HIGHMARK. PPO Blue

Carnegie Mellon University Student Health Plan - Medical

(Actuarial Value .9285– Metal Tier - Platinum)

On the chart below, you'll see what your plan pays for specific services. 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.

105665-03

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period[1]	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 $250 $500
Plan Payment Level – based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit. Individual Family	 None None	 $4,000 $8,000
Total Maximum Out-of-Pocket[2] (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only. Once met, the plan pays 100% of covered services for the rest of the benefit period.) Individual Family	 $5,000 $10,000	 Not Applicable Not Applicable
Outpatient Medical Care Services		
Retail Clinic Visits (including Virtual Visits)	100% after $25 copayment	80% after deductible
Primary Care Provider Visits (including Virtual Visits)	100% after $25 copayment	80% after deductible
Specialist Visits (including Virtual Visits)	100% after $25 copayment	80% after deductible
Virtual Visit Originating Site Fee	100%	80% after deductible
Urgent Care Center Visits	100% after $25 copayment (Copayment does not apply to visits for the treatment of Mental Health or Substance Abuse)	80% after deductible
Telemedicine Services[3]	100% after $20 copayment	Not Covered
Preventive Care Services[4]		
Routine Physical exams (Adult & Pediatric)	100%	Not Covered
Adult immunizations	100%	80% after deductible
Colorectal cancer screenings	100%	80% after deductible
Routine gynecological exam and Pap Smear	100%	80% after deductible
Mammographic Screening	100%	80% after deductible
Routine Screening tests and procedures	100%	80% after deductible
Pediatric immunizations	100%	80% no deductible
Pediatric Vision[5] Exam (including dilation as professional indicated)	 100%	 Not Covered
Frames	100%	Not Covered
Lenses	100%	Not Covered
Pediatric Dental[5] Routine Exam, X-rays, Cleanings, Consultations, Fluoride Treatments, Palliative Treatment (emergency), Sealants and Space Maintainers	 100%	 Not Covered
Other Pediatric Dental Services[6]	50% no deductible	Not Covered
Emergency Room and Ambulance Services		
Emergency Room Services	100% after $125 copayment (waived if admitted)	
Ambulance – Emergency[11]	100%	
Ambulance – Non-Emergency [11]	100%	80% after deductible
Hospital and Medical/Surgical Services (including maternity) [10]		
Hospital Inpatient[7]	100% after $150 Copayment per Inpatient Admission	80% after deductible
Medical Care (including inpatient visits and consultations)	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Maternity (non-preventive facility & professional services)	100%	80% after deductible
Surgical Services	100%	80% after deductible

Therapy, Habilitative and Rehabilitative Services		
Physical Medicine	100% Limit: 30 visits/benefit period each for Habilitative and Rehabilitative (Limits do not apply to services prescribed for the treatment of Mental Health or Substance Abuse)	80% after deductible
Speech Therapy	100% Limit: 30 visits/benefit period each for Habilitative and Rehabilitative (Limits do not apply to services prescribed for the treatment of Mental Health or Substance Abuse)	80% after deductible
Occupational Therapy	100% Limit: 30 visits/benefit period each for Habilitative and Rehabilitative (Limits do not apply to services prescribed for the treatment of Mental Health or Substance Abuse)	80% after deductible
Spinal Manipulations (chiropractic services)	100% Limit: 25 visits/benefit period	80% after deductible
Cardiac Rehabilitation	100%	80% after deductible
Home Infusion and Suite Infusion Therapy	100%	80% after deductible
Other Therapy Services (Chemotherapy, Dialysis, Infusion Therapy, Pulmonary Therapy, Radiation Therapy, Respiratory Therapy)	100%	80% after deductible
Mental Health/Substance Abuse Services		
Inpatient(7)	100%	80% after deductible
Outpatient (includes Virtual Behavioral Health Services)	100%	80% after deductible
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services *Advanced Imaging* (CT, CTA, MRI, MRA, PET scan, PTE/CT scan, etc.)	100% after $40 copayment (Copayment does not apply to services prescribed for the treatment of Mental Health or Substance Abuse)	80% after deductible
Basic Diagnostic Services (standard imaging, (such as skeletal x-rays, ultrasound, diagnostic medical, lab/pathology, allergy testing)	100% after $25 copayment (Copayment does not apply to services prescribed for the treatment of Mental Health or Substance Abuse)	80% after deductible
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	100%	80% after deductible
Home Health Care	100%	80% after deductible
Hospice	100% Respite Care is limited to 7 days every six (6) consecutive months	80% after deductible
Private Duty Nursing	100% Limit: 240 hours/benefit period	80% after deductible
Skilled Nursing Facility Services	100%	80% after deductible
Therapeutic Injections	100%	80% after deductible
Transplant Services	100%	80% after deductible
Coverage Outside of the United States	Coverage for medical services provided outside of the United States is the same as coverage for medical services provided inside the United States. In most cases you will need to pay up front and submit a claim for reimbursement. To learn more, visit www.globalcore.com. Prescription drugs are not covered when dispensed outside the United States	
Travel Assistance Services	Your plan includes a package of Travel Assistance Services to help you when you are traveling outside of your home country or more than 100 miles from your home. This package includes emergency medical evacuation, medical repatriation, return of mortal remains and many other benefits. The maximum benefit per trip is $500,000. See your Travel Assistance Program Brochure for more details	
Prescription Drugs		
Deductible Individual Family	 None None	

Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary[8] Soft Mandatory Generic[9]	**Retail Drugs (31/60/90-day Supply)** $15/$30/$45 generic copayment (Tier 1) $65/$130/$195 non-formulary generic copayment (Tier 3) $35/$70/$105 formulary brand copayment (Tier 2) $65/$130/$195 non-formulary brand copayment (Tier 3) **Maintenance Drugs through Mail Order (90-day Supply)** $30 generic copayment (Tier 1) $130 non-formulary generic copayment (Tier 3) $70 formulary brand copayment (Tier 2) $130 non-formulary brand copayment (Tier 3)

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 benefit summary.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your school's effective date. Contact your school to determine the effective date applicable to your program.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) 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, Behavior Health is eligible under the Outpatient Mental Health Services benefit)

(4) Services are limited to those listed on the Highmark Preventive Schedule and Women's Health Preventive Schedule.

(5) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.

(6) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. See your benefit booklet for more details.

(7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

(8) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for formulary drugs at the specific copayment or coinsurance amounts listed above.

(9) Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copay or coinsurance amounts, which may apply.

(10) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network 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 level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that exceed the plan allowance for such services.

(11) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.