This guide and our web resources are not intended to take the place of plan documents. If there is a conflict between this guide and the plan documents, the plan documents will govern. The Summary Plan Descriptions (SPDs) contain more detailed information. Contact Human Resources Services to submit an HR ticket requesting a hard copy of the SPDs. Carnegie Mellon University 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 reasons upon appropriate action by the university. Notwithstanding any of the prior statements, in all cases, university policies will govern.

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Benefits
Enrollment
When to Enroll in Benefits

Employees may enroll in benefits when they first become eligible and every year during Open Enrollment.

Newly Eligible Employees

Newly eligible employees must enroll in benefits within 30 days of their hire date (or the day they become eligible). Benefit elections will be effective for the remainder of the calendar year, unless the employee experiences a qualified life or family status change midyear (see next page).

When do benefits go into effect?

Benefits always go into effect on the first of the month. For example, if the hire date is the first of the month, the benefits effective date is the same date. Otherwise, the benefits effective date is the first day of the month following the date you were hired or became eligible.

Open Enrollment

Typically held in late fall, Open Enrollment provides you the opportunity to review your benefits coverage and make new elections for the upcoming calendar year.

What happens if I don’t select my benefits during Open Enrollment?

If you do not actively select your benefits for the upcoming year, you will be enrolled in the same benefit plans (or equivalent) at the same level of participation you have in the current year, with the exception of flexible spending accounts.

When do changes made during Open Enrollment go into effect?

Elections made during Open Enrollment become effective the following January 1 and remain in effect for the entire calendar year.

Annual Opportunity to Change your Benefits

Unless you experience a qualifying life or family status change (see next page), Open Enrollment is the only time during the year when you may change your elections.

30 Day Window for Benefits Enrollment

Newly eligible employees have 30 days from the date they become eligible to enroll in or waive benefits. If you do not make elections within 30 days, you will be automatically enrolled in default benefits (see right). Please note that Retirement Savings contributions can be elected or changed at any time.

Default Benefits

Employees are automatically enrolled in certain benefits if elections are not made when they are first eligible or when they have an eligibility change.

Full-Time Employees

The default benefit package for full-time employees costs $55 per month and covers the employee only:

- Medical: UPMC PPO Option 2 ($42)
- Prescription: Caremark Option B ($13)
- Life and AD&D Insurance: Basic ($0)
- Long-Term Disability Insurance: Basic ($0)

Full-time employees will not be enrolled in dental, vision, optional life and AD&D insurance, dependent life insurance, or any flexible spending account.

Part-Time Employees

The default benefit package for part-time employees is the basic life insurance only. Employees will not be enrolled in medical, prescription, or voluntary AD&D insurance. There is no cost associated with part-time default benefits.

Retirement Savings

Newly eligible employees will be enrolled in a qualified default investment for their university retirement contributions with no employee supplemental contributions. (See page 32 for more information.)

Rehired Employees

If you terminate employment (or otherwise lose eligibility) and then resume employment (or otherwise regain the same benefit eligibility) within the same calendar year, your elections in effect on the date you initially lost eligibility will be automatically reinstated. You will not be permitted to make new elections until the next open enrollment period, unless you experience a qualifying life or family status change.
**Life or Family Status Changes**

*Changing benefits outside Open Enrollment*

Life or family changes sometimes require you to change your benefits outside of Open Enrollment. Following IRS regulations, you can make changes to your benefits that are consistent with your life or family status change within 30 days of the date that the status change occurred. If you miss the 30 day enrollment period, you must wait until the next Open Enrollment to make changes.

Supporting documentation to verify a status change, such as a birth certificate, marriage certificate or proof of new coverage, is required. If you experience a life or family status change, but do not yet have the required supporting documentation, please do not wait to request the change in Workday until you receive it. You can separately submit the documentation in Workday within 30 days of making the elections.

In most cases, 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).

### 30 Day Deadline

Employees have 30 days from the event date to request benefit changes in Workday. After electing the new benefits, employees have 30 days to upload required documentation. This includes documentation to verify the status change and to verify newly added dependents.

### Qualifying Life or Family Status Changes

The following life or family status changes allow you to make changes outside of Open Enrollment:

- Marital/domestic partnership status changes (e.g., marriage or registration of partnership, death, divorce or termination of partnership)
- Dependent eligibility changes (e.g., birth or adoption, death, or dependent(s) become(s) 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., domestic to international position change, spouse arriving from overseas)
- Employment status change (e.g., part-time to full-time)

### Examples of Life or Family Status Changes

**Dependent Gains Outside Coverage**

Your daughter obtains her first job and now has her own insurance as of May 1. You have until May 31 to remove her from your plan in Workday. If you submit the request on May 23, you have until June 22 to upload supporting documentation.

**Marriage**

You were married on August 6 and want your new spouse to be covered under your CMU benefits. You have until September 5 to submit the benefit change request in Workday. If you complete the request on August 10, you need to submit a copy of your marriage certificate by September 9. Your spouse’s coverage would become effective on September 1.

### Consistency Rule

The benefit changes you request must be consistent with your life or family status change. For example, if your spouse loses outside medical/prescription coverage, you may add your spouse to your medical/prescription plan, but you would not be able to drop vision coverage.
**How to Enroll in Benefits**

1. **Review Your Benefit Options.**
   Review this guide and utilize our online resources to determine your benefits eligibility. Decide which options work best for you and your family.

2. **Gather Your Information.**
   If adding new dependents to your benefits coverage, you will be required to provide their Social Security numbers and upload a copy of dependent verification documentation to Workday (see page 9 for more information) within 30 days. If enrolling in the Dental DHMO plan, you will need to enter the Provider ID code for your primary care dentist. A link to search for this code is provided in Workday on the enrollment screen.

3. **Enroll Through Workday.**
   Workday is the university’s web-based human resources, payroll, benefits and time tracking system. Visit the [HR Services website](https://www.cmu.edu/hr/service-center/index.html) to log in to Workday using your Andrew ID, password and DUO 2fa. If you need assistance using the system, review the [Workday system guides](https://www.cmu.edu/hr/service-center/help/index.html) or contact Human Resources Services by submitting request for assistance.

4. **Print.**
   Please review your final elections carefully before submitting, and remember to print and/or save a copy for your records.

5. **Follow Up with Required Documentation.**
   If dependent verification documentation and/or life status change supporting documentation is required, please upload these documents to Workday within 30 days if you did not attach the documents at the time of enrollment. (If documentation is not received within the 30-day time frame, your dependent(s) will be removed from coverage.) Evidence of Insurability (EOI) may also be required for life insurance coverage. If you receive an EOI form, please return it to MetLife within the time frame indicated.

---

**Need Help Understanding Your Benefits?**

Human Resources Services is your first stop for questions pertaining to benefits.

**Hours:**
Monday–Friday, 8:30 a.m.–5 p.m. Eastern Time

**Website:**
[https://www.cmu.edu/hr/service-center/index.html](https://www.cmu.edu/hr/service-center/index.html)

Submit an HR Ticket and View FAQs:
[https://www.cmu.edu/hr/service-center/help/index.html](https://www.cmu.edu/hr/service-center/help/index.html)

**Main Phone:**
412-268-4600

**Toll Free:**
844-625-4600

**In Person:**
4516 Henry Street, Pittsburgh, PA 15213
Eligibility and Benefit Plan Contacts
# Benefits Eligibility: Full-Time vs. Part-Time

<table>
<thead>
<tr>
<th>Benefit Program</th>
<th>Full-Time Eligible</th>
<th>Part-Time Eligible</th>
<th>Not Benefits Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scheduled Hours</strong></td>
<td>At least 37.5 hours per week or 100% of a full-time schedule (40 hours for Campus Police Association)</td>
<td>At least 17.5 hours per week or 46.7% of a full-time schedule</td>
<td>Less than 17.5 hours per week or 46.7% of a full-time schedule</td>
</tr>
<tr>
<td>Medical</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Prescription</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Dental</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Vision</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Flexible Spending Accounts (FSAs)</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Life and AD&amp;D Insurance</td>
<td>✓</td>
<td>✓*</td>
<td></td>
</tr>
<tr>
<td>Dependent Life Insurance</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-Term/Long-Term Disability</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuition Benefits</td>
<td>✓*</td>
<td>✓*</td>
<td></td>
</tr>
<tr>
<td>Tuition Benefits for Dependent Children</td>
<td>✓*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University Retirement Contributions</td>
<td>✓</td>
<td>✓*</td>
<td>✓*</td>
</tr>
<tr>
<td>Employee Retirement Contributions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Paid Time Off</td>
<td>✓*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Transportation</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Family Care Concierge Service</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Group X-ercise Classes</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

*Specific eligibility requirements (such as minimum hours worked, service requirement, etc.) or different benefit levels may exist.

If you need more information or have any questions about a specific benefit, please visit the [HR website](#) or contact Human Resources Services at 412-268-4600 or by [submitting an HR ticket for assistance](#).
**DEPENDENT ELIGIBILITY**

Benefits eligible employees may also cover their eligible dependents under certain benefits.

Eligible dependents include:

- same- or opposite-sex spouse or registered domestic partner (see below)
- children (natural born, legally-adopted, stepchildren, children of your domestic partner whom you can claim as your dependent on your U.S. federal income tax return, or children for whom you, your spouse or domestic partner serve as a legal guardian) up to their 26th birthday
- 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

Individuals can only be covered once under a Carnegie Mellon University benefit plan. If your spouse/domestic partner and/or child(ren) are already covered under a CMU benefit plan, you will not be able to add them to coverage under that plan.

**REGISTERING YOUR DOMESTIC PARTNER**

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.

Children of a registered domestic partner whom the employee can claim as a dependent for federal tax purposes may also be added.

See the Domestic Partner Registration Packet [pdf] for a detailed list of the criteria for registering a domestic partnership and the documentation required to be submitted. Registration is subject to approval.

**DEPENDENT VERIFICATION**

Supporting documentation is required when adding dependents to your coverage and must be submitted within 30 days of enrollment. Please refer to Dependent Eligibility Documentation [pdf] for a complete list of acceptable documents. Documentation is uploaded via Workday and will be held confidentially. (If documentation is not received within the 30-day time frame, your dependent(s) will be removed from coverage.)

Please refer to the Workday system guides for detailed instructions regarding how to add dependents in Workday.

---

**SOCIAL SECURITY NUMBER REQUIREMENT**

If you elect benefits that include coverage for dependents, please add their Social Security number(s) (SSNs) in the space provided during enrollment in Workday.* Please note that it is important to provide this information. The Affordable Care Act requires employers to report to the IRS the SSNs of all employees and dependents with minimum essential coverage.

*Please refer to the Workday system guides for detailed instructions regarding how to add dependents in Workday.

---

**DOMESTIC PARTNER TAX CONSEQUENCES**

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 attributed to your domestic partner’s coverage must 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.
# Benefits Resource Directory and Contacts

<table>
<thead>
<tr>
<th>Benefit Provider Name</th>
<th>Policy/Group Number</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| UPMC Health Plan                                  | 005782              | 855-497-8762           | www.upmchealthplan.com
|                                                   | (subgroup varies depending on your plan choice) |                        | www.multiplan.com/upmc (if residing outside PA)                       |
|                                                   |                     |                        | UPMC Provider Search: https://findcare.upmchp.com/find                   |
|                                                   |                     |                        | (enter your member ID to search by plan; non-members can use the “I’m just browsing” tab to browse by provider type and location) | |
| Highmark Blue Cross Blue Shield                   | 13058               | 844-946-6249           | Highmark Provider Search: https://www.highmarkbcbs.com/find-a-doctor     |
|                                                   | (subgroup varies depending on your plan choice) |                        | (search “PPO Blue” in Pennsylvania & “BCBS PPO” outside of Pennsylvania) | |
| **Prescription**                                  |                     |                        |                                                                         |
| CVS/Caremark                                      | RX5806              | 844-910-3902           | www.caremark.com                                                       |
|                                                   |                     | Mail Order Service Enrollment: 800-875-0867 |                                                                         |
| **Dental**                                        |                     |                        |                                                                         |
| United Concordia (UCCI)                           | DHMO: 846329000     | 800-423-7461           | www.ucci.com                                                           |
|                                                   | PPO1: 846327100     |                        | To Find a Dentist: DHMO—search DHMO Concordia Plus General Dentist network |
|                                                   | PPO2: 846328100     |                        | PPOs—search Alliance network                                          |
| **Vision**                                        |                     |                        |                                                                         |
| Davis Vision                                      | Option 1: 4102, Option 2: 4112 | 800-999-5431 | www.davisvision.com                                                   |
| Vision Benefits of America                        | Option 1: 2238; Option 2: 2239 | 800-432-4966 | www.vbaplan.com                                                       |
| **Disability, Life and AD&D Insurance**           |                     |                        |                                                                         |
| MetLife                                           | 166124              | 800-638-6420           | www.metlife.com                                                        |
| **Flexible Spending Accounts & Health Savings Account** |                     |                        |                                                                         |
| WEX                                               | 47321               | 866.451.3399           | https://www.wexinc.com/contact/health/                                  |
| **Retirement Savings**                            |                     |                        |                                                                         |
| TIAA                                              | FSRP 403(b): 102240 | 800-842-2776           | www.tiaa.org/public/tcm/carnegiemellon                                |
| **Employee Assistance Program (EAP)**             |                     |                        |                                                                         |
| **Care@Work Family Care Benefits**                |                     |                        |                                                                         |
| Care.com                                          | N/A                 | 866-814-1638           | https://cmu.care.com                                                    |
Mobile Benefit Provider Resources

**MyUPMC**
Manage your health care at home or on-the-go. With MyUPMC, you can communicate with your doctor, schedule your appointments, and view your medical records, doctors’ notes, and test results. Plus, you can manage the health information for your child or loved one through the Proxy feature.

**Highmark Blue Cross Blue Shield**
The Highmark Blue Cross Blue Shield app allows members to access all of their plan benefits including virtual member ID cards. Use the app to find access to in-network doctors and facilities, access claims information, and view covered family members’ plan information.

**CVS/Caremark**
The CVS/caremark™ app lets you refill mail service prescriptions, track order status, view prescription history and more.

**United Concordia Dental Mobile**
United Concordia Companies, Inc. (UCCI) dental insurance enrollees can use the UCCI app to find a nearby dentist, view claim status, see plan coverage, view and use a virtual UCCI ID card, contact UCCI and access an emergency dental guide.

**Benefits by WEX**
Flexible spending account participants and Health Savings Accounts (HSA) participants can use the WEX app to manage their accounts securely and efficiently; gain instant access to account balances, plan details and recent transactions; and submit a claim and related materials.

**TIAA**
Manage your retirement, banking, and brokerage accounts using the TIAA mobile app. The app provides quick and secure access to all your TIAA finances, and puts 100 years of top money management into the palm of your hand.

**GuidanceNow**
GuidanceResources’ GuidanceNow app enables you to access expert information on a broad variety of topics including wellness, relationships, work, education, legal, financial and lifestyle. Find the nearest legal, child and elder care providers, ask for confidential help and more.

**Care.com**
Access CMU-provided family care benefits and connect with local caregivers for your family. The Care@Work app by Care.com gives 24/7, on-the-go access to care — for both last minute and planned needs.
Medical and Prescription
**Preventive Care Benefits**
CMU plans pay 100% of in-network adult and pediatric preventive care services, according to their preventive care schedule. You will not be required to pay a copay, deductible or coinsurance.

**Medical Plans Overview**

Plans are available through UPMC Health Plan and Highmark Blue Cross Blue Shield

Below is a description of the different types of medical plans Carnegie Mellon offers. Detailed information about the medical plan options is available on the following page. You are encouraged use the provider search tools to verify that your health care providers are in your desired carrier’s network.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider Organization (PPO)</td>
<td>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.</td>
</tr>
<tr>
<td>UPMC or Highmark</td>
<td></td>
</tr>
<tr>
<td>Health Maintenance Organization (HMO)</td>
<td>HMOs have low out-of-pocket expenses (no deductible or coinsurance) but do not provide benefits if you use out-of-network providers (except in the case of an emergency). Referrals to specialist care and related services are not required in most circumstances.</td>
</tr>
<tr>
<td>UPMC</td>
<td></td>
</tr>
<tr>
<td>Exclusive Provider Organization (EPO)</td>
<td>EPOs have low out-of-pocket expenses (no deductible or coinsurance) but do not provide benefits if you use out-of-network providers (except in the case of an emergency). Referrals to specialist care and related services are not required in most circumstances.</td>
</tr>
<tr>
<td>Highmark</td>
<td></td>
</tr>
<tr>
<td>High Deductible PPO with Health Savings Account (HSA)</td>
<td>An HSA is a federally tax-deferred, private savings account designed to give you a way to pay for eligible medical, prescription, dental and vision expenses with tax-free dollars. You decide how much to put in your account (based on IRS limits set each year), and you retain ownership of the account even if you leave CMU or retire.</td>
</tr>
<tr>
<td>UPMC or Highmark</td>
<td></td>
</tr>
</tbody>
</table>

All PPO plans offer network coverage outside of the Pittsburgh area. If you are enrolled in a UPMC PPO plan and reside outside of Western Pennsylvania, you will be automatically moved into the extended nationwide service area. The UPMC HMO plan is only available to employees with a Pennsylvania work location. Search the Highmark and UPMC networks to confirm in-network physicians and facilities.

**Q: What is a deductible?**

A deductible is the amount you are required to pay each calendar year before any coinsurance payments will be made by the plan.

**Q: What is the difference between coinsurance and copayment?**

With coinsurance, the plan pays a set percentage of the allowable amount of the covered expense and you pay the rest up to the annual out-of-pocket maximum.

A copayment is any up-front fixed dollar amount you pay for in-network office visits, emergency room visits, supplies or prescription drugs. The copayment does not count toward the deductible.

**Q: What is an annual out-of-pocket maximum?**

The out-of-pocket maximum is the most you will have to pay for covered medical expenses in a plan year through deductible, copayments and coinsurance before your plan begins to pay 100% of eligible expenses.

**Q: What if I live in PA and have UPMC, but my child lives outside of the Pittsburgh area?**

If you are enrolled in UPMC and your child lives outside of the UPMC network area, you can contact UPMC at 855-497-8762 to have your child moved into their extended network.

If you have a spouse or partner living outside of the area, please submit an HR ticket for assistance to Human Resources Services.
# Medical Plan Comparison

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>PPO Option 1</th>
<th>PPO Option 2</th>
<th>EPO (Highmark) / HMO (UPMC)</th>
<th>High Deductible PPO with HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Annual Deductibles and Out-of-Pocket Maximums</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible (Individual/Family)</td>
<td>$250 / $500</td>
<td>$500 / $1,000</td>
<td>$500 / $1,000</td>
<td>$750 / $1,500</td>
</tr>
<tr>
<td>CMU Contribution to Account (Individual/Family)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Individual/Family)</td>
<td>$1,500 / $3,000</td>
<td>$3,000 / $6,000</td>
<td>$3,500 / $7,000</td>
<td>$1,000 / $2,000</td>
</tr>
<tr>
<td><strong>Copay/Coinsurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Coinsurance Responsibility after Deductible</td>
<td>90%</td>
<td>75%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Primary Care Physician Office Visit</td>
<td>$20</td>
<td>$25</td>
<td>$20</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$35</td>
<td>$40</td>
<td>$35</td>
<td></td>
</tr>
<tr>
<td>Preventive Care (per schedule)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Visit (waived if admitted)</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>

*UCR means 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 deductible or out-of-pocket maximum.

** Member coinsurance responsibility after the deductible is met.
Monthly, pre-tax rates are shown; divide rate by two to obtain biweekly, pre-tax rates. Rates do not include the cost of prescription drug coverage, which is required with medical plan coverage. Prescription rates are shown on page 17.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>PPO Option 1</th>
<th></th>
<th>PPO Option 2</th>
<th></th>
<th>Highmark EPO / UPMC HMO</th>
<th></th>
<th>High Deductible PPO with HSA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td>Part-Time</td>
<td>Full-Time</td>
<td>Part-Time</td>
<td>Full-Time</td>
<td>Part-Time</td>
<td>Full-Time</td>
<td>Part-Time</td>
</tr>
<tr>
<td><strong>Employee Only</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$235</td>
<td>$428</td>
<td>$175</td>
<td>$367</td>
<td>$74</td>
<td>$377.50</td>
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<tr>
<td>UPMC</td>
<td>$95</td>
<td>$289</td>
<td>$42</td>
<td>$233.50</td>
<td>$62</td>
<td>$315.50</td>
<td>$18</td>
<td>$197</td>
</tr>
<tr>
<td><strong>Employee and 1 Child</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$512</td>
<td>$784</td>
<td>$403</td>
<td>$676.50</td>
<td>$396</td>
<td>$777</td>
<td>$292</td>
<td>$573.50</td>
</tr>
<tr>
<td>UPMC</td>
<td>$273</td>
<td>$547</td>
<td>$178</td>
<td>$450.50</td>
<td>$332</td>
<td>$649.50</td>
<td>$80</td>
<td>$359.50</td>
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<tr>
<td><strong>Employee and 2+ Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Highmark</td>
<td>$590</td>
<td>$885</td>
<td>$467</td>
<td>$764.50</td>
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<td>$894</td>
<td>$344</td>
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<tr>
<td>UPMC</td>
<td>$324</td>
<td>$621</td>
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<td>$414</td>
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<td>$410</td>
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<tr>
<td><strong>Employee and Spouse/Partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$669</td>
<td>$986.50</td>
<td>$534</td>
<td>$854</td>
<td>$592</td>
<td>$1,011</td>
<td>$397</td>
<td>$726.50</td>
</tr>
<tr>
<td>UPMC</td>
<td>$375</td>
<td>$694.50</td>
<td>$255</td>
<td>$574</td>
<td>$495</td>
<td>$845</td>
<td>$134</td>
<td>$462</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$984</td>
<td>$1,391.50</td>
<td>$792</td>
<td>$1,205.50</td>
<td>$985</td>
<td>$1,479</td>
<td>$604</td>
<td>$1,030.50</td>
</tr>
<tr>
<td>UPMC</td>
<td>$577</td>
<td>$988</td>
<td>$409</td>
<td>$820</td>
<td>$825</td>
<td>$1,236.50</td>
<td>$242</td>
<td>$665.50</td>
</tr>
</tbody>
</table>
PRESCRIPTION PLANS OVERVIEW

Plans are available through CVS/Caremark

Carnegie Mellon prescription coverage provides access to numerous chain and independent pharmacies, in addition to mail order service for maintenance medication. There are currently two plan options available, which differ by employee contribution rates, copays/coinsurance rates and coverage for non-preferred drugs. Please note that beginning in 2023, Caremark Option A will be frozen to current enrollees only. If you elect to change out of the plan during Open Enrollment, you will not be able to re-enroll in it.

ENROLLING IN A MEDICAL PLAN? YOU MUST ENROLL IN A PRESCRIPTION PLAN.
Employees who enroll in medical plan coverage through CMU must select prescription drug coverage for the same individuals covered under the medical plan.

ENROLLING IN A HIGH DEDUCTIBLE PPO WITH HSA PLAN? You will pay all medical and prescription costs out of pocket until you reach your annual deductible. After you pay your deductible, you will pay copayments until you reach your annual out of pocket maximum.

NO-COST PREVENTIVE CARE DRUGS

All prescription plans offer certain generic preventive care drugs at no cost to you. You will not be required to pay a copay or coinsurance.

PRUDENTRX

All prescription plans now include the option to enroll in the PrudentRx Specialty Drug Copay Program and No-Cost Preventative Drug Schedule. Faculty and staff members who enroll in the program will have the cost of their specialty drug prescriptions reduced to a $0 copay from the current $100 copay. Please note: Participants in the High-Deductible PPO with HSA plan will need to meet their deductible before the PrudentRx Specialty Drug Copay Program will apply.

MAINTENANCE MEDICATIONS

Maintenance medications are drugs prescribed for long-term conditions and are taken on a regular, recurring basis. Caremark provides a mail order service for maintenance drugs. Mail order service prescriptions are 90-day supplies for the cost of a 60-day supply. You can place a mail order request online or by mail. Participants can also utilize the Caremark Maintenance Choice program and receive 90-day supplies of their maintenance drugs at mail order rates when filled at CVS retail pharmacies.

If you need more than three fills of the same prescription, you are required to transition to a 90-day supply and fill the prescription through either mail order services or CVS retail pharmacies utilizing Caremark Maintenance Choice. If you would like to continue to receive 30-day supplies at a retail pharmacy, you will need to contact Caremark to opt out of the Maintenance Program.

BRIDGE SUPPLIES

Caremark participants who want to use mail order but need a refill immediately can call 844-910-3902 to request a five-day bridge supply from a CVS retail pharmacy.

1. Ask for a generic first.

Generic drugs are as safe and effective as brand-name drugs but cost less. Talk to your doctor to see if generics are right for you.

2. Use preferred drugs (if a generic is not available).

When generics are not available, using drugs on the Preferred Drug List is another way to save money. You can find the Caremark Preferred Drug list, as well as an updated list of Formulary Drug Removals, on the HR Benefits Prescription Drug page.

3. Order 90-day supplies (for maintenance drugs).

Maintenance Choice lets you choose to receive your maintenance medications at a CVS retail pharmacy or from the Caremark Mail Order Service at a lower copay.

4. Know your network.

Using an in-network pharmacy generally costs you less. Use the Locate Nearby Pharmacy link at www.caremark.com to find a participating pharmacy near you. Caremark participants can also save 20% on over-the-counter, CVS-brand health-related items with their ExtraCare Health Card.

5. Use the LivingMyLife® Diabetes Management program.

Caremark participants are eligible for free health coaching and diabetes medications and testing supplies (with no copays or coinsurance) through the LivingMyLife® program. Enrollment is voluntary and confidential. For more information call 800-293-7102 or visit the LivingMyLife webpage.
Prescription Plan Comparison

<table>
<thead>
<tr>
<th></th>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Retail</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(up to 30-days supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic (automatic substitution)</td>
<td>$10</td>
<td>$5</td>
</tr>
<tr>
<td>Brand—Preferred</td>
<td>$25</td>
<td>You pay 35% ($100 maximum)</td>
</tr>
<tr>
<td>Brand—Non-Preferred</td>
<td>$40</td>
<td>You pay 100%</td>
</tr>
<tr>
<td>Specialty</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Mail Order Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Maintenance Choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(up to 90-days supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic (automatic substitution)</td>
<td>$20</td>
<td>$10</td>
</tr>
<tr>
<td>Brand—Preferred</td>
<td>$50</td>
<td>You pay 35% ($200 maximum)</td>
</tr>
<tr>
<td>Brand—Non-Preferred</td>
<td>$80</td>
<td>You pay 100%</td>
</tr>
</tbody>
</table>

Deductible and Annual Out-of-Pocket Maximum (OOP Max)

- Deductible — Applies only to enrollees in High Deductible PPO with HSA. The Prescription plan deductible is combined with the Medical plan deductible.
- In-Network: $1,600 per individual / $3,200 per family
- Out-of-Network: $3,200 per individual / $6,400 per family

- Annual Out-of-Pocket Maximum — Enrollees in High Deductible PPO with HSA. The Prescription plan OOP Max is combined with the Medical plan OOP Max.
- In-Network: $3,200 per individual / $6,400 per family
- Out-of-Network: $6,400 per individual / $12,800 per family

- Annual Out-of-Pocket Maximum — Enrollees PPO 1, PPO 2, HMO, and EPO medical plans. Separate from Medical OOP Max.
  - Both In-Network and Out-of-Network: $2,650 per individual / $5,300 per family

Prepaid and Annual Out-of-Pocket Maximum (OOP Max)

Prescription Plan Employee Contributions

Monthly, pre-tax rates are shown; divide rate by two to obtain biweekly, pre-tax rates.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td>Part-Time</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$170</td>
<td>$236</td>
</tr>
<tr>
<td>Employee and 1 Child</td>
<td>$330</td>
<td>$421.50</td>
</tr>
<tr>
<td>Employee and 2+ Children</td>
<td>$376</td>
<td>$475</td>
</tr>
<tr>
<td>Employee and Spouse / Partner</td>
<td>$421</td>
<td>$527.50</td>
</tr>
<tr>
<td>Family</td>
<td>$603</td>
<td>$739</td>
</tr>
</tbody>
</table>

Need Help Choosing a Plan?
Use the Drug Pricing Tool to Compare Costs

The HR Prescription Drug page includes a Drug Pricing Tool to help you anticipate a medication’s cost and your coinsurance/copay amount. Compare the anticipated costs with the premium amounts to see what works best for you.

Q: What is a generic drug?
A: Generic drugs are FDA-approved medically-equivalent drugs manufactured by a pharmaceutical company after the patent has expired on the original manufacturer’s brand-name medication. The prescription plans require that generic drugs be automatically substituted for brand-name medications, when available, as they are generally much less expensive. A penalty will apply if a generic is available but the pharmacy dispenses the name-brand medication for any reason.

Q: What is the difference between preferred and non-preferred drugs?
A: Preferred drugs are brand-name drugs deemed by the CVS/Caremark Pharmacy and Therapeutics Committee to be safe, clinically appropriate and cost-effective.
Non-preferred drugs are brand-name drugs that have preferred alternatives within the same therapeutic category and are typically more expensive.

Q: What is a specialty drug?
A: Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions. They typically require special handling, administration or monitoring. Specialty drugs must be filled through the CVS Specialty Pharmacy.
DENTAL AND VISION
(FULL-TIME EMPLOYEES ONLY)
Carnegie Mellon offers three dental plan options to fit your family’s needs: one DHMO plan and two PPO plans. Dental coverage is available to full-time employees only.

**Dental Plan Comparison**

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>DHMO</th>
<th>Standard PPO</th>
<th>Enhanced PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$13.28</td>
<td>$13.04</td>
<td>$31.94</td>
</tr>
<tr>
<td>Family</td>
<td>$52.50</td>
<td>$46.98</td>
<td>$101.24</td>
</tr>
</tbody>
</table>

DHMO vs. PPO Plans

**DHMO USES THE DHMO CONCORDIA PLUS NETWORK.**
The DHMO plan requires copayments with no deductible, coinsurance, or annual maximum.

You must pre-select a participating primary care dentist or one will be assigned based on your home address. Referrals are required, and you must use participating providers.

**PPO USES THE ALLIANCE NETWORK.**
The PPO plans charge a deductible and coinsurance for covered services and have annual maximums.

You may use out-of-network providers but may be charged for costs above the rates established by UCCI.

**DHMO Network Area**
You must reside in Pennsylvania, Ohio or New Jersey to participate in the DHMO plan. See United Concordia for a primary care dentist.

**Predetermine Benefits**
Ask your dentist to request a predetermination of benefits for treatments with anticipated charges of $300 or more. This will confirm how much the plan will cover and what you will owe before treatment begins.

---

1. See the plan’s schedule of benefits on the HR Benefits page for information on the permitted schedule of covered services.
2. Annual Maximum and Lifetime Maximum are maximum amounts that the plan pays and are per person.
**Vision Plans Overview**

Plans are available through Davis Vision and Vision Benefits of America (VBA)

Carnegie Mellon offers four vision options designed to give you flexibility in choosing your coverage. Vision coverage is available to full-time employees only.

The options and benefit providers differ based on:

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

Check both the [Davis Vision network](#) and the [VBA network](#) to see which providers participate in each plan. You can also call your providers and ask if they participate in either of the plans.

**Vision Plan Employee Contributions**

Monthly, pre-tax rates are shown; divide rate by two to obtain biweekly, pre-tax rates.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Davis Option 1</th>
<th>Davis Option 2</th>
<th>VBA Option 1</th>
<th>VBA Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$1.06</td>
<td>$4.24</td>
<td>$1.30</td>
<td>$4.42</td>
</tr>
<tr>
<td>Family</td>
<td>$6.36</td>
<td>$17.48</td>
<td>$7.78</td>
<td>$18.18</td>
</tr>
</tbody>
</table>

**Additional Vision Plan Features**

Davis Vision and VBA offer various features, including a laser vision correction discount; blended, no-line bifocals (progressive lenses); and polycarbonate lenses (restrictions apply). For more information about features, see the Summary of Benefits for each plan on the [Vision Benefits page](#).

**Q:** How do I access my vision benefits?

**A:**

Davis Vision participants make an appointment with a participating care provider and show their Davis Vision ID card to the provider during the visit. The participating provider submits the claim directly to Davis Vision.

Vision Benefits of America (VBA) participants do not receive ID cards. VBA providers submit electronic claims to VBA using participants’ personal information (date of birth, home zip code and last four digits of the member’s SSN).

**Q:** Can I use out-of-network providers?

**A:**

If you see an out-of-network provider, you must pay for the service in full at the time of the appointment and then submit a Reimbursement Claim Form for appropriate reimbursement at the out-of-network level. Visit the [Vision Benefits page](#) to access the form.
# Vision Plan Comparison

<table>
<thead>
<tr>
<th></th>
<th>Davis Option 1</th>
<th>Davis Option 2</th>
<th>VBA Option 1</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>Once per 2 calendar years for ages 19+; Once per calendar year through age 18</td>
<td>Once per calendar year for all ages</td>
<td>Once per 2 calendar years for ages 19+; Once per calendar year through age 18</td>
<td>Once per calendar year for all ages</td>
</tr>
<tr>
<td>Spectacle frames</td>
<td>Once per 2 calendar years for all ages</td>
<td></td>
<td></td>
<td></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></td>
<td></td>
</tr>
<tr>
<td>Contact lens evaluation and fitting</td>
<td></td>
<td></td>
<td></td>
<td>15% off UCR</td>
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<tr>
<td><strong>Spectacle Lenses (patient payment)</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All ranges of prescriptions and sizes</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Polycarbonate lenses</td>
<td>$0 / $35²</td>
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<td>$0</td>
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<tr>
<td>Oversize lenses</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Standard progressive addition lenses¹</td>
<td>$65</td>
<td>$0</td>
<td>Available starting at $45</td>
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<td>Gradient tinting, ultraviolet coating¹</td>
<td>$15</td>
<td>$12</td>
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<td></td>
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<tr>
<td>Scratch resistant coating¹</td>
<td>$20</td>
<td>$0</td>
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<tr>
<td>Blended bifocals¹</td>
<td>$20</td>
<td></td>
<td></td>
<td>$18 (single vision) / $28 (multi-view vision)</td>
</tr>
<tr>
<td>Corning photo-chromatic lenses¹</td>
<td></td>
<td></td>
<td></td>
<td>$18 (single vision) / $28 (multi-view vision)</td>
</tr>
<tr>
<td>Standard anti-reflective coating (ARC)¹</td>
<td>$40</td>
<td></td>
<td></td>
<td>$40</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Collection</td>
<td>$70 allowance ($120 at Visionworks)</td>
<td>$110 allowance ($160 at Visionworks)</td>
<td>$40 wholesale allowance (approx. $100 – $120 retail value)</td>
<td>$60 wholesale allowance (approx. $150 – $180 retail value)</td>
</tr>
<tr>
<td>The Exclusive Collection (in lieu of allowance)</td>
<td>Paid in Full</td>
<td>Paid in Full</td>
<td>$40 wholesale allowance (approx. $100 – $120 retail value)</td>
<td>$60 wholesale allowance (approx. $150 – $180 retail value)</td>
</tr>
<tr>
<td>Fashion (up to $100 retail value)</td>
<td>Paid in Full</td>
<td>Paid in Full</td>
<td>$40 wholesale allowance (approx. $100 – $120 retail value)</td>
<td>$60 wholesale allowance (approx. $150 – $180 retail value)</td>
</tr>
<tr>
<td>Designer (up to $175 retail value)</td>
<td>Patient pays $20</td>
<td>Patient pays $20</td>
<td>$40 wholesale allowance (approx. $100 – $120 retail value)</td>
<td>$60 wholesale allowance (approx. $150 – $180 retail value)</td>
</tr>
<tr>
<td>Premier (up to $200 retail value)</td>
<td>Patient pays $40</td>
<td></td>
<td>$40 wholesale allowance (approx. $100 – $120 retail value)</td>
<td>$60 wholesale allowance (approx. $150 – $180 retail value)</td>
</tr>
<tr>
<td><strong>Contact Lenses (in lieu of eyeglasses)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Collection</td>
<td>$100 allowance³</td>
<td>$145 allowance³</td>
<td>$140 allowance</td>
<td>$160 allowance</td>
</tr>
<tr>
<td>The Exclusive Collection</td>
<td>2 boxes planned replacement / 4 boxes disposable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically necessary (prior approval)</td>
<td>Included</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹For 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.

²In Davis Vision plans, polycarbonate lenses covered in full for dependent children, monocular patients, and patients with prescriptions +/- 6.00 diopters.

³Can be applied toward disposable or specialty contact lenses (including extended wear, hard/soft bifocal and gas permeable lenses).
Flexible Spending Accounts (Full-Time Employees Only) & Health Savings Accounts (High Deductible PPO with HSA Enrollees Only)
Flexible Spending Accounts Overview

Carnegie Mellon offers both a Health Care Flexible Spending Account and a Dependent Care Reimbursement Account to help you lower your health and dependent care expenses by paying with tax-free money. You decide how much to set aside each year and contributions are deducted in equal amounts each pay period before taxes are taken out.

Flexible spending accounts (FSAs) are offered to full-time employees only. You are not required to participate in other CMU benefits to enroll in the FSAs.

Health Care Flexible Spending Account (HCFSA)

The HCFSA allows you to set aside pre-tax money to pay for qualified health care expenses not otherwise covered by insurance. Examples include deductibles, coinsurance and copays, some over-the-counter medications, dentures, orthodontia, LASIK surgery, contact lens supplies, hearing aid devices and fertility treatments.*

Eligible expenses may be incurred by you or your tax dependents. The IRS prohibits the use of an FSA to cover the health care expenses of someone who cannot be claimed as a dependent for tax purposes.

Per IRS regulations, those enrolled in an HSA cannot contribute to an HCFSA. If you opt to enroll in a High Deductible PPO with HSA plan, you can contribute to a Limited Purpose Flexible Spending Account, which allows you to set aside pre-tax money to pay for qualified dental and vision expenses only.

Dependent Care Reimbursement Account (DCRA)

The DCRA allows you to set aside pre-tax money to pay for qualified dependent day care (not health care) expenses. Examples include day care or nanny fees, care before and after school, day camp during summer vacation and elderly care.*

Expenses incurred by the following dependents are eligible:

- Dependent child(ren) under age 13 who are claimed as dependents on your federal tax return.
- Disabled dependent child(ren) age 13 or older who are claimed as dependents 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 in your home.

To qualify, you and your spouse must work full- or part-time outside of the home, be self-employed or a full-time student, or your spouse must be physically or mentally disabled. Eligible caregivers must be at least 18 and not a relative living in your home.

*For the complete lists of covered expenses, see IRS publication #502 (HCFSA) [pdf] and IRS publication #503 (DCRA).

Elections do not Roll Over to the Next Calendar Year

Unlike other benefits, you must enroll in the HCFSA and DCRA annually during Open Enrollment. If you do not enroll, you will be defaulted to no contributions.

Use it or Lose it Rule

IRS rules state that any contributions that you do not 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.

**FSA Comparison**

<table>
<thead>
<tr>
<th></th>
<th>HCFSA</th>
<th>DCRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution Limits</td>
<td>Between $60 and $3,050 / year</td>
<td>Between $300 and $5,000¹ / year</td>
</tr>
<tr>
<td>Plan Year</td>
<td>Calendar year plus a 2.5 month grace period (Jan 1, 2023 – Mar 15, 2024)</td>
<td>Calendar year (Jan 1, 2023 – Dec 31, 2023)</td>
</tr>
<tr>
<td>Deadline to Request Reimbursement</td>
<td></td>
<td>June 30, 2024</td>
</tr>
<tr>
<td>Eligible expenses</td>
<td>Health care</td>
<td>Day care / Elder care</td>
</tr>
</tbody>
</table>

¹ $2,500 if married, filing separately
# Using Your Flexible Spending Account

## The FSA debit card and reimbursement process

Claims incurred during the plan year should be submitted to WEX by June 30 following the end of the plan year. For the HCFSA, the plan year is the calendar year plus a two-and-a-half month grace period (for example, from January 1, 2023 – March 15, 2024). For the DCRA, the plan year is the calendar year.

You can either pay for expenses using your FSA debit card or pay out-of-pocket and complete a Reimbursement Request Form. The form can be returned to WEX via mail, fax or email. You can also submit claims online via WEX’s website or mobile app.

### FSA Debit Card

WEX provides a debit card that you can use to pay for eligible HCFSA and DCRA expenses. This eliminates the need to pay for the expense up front and file a claim for reimbursement.

For the HCFSA, your full annual election is loaded to your FSA debit card and available up front. For the DCRA, you can only spend up to your account balance (i.e., the amount you have contributed year-to-date).

See the Flexible Spending Accounts page for more information about the FSA debit card, the claims submission process, or to access the Reimbursement Request Form.

### Tax Implications

You can save up to 25% on the money you spend on eligible expenses by contributing to an FSA on a pre-tax basis. However, you should be aware of other financial implications of using these accounts.

- State taxes are owed on DCRA contributions.
- FSA contributions reduce what you may claim in Social Security benefits at retirement.
- Consult a tax expert or the IRS if you use the Earned Income Credit.
- The amount you can contribute to the DCRA is reduced by any additional child care benefits you receive from other sources (such as the Cyert Center Sliding Scale benefit or a spouse’s employer). If you exceed the $5,000 limit, the amount in excess will be considered taxable income.

### How do spending accounts work?

1. Determine your expected out-of-pocket expenses that you will incur in health or dependent care costs.
2. Plan to contribute enough to cover most of your expected expenses, but not more than you will use. Remember, what you do not use, you will lose, as per IRS regulations.
3. The annual amount you elected will be deducted evenly throughout the year from your pay before taxes are assessed.
4. Throughout the year, as you incur eligible health or dependent care expenses, you may pay for them out-of-pocket or with the FSA debit card.
5. For expenses that you pay out-of-pocket, file claims to reimburse yourself with your tax-free money.
6. Claims incurred during the plan year should be submitted to WEX by June 30 following the end of the plan year.

### Can I change my FSA election midyear?

Unless you experience a qualifying life or family status change (see page 5), you cannot change your FSA election midyear. FSA changes must be consistent with the qualifying status change. For example, if you have a baby, you can increase your HCFSA election and/or enroll in the DCRA, but you are not able to stop contributions.
Carnegie Mellon offers both a Health Savings Account and a Limited Purpose Flexible Spending Account to employees who are enrolled in one of the High Deductible PPO with HSA medical plans. These plans are offered to help you lower your health, dental and vision expenses by paying with tax-free money. In 2023, if you are enrolled in the High Deductible PPO with HSA, CMU will contribute toward your HSA at the amount of $250/year for individuals and $500/year for families.

HEALTH SAVINGS ACCOUNT (HSA)

Health Savings Accounts accompany a high deductible health plan and allow you to invest money to pay for qualified medical, prescription, dental and vision expenses. You own this account and can take the account dollars with you if you leave the university. You must be enrolled in a High Deductible PPO health plan to enroll in an HSA.

The IRS prohibits employees from receiving or making HSA contributions if they are:

- Medicare enrollees (Part A, Part B, or Part D)
- Health Care Flexible Spending Accounts (HCFSAs) enrollees

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (LPFSA)

The LPFSA is a special type of FSA that can be paired with an HSA and allows you to use pre-tax dollars to pay for qualified dental and vision expenses. Using funds from your LPFSA instead of your HSA to pay for eligible expenses allows your HSA to continue to grow tax-free into retirement. A Limited Purpose FSA cannot be paired with a Health Care Flexible Spending Account.

WHAT CAN A LPFSA COVER?

There are thousands of eligible items, including:

- Dental and orthodontia office visits and expenses
- Dental implants, veneers, dentures and bridges
- Optometrist and ophthalmologist visits and expenses
- Eye glasses, contacts, prescription sunglasses, solutions and drops
- Laser eye surgery

### Plan Comparison

<table>
<thead>
<tr>
<th>Plan Comparison</th>
<th>HSA</th>
<th>Limited Purpose FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contribution Limits</strong></td>
<td>Between $0 and $3,850 for individuals / year*</td>
<td>Between $60 and $3,050† / year</td>
</tr>
<tr>
<td></td>
<td>Between $0 and $7,750 for families / year*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*55 years and older are eligible to make an annual catch-up contribution of $1,000</td>
<td></td>
</tr>
<tr>
<td><strong>Plan Year</strong></td>
<td>N/A</td>
<td>Calendar year plus a 2.5 month grace period (Jan 1, 2023 – Mar 15, 2024)</td>
</tr>
<tr>
<td><strong>Deadline to Request Reimbursement</strong></td>
<td>N/A</td>
<td>June 30, 2024</td>
</tr>
<tr>
<td><strong>Eligible expenses</strong></td>
<td>Medical, prescription, dental and vision</td>
<td>Dental and vision</td>
</tr>
</tbody>
</table>
Life and AD&D Insurance
**LIFE AND AD&D INSURANCE OVERVIEW**

*Administered by MetLife*

Life insurance provides financial protection to your survivors in the event of your death. The accidental death and dismemberment (AD&D) component provides double the insurance amount if the death is the result of an accident.

You may only adjust your coverage (either opt out of free basic life or purchase/modify optional insurance) during new hire enrollment, Open Enrollment, or life or family status change events.

**NO COST BASIC LIFE INSURANCE**

Carnegie Mellon provides basic life insurance coverage equal to your annual base salary, rounded up to the nearest thousand, up to a maximum of $500,000 at no cost to you. For full-time eligible employees, the basic life insurance includes an AD&D component. For part-time employees, the AD&D can be purchased separately.

**OPTIONAL LIFE AND AD&D INSURANCE (FULL-TIME EMPLOYEES ONLY)**

Full-time eligible employees may purchase optional life insurance from one to five times their basic life insurance amount up to a maximum benefit of $1,500,000 (basic and optional combined).

Optional insurance is available at age-related rates (see chart on page 28). You can purchase dependent life and AD&D insurance for your spouse/domestic partner and child(ren) only if you purchase employee optional life and AD&D insurance.

**VOLUNTARY AD&D INSURANCE (PART-TIME EMPLOYEES ONLY)**

Part-time eligible employees may purchase voluntary AD&D insurance. You may purchase between $10,000 and $250,000 of coverage in increments of $10,000. The cost is $.20 per $10,000.

**ANNUAL BASE SALARY**

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

For those age 70 and over: your basic life insurance coverage is actuarially reduced.

**ELECTING A BENEFICIARY**

Life insurance beneficiaries are not designated or changed within Workday, but through the MetLife Beneficiary website. To access the MetLife website, select the Benefits application from your Workday homepage. Further instructions can be found on the Life and AD&D Insurance page.

**EVIDENCE OF INSURABILITY FOR EMPLOYEE COVERAGE**

High levels of life insurance require you to demonstrate your good health by completing an evidence of insurability form (EOI). The EOI is a 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 MetLife in accordance with their guidelines.

Notes:

- Basic life insurance never requires an EOI.
- Optional life insurance of more than $500,000 requires an EOI.
- Increasing optional life insurance coverage more than one level during Open Enrollment or qualifying life event requires an EOI.
- Enrolling in optional life insurance after initial eligibility requires an EOI regardless of the level of coverage.
Carnegie Mellon offers a life insurance option to full-time benefits eligible employees that provides benefits in the event of the death of their 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 (AD&D) component.

**Spouse/Domestic Partner Life and AD&D Insurance**

If you choose to participate in spouse/domestic partner life and AD&D insurance, your partner will be covered at a level equal to 50% of your employee optional life coverage up to a maximum of $250,000. Rates are the same as optional life and AD&D insurance monthly rates (see next page).

If you and your spouse/domestic partner are both full-time, benefits eligible employees of CMU, you cannot elect spouse/domestic partner insurance. Instead, each of you can enroll in optional life and AD&D insurance (see page 26). If your spouse/domestic partner is a part-time, benefits eligible employee of CMU, 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.

**Dependent Child(ren) Life and AD&D Insurance**

Dependent child(ren) life and AD&D insurance rates 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 CMU, only one of you can elect this option to cover your child(ren). If your child is also a CMU employee, he/she cannot be covered under your dependent life insurance.

Evidence of Insurability for Spouse/Domestic Partner or Child(ren) Coverage

For spouse/domestic partner life and AD&D insurance, an evidence of insurability form (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).

An 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 more than one level during Open Enrollment, an EOI is required. If the coverage increases greater than $50,000 (due to an increase in either your salary or your levels of optional coverage), your spouse/domestic partner will be required to complete an EOI.

For dependent child(ren) life and AD&D 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.
### Employee Optional and Spouse/Domestic Partner Life and AD&D Rates

<table>
<thead>
<tr>
<th>Age (as of January 1, 2023)</th>
<th>Rate for each $1,000/month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$0.053</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$0.063</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$0.067</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$0.076</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$0.086</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$0.136</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$0.196</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$0.316</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$0.529</td>
</tr>
<tr>
<td>70 and over</td>
<td>$1.057</td>
</tr>
</tbody>
</table>

### IRS Uniform Premium Rates

<table>
<thead>
<tr>
<th>Age (as of December 31, 2023)</th>
<th>Value for each $1,000 of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.05</td>
</tr>
<tr>
<td>25 – 29</td>
<td>$0.06</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$0.08</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$0.09</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$0.10</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$0.15</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$0.23</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$0.43</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$0.66</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$1.27</td>
</tr>
<tr>
<td>70 and over</td>
<td>$2.06</td>
</tr>
</tbody>
</table>

### Dependent Child(ren) Life and AD&D Rates

<table>
<thead>
<tr>
<th>Coverage per Child</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,500</td>
<td>$0.36</td>
</tr>
<tr>
<td>$5,000</td>
<td>$0.72</td>
</tr>
<tr>
<td>$10,000</td>
<td>$1.43</td>
</tr>
</tbody>
</table>

#### Note About the Life Insurance Rates
For employee optional life insurance, monthly pre-tax rates are shown; divide rate by two to obtain biweekly pre-tax rates. For spouse life and dependent child(ren) life insurance, monthly post-tax rates are shown; divide rate by two to obtain biweekly post-tax rates.

### 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 on the left).

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.

To calculate your monthly imputed income, subtract $50,000 from your life insurance amount and divide the remainder by 1,000. Multiply that amount by the premium level associated with your age as of December 31, 2023. That is the imputed income that will be taxed monthly.
Disability Insurance
(Full-Time Employees Only)
LONG-TERM DISABILITY INSURANCE OVERVIEW

Administered by MetLife

Long-term disability (LTD) insurance, available to full-time eligible employees, 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 offers two levels of LTD coverage. Both levels of LTD insurance use the same definition of disability.

NO COST BASIC LTD

Basic LTD provides 60% of your monthly base salary, up to a maximum benefit of $15,000 per month. CMU provides basic LTD at no cost to full-time eligible employees.

ENHANCED 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 may not receive 10 COLA increases due to limitations in maximum benefits duration. Enhanced LTD is not available to individuals age 69 and older.)

The cost for the Enhanced LTD benefit is based on your salary. For each $100 of annual salary, your cost will be $0.055 per year. Here is an example for someone with an annual salary of $60,000:

\[
(60,000 \div 100) \times 0.055 = 33.00 \text{ per year (or $2.75 per month)}
\]

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.

Find more information on short-term disability or Workers’ Compensation.

MAXIMUM LTD BENEFIT PERIOD

<table>
<thead>
<tr>
<th>Age Disability Began</th>
<th>Max Benefit Period*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 60 Yrs. Old</td>
<td>Social Security normal retirement age</td>
</tr>
<tr>
<td>60</td>
<td>36 months</td>
</tr>
<tr>
<td>61</td>
<td>30 months</td>
</tr>
<tr>
<td>62</td>
<td>24 months</td>
</tr>
<tr>
<td>63</td>
<td>21 months</td>
</tr>
<tr>
<td>64</td>
<td>18 months</td>
</tr>
<tr>
<td>65</td>
<td>15 months</td>
</tr>
<tr>
<td>66</td>
<td>12 months</td>
</tr>
<tr>
<td>67</td>
<td></td>
</tr>
<tr>
<td>68</td>
<td></td>
</tr>
<tr>
<td>69 and over</td>
<td></td>
</tr>
</tbody>
</table>

*The employee’s maximum benefit period is the period shown above or the employee’s normal retirement age under the 1983 amendments to the Federal Social Security Act, whichever is longer.

TAXES, OTHER POLICIES AND PAYMENTS

LTD benefit payments are considered taxable income. Benefits are offset by benefits received from Social Security, Workers’ Compensation, or other state/group disability payments, up to the maximum for your option. (The benefit will be at least $50/month.) Benefits are not affected by payments from any individual disability policy you have purchased.
More Benefits to Consider
MORE BENEFITS TO CONSIDER
Additional benefits available year-round to faculty and staff

RETIREMENT SAVINGS
Carnegie Mellon automatically makes an 8% contribution (9.78% for employees on a 9-month appointment) for eligible employees at no cost to the employee.

All employees may make either pre-tax or post-tax (Roth) supplemental contributions from their own pay. Employees can enroll or change their contribution at any time during the year, as often as once a month. Changes are effective the first day of the following month.

Learn more about the university’s retirement savings program.

TUITION BENEFITS
Carnegie Mellon enables staff and faculty to further their education, enhance their skills and pursue career development through the Tuition Benefits program.

For full-time employees, the university offers the opportunity to take up to two credit-bearing courses per term at 100% tuition remission through CMU (any type of course) and 50% tuition assistance through any other institution (career-related courses only). For part-time employees, the university offers the opportunity to take one credit bearing course per term at CMU only.

Additionally, Carnegie Mellon offers full-time faculty and staff various levels of tuition benefits at CMU or another institution for their children’s undergraduate education.

EMPLOYEE ASSISTANCE PROGRAM (EAP)
The Employee Assistance Program (EAP) is a CMU-sponsored program for employees and their household members that provides support, resources, and information for personal and work-life issues. CMU’s EAP provider, GuidanceResources, can assist with everything from confidential counseling and legal resources to access to daycare locators and college planning specialists. All EAP services are confidential and provided at no cost to employees.

PAID TIME OFF (PTO)
Paid time off (PTO) provides regular, full-time staff members with days away from work with pay for vacation, illness, personal time or to care for dependents. PTO guidelines and accruals vary based on position, location of employment, hire date and employment type. However, Carnegie Mellon generally offers a maximum of 17 PTO days for new full-time staff employees.

Carnegie Mellon’s U.S. campuses also observe 10 official holidays, during which days the university is closed and non-essential personnel are not expected to work. Additionally, U.S. staff may take up to three floating holidays during the calendar year, based on their hire date and with approval of their immediate supervisor.

Learn more about paid time off and holidays, including specific guidelines and accrual information.

UNIVERSITY ID CARDS
Your CMU id card provides additional benefits, including:

- Use of university facilities and services such as athletic facilities, Group X-ercise classes, libraries and university events
- Discounts for faculty/staff at School of Drama performances
- Syncing with your PNC bank account so it can be used as an ATM card

Eligible dependents of benefits eligible employees can also receive an ID Card. For more information about this benefit, visit The HUB website.
MORE BENEFITS TO CONSIDER
Additional benefits available year-round to faculty and staff

CHILD CARE BENEFITS
Carnegie Mellon supports faculty, staff and their families, and offers two benefit programs to assist with child care costs: the Cyert Center for Early Education Sliding Scale benefit, and a Dependent Care Reimbursement Account. For more information, visit the Child Care Benefits page.

CARE@WORK FAMILY CARE BENEFITS
Carnegie Mellon is pleased to offer family care benefits through Care.com. Through the Care@Work program, Care.com prescreens qualified caregivers to help eligible individuals find backup emergency care for children and adults. The program also includes a free membership to perform self-directed searches for a variety of caregiving needs.

TRANSPORTATION BENEFITS
Benefits eligible faculty and staff in Pittsburgh are entitled to use Allegheny County Port Authority Transit (PAT) system busses, inclines, and the T free of charge. Your ID Card is encoded with your PAT eligibility status automatically — just tap your ID Card on the orange pad on the fare box.

Discounts and Perks may also be available to faculty and staff working outside of the Pittsburgh area.

AETNA TRAVEL INSURANCE
Carnegie Mellon offers free Aetna travel insurance for eligible full-time employees traveling abroad on CMU business for less than 180 days.

RETIREE MEDICAL BENEFITS
Carnegie Mellon offers retiree medical coverage to retired employees and their spouses/domestic partners if they were full-time benefits eligible at the time they retired, and meet other eligibility requirements. For retirees 60–64 years old, coverage is available through COBRA. For those 65 years old and over, CMU offers post-65 plans that coordinate benefits with your Medicare coverage. Options include three Medicare HMO plans, or a Highmark Major Medical and Caremark Supplemental Prescription plan. Rates are based on years of service at CMU.

If you are a faculty or staff member planning on retiring, call the Office of Human Resources to schedule a meeting and review the options available to you.

DISCOUNTS AND PERKS
CMU faculty and staff have access to a number of special discounts and perks. These include enhanced banking, wireless telephone service discounts, relocation and real estate services, and automobile purchase programs.
CONTINUATION OF COVERAGE (COBRA)
When you or a covered dependent lose eligibility to participate in CMU’s health plans, the coverage will be terminated. However, under most circumstances, you may continue the medical/prescription, dental, vision and health care flexible spending account benefits coverage through COBRA. Under COBRA, you will pay the full group cost of the plan, plus a 2% administrative fee. COBRA coverage is generally offered for up to 18 months, or longer depending on the circumstances.

For more detailed information on your COBRA rights, please see page 38.

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, you may change the level of coverage (e.g., family to employee and child). Your group numbers and monthly rates will change, but the plan details remain the same. You cannot make other changes until the next open enrollment period, unless you experience a life or family status change.

At Open Enrollment, you may elect to enroll in any of the benefits which are available to Carnegie Mellon COBRA participants. Former part-time benefits eligible employees/dependents are not eligible for dental and/or vision coverage.

Find detailed information on the COBRA page.

CONTINUING FLEXIBLE SPENDING ACCOUNTS

The Health Care Flexible Spending Account (HCFSA) may be continued under COBRA (although the tax benefits of doing so are affected) in order to incur expenses to use contributed, but not yet claimed, funds.

The Dependent Care Reimbursement Account (DCRA) may not be continued.

ENROLLING IN COBRA BENEFITS

When you separate from the university or lose coverage, CMU’s COBRA administrator (WEX) will send you a COBRA qualifying event notice. You will then have 60 days from the date of cancellation of your coverage or the date of the notification, whichever is later, to elect to continue your benefits through COBRA. You will remit your payments directly to WEX. Your COBRA coverage will be retroactive to the date your coverage would have terminated.

Life or family changes sometimes require you to change your benefits. You can make changes consistent with your status change within 30 days of the status change. (See page 5 for more information about qualifying life or family status changes.)

You may cover eligible dependents under your benefits. (See page 9 for more information about eligible dependents.)

Q: Will I have a lapse in coverage?
A: When you enroll in COBRA, your benefits continue without a lapse. Coverage always ends on the last day of the month and your COBRA starts on the first day of the month following the termination of coverage. For example, if you separated from Carnegie Mellon on October 18, your coverage would be active until October 31 and COBRA would start on November 1.

Q: Can I enroll in COBRA later in the year if I waived coverage initially?
A: If you miss your initial COBRA enrollment window, you will not be able to enroll in COBRA at a later date or during the COBRA Open Enrollment period.

CONTACT WEX

If you have questions about your COBRA enrollment, payments or to request benefit changes, please contact WEX at 866-451-3399.
**COBRA Medical Monthly Participant Rates**

Rates do not include the cost of prescription drug coverage, which is required with medical plan coverage. See chart on the right for prescription rates. Please note that beginning in 2023, Caremark Option A will be frozen to current enrollees only. If you elect to change out of the plan during Open Enrollment, you will not be able to re-enroll in it.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>PPO Option 1</th>
<th>PPO Option 2</th>
<th>EPO (Highmark) / HMO (UPMC)</th>
<th>High Deductible PPO with HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$633.42</td>
<td>$570.18</td>
<td>$694.62</td>
<td>$513.06</td>
</tr>
<tr>
<td>UPMC</td>
<td>$492.66</td>
<td>$433.50</td>
<td>$580.38</td>
<td>$383.52</td>
</tr>
<tr>
<td><strong>Individual and 1 Child</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Highmark</td>
<td>$1,077.12</td>
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<tr>
<td>UPMC</td>
<td>$837.42</td>
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<td>$651.78</td>
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<tr>
<td><strong>Individual and 2+ Children</strong></td>
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<td></td>
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</tr>
<tr>
<td>Highmark</td>
<td>$1,203.60</td>
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<td>$936.36</td>
<td>$824.16</td>
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<td><strong>Individual and Spouse/Partner</strong></td>
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<tr>
<td>Highmark</td>
<td>$1,330.08</td>
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<tr>
<td>UPMC</td>
<td>$1,034.28</td>
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<td>$1,218.90</td>
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<tr>
<td><strong>Family</strong></td>
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<tr>
<td>Highmark</td>
<td>$1,834.98</td>
<td>$1,651.38</td>
<td>$2,012.46</td>
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<td>UPMC</td>
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<td>$1,255.62</td>
<td>$1,680.96</td>
<td>$1,110.78</td>
</tr>
</tbody>
</table>

**COBRA Prescription Monthly Participant Rates**

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$308.04</td>
<td>$148.92</td>
</tr>
<tr>
<td>Individual &amp; 1 Child</td>
<td>$523.26</td>
<td>$252.96</td>
</tr>
<tr>
<td>Individual &amp; 2+ Children</td>
<td>$585.48</td>
<td>$282.54</td>
</tr>
<tr>
<td>Individual &amp; Spouse/Partner</td>
<td>$646.68</td>
<td>$313.14</td>
</tr>
<tr>
<td>Family</td>
<td>$892.50</td>
<td>$431.46</td>
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**COBRA Dental Monthly Participant Rates**

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>DHMO</th>
<th>Standard PPO</th>
<th>Enhanced PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$17.90</td>
<td>$18.34</td>
<td>$38.00</td>
</tr>
<tr>
<td>Family</td>
<td>$56.30</td>
<td>$52.85</td>
<td>$112.78</td>
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**COBRA Vision Monthly Participant Rates**

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Davis Option 1</th>
<th>Davis Option 2</th>
<th>VBA Option 1</th>
<th>VBA Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$4.02</td>
<td>$8.91</td>
<td>$3.14</td>
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<td>Family</td>
<td>$9.16</td>
<td>$21.44</td>
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</table>

*See pages 12–21 for plan information.*
IMPORTANT NOTICES
Notice of COBRA Continuation Coverage Rights

Introduction
You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources Services, 5000 Forbes Ave., Pittsburgh, PA 15213, 412-268-4600.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notice must be sent to: WEX Health Inc., PO Box 2079, Omaha, NE 68103-2079, 866-451-3399.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Carnegie Mellon University Benefit Plan
Carnegie Mellon University Human Resources
5000 Forbes Ave.
Pittsburgh, PA 15213
412-268-2047

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY NOTICE
This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records.
• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records.
• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
• We may say “no” to your request, but we will tell you why in writing within 60 days.

Request confidential communications.
• You can ask us to contact you in a specific way (for example, home or office phone) or to send email to a different address.
• We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share.
• You can ask us not to use or share certain health information for treatment, payment, or our operations.
• We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we have shared information.
• You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, whom we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care, operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.
• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.
• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.
• You can complain if you feel we have violated your rights by contacting us using the information on the back page.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html.
• We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in payment for your care
• Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
• Marketing purposes
• Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in
Help manage the health care treatment you receive.

- We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization.

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
  Example: We use health information about you to develop better services for you.

Pay for your health services.

- We can use and disclose your health information as we pay for your health services.
  Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan.

- We may disclose your health information to your health plan sponsor for plan administration.
  Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

- How else can we use or share your health information? We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research.
  We have to meet many conditions in the law before we can share your information for these purposes. For more information see https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues.

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety

Do research.

- We can use or share your information for research health.

Comply with the law.

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director.

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests.

- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions.

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

  Under the Mental Health Procedures Act in Pennsylvania (50 Pa. Stat. Ann. §7111), documents about a person’s treatment for a mental health condition cannot be disclosed without the person’s written consent, except to: parties that provide treatment to that person; the county administrator; a court (in the course of legal proceedings under this law); or to follow federal law governing disclosure of patient information, if treatment is required by a federal agency.

  The Plan will comply with any applicable state law that requires greater privacy protections than those described herein.

  This notice does not apply to information developed by Carnegie Mellon University in its capacity as employer. Such information is not created or maintained by the Plan and therefore is not protected health information (PHI). Thus, information created or maintained by Carnegie Mellon University for the purpose of administering sick pay or disability or workers’ compensation programs, for example, is not PHI.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, or we will mail a copy to you.

This Notice of Privacy Practices applies to the following organizations.

Carnegie Mellon University
Human Resources Services
5000 Forbes Ave.
Pittsburgh, PA 15213
412-268-4600
hr-help@andrew.cmu.edu

This notice was published and became effective on October 19, 2015.
SPECIAL ENROLLMENT NOTICE
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage or within 60 days from the birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources Services at 412-268-4600.

NEWBORN’S AND MOTHERS’ HEALTH PROTECTION ACT
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN’S HEALTH AND CANCER RIGHTS ACT ANNUAL NOTICE
Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Submit an HR ticket requesting more information to Human Resources Services at https://www.cmu.edu/hr/service-center/help/index.html.

WOMEN’S HEALTH AND CANCER RIGHTS ACT ENROLLMENT NOTICE
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, to see the applicable deductibles and coinsurance that would apply, see the Summary of Benefits and Coverage for your plan. Submit an HR ticket requesting more information on WHCRA benefits to Human Resources Services at https://www.cmu.edu/hr/service-center/help/index.html.

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 https://www.cmu.edu/hr/benefits/health-welfare/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 page 10). If you are unable to resolve the situation with the carrier, please contact Human Resources Services at 412-268-4600 for assistance.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)
If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicare or CHIP and you live in a state listed under the CHIP Model Notice [pdf], contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or contact 877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebca.dol.gov or call 866-444-EBSA (3272).

MEDICARE CREDIBLE COVERAGE NOTICE
MB 0938-0990

Important Notice from Carnegie Mellon University About Your Prescription Drug Coverage and Medicare

The Carnegie Mellon University Benefit Plan
Caremark Prescription Drug Plan
(Option A and Option B)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Carnegie Mellon University and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Carnegie Mellon University has determined that the prescription drug coverage offered by the Carnegie Mellon University Benefit Plan-Caremark Prescription Drug Plan (Option A and Option B) is, on average, very similar to the coverage Medicare offers. This plan is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Carnegie Mellon University coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Carnegie Mellon University coverage, you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Carnegie Mellon University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...
Contact information is provided on the last page of this document. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Carnegie Mellon University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.ssa.gov](http://www.ssa.gov) or call them at 800-772-1213 (TTY 800-325-0778).

**Remember: Keep this Creditable Coverage notice.** If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
Carnegie Mellon University does not discriminate in admission, employment, or administration of its programs or activities on the basis of race, color, national origin, sex, handicap or disability, age, sexual orientation, gender identity, religion, creed, ancestry, belief, veteran status, or genetic information. Furthermore, Carnegie Mellon University does not discriminate and is required not to discriminate in violation of federal, state, or local laws or executive orders.

Inquiries concerning the application of and compliance with this statement should be directed to the Office for Institutional Equity and Title IX, Carnegie Mellon University, 5000 Forbes Avenue, Pittsburgh, PA 15213, telephone 412-268-7125.