HIGHMARK. | PPO Blue

Point Park University Student Plan

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	Network	Out-of-Network
General Provisions		
Benefit Period [1] August 1, 2025 – July 31, 2026	Contract Year	
Deductible (per benefit period) Individual Family	 $500 $1,000	 $1,000 $2,000
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit Individual Family	 Not Applicable Not Applicable	 Not Applicable Not Applicable
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	 $ 8,150 $16,300	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	80% after deductible	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	80% after deductible	60% after deductible
Specialist Office & Virtual Visits	80% after deductible	60% after deductible
Virtual Visit Originating Site Fee	80% after deductible	60% after deductible
Urgent Care Center Visits	80% after deductible	60% after deductible
Telemedicine Services [3]	80% after deductible	Not Covered
Preventive Care [4]		
Routine Adult 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
Routine Pediatric 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
Pediatric Vision [5] Under age 19 only 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
Pediatric Dental [5] Under age 19 only Consultations, Routine Exams, X-rays, Cleanings, Fluoride Treatments, Palliative Treatment (emergency), Sealants and Space Maintainers [6]	100% no deductible	Not Covered
Other Pediatric Dental Services	50% no deductible	Not Covered
Emergency Room and Ambulance Services		
Emergency Room Services	100% after $100 copayment (waived if admitted)	
Ambulance – Emergency [11]	80% after Network deductible	
Ambulance – Non-Emergency [11]	80% after deductible	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity) [10]		
Hospital Inpatient [7]	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services)	80% after deductible	60% after deductible
Medical Care, Surgical Services	80% after deductible	60% after deductible
Therapy, Rehabilitation and Habilitative Services		
Physical Medicine (Rehabilitative and Habilitative)	80% 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	60% after deductible
Occupational Therapy (Rehabilitative and Habilitative)	80% 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	60% after deductible
Respiratory Therapy	80% after deductible	60% after deductible

Speech Therapy (Rehabilitative and Habilitative)	80% after deductible	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	
Spinal Manipulations	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
Mental Health/Substance Abuse		
Inpatient(7)	80% after deductible	60% after deductible
Inpatient Detoxification/Rehabilitation(7)	80% after deductible	60% after deductible
Outpatient **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 medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
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
	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
Prescription Drugs		
Deductible Individual Family	None None	
Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary (8) Soft Mandatory Generic (9)	**Retail Drugs (31-day Supply)** 20% generic copayment 20% brand copayment **Maintenance Drugs through Mail Order (90-day Supply)** 20% generic copayment 20% brand copayment	

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 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.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

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)

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
1-800-876-7639 .

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 ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ 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 1-800-876-7639 .

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