Student Health Plan - Niagara University - WNY LG POS 250D EX Blended with Rx

On the chart below, you'll see what you pay 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.

Benefit	In-Network	Out-of-Network
General Provisions		
Effective Date	08/01/2026	
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	$250	$600
Deductible Accumulation (2)	Embedded	Embedded
Coinsurance - payment based on the plan allowance	20% coinsurance after deductible	30% coinsurance after deductible
Out-of-Pocket Maximum (Includes any medical and prescription drug deductibles, coinsurance, and copays). Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	$7,500	$15,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider (PCP) Office Visits & Virtual Visits	$25 copay	30% coinsurance after deductible
Specialist Office Visits & Virtual Visits	$25 copay	30% coinsurance after deductible
Virtual Visit Provider Originating Site Fee	covered in full	30% coinsurance after deductible
Urgent Care Center Visits	$50 copay	
Telemedicine Services (3)	covered in full	Not Covered
Preventive Care (4)		
Routine Adult		
Physical exams	covered in full	Not Covered
Adult immunizations	covered in full	30% coinsurance after deductible
Routine gynecological exams, including a Pap Test	covered in full	30% coinsurance after deductible
Breast Cancer Screenings	covered in full	30% coinsurance after deductible
Diagnostic services and procedures	covered in full	30% coinsurance after deductible
Routine Pediatric		
Physical exams	covered in full	30% coinsurance after deductible
Pediatric immunizations	covered in full	30% coinsurance after deductible
Diagnostic services and procedures	covered in full	30% coinsurance after deductible
Pediatric Vision Care Routine eye exam	covered in full	not covered
Equipment	covered in full	not covered
Pediatric Dental Care Consultations, Routine Exams, X-rays, Cleanings, Fluoride Treatments, Palliative Treatment (emergency), Occlusal Guard, Sealants & Space Maintainers	$25 copay	not covered
Other Pediatric Dental Services	50% coinsurance	not covered
Emergency Services		
Emergency Room Services (5)	$150 copay after deductible (copay waived if admitted)	
Ambulance	20% coinsurance after deductible	
Hospital and Medical/Surgical Expenses (5)		
Hospital Inpatient	20% coinsurance after deductible	30% coinsurance after deductible
Hospital Outpatient	see service category (i.e. lab, surgery, imaging)	30% coinsurance after deductible
Outpatient Surgery (facility)	20% coinsurance after deductible	30% coinsurance after deductible
Surgical Services (professional)		
Office	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient or Ambulatory Surgery	20% coinsurance after deductible	30% coinsurance after deductible
Inpatient	20% coinsurance after deductible	30% coinsurance after deductible
Medical Care (including inpatient visits and consultations)	20% coinsurance after deductible	30% coinsurance after deductible
Therapy Services		
	20% coinsurance after deductible	30% coinsurance after deductible

Benefit	In-Network	Out-of-Network
Physical Therapy, Speech Therapy & Occupational Therapy	**limit:** 120 visits / condition / benefit period combined, aggregate IN & OON; including rehabilitative and habilitative services	
Respiratory Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Spinal Manipulations	$25 copay for PCP; $25 copay for Specialist	30% coinsurance after deductible
Cardiac Rehabilitation Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Infusion Therapy		
Office	$25 copay for PCP; $25 copay for Specialist	30% coinsurance after deductible
Outpatient	$25 copay for PCP; $25 copay for Specialist	30% coinsurance after deductible
Home	$25 copay for PCP; $25 copay for Specialist	30% coinsurance after deductible
Chemotherapy and Radiation Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Dialysis	20% coinsurance after deductible; covered in full for home dialysis	30% coinsurance after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	20% coinsurance after deductible	30% coinsurance after deductible
Inpatient Detoxification/Rehabilitation	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	covered in full	30% coinsurance after deductible
Outpatient Substance Abuse	covered in full	30% coinsurance after deductible
Other Services		
Acupuncture	$25 copay for PCP; $25 copay for Specialist	30% coinsurance after deductible
	limit: 20 visits / benefit period	
Allergy Extracts	covered in full	30% coinsurance after deductible
Allergy Injections	$25 copay for PCP; $25 copay for Specialist	30% coinsurance after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	covered in full	30% coinsurance after deductible
Assisted Fertilization Procedures (IVF & GIFT & ZIFT excluded)	see service category (i.e. lab, surgery, imaging)	30% coinsurance after deductible
Dental Services Related to Accidental Injury	see service category (i.e. lab, surgery, imaging)	30% coinsurance after deductible
Diabetes Treatment		
Equipment and Supplies	$25 copay/item	30% coinsurance after deductible
Diabetes Education Program	$25 copay	30% coinsurance after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	20% coinsurance after deductible	30% coinsurance after deductible
Standard Imaging	20% coinsurance after deductible	30% coinsurance after deductible
Diagnostic Medical	20% coinsurance after deductible	30% coinsurance after deductible
Mammograms, medically necessary	20% coinsurance after deductible	30% coinsurance after deductible
Pathology/Laboratory	20% coinsurance after deductible	30% coinsurance after deductible
Allergy Testing	$25 copay for PCP; $25 copay for Specialist	30% coinsurance after deductible
Durable Medical Equipment	20% coinsurance after deductible	20% coinsurance after deductible
Prosthetics	20% coinsurance after deductible	30% coinsurance after deductible
Orthotics	20% coinsurance after deductible	30% coinsurance after deductible
External Hearing Aid (Including hearing exam and tinnitus maskers)	Covered in full for external hearing aid services; 20% after deductible for cochlear implant	30% coinsurance after deductible
	Limit: single purchase for one or both ear every three (3) years, aggregate IN & OON for External Hearing Aids. One(1) per ear per lifetime, aggregate IN and OON for Cochlear Implant.	
Home Health Care	$25 copay for PCP; $40 copay for Specialist	30% coinsurance after deductible
	limit: 100 visits / benefit period	
Hospice	20% coinsurance after deductible	30% coinsurance after deductible
Maternity (non-preventive professional services) including dependent daughter	$25 copay for PCP; $25 copay for Specialist (one copay on global professional bill)	30% coinsurance after deductible
Infertility Counseling, Testing and Treatment	see service category (i.e. lab, surgery, imaging)	30% coinsurance after deductible
Skilled Nursing Facility Care	20% coinsurance after deductible	30% coinsurance after deductible
	limit: 100 days / benefit period, aggregate IN & OON	

Benefit	In-Network	Out-of-Network
Transplant Services	20% coinsurance after deductible	30% coinsurance after deductible
Wellness Card	$250 single	not covered
NY Travel Assistance Program	Your plan includes a package of Travel Assistance Services to help you when you are traveling outside of your home country or more than 100 miles from your home. This package includes emergency medical evacuation, medical repatriation, return of mortal remains and many other benefits. The maximum benefit per trip is $500,000. See your Travel Assistance Program Brochure for more details.	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 None None	
Prescription Drug Program(6) SensibleRx Complete Defined by the National Plus NY Pharmacy Network - not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design. .	**Retail Drugs (30 / 60 / 90-day Supply)** generic formulary drugs $20 / $40 / $60 copay brand formulary drugs $60 / $120 / $180 copay generic & brand non-formulary drugs $75 / $150 / $225 copay prescription insulin drugs are covered in full **Specialty Drugs – Retail or Mail Order (31-day Supply)** generic formulary drugs $20 copay brand formulary drugs $60 copay generic & brand non-formulary drugs $75 copay **Maintenance Drugs through Mail Order (30 / 60 / 90-day Supply)** generic formulary drugs $20 / $40 / $50 copay brand formulary drugs $60 / $120 / $150 copay generic & brand non-formulary drugs $75 / $150 / $188 copay prescription insulin drugs are covered in full **Preventive Prescription Drugs – NY Commercial List** **Retail Drugs (31 -day Supply)** covered in full (deductible does not apply) **Maintenance Drugs through Mail Order (90-day Supply)** covered in full (deductible does not apply)	

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This is not a contract. This benefit 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.

2026- GOLD (80.16% ACTUARIAL VALUE)

1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
2) If you are enrolled in a ''Family plan'', with your embedded deductible, once an individual's deductible is satisfied, claim reimbursement for covered services will begin for that member. Once the family deductible is satisfied collectively by covered family members, claim reimbursement will begin for all covered family members. With your embedded out-of-pocket maximum, once an individual's out-of-pocket maximum is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the rest of the benefit period. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is satisfied collectively.
3) Telemedicine Services must be performed by the Highmark Blue Cross Blue Shield Designated Telemedicine Vendor.
4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services 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 services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
6) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved drugs selected for their quality, safety, and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under SensibleRx Complete, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug member cost share indicated plus the difference in cost between the brand and generic drugs. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.