in coinsurance and deductibles for covered expenses in a year before the plan will cover 100% of services (excluding copays). Plans with out-of-network coverage have separate maximums for in-network and out-of-network services, except for the Comprehensive plan.

Usual, Customary & Reasonable (UCR): The fees set by carriers that reflect typical rates for services in your area. In-network providers agree to accept the plan's UCR as payment in full; out-of-network providers may bill you for their charges in excess of the plan's UCR.

2012 Medical Plan Comparison

Plan Feature	PPO Option 1	PPO Option 2	PPO Option 3	High Deductible PPO with HRA	HMO	Comprehensive
Carrier Choices	Highmark, UPMC	Highmark, UPMC	Highmark, UPMC	Highmark, UPMC	HealthAmerica	Highmark
Annual Deductible (Indiv/Family)[1, 2]						
- In-Network Provider	$250 / $500	$250 / $500	$500 / $1,000	$1,000 / $2,000	$0 / $0	$500 / $1,000
- Out-of-Network Provider	$500 / $1,000	$500 / $1,000	$1,000 / $2,000	$2,000 / $4,000	Not covered	
Annual Out-of-Pocket Max (Indiv/Family)[2]						
- In-Network Provider	Deductible only	$1,500 / $3,000	$3,000 / $6,000	$4,500 / $9,000	None	$2,500 / $5,000
- Out-of-Network Provider	$3,000 / $6,000	$3,000 / $6,000	$4,500 / $9,000	Unlimited	Not covered	
Plan Coinsurance Responsibility	(After deductible.)	(After deductible.)	(After deductible.)	(After deductible.)	(After deductible.)	(After deductible.)
- In-Network Provider	100%	80%	80%	80%	100%	80%
- Out-of-Network Provider	60% of UCR[3]	60% of UCR[3]	60% of UCR[3]	60% of UCR[3]	Not covered	80% of UCR[3]
Carnegie Mellon HRA Contribution						
Individual Coverage/Family Coverage	Not applicable	Not applicable	Not applicable	$250 / $500	Not applicable	Not applicable
Physician Visit (Copay/Coinsurance)						
In-Network						
- Office Visit: Primary Care / Specialist	$20 / $35	$20 / $35	$20 / $35	80%	$15 / $30	80%
- Preventive Care (per schedule)[2]	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
- ER Visit (waived if admitted)	$50	$50	$50	80%	$50	80%
Out-of-Network						
- Primary Care and Specialist Office Visit	60% of UCR[3]	60% of UCR[3]	60% of UCR[3]	60% of UCR[3]	Not covered	80% of UCR[3]
- Preventive Care	60% of UCR[3]	60% of UCR[3]	60% of UCR[3]	60% of UCR[3]	Not covered	80% of UCR[3]
- ER Visit (waived if admitted)	$50	$50	$50	80%	$50	80% of UCR[3]
Primary Care Physician Required	No	No	No	No	Yes	No

[1] - The deductible and copay do not apply when adult or pediatric preventive care is performed according to the carrier's schedule. If tests or lab work that are not on the plan's preventive care schedules are performed, the individual's portion of the cost will be applied to the deductible.

[2] - The deductible and out-of-pocket maximum are tracked separately for in- and out-of-network services under all plans, except the Comprehensive plan.

[3] - UCR = usual, customary, and reasonable charges the carrier has established for medical services. Out-of-network providers may bill you for their charges in excess of the UCR. Expenses in excess of the UCR ***do not*** count toward the out-of-pocket maximum.

Medical Insurance Employee Contribution

These medical plan rates do NOT include the cost of prescription drug coverage. See the next page for prescription drug insurance rates.

To calculate your total coverage costs, add together the rates for the medical plan you have selected and the prescription drug coverage you have chosen.

Please note that you must cover the same set of individuals under both your medical and prescription drug coverage. In other words, if you elect to cover yourself and one child under your medical plan, then you must cover yourself and that same child under your prescription drug plan.

All plans will give you a choice of two prescription plans through Caremark.

The biweekly and monthly rates listed below are deducted from your pay before taxes are assessed.

IRS regulations require that the amount you contribute to cover a domestic partner and the amount Carnegie Mellon contributes for that domestic partner coverage must be taxed, unless your partner can be claimed as a dependent on your taxes (see page 19).

Medical Coverage: Biweekly/Monthly Employee Contributions for 2012

Coverage Level	PPO 1	PPO 2	PPO 3	High Deduct. with HRA	HMO	Comprehen.
Employee						
Highmark	$55.50 / $111	$37.00 / $74	$22.50 / $45	$19.00 / $38	N/A	$182.00 / $364
HealthAmerica	N/A	N/A	N/A	N/A	$9.50 / $19	N/A
UPMC	$29.50 / $59	$13.00 / $26	$4.50 / $9	$1.00 / $2	N/A	N/A
Employee & 1 Child						
Highmark	$132.00 / $264	$100.00 / $200	$75.50 / $151	$62.50 / $125	N/A	$350.50 / $701
HealthAmerica	N/A	N/A	N/A	N/A	$52.50 / $105	N/A
UPMC	$87.50 / $175	$55.50 / $111	$39.00 / $78	$22.50 / $45	N/A	N/A
Employee & 2+ Children						
Highmark	$153.50 / $307	$118.50 / $237	$91.00 / $182	$76.00 / $152	N/A	$399.00 / $798
HealthAmerica	N/A	N/A	N/A	N/A	$65.50 / $131	N/A
UPMC	$104.00 / $208	$68.50 / $137	$48.50 / $97	$30.00 / $60	N/A	N/A
Employee & Spouse/DP						
Highmark	$175.50 / $351	$136.50 / $273	$106.00 / $212	$89.50 / $179	N/A	$447.50 / $895
HealthAmerica	N/A	N/A	N/A	N/A	$78.50 / $157	N/A
UPMC	$120.50 / $241	$81.50 / $163	$58.50 / $117	$38.00 / $76	N/A	N/A
Family						
Highmark	$262.00 / $524	$208.50 / $417	$166.50 / $333	$144.00 / $288	N/A	$639.00 / $1278
HealthAmerica	N/A	N/A	N/A	N/A	$130.50 / $261	N/A
UPMC	$186.50 / $373	$132.50 / $265	$97.00 / $194	$69.00 / $138	N/A	N/A

Prescription Drugs

Caremark is our prescription drug carrier. The prescription coverage provides access to numerous chain and independent pharmacies. It also provide mail order service for maintenance medications to help control costs for you and Carnegie Mellon.

The options differ by: employee contribution rates, copays/coinsurance rates, and coverage for non-formulary drugs.

Prescription and Medical Coverage Go Together

If you enroll in one of Carnegie Mellon's medical insurance options, you MUST enroll in a prescription drug plan and cover the same individuals as your medical plan. You must select the same prescription option for all individuals who are being covered.

- Participants in all medical plans must elect a Caremark option.
- If you opt out of Carnegie Mellon's medical coverage, you may not enroll in Carnegie Mellon's prescription drug coverage.
- The Health Care FSA (see page 14) can be used to pay for eligible out-of-pocket prescription costs using pre-tax dollars.
- Caremark participants can save 20% on over-the-counter, CVS-brand health-related items with their ExtraCare Health card. (Call 1-888-543-5938 for more information.)

Using Rx Benefits at a Retail Pharmacy

When you need to (re)fill a prescription at a participating pharmacy, present your ID card to the pharmacist along with your prescription. You'll pay the designated copay or coinsurance.

If you do not present insurance information at the time of your purchase, you may be required to pay for the medicine in full and later file for reimbursement.

Estimate Your Costs

The Caremark web site includes a Drug Pricing Tool to help you anticipate a medication's cost and your coinsurance/copay.

2012 Prescription Drug Plan Comparison - Participant Copays/Coinsurance

	Caremark Option A	Caremark Option B
Retail (Up to 30-day supply)		
Generic (automatic substitution)	$10	$5
Brand - Formulary (no generic available)	$20	35% ($100 maximum)
Brand - Formulary (generic available)	$25	35% ($100 maximum)
Brand Name - Non-formulary[1]	$40[1]	Not Covered[1]
Mail Order (Up to 90-day supply)		
Generic (automatic substitution)	$20	$10
Brand - Formulary (no generic available)	$40	35% ($200 maximum)
Brand - Formulary (generic available	$50	35% ($200 maximum)
Brand Name - Non-formulary[1]	$80[1]	Not Covered[1]
Annual Out-of-Pocket Maximum *(separate from medical plan)*	None	$1,500 individual / $3,000 family

[1] - If a non-formulary medication is deemed medically necessary, it will be covered at the applicable "Brand - Formulary" level.

Prescription Drug Coverage: Biweekly/Monthly Employee Contributions for 2012

Coverage Level	Caremark Option A	Caremark Option B
Individual Employee	$ 15.50 / $ 31.00	$ 3.50 / $ 7.00
Employee and Child	$ 35.00 / $ 70.00	$ 14.50 / $ 29.00
Employee and Children	$ 40.50 / $ 81.00	$ 17.50 / $ 35.00
Employee and Spouse/DP	$ 46.00 / $ 92.00	$20.50 / $ 41.00
Family	$ 68.00 / $ 136.00	$ 33.00 / $ 66.00

Maintenance Medications: Mail Order Services

Caremark provides mail order services for medications you will be taking for more than two months. When you order long-term use medications through mail order, you get a 90-day supply for the cost of a 60-day supply.

You can't beat the convenience of mail order: your pharmacy is as close as your phone or computer! You can also place orders by mail. And since you get a 90-day supply, you only need refills every few *months*, instead of every few weeks.

Mail Order Prices at Retail CVS/pharmacy Locations through Caremark

Caremark participants who register for the **Caremark Maintenance Choice** program can receive *90-day supplies* of their ongoing medications at *mail order rates* from retail CVS/pharmacies. Maintenance Choice participants are *not assessed the MMPP penalty* (see below) when using CVS/pharmacies through this program.

Maintenance Medication Prescription Plan (MMPP)

Using a retail pharmacy for ongoing prescriptions costs both you and the university more. **Under the MMPP, if you repeatedly use retail pharmacies to fill the same prescription, you will incur a penalty.** The first three times you go to the retail pharmacy to fill the same medication, you will only pay the retail copays/coinsurance. **Beginning with the fourth fill at a retail pharmacy, in addition to your copay, you will also be charged the difference in price between the retail cost and the mail-order cost of the medication.** The Caremark MMPP applies to all medications designated as "maintenance" medications. This penalty does not apply for Caremark Maintenance Choice participants using a retail CVS/pharmacy for 90-day supplies (see above).

Prescription Drug Insurance Terms and Features to Understand:

Formulary: a list of medications that have been selected for treating various symptoms or conditions. The medications on the formulary list are selected based on effectiveness, cost, and demand, and are covered at a higher level. The formulary list can be modified at any time by the carrier; refer to the web site for the most up-to-date formulary list.

Generic Drugs: medically-equivalent drugs manufactured by a pharmaceutical company after the patent has expired on the original manufacturer's brand-name medication. Generic drugs have been tested by the FDA to ensure that they contain equivalent active ingredients. The prescription plans require that generic drugs be automatically substituted for brand-name medications, when available, as they are generally much less expensive.

Medical Necessity Waiver: a form submitted by your physician to Caremark that allows an individual to bypass normal plan requirements. Medical necessity waivers should be submitted and approved by the plan in advance of going to the pharmacy.

Non-formulary waivers: medications not on the formulary list can be covered at the brand-name formulary level, if they are medically necessary. Your physician must submit a medical necessity waiver in advance, demonstrating why the non-formulary medication must be used (and/or why the formulary alternatives should not be used).

Generic drug substitution waivers: brand name medications that have a generic equivalent can be used if they are deemed medically necessary. Your physician must submit a medical necessity waiver in advance, demonstrating why the brand-name medication must be used (and/or why the generic alternative should not be used).

Prescriptions for Mail Order

The prescription should be written for a 90-day supply (not 30 days), with refills.

Be sure the prescription is signed and written legibly.

New prescriptions take up to two weeks (refills are usually faster). Request samples or a script for a short-term supply to tide you over.

Bridge Supplies

Caremark participants who want to use mail order, but need a refill immediately can call 1-877-347-7444 to request a 5-day bridge supply from a CVS/pharmacy.

Participating Pharmacies

Thousands of chain and independent pharmacies participate in the network. See http://www.cmu.edu/hr/benefits/benefit_programs/prescription/index.html for a link to a pharmacy locator.

Going Out Of Network

Caremark participants who use an out-of-network pharmacy must pay for the medicine and then submit for reimbursement. The refund will be the network cost minus your responsibility.

Dental

United Concordia Companies, Inc. (UCCI), a subsidiary of Highmark Blue Cross/Blue Shield, is the administrator of our dental program. Carnegie Mellon offers three dental options to fit your family's needs: two dental PPO plans and a dental HMO plan.

Keeping Your Teeth and Your Body Healthier

- The PPOs include the Smile for Health program, which provides maternity dental benefits and enhanced oral disease detection and prevention benefits.
- Preventive services do not apply to the annual maximum in the PPO plans, so there's no reason to skip annual exams and cleanings.

Dental Options: Biweekly/Monthly Contributions for 2012

Coverage Level	DHMO Rates	PPO 1 Rates	PPO 2 Rates
Individual	$ 5.83 / $ 11.66	$ 5.83 / $ 11.66	$ 14.04 / $ 28.08
Family	$ 23.46 / $ 46.92	$ 20.80 / $ 41.60	$ 44.97 / $ 89.94

Dental Options - Coverage[1] Highlights for 2012

	DHMO[2]	PPO Option 1[1]	PPO Option 2[1]
Deductible (individual/family)	None	$50 / $150	$25 / $75
Class I Services:[3] ***Cleanings and Exams*** (DHMO: once in any 6 consecutive months; PPO: 2 per calendar year) ***Bitewing X-rays*** (DHMO: to age 14, once in any 6 consecutive months & age 14+, once per 12 consecutive months; PPO: 2 per calendar year, any age) ***Full Mouth X-rays*** (once per 3 years) ***Fluoride Treatment*** – to age 19 (DHMO: once every 6 consecutive months; PPO: 2 per calendar year)	100%[2]	100%	100%
Class II Services:[3] (fillings, root canals, periodontics, oral surgery)	96%[2]	50% (includes white fillings)	80% (includes white fillings)
Class III Services:[3] (prosthetics, crowns, inlays, onlays)[3]	54%[2]	25%	50% (includes implants)
Class IV Services: Orthodontics[3]	40%[2] (children only)	Not Covered	50% (includes adults)
Annual Maximum (excludes diagnostic and preventive services, and orthodontics & implants)	None	$1,000	$1,500
Lifetime Maximum: Orthodontics / Implants	None / N/A	N/A	$1,500 / $3,000

[1] - In-network and out-of-network services will be paid at the same rate, although out-of-network providers may bill you for their charges in excess of UCCI's rates.

[2] - **The percentages under the DHMO are approximations.** A member copayment schedule outlines the covered service and its copayment.

[3] - See the plan's schedule of benefits for information on the permitted schedule of covered services.

Dental PPO vs HMO

The DHMO requires co-payments with no deductible, coinsurance, or annual maximum. A primary care dentist and referrals are required. You must use participating providers. You must be in Western PA to participate in the DHMO.

The PPOs charge a deductible and coinsurance for covered services. You may use out-of-network providers, but they may charge you for costs above the rates established by UCCI.

Concordia Networks

- The PPO plans utilize the Advantage PLUS network.
- The DHMO uses the DHMO Concordia Plus network. You must pre-select a participating primary care dentist, or one will be assigned to you based on your home address.

Search the networks online at: http://www.ucci.com.

Pre-Determine Benefits

Ask your dentist to request a pre-determination of benefits for treatments with anticipated charges of $300+. This will confirm how much the plan will cover and what you will owe before treatment begins.

Basic HMO Benefits

Our HealthAmerica HMO plan provides some dental care discounts. Review the HMO benefits summary for more information on these discounts.

Vision

The administrators of our vision options are Davis Vision (a subsidiary of Highmark Blue Cross/Blue Shield), and Vision Benefits of America (VBA). There are four vision options, which are designed to give you flexibility in choosing your coverage.

The options and vendors differ based on:

- coverage levels for various services and products,
- frequency of covered services,
- network of participating providers, and
- process for obtaining services.

Vision Care: Biweekly/Monthly Contributions for 2012

Coverage Level	Davis Option 1	Davis Option 2	VBA Option 1	VBA Option 2
Individual	$ 0.50 / $ 1.00	$ 2.00 / $ 4.00	$ 0.57 / $ 1.14	$ 2.00 / $ 4.00
Family	$ 3.00 / $ 6.00	$ 8.25 / $ 16.50	$ 3.44 / $ 6.88	$ 8.25 / $ 16.50

Obtaining Vision Care

Davis Vision Participants

- Make an appointment with a participating vision care provider.
- During your appointment, simply show your Davis Vision ID card to the provider, who will then submit a claim to Davis Vision.
- When using a non-participating provider, pay for the service in full and then submit a claim for reimbursement of eligible expenses at the out-of-network level.

Vision Benefits of America (VBA) Participants

Many VBA providers can submit electronic claims, so that participants do not need to request a benefit form in advance. The VBA web site (www.visionbenefits.com) provides information about providers equipped for electronic claims.

When using providers without the ability to file electronic claims, VBA participants must request a benefit form before seeking services from a participating provider. **If you do not get a benefit form prior to your appointment, the visit will be considered out-of-network.**

- Request a benefit form from the VBA web site or by calling 1-800-432-4966 *before making an eye appointment.* A personalized benefit form will be mailed to you within a few days.
- You may also pick up a benefit form and VBA Participating Provider list in person at the South Hills VBA office by calling and requesting it in advance.

When using out-of-network services, pay for the service in full at the appointment. Then, request and submit a benefit form and itemized receipts to VBA for out-of-network reimbursement.

Check the Networks

Check both the Davis Vision and VBA networks online to see which providers participate in each plan. You can also call your providers and ask if they participate in either of the plans.

Benefits Schedule

The coverage comparison chart shows how each plan covers many of the most commonly used features. You should review the schedule of benefits for each plan for a more complete listing of covered and non-covered services, and to see how the plans reimburse out-of-network services.

Davis Vision and VBA Added Features

- Laser vision correction discount
- Blended, no-line bifocals (aka - Progressive Lenses)
- Polycarbonate lenses (restrictions apply)

Davis Vision and VBA offer other various features. Please see the plan summaries for more information.

Basic HMO Benefits

Our HealthAmerica HMO plan includes limited vision care discounts. Review the HMO benefits summary for more information on these discounts.

2012 Vision Care Options[1] - In-Network Plan Highlights

Vision Benefit	Davis Option 1:	VBA Option 1:	Davis Option 2:	VBA Option 2:
Frequency	**From date of last service:**	**Per calendar year(s):**	**From date of last service:**	**Per calendar year:**
Eye exams, lenses, contacts	24 months for ages 19+ 12 months through age 18	Once per 2 years, age 19+ Once per year, thru age 18	12 months for all	Once per year for all
Spectacle Frames	24 months for all	Once per 2 years for all	12 months for all	Once per year for all
Eye Examination				
Eye exam with dilation	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Contact lens evaluation and fitting	Paid in Full	See Contact Lens allowance below.[2]	Paid in Full	See Contact Lens allowance below.[2]
Spectacle Lenses (patient pays:)	***Patient Pays:***	***Patient Pays:***	***Patient Pays:***	***Patient Pays:***
All ranges of prescriptions and sizes	$0	$0	$0	$0
Polycarbonate lenses[3]	$0 / $35/[3]	$0 for all	$0 / 35/[3]	$0 for all
Oversize lenses	$0	$0	$0	$0
Specialty Lens Options[1]				
Standard Progressive Addition Lenses	$65	Available starting at $45	$0	Available starting at $45
Gradient tinting, ultraviolet coating	$15	$12	$15	$12
Scratch resistant coating	$20	$0	$20	$0
Blended bifocals	$20	$0	$20	$0
Corning photochromatic lenses	$20	$18 / $28	$20	$18 / $28
Standard anti-reflective coating (ARC)	$40	$40	$40	$40
Frames				
Retail	$60 allowance	$40 wholesale allowance (approx $80-$105 retail value)	$100 allowance	$60 wholesale allowance (approx $120-$160 retail value)
Exclusive Collection of Frames		Frames available at discounted prices.		Frames available at discounted prices.
Fashion (up to $100 retail value)	Paid in full		Paid in full	
Designer (up to $175 retail value)	Patient pays $20		Patient pays $20	
Premier (up to $200 retail value)	Patient pays $40		Patient pays $40	
Contact Lenses				
Elective Allowance	$75[4] allowance	$140[2] allowance (includes lenses, exam and fitting)	--	$160[2] allowance (includes lenses, exam and fitting)
Disposables	--		$120 allowance	
Conventional	--		$110[5] allowance	
Medically Necessary (prior approval)	Included	UCR	Included	UCR

[1] - For plan payments for other specialty options, out-of-network reimbursement schedule, or value added features, see the HR web site for links to additional information and the carriers.

[2] - VBA contact lens allowance is applied to *all* services, including the contact lens exam, fitting and/or lenses.

[3] - In Davis Vision plans, polycarbonate lenses covered in full for dependent children, monocular patients, and patients with prescriptions >= +/- 6.00 diopters.

[4] - Can be applied toward disposable or speciality contact lenses (including extended wear, hard/soft bifocal and gas permeable lenses).

[5] - Including, but not limited to, hard/soft daily wear, bifocal, toric and gas permeable.

Using an HCFSA with the HRA Health Plan

If you select a High Deductible PPO with HRA health plan, expenses that may be covered by both an HRA or an HCFSA should be submitted to your HCFSA first.

Only when your HCFSA account has been completely depleted should claims be submitted to your HRA. HRA funds can roll over to the next year, so it is better to have excess funds in your HRA than to forfeit unclaimed money from your HCFSA account.

Estimating Health Care Expenses

Review the list of eligible expenses to ensure you know which expenses can be reimbursed.

The best predictor of future health care use is previous usage patterns. Your current health, Rx, dental and vision carriers' web sites or customer service department can provide you with a summary of your plan usage over the last year.

To estimate your expenses in 2012, consider the following:

- Copays for office visits
- Deductibles and coinsurance
- Eligible expenses that are not covered by insurance
- Expenses that exceed the plan maximum
- Anticipated major expenses: surgeries, hospital stays, braces, etc.

Health Care Flexible Spending Account

Health Care Flexible Spending Accounts (HCFSA) allow you to set aside pre-tax money to pay for qualified health care expenses not otherwise covered by insurance. You will not pay taxes on the portion of your income that goes into these accounts, saving you a significant amount.

The HCFSA is administered by Benefit Coordinators Corporation (BCC). You must enroll annually to participate in the HCFSA—previous year contributions will not roll over to the next year at Open Enrollment.

You may contribute up to $5,000 in 2012, or as little as $60. (Note that the maximum contribution is expected to decrease to $2,500 in 2013, as per federal law.) You are not required to participate in other Carnegie Mellon benefits to enroll in the HCFSA.

Eligible expenses may be incurred by you or your dependents. However, *the IRS prohibits the use of an HCFSA to cover the health care expenses of a domestic partner who cannot be claimed as a dependent on your federal taxes.*

The amount you defer during 2012 will be available to reimburse eligible expenses incurred during both the calendar year and a 2.5–month grace period (January 1, 2012–March 15, 2013). In order to be reimbursed, eligible expenses must be submitted by June 30, 2013 with the appropriate documentation, if required.

How the Account Works: Using a Debit Card for Most Claims

- Estimate your out-of-pocket health care expenses for the upcoming plan year. Throughout the year, you'll contribute money to your account on a pre-tax basis.
- As you incur eligible health care expenses, you will use the debit card to pay for them. The card works just like a standard debit/credit card. The expenses will be deducted from your account balance.
- BCC will notify you if explanatory documentation is needed to substantiate the claim. Most expenses will not require documentation.
- For providers who do not accept debit/credit card payment, you will need to pay for expenses out of your own pocket. You will then need to submit a paper claim for reimbursement with the money in your account.

Estimate Carefully: Use It or Lose It!

IRS rules state that any contributions that you don't use for expenses incurred in the plan year will be forfeited. Estimate carefully and only put money into your account that you are sure you will use.

What Expenses Are Covered? Highlights of Eligible HCFSA Expenses

In order to estimate accurately, you need to know what services/expenses are eligible for reimbursement. See the following document for a complete list:

IRS publication #969: http://www.irs.gov/pub/irs-pdf/p969.pdf

Some examples of expenses that may be covered include:

- Deductibles, coinsurance and copays under the medical, Rx, dental, and vision plans. (*Not health plan contributions, as they are deducted pre-tax.*)
- Expenses beyond the coverage limit or some services not covered by the plan.
- Amounts you are billed when seeking care from an out-of-network provider.
- Medical supplies, such as band-aids, contact lens supplies, and equipment.
- Fertility treatments, childbirth classes, or sterilization procedures.
- Out-of-pocket orthodontia expenses.

Long-Term Disability Insurance

Long-term disability (LTD) insurance replaces a portion of your income and continues contributions to your retirement plan if you sustain an illness or injury that prevents you from working for more than 180 days.

The program, administered by MetLife, offers two levels of LTD coverage. (Basic LTD is provided at no cost to you by default.) Both levels of LTD insurance use the same definition of disability.

- **Basic LTD** provides 60% of your monthly base salary, up to a maximum benefit of $15,000 per month. There is no employee charge for Basic LTD.
- **Enhanced LTD** provides 60% of your monthly base salary and makes a cost-of-living adjustment (COLA) of 5% a year, for up to 10 years. After 10 COLA increases, your benefit amount will remain fixed. (*NOTE: Those age 55 and older do not receive 10 COLA increases due to limitations in maximum benefits duration. Enhanced LTD is not applicable to individuals age 69+.*)
- The cost for the Enhanced LTD benefit is based on your salary. For each $100 of annual salary, your cost will be $0.06 per year.

  Example: someone with an annual salary of $50,000:

  (50,000 ÷ 100) x $0.06 = $30.00 per year

  $30 ÷ 12 = $2.50 per month / $30 ÷ 24 = $1.25 per biweekly pay

Deciding If You Need Enhanced LTD Coverage

When deciding between Basic or Enhanced LTD, consider the following issues:

- *If I were to become disabled, would I/my family have other income to provide for basic needs?*
- *How much income is sufficient to meet my needs or that of my family?*
- *Do I have other benefits that would pay me if I became disabled?*
- *How would these additional benefits affect my LTD payments? (see right)*
- *How many years could I receive LTD payments - how many COLA increases could I receive? (see chart at right)*
- *How likely am I to become disabled - what is my tolerance for that risk?*
- *What is 5% of the monthly benefit (60% of my monthly salary)? Is the additional expense worth it to me for that increased benefit?*

Coverage Before LTD Begins:

LTD benefits will not be paid until you have been disabled for 180 days. The Short-Term Disability (STD) program provides benefits for non-work-related illnesses or injuries that last from 7 to 180 days. STD provides 60% of your base salary. All full-time faculty, staff and CPA are automatically covered under the STD program as of their benefits-eligibility date.

Workers' Compensation (WC) provides benefits for work-related illnesses and injuries. If you remain disabled for more than 180 days, you may apply for LTD benefits. Your LTD benefits will be offset by any WC benefits you may be receiving. All employees are automatically covered under WC from their date of hire.

For more information on the Short-Term Disability or Worker's Compensation plans, go to the Human Resources web site at http://www.cmu.edu/hr/benefits.

Waiting Period

You are eligible for LTD coverage when you have completed one year of full-time service at Carnegie Mellon, unless you provide proof that you had previous LTD coverage within three months of your hire. Your election will take effect at the end of the waiting period.

If you elect Enhanced LTD, the contribution will not be taken from your pay until your coverage actually takes effect.

Taxes, Other Policies & Payments

LTD benefit payments are considered taxable income.

LTD benefits are offset by social security, worker's compensation, or other state/group disability payments you receive, up to the maximum for your option. (The benefit will be at least $50/month.) Benefits are not affected by payments from any individual disability policy you have purchased.

Maximum LTD Benefit Duration

Age when disability began	Maximum benefit duration
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Life and AD&D Insurance

FREE Basic Life and AD&D Insurance

Carnegie Mellon provides, *at no cost to you,* basic life insurance coverage equal to your annual base salary, rounded up to the nearest thousand. You may opt out of the university's free basic life insurance coverage.

Supplemental Life and AD&D Insurance

You may purchase Supplemental Life Insurance, from 1 to 4 times your annual base salary, up to a maximum benefit of $1 million (basic and supplemental combined).

Supplemental insurance is available at age-related rates (see chart, right). The amount of Supplemental Insurance that you purchase will determine the amount of dependent life insurance you can get for your spouse/ domestic partner and is required to participate in dependent child life insurance (see next page).

Accidental Death & Dismemberment

The life insurance benefit includes an accidental death and dismemberment component. If your death is the result of an accident, your beneficiary will receive double the insurance amount. Certain amounts are also paid if you lose a limb or certain vital functions in an accident.

Supplemental Life/ AD&D Monthly Rate

Age (as of Jan 1, 2012)	Rate for each $1,000/month
Under 30	$0.070
30 - 34	$0.083
35 - 39	$0.089
40 - 44	$0.101
45 - 49	$0.112
50 - 54	$0.177
55 - 59	$0.255
60 - 64	$0.411
65 - 69	$0.687
70 and over*	$1.389

* Coverage for those age 70+ are actuarially reduced.

Statement of Health (SOH)

High levels of life insurance require you to demonstrate your good health by completing a Statement of Health (SOH). The SOH is a detailed medical questionnaire, though a medical exam may also be required. If a SOH is required, you will be covered at your previous level (or the guaranteed issue) until the SOH has been approved. You will only be charged for the coverage you are receiving. Approval is determined by MetLife in accordance with its guidelines.

- Basic life insurance coverage never requires a SOH.
- Supplemental insurance of more than $500,000 will require a SOH.

Imputed Income Tax

The value of life Insurance greater than $50,000 is taxable by the IRS. This is known as "imputed income." The IRS calculates the value of group life insurance using "uniform premium levels" based on your age and the amount of coverage you have (see chart, right).

Carnegie Mellon is required to withhold federal taxes based on the *value* of your life insurance coverage in excess of $50,000. To reduce your tax liability, you can limit your life insurance to $50,000. However, the impact of the imputed income taxes is generally small.

IRS Uniform Premium Rates

Age (as of Dec 31, 2012)	Value per $1,000 of coverage
Under 25	$0.05
25 - 29	$0.06
30 - 34	$0.08
35 - 39	$0.09
40 - 44	$0.10
45 - 49	$0.15
50 - 54	$0.23
55 - 59	$0.43
60 - 64	$0.66
65 - 69	$1.27
70 and over	$2.06

"Base Salary"

Your life insurance base salary is calculated when you start employment, and annually thereafter in October for the following year. For those on a 12-month appointment, this is your annual salary. For those on a 9-month appointment, this is 11/9 times your academic year salary. It does not include overtime, faculty summer salary, or other special compensation. The benefit is not modified if your salary changes mid-year.

Increasing Life Insurance Coverage

At Open Enrollment or when you experience a life status change, you may increase your supplemental coverage by one level only. If your supplemental coverage goes above $500,000, you will need to complete a Statement of Health.

Beneficiary Info

To designate or change your beneficiary, complete the MetLife Beneficiary Form and mail it directly to MetLife, or register at http://mybenefits.metlife.com and designate your beneficiaries online.

Special Features of Supplemental Life

No-Cost Will Preparation for you and your spouse/partner

Enhanced Portability if you leave the university

Accelerated Benefits Option if you are terminally ill

Total Control Account to help beneficiaries manage the benefits of the policy

Dependent Life Insurance

Carnegie Mellon offers a life insurance option that provides benefits in the event of the death of your spouse/domestic partner (DP) and/or dependent children.

The rate for this insurance is deducted from your pay after taxes have been assessed. Dependent Life Insurance also includes an Accidental Death & Dismemberment component. If a death is the result of an accident, you will receive double the insurance amount. Certain amounts are also paid if there is a loss of a limb or certain vital functions as a result of an accident.

Spouse/Domestic Partner (DP) Life and AD&D Insurance

You may purchase life insurance to cover your spouse or partner if you purchase Employee Supplemental Life and AD&D Insurance. If you choose to participate in Spouse/DP insurance program, your partner will be covered at a level equal to **50% of your Employee Supplemental Life coverage**, up to a maximum of $250,000.

- If you and your spouse/DP are both full-time, benefits-eligible employees of Carnegie Mellon, you cannot elect Spouse/DP Insurance. Instead, each of you can enroll in our Supplemental Life Insurance (see previous page).
- If your spouse/DP is a part-time, benefits-eligible employee of Carnegie Mellon, you may purchase Dependent Life Insurance for him/her. However, your partner *will not be eligible to receive free basic life insurance or to purchase additional AD&D coverage from the university*.

Statement of Health (SOH) for Spouse/Domestic Partner Life Insurance

- A SOH is not required for coverage of $50,000 or less at initial eligibility (within 30 days of your hire, marriage or registration of partnership).
- SOH is required for coverage of more than $50,000 at initial eligibility.
- If you elect to cover your spouse/DP for the first time or increase their coverage during Open Enrollment, a SOH is required.
- **If the coverage increases to greater than $50,000 (due to an increase in either your salary or your levels of supplemental coverage), your partner will be required to complete a Statement of Health.**

(Faculty and staff who retained their 2007 level of spouse/DP life insurance coverage may keep their spouse/DP at that level.)

Dependent Child(ren) Life and AD&D Insurance

Dependent Child(ren) Insurance rates (see chart, right) cover ALL of your dependent children up to age 26 for one price - *you do NOT need to multiply the rate by the number of children covered under the plan*. If you and your spouse/DP are both full-time, benefits-eligible employees of Carnegie Mellon, only one of you can elect this option to cover the child(ren).

Statement of Health for Dependent Children Insurance

- A SOH is not required at any level at initial eligibility (within 30 days of your hire, or their birth or adoption).
- Enrolling for the first time during Open Enrollment will require a SOH.
- Increasing your children's coverage will require that your children satisfy SOH.

Life Insurance Carrier

MetLife is the carrier for our Employee and Dependent Life Insurance programs. Determinations about insurability are made by MetLife in accordance with their underwriting guidelines.

Spouse/DP Life and AD&D Monthly Rate

Age (as of Jan 1, 2012)	Rate for each $1,000/month
Under 30	$0.070
30 - 34	$0.083
35 - 39	$0.089
40 - 44	$0.101
45 - 49	$0.112
50 - 54	$0.177
55 - 59	$0.255
60 - 64	$0.411
65 - 69	$0.687
70 and over*	$1.389

* Coverage for those age 70+ are actuarially reduced.

Dependent Child Life and AD&D Monthly Rate

Coverage per Child*	Biweekly / Monthly Rate
$2,500	$0.20 / $0.40
$5,000	$0.40 / $0.80
$10,000	$0.80 / $1.60

* Coverage for children age 14 days to 6 months is 10% of amount shown.

Dependent Care Reimbursement Account

The Dependent Care Reimbursement Account (DCRA) allows you to set aside pre-tax money to pay for qualified dependent day care (not health care) expenses. You will not pay taxes on the income that goes into these accounts, saving you 15% or more.

You may contribute up to $5,000 per year ($2,500 if married, filing separately); *the minimum contribution is $300 per year.* You must enroll annually in the DCRA—previous contribution rates will not roll over to the next year at Open Enrollment.

Expenses must be incurred during the calendar year (Jan. 1–Dec. 31, 2012), and claims must be submitted by June 30, 2013. In order to claim expenses, you and your spouse must work full- or part-time outside the home, be self-employed or be a full-time student, or your spouse must be physically or mentally disabled.

Eligible dependents include:

- Dependent child(ren) under age 13 who are claimed as dependents on your federal taxes.
- Disabled dependent child age 13 or older who is claimed as a dependent on your federal tax return.
- A disabled spouse, parent or other adult dependent who is incapable of caring for themselves and who spends at least 8 hours a day in your home.
- *The IRS prohibits the use of a DCRA for the expenses of someone who cannot be claimed as a dependent for tax purposes.*

How the Account Works

Estimate your out-of-pocket expenses for child care/adult care for the upcoming plan year. Throughout the year, you will contribute to your account on a pre-tax basis. As you incur eligible expenses during the year, you will pay for them out of your own pocket. You will then be reimbursed with the money in your account by filing a claim.

Estimate Carefully: Use It or Lose It!

IRS rules state that any contributions that you don't use for expenses incurred in the plan year will be forfeited. Estimate carefully and only put money into your account that you are sure you will use.

What Expenses Are Covered?

In order to take full advantage of the DCRA, you need to know the specific services or expenses that can be submitted for reimbursement. See:

IRS publication #503: http://www.irs.gov/pub/irs-pdf/p503.pdf

Highlights of Eligible DCRA Expenses

Below are some examples of expenses that may be covered:

- Day care or nanny/sitter fees while you work or attend school.
- Licensed nursery schools/day care centers, including the Cyert Center.
- Care before and after school.
- Day camp for children under age 13 during the summer vacation.
- Elderly care for a parent residing in your home while you work/attend school.

Note: Eligible caregivers must be at least 18 and not a relative living in your home.

DCRA Administrator

The Dependent Care Account is administered by Benefit Coordinators Corporation (BCC).

Other Child Care Benefits

The amount you can contribute to a DCRA is reduced by any additional child care benefits you receive from other sources (such as the Cyert Center or a spouse's employer). If you exceed $5,000 limit, the amount in excess will be considered taxable income.

Tax Implications

- State taxes are owed on DCRA contributions.
- DCRA contributions reduce what you may claim in Social Security benefits at retirement.
- Consult a tax expert or the IRS if you use the Earned Income Tax Credit.

Calculating Your DCRA Contributions

- Calculate your expected eligible dependent care expenses for 2012. Your eligible expenses are limited to $5,000.
- Subtract any other child care benefits you are receiving.
- Divide your eligible expenses by the number of months in the calendar year you will be contributing (usually 9 or 12, based on how you are paid) to get your monthly contribution.

Benefits for Domestic Partners

Benefits-eligible employees may elect to cover their same- or opposite-sex domestic partner under the insurance benefits to which married spouses are entitled, except where IRS regulations prohibit the provision of such benefits. If your relationship meets the university's eligibility criteria, your partner is eligible to receive medical, prescription, dental, vision, and dependent life insurance benefits.

A domestic partner may be covered under one's insurance plan if:

- the relationship has continued for at least 12 consecutive months,
- the couple can demonstrate that the committed relationship is substantially similar to that of a married couple. See the **Domestic Partner Registration Kit** to review the detailed list of the criteria that meets this requirement.

A domestic partner may be eligible to receive a limited number of non-insurance benefits (such as a university ID card) if you attest to a committed relationship of at least 3 consecutive months.

See the **Domestic Partner Registration Kit** for a detailed list of the criteria for registering a domestic partnership and the forms required to do so.

Enrollment Process for Individuals With Domestic Partners

If a domestic partnership is not already registered with the university, you must complete a hard copy of the:

- "Carnegie Mellon Registration Statement of Domestic Partnership" form
- "Benefits Enrollment/Change" form
- "Request for ID Cards for Family Members/Registered Domestic Partner" form, if your Partner is requesting a university ID card
- Dependent Partner Certification for Dependent Tax Status form (if your partner is claimed as a dependent for federal tax purposes)

All forms should be sent to the Benefits Office at 319 South Craig Street. *The Registration Statement is subject to approval by Human Resources.* All registration and termination statements of domestic partnerships will be held confidentially in Human Resources.

Once a partnership has been registered, you can use the HR Connection system for Open Enrollment or when a qualified life or family status change occurs.

<u>NOTE:</u> Carnegie Mellon only provides coverage for dependent children who can be claimed by an individual for federal tax purposes. If you cannot claim the children of your domestic partner, then you cannot cover those dependents under your Carnegie Mellon benefits.

Tax Consequences of Domestic Partner Coverage

The IRS prohibits providing benefits on a pre-tax basis on behalf of dependents who do not meet the IRS Code, Section 152 definition of a dependent.

If your situation does not meet the IRS standard for pre-tax reduction, the portion of your contribution that is used to add your partner to your coverage must therefore be deducted from your pay on an after-tax basis.

In addition, employer-provided coverage for a domestic partner who does not meet the IRS definition of a dependent is considered to be taxable income to the individual at the fair market value of the coverage. The difference in the university contribution between the level of coverage that includes your partner and the level that does not cover him/her will be noted as additional income on your pay stub and will be assessed federal taxes.

See the Domestic Partner Registration Kit, available from http://www.cmu.edu/hr/benefits/benefit_admin/partners.html, for more information about the tax implications associated with covering domestic partners.

Changes Limited to Open Enrollment or Life Changes

The IRS allows contributions for your benefits coverage to be taken out of your pay before taxes are calculated, which reduces your taxes and saves you money. However, they only permit you to make changes to your coverage during an annual Open Enrollment or when you experience certain life or family status changes.

Qualifying Life or Family Status Change

Qualified life or family status changes that allow you to make changes to your benefits within 30 days of the event include:

- *Marital/Domestic Partnership Status Changes* (marriage/registration of partnership, death, divorce/termination of partnership)
- *Number of Covered Dependent Children Changes* (birth or adoption, death, dependent becomes ineligible for coverage)
- *Coverage from Another Source is Gained or Lost*
- Significant Change in Cost or Coverage of Plan (as defined by the university)
- *Change in University Location* (such as Pittsburgh to the West Coast or an international location, if your current plan does not provide coverage in the new area)

Contact the Carriers

Most questions or concerns about your coverage, filing claims, or eligible expenses should be first directed to the carrier of the plan you selected. Contact information for each of our carriers is found on the next page. You should have your group and ID numbers available when you contact the carrier so they can see the specific provisions of the Carnegie Mellon plan.

Denial of Coverage Appeals

If a claim that is submitted to one of our benefit plans is denied by the carrier and you are not in agreement with the denial, you should follow these procedures:

For Medical Appeals:

Appeals concerning a medical treatment plan or medical assessment can only be appealed through the carrier. Please follow the procedures outlined in your plan booklet to appeal a medical decision. Plan Booklets are available on the Human Resources web site at http://www.cmu.edu/hr/benefits/benefit_programs/index.html.

For Other (Administrative) Appeals:

1. If you believe the denial was made in error, **contact the carrier directly** to begin the appeals process. (See Contact Information on the next page.)
2. If you are unable to resolve the situation with the carrier, please contact Human Resources at 412-268-2047 for assistance in working with the carrier.
3. Human Resources can also provide you with information about filing a formal appeal with the carrier to challenge the denial.

COBRA Information (Continuation of Coverage)

When you or a dependent covered by a Carnegie Mellon medical, prescription, dental or vision plan loses coverage, in most circumstances, we are required to send you information about COBRA, which provides the opportunity to continue these benefits at group rates. Your group numbers (except prescription) and monthly rates will change when your plan is continued through COBRA. See the COBRA Benefits Workbook for more information about continuation of benefits through COBRA if you or a dependent loses eligibility.

Contact Information

Do you need more information about a specific benefit option? Contact the carrier directly to request details about your coverage, provider networks, directories, and claims issues.

For issues related to eligibility or enrollment, or unresolved claim issues, contact the Human Resources Benefits Office at 412-268-2047 or hrhelp@andrew.cmu.edu. Please see the HR web site (http://www.cmu.edu/hr/benefits/contact_carriers.html) for links to the plans.

Medical Care Options

Highmark

Phone: 1-800-472-1506

Web: http://www.highmarkbcbs.com

UPMC Health Plan

Phone: 1-877-381-3764

Web: http://www.upmchealthplan.com

HealthAmerica

Phone: 1-800-735-4404 or 412-553-5575

Web: http://www.healthamerica.cvty.com

Prescription Drug Plan Options

Caremark

Phone: 1-877-347-7444

Web: http://www.caremark.com

Mail Order Service

Phone: 1-800-222-3383 (prescription refills)

FastStart®: 1-800-875-0867 (enrollment)

Dental Care Options

United Concordia Companies, Inc. (UCCI)

Phone: 1-800-423-7461

Web: http://www.ucci.com

Vision Care Options

Davis Vision

Phone: 1-800-999-5431

Web: http://www.davisvision.com

Reference control code: 4102

Vision Benefits of America (VBA)

Phone: 1-800-432-4966

Web: http://www.visionbenefits.com

Life and AD&D Insurance; Long-Term Disability

MetLife

Employee/Dependent Life and AD&D Insurance

Phone: 1-866-492-6983

Web: http://mybenefits.metlife.com

Long-Term Disability Insurance

Phone: 1-800-858-6506

Web: http://www.metlife.com

Health Care Flexible Spending Account; Dependent Care Reimbursement Account

Benefit Coordinators Corporation (BCC)

Phone: 1-800-685-6100 (customer service)

Fax: 1-412-276-7185

Web: http://www.benxcel.com

Benefits Glossary of Terms

Accidental Death & Dismemberment; AD&D

A component of life insurance coverage: in the event of one's accidental death, the benefit payable will double. If one loses a limb or other vital function, benefits will be paid according to a schedule.

After-tax dollars

Salary dollars from which federal, state and social security taxes have already been deducted.

Allowable amount; Allowable expense

The highest amount a benefit plan will pay for a specific covered service. This amount is based on the UCR for such service. (See *Usual, Customary and Reasonable*.)

Annual maximum

The most the plan will pay for covered services in the calendar year in which your elections are in effect.

Coinsurance

The plan pays a set percentage of the allowable amount of the covered expense. You pay the rest, up to an annual out-of-pocket maximum. Charges in excess of the UCR are not included; you are responsible for any such charges if you use an out-of-network provider.

Coordination of Benefits; COB

When a member is covered under more than one benefit plan, COB determines which plan is primarily responsible. Charges not covered by the primary plan may be submitted to the secondary plan. Benefits provided by an employer are primary; benefits provided through a spouse's employer are secondary.

Copayment; copay

Any up-front amount you pay for in-network office visits, supplies or prescription drugs through your medical or prescription plan. The copayment does not count toward the deductible or out-of-pocket maximum.

Coverage level

The individuals covered by the benefit plan. The coverage level for medical must match the coverage level for prescription. The coverage level for medical and dental coverage may vary.

Covered expenses; covered services

Those services or supplies eligible for payment under the option you have elected. Insurance contracts and booklets provide a list of covered expenses for each plan.

Deductible

The amount you are required to pay each year before any coinsurance payments will be made under the medical or dental plan option. Deductibles vary. Copays for office visits do not apply to the deductible.

Eligible dependents

These include:

- your spouse or registered domestic partner
- your children up to age 26
- your unmarried, dependent children of any age who, upon attainment of age 19, were covered under the particular benefit and were disabled as defined in the information provided by the third party administrator or insurance company

Employee; eligible employee

Active faculty, staff, Campus Police Association and Teamsters Local 249 employees of Carnegie Mellon working at least 37.5 hours per week in an appointment of four consecutive months or longer. (Serial appointments of less than four months each do not satisfy this requirement.) Some employees on leave of absence may be considered active for benefit purposes.

Guaranteed Issue

The life insurance you can receive at initial eligibility without needing to submit a Statement of Health.

Health Maintenance Organization; HMO

A medical program, available in limited areas, that provides services when members use network providers. Carnegie Mellon provides one HMO option, through HealthAmerica.

Health Reimbursement Account (HRA)

An account set up by the university that you can use to pay for eligible health care expenses ($250 individual/$500 family). Unused contributions can be rolled over to the following year, up to a maximum. The money in the account is forfeited if your participation in the HRA plan ends. The HRA is paired with a high deductible PPO plan.

Imputed income

The value of benefits that the IRS taxes as though it were additional salary. This includes high levels of life insurance or dependent care benefits and medical/Rx benefits for domestic partners.

Benefits Glossary of Terms (continued)

Long-term disability insurance; LTD

In the event you are unable to work for more than 180 days due to an illness or injury, LTD coverage provides 60% replacement income and continues retirement contributions.

Maintenance drug

A medication prescribed for a chronic condition (such as high blood pressure) that will be taken for more than 60 days. For maximum savings, maintenance drugs should be filled via mail order.

Maximum eligible/allowable expense;

The total amount payable for a given service or supply under a plan. This amount is determined by the insurance company based on the typical cost for the service.

Network Allowance

Amount the participating provider contractually agrees to accept as payment in full.

Open Enrollment; Open Enrollment Period; OE

The annual period of time during which employees have an opportunity to review and select alternate benefit plans offered through the Healthy Solutions program.

Opt Out

Your decision not to be covered for a given benefit.

Out-of-Pocket Maximum

The highest amount you are required to pay in coinsurance and deductibles for any covered expenses in a calendar year. (Using non-participating providers may result in additional costs not included in your out-of-pocket maximum.)

Preferred Provider Organization; PPO

A medical plan that provides a higher level of coverage when you use the preferred network of providers. Out-of-network services result in higher out-of-pocket costs.

Pre/before-tax dollars

Income on which no federal taxes are paid when used to purchase a benefit option or placed in a reimbursement account under a qualified flexible benefits program.

Preventive care

Medical services designed to avoid illness or promote wellness. These services include routine physicals, certain diagnostic tests and immunizations. The medical and dental plans pay 100% for preventive care that is performed in-network in accordance with their schedule.

Primary Care Physician; PCP

Although you should have a primary care physician (PCP) with any plan, only the HMO plans require you to designate a PCP. The PCP handles all routine medical care and can arrange referrals to specialist care and related services.

Primary Care Dentist; PCD

Dental HMO plans require you to designate one primary care dentist (PCD). The PCD handles all routine dental care and will arrange referrals to specialist care services (required for benefits coverage in the DHMO).

Salary

For Life, AD&D and LTD insurance purposes, your salary is calculated in October, and is rounded up to the nearest $1,000. Changes in salary will be reflected in the following year's Open Enrollment materials. For employees with a 12-month appointment, this is your fiscal year salary. For employees with a 9-month appointment, this is 11/9 times your academic year salary. Your salary excludes overtime, pay for appointments lasting less than four months, faculty summer salary and other special compensation.

Term life insurance; Group term life insurance

An insurance policy that pays a set amount in the event of the death of the insured person. This type of policy ends when your employment ends unless you make arrangements with the insurance company to continue it. It has no cash value and you cannot borrow against it.

Usual, Customary and Reasonable; UCR

The fees set by the carrier that reflect typical fees charged for services in your area. Carriers assign UCR levels to all services and pay claims based on them. Expenses above the UCR will not be paid under the terms of the benefit plans. Out-of-network providers may bill you for their charges in excess of the UCR.

HR Human Resources

Solve Problems + Create Solutions = Value Added

Carnegie Mellon University does not discriminate and Carnegie Mellon University is required not to discriminate in admission, employment, or administration of its programs or activities on the basis of race, color, national origin, sex or handicap in violation of Title VI of the Civil Rights Act of 1964, Title IX of the Educational Amendments of 1972 and Section 504 of the Rehabilitation Act of 1973 or other federal, state, or local laws or executive orders.

In addition, Carnegie Mellon University does not discriminate in admission, employment, or administration of its programs on the basis of religion, creed, ancestry, belief, age, veteran status, sexual orientation or gender identity. Carnegie Mellon does not discriminate in violation of federal, state, or local laws or executive orders. However, in the judgment of the Carnegie Mellon Human Relations Commission, the Presidential Executive Order directing the Department of Defense to follow a policy of "Don't ask, don't tell, don't pursue" excludes openly gay, lesbian and bisexual students from receiving ROTC scholarships or serving in the military. Nevertheless, all ROTC classes at Carnegie Mellon University are available to all students.

Inquiries concerning application of these statements should be directed to the provost, Carnegie Mellon University, 5000 Forbes Avenue, Pittsburgh, PA 15213, telephone 412-268-6684 or the vice president for enrollment, Carnegie Mellon University, 5000 Forbes Avenue, Pittsburgh, PA 15213, telephone 412-268-2056.

Carnegie Mellon University publishes an annual campus security report describing the university's security, alcohol and drug, and sexual assault policies and containing statistics about the number and type of crimes committed on the campus during the preceding three years. You can obtain a copy by contacting the Carnegie Mellon Police Department at 412-268-2323. The security report is also available online.

Obtain general information about Carnegie Mellon University by calling 412-268-2000.

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