

HealthySolutions
Helping you choose smart and live well.

2012 BENEFITS WORKBOOK

FOR COBRA PARTICIPANTS THROUGH CARNEGIE MELLON

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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Make Elections Using the COBRA Enrollment/Change Form

To enroll in or change your benefits, use the Benefits Enrollment/Change Form for COBRA Participants.

1. Complete the entire form, and be sure to sign the form before returning it.
2. Return the form to Human Resources - Benefits Office. It must be received no later than 5:00 p.m. on Monday, November 14, 2011.
3. Your benefit elections will become effective January 1, 2012 and will remain in effect for the remainder of the calendar year (or until your benefits eligibility ends, whichever comes first).
4. If you do not submit a Benefits Enrollment/Change Form, your current benefits will continue into 2012. You cannot change your benefits in 2012 unless you experience a qualifying life or family status change.

Healthy Solutions Benefits

Carnegie Mellon offers a broad range of benefit options under the Healthy Solutions umbrella. We are pleased to enable you to continue your participation in the medical, prescription drug, dental and/or vision plans through COBRA.

Who Is COBRA Benefits Eligible?

You may participate in COBRA if you or a dependent loses benefits eligibility or stops coverage from Carnegie Mellon for some reason. However, employees who are terminated for cause may not be eligible for COBRA benefits continuation.

When you begin participation in COBRA, you may only continue the benefits in which you were enrolled at the time your coverage was lost. However, at Open Enrollment, you may elect to enroll in any of the benefits which are available to COBRA participants.

You may cover eligible dependents under your benefits. Eligible dependents include:

- your spouse/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

Enrolling for Benefits When You Lose Carnegie Mellon Coverage

When you separate from the university or drop/lose coverage, Benefit Coordinators Corporation (BCC), our COBRA administrator, will contact you within 30 days. You will then have 60 days from the date of cancellation of your coverage or the date of BCC's notification, whichever is later, to elect to continue your benefits through COBRA. Your COBRA coverage will be retroactive to the date your coverage would have terminated.

When you elect COBRA coverage, you will be covered under the same plan you had as an employee, but may change the level of coverage. You cannot make other changes until the next Open Enrollment period, unless you experience a life or family status change. However, if you will be relocating to an area outside of Western Pennsylvania and were enrolled in an HMO or dental HMO, you will need to elect a different plan that has providers in your area.

Enrolling for Benefits When You Experience a Status Change

Family or life changes sometimes require you to change your benefits. You can make changes consistent with your status change within 30 days of the status change.

- In most circumstances, you may not change the carrier or option (e.g. UPMC to Highmark, or PPO to HMO), 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 14 for a list of qualifying life or family status changes that permit you to make benefit changes mid-year.

Continuing Benefits: COBRA

When an individual covered by a Carnegie Mellon medical plan loses coverage, our COBRA coordinator (BCC) sends the employee information about benefits continuation through COBRA.

If your employment with the university ends, if you or your dependents lose benefits eligibility (ex. - switching to part-time status), or if you drop coverage due to a life status change, then you will receive COBRA information.

You may continue your benefits through COBRA or discontinue participation.

Switching Plans When Relocating

If you relocate outside of Western PA, you may change your benefits if your current plan does not have coverage in your new location. Highmark and UPMC have U.S. networks. Those located outside of Western PA may not select a medical or dental HMO. To change benefits:

- Write a letter stating your desire to switch to a new plan due to a relocation.
- Specify the plan and level of coverage (individual, family, etc.) you will need.
- Mail the letter to: Benefit Coordinators Corporation, 100 Ryan Court, Suite 200, Pittsburgh, PA 15205, ATTN: COBRA Department.

Need Assistance Enrolling?

Human Resources is available to assist you in understanding your benefit options. To reach us:

- Send an e-mail to hrhelp@andrew.cmu.edu.
- Schedule a one-on-one enrollment session with a Benefits Specialist. Call 412-268-2047 to schedule.
- 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.

Enrolling In Benefits at Open Enrollment: October 31–November 14, 2011

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 OE 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, OE is the only time during the year when you may change your benefit elections.**

Review Your Benefits and Actively Enroll

It is very important that you review your benefit options and make your choices for next year during the OE period. Doing so ensures that your coverage meets your needs and that there are no election or dependent data errors. Make your elections early in the OE period so that you have enough time to resolve any questions that may arise.

Benefits - What's New for 2012?

BENEFIT	CHOICES	CHANGES FOR 2012
Medical	Highmark, UPMC or HealthAmerica carriers	Rates have increased for the Comprehensive and HMO plans. PPO plan rates remain unchanged. 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 www.highmarkchoicematters.com , www.KeepYourDoc.com , and 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.
Prescription Drug	Caremark Option A or Option B	Rates remain unchanged for both options.
Dental	UCCI DHMO UCCI PPO Option 1 or Option 2	Rates have changed. You may now cover children up to age 26, regardless of student status. Dental is now an annual election.
Vision	Davis Vision Option 1 or Option 2 VBA Option 1 or Option 2	Rates have changed for VBA Option 1. The rates for the other options are unchanged. You may now cover children up to age 26, regardless of student status. Vision is now an annual election.

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.

Preventive Care Benefits

Our plans pay 100% of in-network adult and pediatric preventive care services, according to the carrier's preventive care schedule. You will not be required to pay a copay, deductible or coinsurance.

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.

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

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.

You will be billed monthly for the contributions listed below.

Medical Coverage: Monthly COBRA Contributions for 2012

Coverage Level	PPO 1	PPO 2	PPO 3	High Deduct. with HRA	HMO	Comprehen.
Individual						
Highmark	\$ 371	\$ 334	\$ 304	\$ 288	N/A	\$ 655
HealthAmerica	N/A	N/A	N/A	N/A	\$ 296	N/A
UPMC	\$ 318	\$ 279	\$ 250	\$ 235	N/A	N/A
Individual & Child						
Highmark	\$ 631	\$ 566	\$ 516	\$ 490	N/A	\$1,113
HealthAmerica	N/A	N/A	N/A	N/A	\$ 503	N/A
UPMC	\$ 541	\$ 475	\$ 425	\$ 399	N/A	N/A
Individual & Children						
Highmark	\$ 706	\$ 633	\$ 577	\$ 547	N/A	\$ 1,244
HealthAmerica	N/A	N/A	N/A	N/A	\$ 562	N/A
UPMC	\$ 604	\$ 531	\$ 475	\$ 446	N/A	N/A
Individual & Spouse/DP						
Highmark	\$ 779	\$ 700	\$ 638	\$ 605	N/A	\$ 1,375
HealthAmerica	N/A	N/A	N/A	N/A	\$ 621	N/A
UPMC	\$ 667	\$ 588	\$ 525	\$ 493	N/A	N/A
Family (Individual, Spouse/DP and Children)						
Highmark	\$ 1,075	\$ 965	\$ 880	\$ 834	N/A	\$ 1,897
HealthAmerica	N/A	N/A	N/A	N/A	\$ 857	N/A
UPMC	\$ 921	\$ 811	\$ 725	\$ 679	N/A	N/A

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.

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.)

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 (<i>separate from medical plan</i>)	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 COBRA Contributions for 2012

Coverage Level	Caremark Option A	Caremark Option B
Individual	\$ 96	\$ 71
Individual and Child	\$ 162	\$ 121
Individual and Children	\$ 182	\$ 136
Individual and Spouse/DP	\$ 201	\$ 149
Family	\$ 276	\$ 206

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.

Check the Networks

Check both the Davis Vision and VBA networks online to see which doctors 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 COBRA Contributions for 2012

Coverage Level	Davis Option 1	VBA Option 1	Davis Option 2	VBA Option 2
Individual	\$ 3.78	\$ 2.86	\$ 8.40	\$ 9.03
Family	\$ 9.30	\$ 8.36	\$20.23	\$ 22.36

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 Corning 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 \$12 \$0 \$0 \$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.

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.

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 COBRA Contributions for 2012

Coverage Level	DHMO Rates	PPO 1 Rates	PPO 2 Rates
Individual	\$ 16.62	\$ 16.39	\$ 33.57
Family	\$ 52.25	\$ 47.25	\$ 96.55

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.

Benefits for Domestic Partners

COBRA participants may elect to cover their same- or opposite-sex domestic partner under their benefits. If your relationship meets the university's eligibility criteria, your partner is eligible to receive medical, prescription, dental, and vision 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.

NOTE: 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.

Continuing a Flexible Spending Account through COBRA

If you choose to stop contributing toward your Health Care Flexible Spending Account at the time of your separation from the university, you may use the money that you had already contributed to the account only for expenses incurred before your termination of employment. If you want to use the money in your account for expenses incurred after your separation from the university, you must continue to contribute to the account for the remainder of the year. Any money you contribute to your Health Care Flexible Spending account after leaving the university will be on a post-tax basis, however.

Changes Limited to Open Enrollment or Life Changes

You are only permitted to make changes to your coverage during an annual Open Enrollment period 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.

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.

Qualifying Life or Family Status Change

Qualified life or family status changes that allow you to make changes to your benefits within 3 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 your 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

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)

Caremark Maintenance Choice

Phone: 1-877-347-7444 (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>

Health Care Flexible Spending Account

Benefit Coordinators Corporation (BCC)

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

Fax: 1-412-276-7185

Web: <http://www.benxcel.com>

COBRA Plan Administrator

Benefit Coordinators Corporation (BCC)

Phone: 1-800-685-6100

Mailing Address:

111 Ryan Court - Suite 300,

Pittsburgh, PA 15205

Attention: COBRA Department

COBRA and Medicare For Those Age 65 and Older

Signing Up for Medicare Parts A and B

If you aren't getting Social Security benefits or Railroad Retirement Board benefits (which automatically enrolls you in Medicare when you become eligible), you will need to sign up for Part A and B. You should contact Social Security three months before you turn age 65.

You can sign up during the following times:

- **Initial Enrollment Period**—When you are first eligible for Medicare. (This is a 7-month period that begins three months before the month you turn age 65, includes the month you turn age 65, and ends three months after the month you turn age 65.)
- **General Enrollment Period**—Between January 1 and March 31 each year. Your coverage will begin July 1. You may have to pay a higher premium for late enrollment. See below.
- **Special Enrollment Period**—If you wait to sign up for Medicare because you are covered by a group health plan from your employer or a spouse's employer, you can sign up anytime while you have group health plan coverage or during the 8-month period that begins the month after the employment ends or the group health plan coverage ends (whichever happens first). **Even if you have COBRA coverage, you must enroll during the 8-month period that begins the month after your active employment coverage ends.**

Delaying Medicare Enrollment Results in a Penalty

If you don't sign up for Part B when you are first eligible, you may have to pay a late enrollment penalty *for as long as you have Medicare*. Your monthly premium for Part B may go up *10% for each full 12-month period that you could have had Part B, but didn't sign up for it*.

This penalty is waived if you are covered by a group health plan from your employer or a spouse's employer. NOTE: Coverage through COBRA is NOT considered participation in a group health plan for the purpose of avoiding the late enrollment penalty.

When Your Employment Ends:

When your employment ends and you are age 65 or older, three things generally happen:

1. You may get a chance to elect COBRA coverage, which continues your health coverage through the employer's plan (in most cases for only 18 months) and probably at a higher cost to you.
2. You may get a special enrollment period to sign up for Part B without a penalty. This period will run for 8 months and begins the month after your employment ends. If you enroll in Part B after the 8-month special enrollment period, you may have to pay a late enrollment penalty. *This applies whether or not you elect COBRA.*
3. When you sign up for Part B, you have a 6-month Medigap open enrollment period which gives you a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can't be delayed or repeated.

Source:

Medicare and You 2010, Centers for Medicare and Medicaid Services,
<http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>



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.

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.

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. Copays for office visits do not apply to the deductible.

Health Maintenance Organization; HMO

A medical program, available in limited areas, that provides services when members use network providers.

Health Reimbursement Account (HRA)

An account set up by the university that you can use to pay for eligible health care expenses. 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.

Maintenance drug

A medication prescribed for a chronic condition 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; OE

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

Out-of-Pocket Maximum

The highest amount you are required to pay in coinsurance and deductibles for covered expenses in a calendar year. (Using non-participating providers may result in additional costs.)

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 must be performed in-network in accordance with the plan's schedule of preventive services.

Primary Care Physician

A physician who handles all routine medical care and can arrange referrals to specialist care and related services. A PCP is required by the HMO.

Primary Care Dentist

Dental HMO plans require you to designate one primary care dentist (PCD) who handles all routine dental care and will arrange referrals to specialist care services.

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.