Carnegie Mellon University
EPO Blue

On the chart below, you'll see what your plan pays for specific services. You are responsible for paying for non-emergency services received from an out-of-network provider. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Group #s: 106229-00/01/70/71

Benefit	In Network
General Provisions	
Effective Date	1/1/2025
Benefit Period (1)	Calendar Year
Deductible (per benefit period) Individual Family	None
Plan Pays – payment based on the plan allowance	100%
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	$1,000 Individual $2,000 Family
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.	$1,000 Individual $2,000 Family
Office/Clinic/Urgent Care Visits	
Retail Clinic Visits & Virtual Visits *(in instances of Virtual Visits with your provider, the copayment will be $5)*	100% after $20 copayment
Primary Care Provider & OB/GYN Office Visits *(in instances of Virtual Visits with your provider, the copayment will be $5)*	100% after $20 copayment
Specialist Office Visits & Virtual Visits *(in instances of Virtual Visits with your provider, the copayment will be $5)*	100% after $35 copayment
Urgent Care Center Visits	100% after $35 copayment
Telemedicine Services (3)	100% after $5 copayment
Preventive Care (4)	
Routine Adult (4) Physical Exams	 100%
Adult Immunizations	100%
Routine Gynecological Exams, including a Pap Test	100%
Mammograms, Annual Routine	100%
Mammograms, Medically Necessary	100%
Diagnostic Services and Procedures (including PSA and Digital Rectal Exam)	100%
Routine Pediatric (4) Physical Exams	100% 100%
Pediatric Immunizations	100%
Diagnostic Services and Procedures	100%
Emergency Services	
Emergency Room Services	100% after $100 copayment
Ambulance - Emergency (5)	100%
Ambulance- Non-Emergency (5)	Not Covered
Hospital and Medical / Surgical Expenses (including maternity)	
Hospital Inpatient	100%
Hospital Outpatient	100%
Maternity (non-preventive facility & professional services)	100%
Maternity for Dependent Daughters	100%

Benefit	In Network
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100%
Therapy and Rehabilitation Services	
Physical Medicine (*Including Habilitative Therapy)*	100% after $20 copayment limit: 60 visits/benefit period aggregate with speech therapy and occupational therapy
Respiratory Therapy	100%
Speech Therapy (*Including Habilitative Therapy)*	100% after $20 copayment limit: 60 visits/benefit period aggregate with occupational therapy and physical medicine
Occupational Therapy (*Including Habilitative Therapy)*	100% after $20 copayment limit: 60 visits/benefit period aggregate with speech therapy and physical medicine
Spinal Manipulations	100% after $35 copayment limit: 40 visits/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%
Mental Health / Substance Abuse	
Inpatient Mental Health Services	100%
Inpatient Detoxification / Rehabilitation	100%
Outpatient Mental Health Services *(in instances of Virtual Visits with your provider, the copayment will be $5)*	100% after $20 copayment
Outpatient Substance Abuse Services	100% after $20 copayment
Other Services	
Allergy Extracts and Injections	100%
Applied Behavior Analysis for Autism Spectrum Disorder (6)	100%
Assisted Fertilization Procedures	not covered
Dental Services Related to Accidental Injury	100%
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100%
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%
Durable Medical Equipment, Orthotics and Prosthetics	100%
Home Health Care	100%
Hospice	100%
Infertility Counseling, Testing and Treatment (7)	100%
Private Duty Nursing	100%
Skilled Nursing Facility Care	100% limit: 100 days/benefit period
Transplant Services	100%
Precertification/Authorization Requirements (8)	Yes

Questions? Call 1-800-215-7865

Reference Code: P0020523

(Please have your Reference Code ready when you call.)

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Calendar Year. The Calendar Year runs from January 1 through December 31st.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays and any qualified medical expense. Prescription drug expenses are subject to a separate prescription drug TMOOP.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider (AmWell). Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
(4) Services are limited to those listed on the Highmark Enhancements Preventive Schedule with Enhancements including Women's Health Preventive Schedule. Lab/Diagnostic services billed with a routine diagnosis and procedure code, and not part of the Highmark Preventive Schedule, will be subject to the applicable in-network or out of network cost share.
(5) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.
(6) Services for the treatment of Autism Spectrum Disorders are covered for eligible members to age 21. After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits.

(7) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(8) If you receive services from an out-of-area provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.