

## 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.

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Benefit	Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year	
<b>Deductible</b> (per benefit period)		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
<b>Plan Pays</b> – payment based on the plan allowance	80% after deductible	60% after deductible
<b>Out-of-Pocket Limit</b> (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	Not Applicable
Family	Not Applicable	Not Applicable
<b>Total Maximum Out-of-Pocket</b> <sup>(2)</sup> (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	\$ 8,150	Not Applicable
Family	\$16,300	Not Applicable
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits &amp; Virtual Visits</b>	80% after deductible	60% after deductible
<b>Primary Care Provider Office Visits &amp; Virtual Visits</b>	80% after deductible	60% after deductible
<b>Specialist Office &amp; Virtual Visits</b>	80% after deductible	60% after deductible
Virtual Visit Originating Site Fee	80% after deductible	60% after deductible
<b>Urgent Care Center Visits</b>	80% after deductible	60% after deductible
<b>Telemedicine Services</b> <sup>(3)</sup>	80% after deductible	Not Covered
<b>Preventive Care</b> <sup>(4)</sup>		
<b>Routine Adult</b>		
Physical exams	100% no deductible	Not Covered
Adult immunizations	100% no deductible	60% after deductible
Colorectal cancer screening	100% no deductible	60% after deductible
Routine gynecological exams, including a Pap Test	100% no deductible	60% after deductible
Mammograms, annual routine and medically necessary	100% no deductible	60% after deductible
Diagnostic services and procedures	100% no deductible	60% after deductible
<b>Routine Pediatric</b>		
Physical exams	100% no deductible	Not Covered
Pediatric immunizations	100% no deductible	60% no deductible
Diagnostic services and procedures	100% no deductible	60% after deductible
<b>Pediatric Vision</b> <sup>(5)</sup>		
Exam (including dilations, as professional indicated)	100% no deductible	Not Covered
Pediatric frame selection	100% no deductible	Not Covered
Standard eyeglass lenses (per pair)	100% no deductible	Not Covered
<b>Pediatric Dental</b> <sup>(5)</sup>		
Routine Exam/Cleanings	100% no deductible	Not Covered
Basic Services (Fluoride treatments, sealants, consultations)	50% no deductible	Not Covered
Major Services (including crowns, inlays, onlays, crown repair, root canals, etc.)	50% no deductible	Not Covered
Orthodontics <sup>(6)</sup> (Medically necessary with prior approval)	50% no deductible	Not Covered
<b>Emergency Room and Ambulance Services</b>		
<b>Emergency Room Services</b>	100% after \$100 copayment (waived if admitted)	
<b>Ambulance – Emergency</b> <sup>(11)</sup>	80% after Network deductible	
<b>Ambulance – Non-Emergency</b> <sup>(11)</sup>	80% after deductible	60% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b> <sup>(7)</sup>	80% after deductible	60% after deductible
<b>Hospital Outpatient</b>	80% after deductible	60% after deductible
<b>Maternity</b> (non-preventive facility & professional services)	80% after deductible	60% after deductible
<b>Medical Care, Surgical Services</b>	80% after deductible	60% after deductible
<b>Therapy, Rehabilitation and Habilitative Services</b>		
<b>Physical Medicine</b> <sup>(8)</sup> (Rehabilitative and Habilitative)	80% after deductible	60% after deductible
	Limit: 30 visits/benefit period each for Habilitative and Rehabilitative	

Benefit	Network	Out-of-Network
<b>Occupational Therapy</b> <sup>(8)</sup> (Rehabilitative and Habilitative)	80% after deductible	60% after deductible
	Limit: 30 visits/benefit period each for Habilitative and Rehabilitative	
<b>Respiratory Therapy</b>	80% after deductible	60% after deductible
<b>Speech Therapy</b> (Rehabilitative and Habilitative) <sup>(8)</sup>	80% after deductible	60% after deductible
	Limit: 30 visits/benefit period each for Habilitative and Rehabilitative	
<b>Spinal Manipulations</b>	80% after deductible	60% after deductible
<b>Home Infusion Therapy</b>	80% after deductible	60% after deductible
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient</b> <sup>(7)</sup>	80% after deductible	60% after deductible
<b>Inpatient Detoxification/Rehabilitation</b> <sup>(7)</sup>	80% after deductible	60% after deductible
<b>Outpatient</b> Includes Virtual Behavioral Health Visits	80% after deductible	60% after deductible
<b>Other Services</b>		
<b>Allergy Extracts and Injections</b>	80% after deductible	60% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	Not Covered
<b>Dental Services Related to Accidental Injury</b>	80% after deductible	60% after deductible
<b>Diagnostic Services</b> <i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
	<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	80% after deductible	60% after deductible
<b>Home Health Care</b>	80% after deductible	60% after deductible
<b>Hospice</b>	80% after deductible	60% after deductible
	Respite Care is limited to 7 days every six (6) consecutive months	
<b>Private Duty Nursing</b>	80% after deductible	60% after deductible
	Limit: 240 hours/benefit period	
<b>Skilled Nursing Facility Care</b>	80% after deductible	60% after deductible Limit: 100 days/benefit period
<b>Therapeutic Injections</b>	80% after deductible	60% after deductible
<b>Transplant Services</b>	80% after deductible	60% after deductible
<b>Prescription Drugs</b>		
<b>Deductible</b> Individual Family	None None	
Prescriptions filled at a non-network pharmacy are not covered.	<b>Retail Drugs (31-day Supply)</b> 20% generic copayment 20% brand copayment	
Your plan uses the HCR Comprehensive Formulary with an Open Formulary Benefit Design <sup>(8)</sup>	<b>Maintenance Drugs through Mail Order (90-day Supply)</b> 20% generic copayment 20% brand copayment	
Soft Mandatory Generic <sup>(9)</sup>	20% generic copayment 20% 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 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](mailto: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)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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。  
請致電 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.

Wann du Deutsch schwetzsch, kannsch du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannsch du 1-800-876-7639 uffrufe.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.  
1-800-876-7639 로 전화.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم  
1-800-876-7639 .

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-800-876-7639 નંબર પર ફોન કરો.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa.  
Zadzwoń 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w.  
Rele nan 1-800-876-7639.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូន  
លោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-800-876-7639 ។

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyonang tulong sa wika. Tumawag sa 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان  
با تماس با شماره 1-800-876-7639 .

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká  
a'doowól, éí bee ná'ahóót'i'. Kojí' hodíłnih 1-800-876-7639.