## Point Park University Student Plan

**2022 - (GOLD METAL TIER-) (83.23% ACTUARIAL VALUE)**

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.

### Deductible (per benefit period)
- **Individual**: $500
- **Family**: $1,000

### Plan Pays – payment based on the plan allowance
- **Individual**: 80% after deductible
- **Family**: 60% 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**: Not Applicable
- **Family**: Not Applicable

### Total Maximum Out-of-Pocket
- **Individual**: $8,150
- **Family**: $16,300

## Preventive Care

### Routine Adult
- **Physical exams**: 100% no deductible
- **Adult immunizations**: 100% no deductible
- **Cancer screening**: 100% no deductible
- **Routine gynecological exams, including a Pap Test**: 100% no deductible
- **Mammograms, annual routine and medically necessary**: 100% no deductible
- **Diagnostic services and procedures**: 100% no deductible

### Routine Pediatric
- **Physical exams**: 100% no deductible
- **Pediatric immunizations**: 100% no deductible
- **Diagnostic services and procedures**: 100% no deductible

### Pediatric Vision
- **Exam (including dilations, as professional indicated)**: 100% no deductible
- **Pediatric frame selection**: 100% no deductible
- **Standard eyeglass lenses (per pair)**: 100% no deductible

### Pediatric Dental
- **Routine Exam/Cleanings**: 100% no deductible
- **Basic Services (Fluoride treatments, sealants, consultations)**: 50% no deductible
- **Major Services (including crowns, inlays, onlays, crown repair, root canals, etc.)**: 50% no deductible
- **Orthodontics (Medically necessary with prior approval)**: 50% no deductible

### Emergency Room and Ambulance Services
- **Emergency Room Services**: 100% after $100 copayment (waived if admitted)
- **Ambulance – Emergency**
  - **Contract Year**: 80% after Network deductible
- **Ambulance – Non-Emergency**
  - **Contract Year**: 80% after deductible

### Hospital and Medical/Surgical Expenses (including maternity)
- **Hospital Inpatient**
  - **Contract Year**: 80% after deductible
- **Hospital Outpatient**
  - **Contract Year**: 80% after deductible

### Medical Care, Surgical Services
- **Contract Year**: 80% after deductible

### Therapy, Rehabilitation and Habilitative Services
- **Physical Medicine (Rehabilitative and Habilitative)**
  - **Contract Year**: 80% after deductible
This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

08/2022

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy (Rehabilitative and Habilitative)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Speech Therapy (Rehabilitative and Habilitative)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

**Mental Health/Substance Abuse**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (7)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Inpatient Detoxification/Rehabilitation (7)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Includes Virtual Behavioral Health Visits</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

**Other Services**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Extracts and Injections</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Assisted Fertilization Procedures</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dental Services Related to Accidental Injury</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment, Orthotics and Prosthetics</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Respite Care is limited to 7 days every six (6) consecutive months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Limit: 240 hours/benefit period</td>
<td></td>
<td></td>
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<tr>
<td>Skilled Nursing Facility Care</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Limit: 100 days/benefit period</td>
<td></td>
<td></td>
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<tr>
<td>Therapeutic Injections</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
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</tbody>
</table>

**Prescription Drugs**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Individual Family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Prescriptions filled at a non-network pharmacy are not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your plan uses the HCR Comprehensive Formulary with an Open Formulary Benefit Design (8)</td>
<td></td>
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</tr>
<tr>
<td>Retail Drugs (31-day Supply)</td>
<td>20% generic copayment</td>
<td>20% brand copayment</td>
</tr>
<tr>
<td>Maintenance Drugs through Mail Order (90-day Supply)</td>
<td>20% generic copayment</td>
<td>20% brand copayment</td>
</tr>
</tbody>
</table>

(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 Out-of-Pocket (TMOOP) is mandated by the federal government effective with plan years beginning on or after January 1, 2014. With plan years beginning on or after January 1, 2017, TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. TMOOP cannot be more than $7,900 for individual and $15,800 for two or more persons.

(3) Services must be performed by a Highmark approved telemedicine provider.

(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) Limit does not apply to Habilitative services for the treatment of a Mental Health or Substances Abuse diagnosis.

(9) 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.

(10) 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.

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

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, including sex stereotypes and gender identity. The Plan 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 Plan 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 Plan 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 Plan:

- 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 Plan 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 for Civil Rights Complaint Portal, available at https://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
1-800-368-1019, 800-537-7697 (TDD)


If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务，
请致电 1-800-876-7639.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.