For more information about 2015 benefits, go online to http://www.cmu.edu/hr/benefits.
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Need Assistance Understanding Your Benefits?

The CMUWorks Service Center is available to assist you in understanding your benefit options and to help you enroll.

- Email: cmu-works@andrew.cmu.edu
- Phone: 412-268-4600 (toll free 844-625-4600) Monday through Friday, 8:30 a.m. to 5:00 p.m. (Eastern Time)
- Online: http://www.cmu.edu/cmuworks

Coordination of Benefits

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

Make Elections Through Workday

To enroll in or change your benefits, use Workday. Follow the instructions and read all of the information on each screen.

Visit the My Workday Toolkit (https://www.cmu.edu/my-workday-toolkit/index.html) for information about how to use Workday.

Dependent verification for newly-added dependents must be provided within 30 days of making your elections or the dependent(s) will be removed from coverage.
Benefits Overview

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

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

The contributions for all of these benefits (except dependent life insurance) are deducted from your pay before taxes are assessed.

Work-Life and Retirement Benefits

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

Full-Time Work-Life Benefits That Do Not Require Enrollment

Elections Include:

• Carnegie Mellon contributions into a retirement account on your behalf
• Employee supplemental retirement contributions into a tax-deferred or Roth retirement account
• Tuition benefits for employees and their children
• Paid time off, paid holidays and leaves of absence
• Child Care benefits (e.g., Cyert Center)
• Free use of the Allegheny County Port Authority Transit (PAT) system
• Employee assistance plan and life management resources
• Professional Development Services programs
• Carnegie Mellon ID card (and the access and discounts associated with it)
• Financial benefits (e.g., banking, real estate services, wireless and automobile discounts)

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

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

Enrollment in Work-Life Benefit Programs

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

For more information about benefits, go online to http://www.cmu.edu/hr/benefits.
New Hire Benefits Enrollment

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

Benefits Effective Date

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

Default Benefits for New Hires

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

Enrolling In Benefits at Open Enrollment

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

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

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

Life or Family Status Changes During the Year

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

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

See page 20 for a list of qualifying life/family status changes that permit you to make changes.

For more information about benefits, go online to http://www.cmu.edu/hr/benefits.
Medical
You can select a medical plan offered by UPMC, Highmark or HealthAmerica. To be sure your current provider is in a particular carrier’s network, contact the carrier or provider directly or look online.

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

Health Maintenance Organization (HMO) Plan
(Available through HealthAmerica)
HMOs have low out-of-pocket expenses, but do not provide benefits if you use out-of-network providers (except in the case of an emergency). You will select a primary care physician (PCP) who will help coordinate your care, although referrals to specialist care and related services are not required in most circumstances.

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.

Please refer to the Benefits Glossary of Terms at the end of this workbook for medical insurance terms and definitions.
# Medical Plan Comparison

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>PPO Option 1</th>
<th>PPO Option 2</th>
<th>High Deductible PPO with HRA</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Choices</td>
<td>Highmark, UPMC</td>
<td>Highmark, UPMC</td>
<td>Highmark, UPMC</td>
<td>HealthAmerica</td>
</tr>
<tr>
<td><strong>Annual Deductible (Indiv/Family)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network Provider</td>
<td>$250 / $500</td>
<td>$350 / $700</td>
<td>$1,000 / $2,000</td>
<td>$0 / $0</td>
</tr>
<tr>
<td>Out-of-Network Provider</td>
<td>$500 / $1,000</td>
<td>$500 / $1,000</td>
<td>$2,000 / $4,000</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Max (Indiv/Family)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network Provider</td>
<td>$1,500 / $3,000</td>
<td>$2,500 / $5,000</td>
<td>$4,500 / $9,000</td>
<td>$1,000 / $2,000</td>
</tr>
<tr>
<td>Out-of-Network Provider</td>
<td>$3,000 / $6,000</td>
<td>$3,000 / $6,000</td>
<td>Unlimited</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Plan Coinsurance Responsibility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network Provider</td>
<td>90%</td>
<td>80%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>Out-of-Network Provider</td>
<td>60% of UCR&lt;sup&gt;3&lt;/sup&gt;</td>
<td>60% of UCR&lt;sup&gt;3&lt;/sup&gt;</td>
<td>60% of UCR&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Carnegie Mellon HRA Contribution</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Coverage/Family Coverage</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>$250 / $500</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Physician Visit (Copay/Coincursance)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit: Primary Care / Specialist</td>
<td>$20 / $35</td>
<td>$20 / $35</td>
<td>80%</td>
<td>$15 / $30</td>
</tr>
<tr>
<td>Preventive Care (per schedule)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>ER Visit (waived if admitted)</td>
<td>$100</td>
<td>$100</td>
<td>80%</td>
<td>$50</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit: Primary Care / Specialist</td>
<td>60% of UCR&lt;sup&gt;3&lt;/sup&gt;</td>
<td>60% of UCR&lt;sup&gt;3&lt;/sup&gt;</td>
<td>60% of UCR&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>60% of UCR&lt;sup&gt;3&lt;/sup&gt;</td>
<td>60% of UCR&lt;sup&gt;3&lt;/sup&gt;</td>
<td>60% of UCR&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Not covered</td>
</tr>
<tr>
<td>ER Visit (waived if admitted)</td>
<td>$100</td>
<td>$100</td>
<td>80%</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Primary Care Physician Required</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<sup>1</sup> The deductible and copay do not apply when adult or pediatric preventive care is performed according to the plan’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.

<sup>2</sup> The deductible and out-of-pocket maximum are tracked separately for in- and out-of-network services under all plans. The annual out-of-pocket maximum includes deductible, copays, and coinsurance.

<sup>3</sup> 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.
Employee Contributions for 2015

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>PPO 1 Biweekly/Monthly</th>
<th>PPO 2 Biweekly/Monthly</th>
<th>High Deductible PPO w/ HRA Biweekly/Monthly</th>
<th>HMO Biweekly/Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$92.50 / $185</td>
<td>$64 / $128</td>
<td>$33 / $66</td>
<td>N/A</td>
</tr>
<tr>
<td>HealthAmerica</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$13.50 / $27</td>
</tr>
<tr>
<td>UPMC</td>
<td>$39.50 / $79</td>
<td>$17 / $34</td>
<td>$1 / $2</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Employee &amp; 1 Child</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$202 / $404</td>
<td>$166.50 / $333</td>
<td>$108 / $216</td>
<td>N/A</td>
</tr>
<tr>
<td>HealthAmerica</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$73 / $146</td>
</tr>
<tr>
<td>UPMC</td>
<td>$111 / $222</td>
<td>$74 / $148</td>
<td>$33 / $66</td>
<td></td>
</tr>
<tr>
<td><strong>Employee &amp; 2+ Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$233.50 / $467</td>
<td>$193.50 / $387</td>
<td>$131 / $262</td>
<td>N/A</td>
</tr>
<tr>
<td>HealthAmerica</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$91.50 / $183</td>
</tr>
<tr>
<td>UPMC</td>
<td>$131.50 / $263</td>
<td>$90 / $180</td>
<td>$45.50 / $91</td>
<td></td>
</tr>
<tr>
<td><strong>Employee &amp; Spouse/Partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$265 / $530</td>
<td>$221 / $442</td>
<td>$155 / $310</td>
<td>N/A</td>
</tr>
<tr>
<td>HealthAmerica</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$109 / $218</td>
</tr>
<tr>
<td>UPMC</td>
<td>$151.50 / $303</td>
<td>$106.50 / $213</td>
<td>$57 / $114</td>
<td></td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$389.50 / $779</td>
<td>$328.50 / $657</td>
<td>$249 / $498</td>
<td>N/A</td>
</tr>
<tr>
<td>HealthAmerica</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$181.50 / $363</td>
</tr>
<tr>
<td>UPMC</td>
<td>$233 / $466</td>
<td>$171 / $342</td>
<td>$103 / $206</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

For more information about benefits, go online to [http://www.cmu.edu/hr/benefits](http://www.cmu.edu/hr/benefits).
Prescription Drugs

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

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

Prescription and Medical Coverage Go Together

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

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

Prescription Drug Plan Comparison

<table>
<thead>
<tr>
<th></th>
<th>Caremark Option A</th>
<th>Caremark Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail (Up to 30-days supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic (automatic substitution)</td>
<td>$10</td>
<td>$5</td>
</tr>
<tr>
<td>Brand—Formulary (no generic available)</td>
<td>$20</td>
<td>35% ($100 maximum)</td>
</tr>
<tr>
<td>Brand—Formulary (generic available)</td>
<td>$25</td>
<td>35% ($100 maximum)</td>
</tr>
<tr>
<td>Brand Name—Non-formulary</td>
<td>$40¹</td>
<td>Not Covered¹</td>
</tr>
<tr>
<td><strong>Mail Order (Up to 90-days supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic (automatic substitution)</td>
<td>$20</td>
<td>$10</td>
</tr>
<tr>
<td>Brand—Formulary (no generic available)</td>
<td>$40</td>
<td>35% ($200 maximum)</td>
</tr>
<tr>
<td>Brand—Formulary (generic available)</td>
<td>$50</td>
<td>35% ($200 maximum)</td>
</tr>
<tr>
<td>Brand Name—Non-formulary</td>
<td>$80¹</td>
<td>Not Covered¹</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum (separate from medical plan)</strong></td>
<td>$2,100 individual / $4,200 family</td>
<td>$1,500 individual / $3,000 family</td>
</tr>
</tbody>
</table>

¹ If a non-formulary medication is deemed medically necessary, it may be covered at the applicable “Brand—Formulary” level.

Employee Contributions for 2015

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Caremark Option A Biweekly/Monthly</th>
<th>Caremark Option B Biweekly/Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$26.50 / $53</td>
<td>$3.50 / $7</td>
</tr>
<tr>
<td>Employee &amp; 1 Child</td>
<td>$60.50 / $121</td>
<td>$14.50 / $29</td>
</tr>
<tr>
<td>Employee &amp; 2+ Children</td>
<td>$69.50 / $139</td>
<td>$17.50 / $35</td>
</tr>
<tr>
<td>Employee and Spouse/Partner</td>
<td>$79 / $158</td>
<td>$20.50 / $41</td>
</tr>
<tr>
<td>Family</td>
<td>$117.50 / $235</td>
<td>$33 / $66</td>
</tr>
</tbody>
</table>

For more information about benefits, go online to [http://www.cmu.edu/hr/benefits](http://www.cmu.edu/hr/benefits).
Using Rx Benefits at a Retail Pharmacy

When you need to fill a prescription at a participating pharmacy, present your Caremark 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.

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-days supply for the cost of a 60-days supply.

You can place orders online or by mail. And since you get a 90-days supply, you only need refills every few months, instead of every few weeks.

Mail Order Prices at Retail CVS Pharmacy Locations

Caremark participants can take advantage of the Caremark Maintenance Choice program and receive 90-days 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-days supplies (see above).

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.

Please refer to the Benefits Glossary of Terms at the end of this workbook for prescription drug insurance terms and definitions.
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 PPO plans 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.

Employee Contributions for 2015

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>DHMO Biweekly/Monthly</th>
<th>PPO 1 Biweekly/Monthly</th>
<th>PPO 2 Biweekly/Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$5.83 / $11.66</td>
<td>$5.83 / $11.66</td>
<td>$14.04 / $28.08</td>
</tr>
<tr>
<td>Family</td>
<td>$23.46 / $46.92</td>
<td>$20.80 / $41.60</td>
<td>$44.97 / $89.94</td>
</tr>
</tbody>
</table>

Dental Plan Comparison

<table>
<thead>
<tr>
<th>Service</th>
<th>DHMO</th>
<th>PPO 1</th>
<th>PPO 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (individual/family)</td>
<td>None</td>
<td>$50 / $150</td>
<td>$25 / $75</td>
</tr>
<tr>
<td>Class I Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanings and Exams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(DHMO: once in any 6 consecutive months; PPO: 2 per calendar year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing X-rays</td>
<td>100%2</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(DHMO: to age 14, once in any 6 consecutive months &amp; age 14+, once per 12 consecutive months; PPO: 2 per calendar year, any age)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Mouth X-rays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(once per 3 years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>— to age 19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(DHMO: once every 6 consecutive months; PPO: 2 per calendar year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class II Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(fillings, root canals, periodontics, oral surgery)</td>
<td>see copay2 schedule</td>
<td>50% (includes white fillings)</td>
<td>80% (includes white fillings)</td>
</tr>
<tr>
<td>Class III Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(prosthetics, crowns, inlays, onlays)</td>
<td>see copay2 schedule</td>
<td>25%</td>
<td>50% (includes implants)</td>
</tr>
<tr>
<td>Class IV Services: Orthodontics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Maximum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(excludes diagnostic and preventive services, and orthodontics &amp; implants)</td>
<td>N/A</td>
<td>$1,000</td>
<td>$1,500</td>
</tr>
<tr>
<td>Lifetime Maximum:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontics / Implants</td>
<td>N/A</td>
<td>N/A</td>
<td>$1,500 / $3,000</td>
</tr>
</tbody>
</table>

Dental PPO vs HMO

- The DHMO requires copayments with no deductible, coinsurance, or annual maximum. A primary care dentist and referrals are required. You must use participating providers. You must be in Pennsylvania 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 Alliance 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.

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.

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 A member copayment schedule outlines the covered services copayments for the DHMO plan. Please refer to the copayment schedule posted on the dental plan webpage at http://www.cmu.edu/hr/benefits/benefit_programs/dental.html.
3 See the plan’s schedule of benefits for information on the permitted schedule of covered services.

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

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**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.

**Employee Contributions for 2015**

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Davis Option 1 Biweekly/Monthly</th>
<th>VBA Option 1 Biweekly/Monthly</th>
<th>Davis Option 2 Biweekly/Monthly</th>
<th>VBA Option 2 Biweekly/Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0.53 / $1.06</td>
<td>$0.61 / $1.22</td>
<td>$2.12 / $4.24</td>
<td>$2.00 / $4.00</td>
</tr>
<tr>
<td>Family</td>
<td>$3.18 / $6.36</td>
<td>$3.67 / $7.34</td>
<td>$8.74 / $17.48</td>
<td>$8.25 / $16.50</td>
</tr>
</tbody>
</table>

**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**

VBA does not issue member ID cards. Most VBA providers can submit electronic claims based on your personal information. If your provider cannot submit electronic claims you will need to request a benefit form in advance. If you do not get a benefit form prior to your appointment, the visit will be considered out-of-network. The VBA website (www.visionbenefits.com) provides information about providers equipped for electronic claims.

- Request a benefit form from the VBA website 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.

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For more information about benefits, go online to [http://www.cmu.edu/hr/benefits](http://www.cmu.edu/hr/benefits).
## Vision Plan Comparison

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

---

1 For plan payments for other specialty options, out-of-network reimbursement schedule, or value added features, see the HR website 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 \(\geq +/- 6.00\) 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.
**Health Care Flexible Spending Account**

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

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

You may contribute up to $2,500 per calendar year, or as little as $60. You are not required to participate in other Carnegie Mellon benefits to enroll in the HCFSA.

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

The amount you defer during 2015 will be available to reimburse eligible expenses incurred during both the calendar year and a 2.5 month grace period (January 1, 2015–March 15, 2016). In order to be reimbursed, eligible expenses must be submitted by June 30, 2016 with the appropriate documentation, if required.

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

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

**Estimate Carefully: Use It or Lose It**

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

**What Expenses Are Covered? Highlights of Eligible HCFSA Expenses**

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


Some examples of expenses that may be covered include:

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

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**For more information about benefits, go online to [http://www.cmu.edu/hr/benefits](http://www.cmu.edu/hr/benefits).**
Dependent Care Reimbursement Account

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

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

Expenses must be incurred during the calendar year (January 1–December 31, 2015), and claims must be submitted by June 30, 2016. In order to claim expenses, you and your spouse must work full- or part-time outside the home, be self-employed or be a full-time student, or your spouse must be physically or mentally disabled.

Eligible dependents include:

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

How the Account Works

Estimate your out-of-pocket expenses for child care/adult care for the upcoming plan year. Throughout the year, you will contribute to your account on a pre-tax basis. As you incur eligible expenses during the year, you will pay for them out of your own pocket. You will then be reimbursed with the money in your account by filing a claim. Please note that you can only be reimbursed up to your account balance (i.e. the amount you have contributed year-to-date).

Estimate Carefully: Use It or Lose It

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

What Expenses Are Covered?

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


Highlights of Eligible DCRA Expenses

Below are some examples of expenses that may be covered:

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

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

For more information about benefits, go online to [http://www.cmu.edu/hr/benefits](http://www.cmu.edu/hr/benefits).
Long-term Disability Insurance

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

The program, administered by Sun Life Financial, offers two levels of LTD coverage. Both levels of LTD insurance use the same definition of disability.

- **Basic LTD** provides 60% of your monthly base salary, up to a maximum benefit of $15,000 per month. There is no employee charge for Basic LTD.

- **Enhanced LTD** provides 60% of your monthly base salary and makes a cost-of-living adjustment (COLA) of 5% a year, for up to 10 years. After 10 COLA increases, your benefit amount will remain fixed. *(NOTE: Those age 55 and older do not receive 10 COLA increases due to limitations in maximum benefits duration. Enhanced LTD is not applicable to individuals age 69+.)*

- The cost for the Enhanced LTD benefit is based on your salary. For each $100 of annual salary, your cost will be $0.06 per year.

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

  \[(50,000 \div 100) \times 0.06 = 30.00 \text{ per year}\]

  \[30 \div 12 = 2.50 \text{ per month} \quad 30 \div 24 = 1.25 \text{ per biweekly pay}\]

### Deciding If You Need Enhanced LTD Coverage

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

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

### Coverage Before LTD Begins

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

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

For more information on the Short-Term Disability or Worker’s Compensation plans, go to the Human Resources website at [http://www.cmu.edu/hr/benefits](http://www.cmu.edu/hr/benefits).
Life and Accidental Death & Dismemberment (AD&D) Insurance

FREE Basic Life and AD&D Insurance

Carnegie Mellon provides, at no cost to you, basic life insurance coverage equal to your annual base salary, rounded up to the nearest thousand. You may opt out of the university’s free basic life insurance coverage. The life insurance benefit includes an accidental death and dismemberment component. Certain amounts are also paid if you lose a limb or certain vital functions in an accident.

Supplemental Life and AD&D Insurance

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

Supplemental Life and AD&D insurance is available at age-related rates (see chart to the right). You can purchase dependent life and AD&D insurance for your spouse/domestic partner and child(ren) only if you purchase employee supplemental life and AD&D insurance.

Evidence of Insurability

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

- Basic life insurance coverage never requires an EOI.
- Supplemental insurance of more than $500,000 will require an EOI.
- Enrolling in supplemental insurance after initial eligibility requires an EOI regardless of level of coverage.

Imputed Income Tax

The value of life insurance greater than $50,000 is taxable by the IRS. This is known as imputed income. The IRS calculates the value of group life insurance based on your age and the amount of coverage you have (see chart to the right). Carnegie Mellon is required to withhold federal taxes based on the value of your life insurance coverage in excess of $50,000. To reduce your tax liability, you can limit your life insurance to $50,000. However, the impact of the imputed income taxes is generally small.

To calculate your monthly imputed income:
1) Subtract $50,000 from your life insurance amount. Divide the remainder by 1,000.
2) Multiply that amount by the premium level associated with your age as of December 31, 2015. That is the imputed income that will be taxed.

Beneficiary Info

To designate or change your beneficiaries, visit www.wpsenroll.com. For detailed information, please read Choosing Your Beneficiaries [pdf].

Special Features of Supplemental Life

Online Will Preparation for you and your spouse/partner
Enhanced Portability if you leave the university
Accelerated Benefits Option if you are terminally ill

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

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

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

Spouse/Domestic Partner Life and AD&D Insurance

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

- If you and your spouse/domestic partner are both full-time, benefits-eligible employees of Carnegie Mellon, you cannot elect Spouse/Domestic Partner Insurance. Instead, each of you can enroll in our Supplemental Life Insurance (see page 17).
- If your spouse/domestic partner is a part-time, benefits-eligible employee of Carnegie Mellon, you may purchase Dependent Life Insurance for him/her. However, your partner will not be eligible to receive free basic life insurance or to purchase additional AD&D coverage from the university.

Evidence of Insurability (EOI) for Spouse/Domestic Partner Life Insurance

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

Dependent Child(ren) Life and AD&D Insurance

You may purchase life insurance to cover your dependent children only if you purchase Employee Supplemental Life and AD&D Insurance. Dependent Child(ren) Insurance rates (see chart to the left) cover ALL of your dependent children for one price—you do NOT need to multiply the rate by the number of children covered under the plan. If you and your spouse/domestic partner are both full-time, benefits-eligible employees of Carnegie Mellon, only one of you can elect this option to cover the child(ren).

Evidence of Insurability for Dependent Child(ren) Insurance

- An EOI is not required at any level at initial eligibility (within 30 days of your hire, or their birth or adoption).
- Enrolling for the first time during Open Enrollment will require an EOI.
- Increasing your children’s coverage will require that your children satisfy EOI.
Benefits for Domestic Partners

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

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

• the relationship has continued for at least 12 consecutive months,
• the couple can demonstrate that the committed relationship is substantially similar to that of a married couple.

See the Domestic Partner Registration Kit (http://www.cmu.edu/hr/benefits/benefit_admin/dependents.html) 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
• 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 CMUWorks Service Center. The Registration Statement is subject to approval. All registration and termination statements of domestic partnerships will be held confidentially.

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.

Tax Consequences of Domestic Partner Coverage

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

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

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

See the Domestic Partner Registration Kit, available at http://www.cmu.edu/hr/benefits/benefit_admin/dependents.html, for more information about the tax implications associated with covering domestic partners.
QUALIFYING LIFE OR FAMILY STATUS CHANGES

Qualified life or family status changes that allow you to make changes to your benefits outside of the Open Enrollment period include:

- Marital/domestic partnership status changes (e.g., marriage/registration of partnership, death, divorce/termination of partnership)
- Number of covered dependent children changes (e.g., 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)
- Relocation (e.g., moving outside of HMO area, domestic to international position)
- Employment status change (e.g., part-time to full-time)

Following IRS regulations, you can make changes consistent with your life or family status change within 30 days of the date the status change occurred.

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 at http://www.cmu.edu/hr/benefits/benefit_programs/index.html.

FOR OTHER (ADMINISTRATIVE) APPEALS

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.)

If you are unable to resolve the situation with the carrier, please contact the CMUWorks Service Center at 412-268-4600 for assistance.

COBRA INFORMATION (CONTINUATION OF COVERAGE)

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

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

For issues related to eligibility or enrollment, or unresolved claim issues, contact the CMUWorks Service Center at 412-268-4600 or cmu-works@andrew.cmu.edu.

Medical Plan Options

Highmark
1-800-472-1506
http://www.highmarkbcbs.com

UPMC Health Plan
1-855-497-8762
http://www.upmchealthplan.com

HealthAmerica
1-800-735-4404
http://www.healthamerica.cvty.com

Vision Plan Options

Davis Vision
1-800-999-5431
http://www.davisvision.com
Reference control code: 4102

Vision Benefits of America (VBA)
1-800-432-4966
http://www.visionbenefits.com

Life and AD&D Insurance;
Long-Term Disability

Sun Life Financial
1-800-247-6875
http://www.sunlife.com/us

Health Care Flexible Spending Account;
Dependent Care Reimbursement Account

Benefit Coordinators Corporation (BCC)
1-800-685-6100
https://www.mywealthcareonline.com/bccsmartcare/
Fax: 1-412-276-7185

Prescription Drug Plan Options

Caremark
1-877-347-7444
http://www.caremark.com
Mail Order Service
FastStart®: 1-800-875-0867 (enrollment)

Dental Plan Options

United Concordia Companies, Inc. (UCCI)
1-800-423-7461
http://www.ucci.com
Benefits Glossary of Terms

Accidental Death & Dismemberment (AD&D)
A component of life insurance coverage; in the event of one’s accidental death, the benefit payable will double. If one loses a limb or other vital function, benefits will be paid according to a schedule.

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

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

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

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

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

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

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

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

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

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

Formulary
A list of medications which are preferred drugs in a pharmacy benefit plan. The formulary serves as a guide for prescribing, dispensing and use. Drugs included in the formulary are selected on the basis of safety, effectiveness and cost, and are covered at a higher level. The formulary list can be modified at any time by the carrier; refer to the website 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.

Generic Drug Substitution Waivers
Brand name medications that have a generic equivalent can be used if they are authorized as 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).

Guaranteed issue
The life insurance you can receive at initial eligibility without needing to submit evidence of insurability.

For more information about benefits, go online to http://www.cmu.edu/hr/benefits.
Benefits Glossary of Terms (continued)

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 of three years. The money in the account is forfeited if your participation in the HRA plan ends. The HRA is paired with a high deductible PPO plan.

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

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

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

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

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.

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

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).

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 benefit program.

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

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

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

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

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

**Primary Care Dentist (PCD)**

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

**Salary/ Base Salary**

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

**Term life insurance/ group term life insurance**

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

**Usual, Customary and Reasonable (UCR)**

The fees set by the carrier that reflect typical fees charged for services in your area. Carriers assign UCR levels to all services and pay claims based on them. Expenses above the UCR will not be paid under the terms of the benefit plans. Out-of-network providers may bill you for their charges in excess of the UCR.
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Inquiries concerning the application of and compliance with this statement should be directed to the vice president for campus affairs, Carnegie Mellon University, 5000 Forbes Avenue, Pittsburgh, PA 15213, telephone 412-268-2056.