
 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [www.Caremark.com](http://www.Caremark.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-347-7444 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| <b>What is the overall <u>deductible</u>?</b>                             | There is no deductible   |  |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | N/A  |  |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No   |  |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | Annual Out-of-Pocket Limit<br>\$2,650 / Individual<br>\$5,300 / Family   | Separate from medical out-of-pocket limit.   |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | Premiums, penalties, balance-billed charges, prescriptions this plan does not cover.   | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. For a list of the retail and mail-order pharmacies, visit <a href="http://www.Caremark.com">www.Caremark.com</a> and use the "Locate Nearby Pharmacy" tool. A list of specialty pharmacies is also available. |  |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | See Medical Plan Summary   |  |

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

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

\* For more information about limitations and exceptions, see the plan or policy document at [www.Caremark.com](http://www.Caremark.com).

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|--|--|--|--|--|
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| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.Caremark.com">www.Caremark.com</a> | Generic drugs  | Retail: \$10.00<br>Mail-Order (Up to 90-day supply): \$20.00 | Reimbursed at contracted in-network rate less co-pay |  |
|  | Preferred brand drugs<br><br>(For Caremark's Preferred Drug List, please access: <a href="https://www.caremark.com/portal/asset/Advanced_Control_Specialty_Performance_Drug_List.pdf">https://www.caremark.com/portal/asset/Advanced_Control_Specialty_Performance_Drug_List.pdf</a> ) | Retail: \$25.00<br>Mail-Order (Up to 90-day supply): \$50.00 | Reimbursed at contracted in-network rate less co-pay | When a generic is available but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name drug and the generic drug plus the generic copayment. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, visit the HR Benefits Prescription page, or call Caremark at 1-877-347-7444. |
|  | Non-preferred brand drugs  | Retail: \$40.00<br>Mail-Order (Up to 90-day supply): \$80.00 | Reimbursed at contracted in-network rate less co-pay | When a generic is available but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name drug and the generic drug plus the generic copayment. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, visit the HR Benefits Prescription page, or call Caremark at 1-877-347-7444. |
|  | Specialty drugs  | \$ 100.00  | N/A  | Specialty drugs must be filled through the CVS Specialty Pharmacy ( <a href="http://www.cvsspecialty.com">www.cvsspecialty.com</a> ). Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, visit the HR Benefits Prescription page, or call Caremark at 1-877-347-7444.   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | See Medical Plan Summary                                     | See Medical Plan Summary                             |  |
|  | Physician/surgeon fees   | See Medical Plan Summary                                     | See Medical Plan Summary                             |  |
| <b>If you need immediate medical attention</b>   | <u>Emergency room care</u>   | See Medical Plan Summary                                     | See Medical Plan Summary                             |  |

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| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|  | <u>Emergency medical transportation</u>   | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | <u>Urgent care</u>                        | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | Physician/surgeon fees                    | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | Inpatient services                        | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
| <b>If you are pregnant</b>   | Office visits                             | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | Childbirth/delivery professional services | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | Childbirth/delivery facility services     | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | <u>Rehabilitation services</u>            | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | <u>Habilitation services</u>              | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | <u>Skilled nursing care</u>               | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | <u>Durable medical equipment</u>          | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
|  | <u>Hospice services</u>                   | See Medical Plan Summary                     | See Medical Plan Summary                           |  |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | Not Covered                                  | Not Covered  |  |
|  | Children's glasses                        | Not Covered                                  | Not Covered  |  |
|  | Children's dental check-up                | Not Covered                                  | Not Covered  |  |

\* For more information about limitations and exceptions, see the plan or policy document at [www.Caremark.com](http://www.Caremark.com).

## Excluded Services & Other Covered Services:

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

- To find covered drugs visit <https://www.cmu.edu/hr/benefits/health-welfare/prescription/index.html> and use the applicable “check drug cost” link. You can also call Caremark at 1-877-347-7444 for assistance.

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

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

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

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

### Does this plan provide Minimum Essential Coverage? Yes.

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

### Does this plan meet the Minimum Value Standards? Yes.

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

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-347-7444.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-347-7444.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-347-7444.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-347-7444.

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

About these Coverage Examples:



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

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

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

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

**Total Example Cost** \$12,800

**In this example, Peg would pay:**

| Cost Sharing                      |            |
|-----------------------------------|------------|
| Deductibles                       | \$350      |
| Copayments                        | \$35       |
| Coinsurance                       | \$2,490    |
| What isn't covered                |            |
| Limits or exclusions              | \$2,875    |
| <b>The total Peg would pay is</b> | <b>\$0</b> |

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

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

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

**Total Example Cost** \$7,400

**In this example, Joe would pay:**

| Cost Sharing                      |            |
|-----------------------------------|------------|
| Deductibles                       | \$350      |
| Copayments                        | \$35       |
| Coinsurance                       | \$1,410    |
| What isn't covered                |            |
| Limits or exclusions              | \$1,795    |
| <b>The total Joe would pay is</b> | <b>\$0</b> |

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

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

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

**Total Example Cost** \$1,900

**In this example, Mia would pay:**

| Cost Sharing                      |            |
|-----------------------------------|------------|
| Deductibles                       | \$350      |
| Copayments                        | \$35       |
| Coinsurance                       | \$310      |
| What isn't covered                |            |
| Limits or exclusions              | \$695      |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

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