Medicare Advantage Renewal

Client Name: Carnegie Mellon University
Group Name: Carnegie Mellon University
Effective Date: 1/1/2027

Client Number: 037672
Group Number: 0584584

Current Membership: 6
Invoicing: Direct Employer Billed

	2026 Benefits		2027 Benefits	
	Security Blue HMO-POS		Security Blue HMO-POS	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0		$0	
Coinsurance (see specific benefits for cost sharing)	0%	0%	0%	0%
In-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$3,400	Not Applicable	$3,400	Not Applicable
Combined In and Out-of-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$8,300		$8,300	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$10	$10	$10	$10
Office Visits - Specialist	$20	$20	$20	$20
Radiation Therapy	$0	$0	$0	$0
Emergency Room (waived if admitted within 3 days)	$50		$50	
Urgent Care	$40		$40	
Ambulance (Emergent)	$25		$25	
Ambulance (Non-Emergent)	$25	Not Covered	$25	Not Covered
Routine Transportation Combined 24 one-way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	$10	Not Covered	$10	Not Covered
More than 20 Preventive Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Hospital, Home Health Care, and Skilled Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital (Inpatient)	0%	0%	0%	0%
Observation Room/Outpatient Surgery (Hospital)	0%	0%	0%	0%
Outpatient Surgery (Ambulatory Center)	0%	0%	0%	0%
Home Health Care	0%	Not Covered	0%	Not Covered
Skilled Nursing Facility (100 days per benefit period)	0% days 1-100	0% days 1-100	0% days 1-100	0% days 1-100
Dialysis	$0	20%	$0	20%
Mental Health/Chemical Dependence Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health (Inpatient, 190-day lifetime limit)	0%	0%	0%	0%
Mental Health (Outpatient)	$20	$20	$20	$20
Mental Health (Outpatient with Psychiatrist)	$20	$20	$20	$20
Alcohol Substance Abuse (Inpatient)	0%	0%	0%	0%
Alcohol Substance Abuse (Outpatient)	$20	$20	$20	$20
Laboratory and X-ray Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Laboratory Testing (Physician Office/Free Standing Lab)	0%	0%	0%	0%
Laboratory Testing (Outpatient Facility)	0%	0%	0%	0%
X-rays	0%	0%	0%	0%
Advanced Radiology (MRI, MRA, PET, and CT)	0%	0%	0%	0%
Rehabilitation Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physical, Occupational, and Speech Therapy	$20	$20	$20	$20
Chiropractor Medicare Covered	$20	$20	$20	$20
Cardiac Rehab	0%	0%	0%	0%
Vision	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Vision Exam	$20	$20	$20	$20
Routine Vision Exam (Offered through Davis Vision)	$0	Not Covered	$0	Not Covered
Annual allowance (lenses and frames) Offered through Davis Vision	$0 for Davis Vision Fashion Collection frames and standard lenses or $150 benefit maximum for all others.		$0 for Davis Vision Fashion Collection frames and standard lenses or $150 benefit maximum for all others.	
Hearing	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic Hearing Exam	$20	$20	$20	$20
Routine Hearing Exam (TruHearing)	$20	Not Covered	$20	Not Covered
Hearing Aid Benefit (TruHearing)	TruHearing: You pay a $499 copay for the Advanced or a $799 copay for the Premium hearing aid. Up to 2 hearing aids per year.	Not Applicable	TruHearing: You pay a $499 copay for the Advanced or a $799 copay for the Premium hearing aid. Up to 2 hearing aids per year.	Not Applicable
Dental				
Routine Dental	Not Covered		Not Covered	
Supplies, Equipment, and Devices	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Durable Medical Equipment	15%	Not Covered	15%	Not Covered
Prosthetics	15%	Not Covered	15%	Not Covered
Oxygen	15%	Not Covered	15%	Not Covered
Diabetic Supplies	15%	Not Covered	15%	Not Covered
Fitness Program	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Highmark Fitness Program	Nationwide Fitness Network		Nationwide Fitness Network	

Medicare Advantage Renewal

Client Name: Carnegie Mellon University | **Client Number: 037672** | **Current Membership: 6**
Group Name: Carnegie Mellon University | **Group Number: 0584584** | **Invoicing: Direct Employer Billed**
Effective Date: 1/1/2027

	2026 Benefits		2027 Benefits	
Part B Drugs	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Immunosuppressive Drugs	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Oral Chemotherapy Drugs	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Physician Administered Injectables	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Nebulizer Inhalation	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Part B drugs (other)	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Value Added Rider	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Routine Chiropractic - These are routine/not medically necessary services that are not covered by Original Medicare. Chiropractic visits are limited to 8 visits per calendar year.	Not Covered	Not Covered	Not Covered	Not Covered
Routine Podiatry - These are routine/not medically necessary services that are not covered by Original Medicare. Podiatry visits are limited to 10 visits per calendar year.	Not Covered	Not Covered	Not Covered	Not Covered
Meal Plan - 2 meals per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay	Not Covered	Not Applicable	Not Covered	Not Applicable
Prescription Drugs - Part D				
True Out of Pocket (TrOOP) Costs Threshold	$2,100		$2,400	
Formulary	Incentive		Incentive	
Medicare Excluded Part D Prescription Drug Rider	Not Covered		Not Covered	
Prescription Deductible	Not Applicable		Not Applicable	
Retail Prescription Drugs (31 day supply)	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic)	$10.00	$15.00	$10.00	$15.00
Tier 2 (Non-Preferred Generic)	$10.00	$15.00	$10.00	$15.00
Tier 3 (Preferred Brand & Generic)	$25.00	$30.00	$25.00	$30.00
Tier 4 (Non-Preferred)	$55.00	$60.00	$55.00	$60.00
Tier 5 (Specialty)	$60.00	$60.00	$60.00	$60.00
Mail Order Prescription Drugs	**Express Scripts**	**Pharmacies**	**Express Scripts**	**Pharmacies**
Tier 1 (Preferred Generic)	$25.00	$37.50	$25.00	$37.50
Tier 2 (Non-Preferred Generic)	$25.00	$37.50	$25.00	$37.50
Tier 3 (Preferred Brand & Generic)	$62.50	$75.00	$62.50	$75.00
Tier 4 (Non-Preferred)	$137.50	$150.00	$137.50	$150.00
Tier 5 (Specialty)	$60.00	$60.00	$60.00	$60.00
Retail and Mail Order Days Supply Limit	- Retail or Mail Order -Tier 1 & 2 - Up to a 100 day supply - Retail or Mail Order - Tier 3 & 4 - Up to a 90 day supply - Specialty Drugs are limited to a 31-day supply		- Retail or Mail Order -Tier 1 & 2 - Up to a 100 day supply - Retail or Mail Order - Tier 3 & 4 - Up to a 90 day supply - Specialty Drugs are limited to a 31-day supply	
Catastrophic Phase	After reaching the True Out of Pocket (TrOOP) costs of $2,100, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.		After reaching the True Out of Pocket (TrOOP) costs of $2,400, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	
Total Premium Per Member, Per Month	**$333**		**$340**	

This is a summary of the most commonly used benefits. It does not include a full list of benefits.

Please return to your Senior Markets Client Manager or fax to 1-833-841-8072

Signature _____ Date _____

Printed Name _____ Title _____

EGHP_24_3669_M

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal. Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:
Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, or Highmark Senior Health Company.
Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.
West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company.
All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.
The Blue Cross(c), Blue Shield(c), Cross, and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.
TruHearing is a registered trademark of TruHearing, Inc., a separate company. Davis Vision is an independent company that provides the network and administers vision benefits for Highmark members. Express Scripts® is a separate company. Other Pharmacies/Physicians/Providers are available in our network.
The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)
Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.
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Medicare Advantage Renewal

Client Name: Carnegie Mellon University
Group Name: Carnegie Mellon University
Effective Date: 1/1/2027

Client Number: 037672
Group Number: 0584585

Current Membership: 6
Invoicing: Direct Employer Billed

	2026 Benefits		2027 Benefits	
	Security Blue HMO-POS		Security Blue HMO-POS	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0		$0	
Coinsurance (see specific benefits for cost sharing)	0%	0%	0%	0%
In-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$3,400	Not Applicable	$3,400	Not Applicable
Combined In and Out-of-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$8,300		$8,300	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$10	$10	$10	$10
Office Visits - Specialist	$20	$20	$20	$20
Radiation Therapy	$0	$0	$0	$0
Emergency Room (waived if admitted within 3 days)	$50		$50	
Urgent Care	$40		$40	
Ambulance (Emergent)	$25		$25	
Ambulance (Non-Emergent)	$25	Not Covered	$25	Not Covered
Routine Transportation Combined 24 one-way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	$10	Not Covered	$10	Not Covered
More than 20 Preventive Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Hospital, Home Health Care, and Skilled Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital (Inpatient)	0%	0%	0%	0%
Observation Room/Outpatient Surgery (Hospital)	0%	0%	0%	0%
Outpatient Surgery (Ambulatory Center)	0%	0%	0%	0%
Home Health Care	0%	Not Covered	0%	Not Covered
Skilled Nursing Facility (100 days per benefit period)	0% days 1-100	0% days 1-100	0% days 1-100	0% days 1-100
Dialysis	$0	20%	$0	20%
Mental Health/Chemical Dependence Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health (Inpatient, 190-day lifetime limit)	0%	0%	0%	0%
Mental Health (Outpatient)	$20	$20	$20	$20
Mental Health (Outpatient with Psychiatrist)	$20	$20	$20	$20
Alcohol Substance Abuse (Inpatient)	0%	0%	0%	0%
Alcohol Substance Abuse (Outpatient)	$20	$20	$20	$20
Laboratory and X-ray Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Laboratory Testing (Physician Office/Free Standing Lab)	0%	0%	0%	0%
Laboratory Testing (Outpatient Facility)	0%	0%	0%	0%
X-rays	0%	0%	0%	0%
Advanced Radiology (MRI, MRA, PET, and CT)	0%	0%	0%	0%
Rehabilitation Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physical, Occupational, and Speech Therapy	$20	$20	$20	$20
Chiropractor Medicare Covered	$20	$20	$20	$20
Cardiac Rehab	0%	0%	0%	0%
Vision	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Vision Exam	$20	$20	$20	$20
Routine Vision Exam (Offered through Davis Vision)	$0	Not Covered	$0	Not Covered
Annual allowance (lenses and frames) Offered through Davis Vision	$0 for Davis Vision Fashion Collection frames and standard lenses or $150 benefit maximum for all others.		$0 for Davis Vision Fashion Collection frames and standard lenses or $150 benefit maximum for all others.	
Hearing	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic Hearing Exam	$20	$20	$20	$20
Routine Hearing Exam (TruHearing)	$20	Not Covered	$20	Not Covered
Hearing Aid Benefit (TruHearing)	TruHearing: You pay a $499 copay for the Advanced or a $799 copay for the Premium hearing aid. Up to 2 hearing aids per year.	Not Applicable	TruHearing: You pay a $499 copay for the Advanced or a $799 copay for the Premium hearing aid. Up to 2 hearing aids per year.	Not Applicable
Dental				
Routine Dental	Not Covered		Not Covered	
Supplies, Equipment, and Devices	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Durable Medical Equipment	15%	Not Covered	15%	Not Covered
Prosthetics	15%	Not Covered	15%	Not Covered
Oxygen	15%	Not Covered	15%	Not Covered
Diabetic Supplies	15%	Not Covered	15%	Not Covered
Fitness Program	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Highmark Fitness Program	Nationwide Fitness Network		Nationwide Fitness Network	
Part B Drugs	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

Medicare Advantage Renewal

Client Name: Carnegie Mellon University | **Client Number: 037672** | **Current Membership: 6**
Group Name: Carnegie Mellon University | **Group Number: 0584585** | **Invoicing: Direct Employer Billed**
Effective Date: 1/1/2027

	2026 Benefits		2027 Benefits	
Immunosuppressive Drugs	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Oral Chemotherapy Drugs	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Physician Administered Injectables	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Nebulizer Inhalation	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Part B drugs (other)	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max	10%/$300 Qrtly Max
Value Added Rider	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
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Meal Plan - 2 meals per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay	Not Covered	Not Applicable	Not Covered	Not Applicable
Prescription Drugs - Part D				
True Out of Pocket (TrOOP) Costs Threshold	$2,100		$2,400	
Formulary	Incentive		Incentive	
Medicare Excluded Part D Prescription Drug Rider	Not Covered		Not Covered	
Prescription Deductible	Not Applicable		Not Applicable	
Retail Prescription Drugs (31 day supply)	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic)	$10.00	$15.00	$10.00	$15.00
Tier 2 (Non-Preferred Generic)	$10.00	$15.00	$10.00	$15.00
Tier 3 (Preferred Brand & Generic)	$25.00	$30.00	$25.00	$30.00
Tier 4 (Non-Preferred)	$55.00	$60.00	$55.00	$60.00
Tier 5 (Specialty)	$60.00	$60.00	$60.00	$60.00
Mail Order Prescription Drugs	**Express Scripts**	**Pharmacies**	**Express Scripts**	**Pharmacies**
Tier 1 (Preferred Generic)	$25.00	$37.50	$25.00	$37.50
Tier 2 (Non-Preferred Generic)	$25.00	$37.50	$25.00	$37.50
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Tier 4 (Non-Preferred)	$137.50	$150.00	$137.50	$150.00
Tier 5 (Specialty)	$60.00	$60.00	$60.00	$60.00
Retail and Mail Order Days Supply Limit	- Retail or Mail Order -Tier 1 & 2 - Up to a 100 day supply - Retail or Mail Order - Tier 3 & 4 - Up to a 90 day supply - Specialty Drugs are limited to a 31-day supply		- Retail or Mail Order -Tier 1 & 2 - Up to a 100 day supply - Retail or Mail Order - Tier 3 & 4 - Up to a 90 day supply - Specialty Drugs are limited to a 31-day supply	
Catastrophic Phase	After reaching the True Out of Pocket (TrOOP) costs of $2,100, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.		After reaching the True Out of Pocket (TrOOP) costs of $2,400, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	
Total Premium Per Member, Per Month	**$333**		**$340**	

This is a summary of the most commonly used benefits. It does not include a full list of benefits.

Please return to your Senior Markets Client Manager or fax to 1-833-841-8072

Signature _____ Date _____

Printed Name _____ Title _____

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West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company.
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我們能夠提供與資源服務為您最費觀健康跃翅觀痢瘤的