

Point Park University Student Plan 2025 - (GOLD METAL TIER-) (84 20% ACTUARIA)

2025 - {GOLD METAL TIER-} (84.20% 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.

017242-18

Benefit Period August 1, 2025 - July 31, 2026 Contract Year	hospital.		017242-18
Benefit Period (**) August 1, 2025 – July 31, 2026 Deductible (per benefit period) Individual Family \$1,000 \$1,000 \$2,000 \$1,000 \$2,000 \$1,000 \$2,000 \$1,000 \$2,000 \$2,000 \$1,000 \$2,000 \$2,000 \$2,000 \$2,000 \$2,000 \$2,000 \$2,000 \$2,000 \$2,000 \$2,000 \$3,000 \$4,00	Benefit	Network	Out-of-Network
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Family S1,000 \$2,000 Pain Pays — payment based on the plan allowance 80% after deductible 60% after deductible Family Not Applicable S16,300 Not Applicable Not Applicable S16,300 Not Appl	Deductible (per benefit period)	· ·	
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Individual Family Not Applicable Not	Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Total Maximum Out-of-Pocket (**) (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 S16,300 Not Applicable **Retail Clinic Visits & Virtual Visits **Retail Clinic Visits **Retail Clinic Vi	Out-of-Pocket Limit	· ·	
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			60% after deductible
		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	
	Respiratory Therapy		60% after deductible

	80% after deductible	60% after deductible	
Speech Therapy		n for Habilitative and Rehabilitative	
(Rehabilitative and Habilitative)	Limits do not apply to services prescribed for the treatment		
Spinal Manipulations	of Mental Health or Substance Abuse 80% after deductible 60% after deductible		
Home Infusion Therapy	80% after deductible	60% after deductible	
Other Therapy Services (Cardiac Rehab, Infusion Therapy,			
Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible	
	lealth/Substance Abuse		
Inpatient ⁽⁷⁾	80% after deductible	60% after deductible	
Inpatient Detoxification/Rehabilitation ⁽⁷⁾	80% after deductible	60% after deductible	
Outpatient	000/ 6 1 1 (1)		
Includes Virtual Behavioral Health Visits	80% after deductible	60% after deductible	
	Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible	
Assisted Fertilization Procedures	Not Covered	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible	
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible	
Basic Diagnostic Services (standard imaging, diagnostic	80% after deductible	60% after deductible	
medical, lab/pathology, allergy testing)			
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible	
Home Health Care	80% after deductible	60% after deductible	
Hospice	80% after deductible	60% after deductible	
	Respite Care is limited to 7 days every six (6) consecutive months		
Private Duty Nursing	80% after deductible 60% after deductible		
Filvate Duty Nuising	Limit: 240 hours/benefit period		
Skilled Nursing Facility Care	80% after deductible	60% after deductible	
•		Limit: 100 days/benefit period	
Therapeutic Injections	80% after deductible	60% after deductible	
Transplant Services	80% after deductible	60% after deductible	
	rescription Drugs		
Deductible In the dead of the second of the			
Individual	None		
Family	None (04 days 0 marks)		
Prescriptions filled at a non-network pharmacy are not covered.	Retail Drugs (31-day Supply)		
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Your plan uses the Comprehensive Formulary (8)	Malatanana Dan d	- Mail Onder (00 dess Ossauls)	
Soft Mandatory Generic (9)	Maintenance Drugs through Mail Order (90-day Supply)		
	20% generic copayment 20% brand copayment		
	only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / p		

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) 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
- (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.



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

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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 Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht 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 1-876-7639 .

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 हો, તો તમને ભાષા સहાયતા 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 ហើយត្រូវការសេវាកម្មជំនួយផ្នែកកាសាដែលអាចផ្ដល់ជូន 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 serbisyong 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 663--876-870 .

Diné k'ehgo yánítti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Koji' hodíilnih 1-800-876-7639.