Carnegie Mellon University Student Health Plan

(91.28% Actuarial Value – Metal Tier - Platinum)

HIGHMARK. | PPO Blue

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.

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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 (includes deductible and coinsurance; excludes copayments and prescription drug cost sharing) Once met, the plan pays 100% of covered medical and pediatric dental services for the rest of the benefit period. 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	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[10]	100%	
Ambulance – Non-Emergency [10]	100%	80% after deductible
Hospital and Medical/Surgical Services (including maternity)		
Hospital Inpatient[8]	100% after $150 Inpatient Deductible per Admission	80% after deductible
Hospital Outpatient	100%	80% after deductible
Maternity (non-preventive facility & professional services)	100%	80% after deductible
Inpatient Medical Care Services, Surgical Services	100%	80% after deductible

Therapy, Habilitative and Rehabilitative Services		
Physical Medicine[8]	100%	80% after deductible
	Limit: 30 visits/benefit period each for Habilitative and Rehabilitative	
Speech Therapy[8]	100%	80% after deductible
	Limit: 30 visits/benefit period each for Habilitative and Rehabilitative	
Occupational Therapy[8]	100%	80% after deductible
	Limit: 30 visits/benefit period each for Habilitative and Rehabilitative	
Spinal Manipulations	100%	80% after deductible
	Limit: 25 visits/benefit period	
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% after $150 Inpatient Deductible per Admission	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	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after $25 copayment	80% after deductible
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	100%	80% after deductible
Elective Abortion (facility and professional)	100%	80% after deductible
Home Health Care	100%	80% after deductible
Hospice	100%	80% after deductible
	Respite Care is limited to 7 days every six (6) consecutive months	
Private Duty Nursing	100%	80% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Services	100%	80% after deductible
Therapeutic Injections	100%	80% after deductible
Transplant Services	100%	80% after deductible
Prescription Drugs		
Deductible Individual Family	None None	
Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the HCR Comprehensive Formulary[9] Soft Mandatory Generic[9]	**Retail Drugs (31/60/90-day Supply)** $15/$30/$45 generic copayment $65/$130/$195 non-formulary generic copayment $35/$70/$105 formulary brand copayment $65/$130/$195 non-formulary brand copayment **Maintenance Drugs through Mail Order (90-day Supply)** $30 generic copayment $130 non-formulary generic copayment $70 formulary brand copayment $130 non-formulary brand copayment	

(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) Services must be performed by a Highmark approved telemedicine provider.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(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) If you receive services from an out-of-area provider or a provider who does not participate with the local Blue Cross and/or Blue Shield plan, you must contact Highmark Utilization Management prior to a planned inpatient admission, 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.
(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and by their cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.
8/2022

(9) Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.
(10) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.