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2012 BENEFITS WORKBOOK

FOR INDIVIDUALS ON A LONG-TERM DISABILITY
LEAVE OF ABSENCE

TAKE CHARGE OF YOUR BENEFITS

OPEN ENROLLMENT FOR 2012 BENEFITS

October 31 - November 14, 2011

BENEFITS EFFECTIVE DATE

January 1, 2012



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

Carnegie Mellon
HUMAN RESOURCES

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.

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New for 2012

1. There are increases to the Comprehensive and HMO medical options, the VBA Option 1 vision plan, and the dental options.
2. Adult Children up to age 26 are now eligible for coverage in the dental and vision plans, regardless of student status.
3. Dental and vision coverage are now annual elections.
4. Depending on how the current issues between Highmark and UPMC are resolved, some faculty and staff may see changes to provider networks in the coming year. Please speak to your doctors and refer to <http://highmarkchoicematters.com>, <http://www.KeepYourDoc.com> and <http://www.PatientCareAssurance.com> if you have questions about which health plan is right for you. The university does not have any additional information other than this.

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.

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.

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.

Elections made during Open Enrollment will become effective the following January 1 and will remain in effect for the entire calendar year or until your benefits eligibility ends, whichever comes first. **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.
- Supporting documentation - such as a birth certificate, marriage license, or proof of new coverage - is required to verify a status change.

See page 12 for a list of qualifying life or family status changes that permit you to make benefit changes mid-year.

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 Benefit 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.

Who Is LTD Benefits Eligible

LTD benefits eligibility is granted to faculty, staff, Campus Police Association, or Teamsters Local 249 employees who, prior to their disability leave of absence began:

- worked at least 37.5 hours per week or 100% of a full-time schedule
- were 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 adult, unmarried, dependent children 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

Active employees are eligible for different benefits, and should refer to the Benefits Workbook for their employment status.

Preventive Care Benefits

Our plans pay 100% of in-network adult and pediatric preventive care services, according to the carrier's 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. Individuals located outside of Western PA may not select the HealthAmerica HMO. Those on an international appointment are eligible for coverage through our international benefits plan.

Medical

You can select plans from the UPMC, Highmark or HealthAmerica carriers. To be sure your current provider is in a particular carrier's network, contact the carrier or provider directly or 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 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 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, participating providers have agreed to accept the insurance reimbursement as payment in full and cannot bill you for 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.

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						
- In-Network Provider	(After deductible.) 100%	(After deductible.) 80%	(After deductible.) 80%	(After deductible.) 80%	(After deductible.) 100%	(After deductible.) 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 – Monthly Contribution Rates

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 monthly rates listed below are deducted from your LTD benefit 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.

Medical Coverage: Monthly Contributions for 2012

Coverage Level	PPO 1	PPO 2	PPO 3	High Deductible with HRA	HMO	Comprehensive
Individual						
Highmark	\$111.00	\$74.00	\$45.00	\$38.00	N/A	\$364.00
HealthAmerica	N/A	N/A	N/A	N/A	\$19.00	N/A
UPMC	\$59.00	\$26.00	\$9.00	\$2.00	N/A	N/A
Individual & 1 Child						
Highmark	\$264.00	\$200.00	\$151.00	\$125.00	N/A	\$701.00
HealthAmerica	N/A	N/A	N/A	N/A	\$105.00	N/A
UPMC	\$175.00	\$111.00	\$78.00	\$45.00	N/A	N/A
Individual & 2+ Children						
Highmark	\$307.00	\$237.00	\$182.00	\$152.00	N/A	\$798.00
HealthAmerica	N/A	N/A	N/A	N/A	\$131.00	N/A
UPMC	\$208.00	\$137.00	\$97.00	\$60.00	N/A	N/A
Individual & Spouse/DP						
Highmark	\$351.00	\$273.00	\$212.00	\$179.00	N/A	\$895.00
HealthAmerica	N/A	N/A	N/A	N/A	\$157.00	N/A
UPMC	\$241.00	\$163.00	\$117.00	\$76.00	N/A	N/A
Family						
Highmark	\$524.00	\$417.00	\$333.00	\$288.00	N/A	\$1278.00
HealthAmerica	N/A	N/A	N/A	N/A	\$261.00	N/A
UPMC	\$373.00	\$265.00	\$194.00	\$138.00	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: monthly 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.
- 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: Monthly Contributions for 2012

Coverage Level	Caremark Option A	Caremark Option B
Individual	\$ 31.00	\$ 7.00
Individual and Child	\$ 70.00	\$ 29.00
Individual and Children	\$ 81.00	\$ 35.00
Individual and Spouse/DP	\$ 92.00	\$ 41.00
Family	\$ 136.00	\$ 66.00

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.

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).

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: Monthly Contributions for 2012

Coverage Level	DHMO Rates	PPO 1 Rates	PPO 2 Rates
Individual	\$ 11.66	\$ 11.66	\$ 28.08
Family	\$ 46.92	\$ 41.60	\$ 89.94

Dental Options - Coverage¹ 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 <i>Cleanings and Exams</i> (DHMO: once in any 6 consecutive months; PPO: 2 per calendar year) <i>Bitewing X-rays</i> (DHMO: to age 14, once in any 6 consecutive months & age 14+, once per 12 consecutive months; PPO: 2 per calendar year, any age) <i>Full Mouth X-rays</i> (once per 3 years) <i>Fluoride Treatment</i> – 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: Orthodontics³	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.

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.

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: Monthly Contributions for 2012

Coverage Level	Davis Option 1	Davis Option 2	VBA Option 1	VBA Option 2
Individual	\$ 1.00	\$ 4.00	\$ 1.14	\$ 4.00
Family	\$ 6.00	\$ 16.50	\$ 6.88	\$ 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.

2012 Vision Care Options¹ - In-Network Plan Highlights

Vision Benefit	Davis Option 1:	VBA Option 1:	Davis Option 2:	VBA Option 2:
Frequency Eye exams, lenses, contacts Spectacle Frames	From date of last service: 24 months for ages 19+ 12 months through age 18 24 months for all	Per calendar year(s): Once per 2 years, age 19+ Once per year, thru age 18 Once per 2 years for all	From date of last service: 12 months for all 12 months for all	Per calendar year: Once per year for all Once per year for all
Eye Examination Eye exam with dilation Contact lens evaluation and fitting	Paid in Full Paid in Full	Paid in Full See Contact Lens allowance below. ²	Paid in Full Paid in Full	Paid in Full See Contact Lens allowance below. ²
Spectacle Lenses (patient pays:) All ranges of prescriptions and sizes Polycarbonate lenses ³ Oversize lenses Specialty Lens Options¹ Standard Progressive Addition Lenses Gradient tinting, ultraviolet coating Scratch resistant coating Blended bifocals Coming photochromatic lenses Standard anti-reflective coating (ARC)	Patient Pays: \$0 \$0 / \$35 ³ \$0 \$65 \$15 \$20 \$20 \$20 \$40	Patient Pays: \$0 \$0 for all \$0 Available starting at \$45 \$12 \$0 \$0 \$18 / \$28 \$40	Patient Pays: \$0 \$0 / 35 ³ \$0 Available starting at \$45 \$15 \$20 \$20 \$20 \$18 / \$28 \$40	Patient Pays: \$0 \$0 for all \$0 Available starting at \$45 \$12 \$0 \$0 \$18 / \$28 \$40
Frames Retail Exclusive Collection of Frames Fashion (up to \$100 retail value) Designer (up to \$175 retail value) Premier (up to \$200 retail value)	\$60 allowance Paid in full Patient pays \$20 Patient pays \$40	\$40 wholesale allowance (approx \$80-\$105 retail value) Frames available at discounted prices.	\$100 allowance Paid in full Patient pays \$20 Patient pays \$40	\$60 wholesale allowance (approx \$120-\$160 retail value) Frames available at discounted prices.
Contact Lenses Elective Allowance Disposables Conventional Medically Necessary (prior approval)	\$75 ⁴ allowance -- -- Included	\$140 ² allowance (includes lenses, exam and fitting) UCR	-- \$120 allowance \$110 ⁵ allowance Included	\$160 ² allowance (includes lenses, exam and fitting) 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 specialty 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.

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.

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.

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 Location* (if your current plan does not provide coverage in the new area)

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.

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
1-800-547-9378 (Highmark HMO)
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 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>

Long-Term Disability

MetLife

Phone: 1-800-858-6506
Web: <http://www.metlife.com>

Benefits Glossary of Terms

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 adult, unmarried, dependent children 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.

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.

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 expense; Maximum 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.

Benefits Glossary of Terms (continued)

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.

Option; Benefit option

One of the choices you have within a benefit category.

Opt Out

Your decision not to be covered for a given benefit. No benefits will be payable.

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.

Preventive care

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

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).

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.



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.