HIGHMARK. PPOBlue
A Preferred-Provider Program

Summary of PPOBlue *Benefits*

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Carnegie Mellon University Student Health Plan 12804-23 Standard

Benefit	Network	Out-of-Network
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $350 $700	
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80% after deductible	50% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100% PRC) Individual Family	 $3,000 $6,000	
Lifetime Maximum (per person)	$1,000,000 (excluded prescription drug)	
Primary Care Physician Office Visits	80% after deductible	50% after deductible
Specialist Office Visits	80% after deductible	50% after deductible
Preventive Care ***Adult*** Routine physical exams	 100% after $20 copayment	 Not covered
Adult Immunizations	100$ after $20 copayment	50%(deductible does not apply)
Therapeutic Injections	100% after $20 copayment	50% after deductible
Routine gynecological exams, including a Pap Test	100% after $20 copayment (maximums do not apply)	50% (deductible does not apply)
Mammograms, annual routine(age 40 plus) and medically necessary	100%	50% after deductible
Pediatric Routine physical exams	 100% after $20 copayment	 Not covered
Pediatric immunizations	100% after $20 copayment (maximums do not apply)	50% (deductible/maximums do not apply)
Emergency Room Services	80% after $100 copay, deductible applies	
Spinal Manipulations	80% after deductible	50% after deductible
	Limit: 25 visits/benefit period	
Physical Medicine	80% after deductible	50% after deductible
	Limit: 25 visits/benefit period	
Speech Therapy	80% after deductible	50% after deductible
	Limit: 25 visits/benefit period	
Occupational Therapy	80% after deductible	50% after deductible
	Limit: 25 visits/benefit period	
Allergy Extracts and Injections	80% after deductible	50% after deductible
Ambulance	80% after deductible	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	50% after deductible
Diabetes Treatment	80% after deductible	50% after deductible
Diagnostic Services (including routine) ***Advanced Imaging*** (MRI, CAT Scan, PET scan, etc.)	80% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	50% after deductible
Enteral Formulae	80% (deductible does not apply)	50% (deductible does not apply)
Home Infusion Therapy	80% after deductible	50% after deductible
Home Health Care	80% after deductible	50% after deductible
Hospice	80% after deductible	50% after deductible
Hospital Services – Inpatient	80% after deductible	50% after deductible
Hospital Services – Outpatient	80% after deductible	50% after deductible

Benefit	Network	Out-of-Network
Infertility Counseling, Testing and Treatment(2)	80% after deductible	50% after deductible
Maternity (facility & professional services)	80% after deductible	50% after deductible
Medical/Surgical Expenses (Except Office Visits)	80% after deductible	50% after deductible
Mental Health – Inpatient(3)	80% up to out-of-pocket; 100% thereafter	50% up to out-of-pocket; 100% thereafter
Mental Health – Outpatient(3)	80% up to out-of-pocket; 100% thereafter	50% up to out-of-pocket; 100% thereafter
Private Duty Nursing	80% after deductible	
Respiratory Therapy	80% after deductible	50% after deductible
Skilled Nursing Facility Care	80% after deductible	50% after deductible Limit: 60 days/benefit period
Substance Abuse – Inpatient Detoxification	80% up to out-of-pocket; 100% thereafter	50% up to out-of-pocket; 100% thereafter
	Limit: 7 days/admission; 4 admissions/lifetime	
Substance Abuse – Inpatient Rehabilitation	80% up to out-of-pocket; 100% thereafter	50% up to out-of-pocket; 100% thereafter
	Limit: 30 days/benefit period; 90 days/lifetime	
Substance Abuse – Outpatient	80% up to out-of-pocket; 100% thereafter	50% up to out-of-pocket; 100% thereafter
	Limit: 60 visits/benefit period; 120 visits/lifetime	
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	50% after deductible
Transplant Services	80% after deductible	50% after deductible
Precertification Requirements(4)	Yes	
Premier Prescription Drug Program ***Defined by Premier Gold Pharmacy Network - Not Physician Network.*** ***(Prescriptions filled at a non-network pharmacy are not covered.)***	**Retail Drugs** $15 Generic copayment $30 Brand copayment $45 Brand Nonformulary copayment **31 day supply(5)** **Maintenance Drugs through Mail Order** $30 Generic copayment $60 Brand copayment $90 Brand Nonformulary copayment **90 day supply(5)**	

Questions? Call 1-800-215-7865

Reference Code: P0110509

(Please have your Reference Code ready when you call)

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

(2) 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.

(3) State mandated benefits (30 inpatient days and 60 outpatient visits annually with the right to exchange inpatient days for outpatient visits on a one-for-two basis) may apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa, delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see above-referenced benefits for plan limits).

(4) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. 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.

(5) 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 both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your doctor specifies a brand name drug. Your payment is the price different between the brand and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply