Carnegie Mellon University - EPO Bue

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	January 1, 2027
Benefit Period (1)	Calendar Year
Deductible (per benefit period) Individual Family	 $250 $500
Plan Pays – payment based on the plan allowance	90% after deductible
Out-of-Pocket Limit (Includes coinsurance, copays and deductible) Once met, the plan pays 100% coinsurance for the rest of the benefit period. Individual Family	 $1,500 $3,000
Total Maximum Out-of-Pocket (Includes any medical and prescription drug deductibles, coinsurance, and copays, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $1,500 $3,000
Office/Clinic/Urgent Care Visits	
Retail Clinic Visits & Virtual Visits	100% after $25 copay
Primary Care Provider (PCP) Office Visits & Virtual Visits	90% after $25 copay
Specialist Office Visits & Virtual Visits	90% after $40 copay; $25 copay for ob/gyn
Virtual Visit Provider Originating Site Fee	90% after deductible
Urgent Care Center Visits	100% after $40 copay
On-Demand Telemedicine Services (3)	90% after $5 copay
Preventive Care (4)	
Routine Adult Physical Exams	 100% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)
Colorectal Cancer Screening	100% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)
Routine Pediatric Physical Exams	 100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)
Emergency Services	
Emergency Room Services (5)	100% after $150 copay (waived if admitted)
Ambulance - Emergency and Non-Emergency	90% after deductible
Ambulance - Emergency and Non-Emergency (air ambulance)	not covered
Hospital and Medical / Surgical Expenses (5)	
Hospital Inpatient (including maternity)	90% after deductible
Hospital Outpatient	90% after deductible
Outpatient Surgery (facility)	90% after deductible
Surgical Services (professional)	90% after deductible
Maternity (non-preventive professional services) including dependent daughter	90% after deductible
Medical Care (including inpatient visits and consultations)	90% after deductible

Benefit	In Network
Therapy Services	
Physical Medicine	100% after $25 copay limit: 60 visits/benefit period aggregate with speech therapy and occupational therapy including rehabilitative services and habilitative services - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse
Speech Therapy	100% after $25 copay limit: 60 visits/benefit period aggregate with occupational therapy and physical medicine including rehabilitative services and habilitative services - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse
Occupational Therapy	100% after $25 copay limit: 60 visits/benefit period aggregate with speech therapy and physical medicine including rehabilitative services and habilitative services - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse
Respiratory Therapy	90% after deductible
Spinal Manipulations	100% after $40 copay limit: 40 visits/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible Limit: 36 visits/benefit period for cardiac rehab
Mental Health / Substance Abuse	
Inpatient Mental Health Services	90% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	90% after $25 copay
Outpatient Substance Abuse Services	90% after $25 copay
Other Services	
Allergy Extracts and Injections	90% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	90% after deductible
Assisted Fertilization Procedures	not covered
Dental Services Related to Accidental Injury (10)	see service category (i.e. lab, surgery, imaging)
Diabetes Treatment	
Equipment and Supplies	90% after deductible
Diabetes Education Program	90% after deductible
Diagnostic Services	
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible
Mammograms, Medically Necessary	90% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible
Enteral Foods	90% (deductible does not apply)
Home Health Care	90% after deductible
Home Infusion and Suite Infusion Therapy	90% after deductible
Hospice	90% after deductible
Infertility Counseling, Testing and Treatment (8) (10)	90% after deductible
Private Duty Nursing	90% after deductible
Skilled Nursing Facility Care	90% after deductible limit: 100 days/benefit period
Therapeutic Injections	90% after deductible
Transplant Services (10)	90% after deductible
Precertification/Authorization Requirements (9)	Yes

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 which runs from January 1 to December 31.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include any deductibles, coinsurance, and copays. Prescription drug expenses are subject to a separate prescription drug TMOOP. If you are enrolled in a "Family plan", with your aggregate deductible, once an individual's deductible is satisfied, claim reimbursement for covered services will begin for that member. Once the family deductible is satisfied collectively by covered family members, claim

reimbursement will begin for all covered family members. With your aggregate out-of-pocket limit, once an individual's out-of-pocket is satisfied, claim reimbursement for covered services will increase to 100% that member. Once the family out-of-pocket is satisfied collectively by covered family members, then 100% claim reimbursement for covered services will begin for all covered family members. With your aggregate TMOOP, once an individual's TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the rest of the benefit period. Claims for the remaining family members will pay at 100% once the family TMOOP amount is satisfied collectively.
(3) On-Demand Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
(7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist, or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant, or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders 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). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
(8) 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.
(9) 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.
(10) Covered Services will be covered according to the benefit category to which they apply (e.g. outpatient surgery, hospital inpatient, diagnostic services).

Highmark Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

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 of Civil Rights Complaint Portal, available at 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
Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

---

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

U65_BCBS_M_1Col_10pt_blk_1c_2025

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́. Pe nọmba tó wà lẹhin kaádì ìdánimọ rẹ (TTY: 711) fún iranlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码： 711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કૉલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).