

Student Health Plan - University at Buffalo Medical Students - WNY LG POS 8200 EX Coinsurance 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	07/01/2026	
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$50	\$300
Family	\$100	\$600
Deductible Accumulation (2)	Embedded	
Coinsurance - payment based on the plan allowance	10% 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	\$6,850	\$13,700
Family	\$13,700	\$27,400
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider (PCP) Office Visits & Virtual Visits	10% coinsurance after deductible	30% coinsurance after deductible
Specialist Office Visits & Virtual Visits	10% coinsurance after deductible	30% coinsurance after deductible
Virtual Visit Provider Originating Site Fee	0% coinsurance after deductible	30% coinsurance after deductible
Urgent Care Center Visits	10% coinsurance after deductible	
Telemedicine Services (3)	10% coinsurance after deductible	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 copayment (deductible does not apply)	Not covered
Other Pediatric Dental Services	50% coinsurance	not covered
Emergency Services		
Emergency Room Services (5)	10% coinsurance after deductible (coinsurance waived if admitted)	
Ambulance	10% coinsurance after deductible	
Hospital and Medical/Surgical Expenses (5)		
Hospital Inpatient	10% coinsurance after deductible	30% coinsurance after deductible
Hospital Outpatient	see service category (i.e. lab, surgery, imaging)	30% coinsurance after deductible
Outpatient Surgery (facility)	10% coinsurance after deductible	30% coinsurance after deductible
Surgical Services (professional)		
Office	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient or Ambulatory Surgery	10% coinsurance after deductible	30% coinsurance after deductible
Inpatient	10% coinsurance after deductible	30% coinsurance after deductible
Medical Care (including inpatient visits and consultations)	10% coinsurance after deductible	30% coinsurance after deductible

Benefit	In-Network	Out-of-Network
Therapy Services		
Physical Therapy, Speech Therapy & Occupational Therapy	10% coinsurance after deductible Benefit Limit: 60 visits per condition per benefit period, aggregate IN & OON; including rehabilitative and habilitative services	30% coinsurance after deductible
Respiratory Therapy	10% coinsurance after deductible	30% coinsurance after deductible
Spinal Manipulations	10% coinsurance after deductible	30% coinsurance after deductible
Cardiac Rehabilitation Therapy	10% coinsurance after deductible	30% coinsurance after deductible
Infusion Therapy		
Office	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient	10% coinsurance after deductible	30% coinsurance after deductible
Home	10% coinsurance after deductible	30% coinsurance after deductible
Chemotherapy and Radiation Therapy	10% coinsurance after deductible	30% coinsurance after deductible
Dialysis	10% coinsurance after deductible	30% coinsurance after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	10% coinsurance after deductible	30% coinsurance after deductible
Inpatient Detoxification/Rehabilitation	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient Substance Abuse	10% coinsurance after deductible	30% coinsurance after deductible
Other Services		
Allergy Extracts	10% coinsurance after deductible	30% coinsurance after deductible
Allergy Injections	10% coinsurance after deductible	30% coinsurance after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	10% coinsurance after deductible	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	10% coinsurance after deductible	30% coinsurance after deductible
Diabetes Education Program	10% coinsurance after deductible	30% coinsurance after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	10% coinsurance after deductible	30% coinsurance after deductible
Standard Imaging	10% coinsurance after deductible	30% coinsurance after deductible
Diagnostic Medical	10% coinsurance after deductible	30% coinsurance after deductible
Mammograms, medically necessary	10% coinsurance after deductible	30% coinsurance after deductible
Pathology/Laboratory	10% coinsurance after deductible	30% coinsurance after deductible
Allergy Testing	10% coinsurance after deductible	30% coinsurance after deductible
Durable Medical Equipment	10% coinsurance after deductible	30% coinsurance after deductible
Prosthetics	10% coinsurance after deductible	30% coinsurance after deductible
Orthotics	10% coinsurance after deductible	30% coinsurance after deductible
External Hearing Aid (Including hearing exam and tinnitus maskers)	0% after deductible for external hearing aid services; 10% after deductible for cochlear implant 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.	30% coinsurance after deductible
Home Health Care	10% coinsurance after deductible	30% coinsurance after deductible limit: Unlimited
Hospice	10% coinsurance after deductible	30% coinsurance after deductible
Maternity (non-preventive professional services) including dependent daughter	0% coinsurance after deductible	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	10% coinsurance after deductible limit: 100 days / benefit period, aggregate IN & OON	30% coinsurance after deductible
Transplant Services	10% coinsurance after deductible	30% coinsurance after deductible
Wellness Card	\$250	not covered
Prescription Drugs		
Prescription Drug Deductible		
Individual		None
Family		None

Benefit	In-Network	Out-of-Network
<p>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.</p> <p>Your plan uses the Comprehensive Formulary with Incentive Benefit Design.</p>	<p>Retail Drugs (30/60/90-day Supply) Generic Formulary Drugs: \$10 / \$20 / \$30 copayment Brand Formulary Drugs: \$25 / \$50 / \$75 copayment Generic & Brand Non-Formulary Drugs: \$50 / \$100 / \$150 copayment Cost-sharing for Prescription Insulin Drugs will be \$0</p> <p>Specialty Drugs – Retail or Mail Order (31-day Supply) Generic Formulary Drugs \$10 copayment Brand Formulary Drugs \$25 copayment Generic & Brand Non-Formulary Drugs \$50 copayment</p> <p>Maintenance Drugs through Mail Order (30/60/90-day Supply) Generic Formulary Drugs: \$10 / \$20 / \$25 copayment Brand Formulary Drugs: \$25 / \$50 / \$62.50 copayment Generic & Brand Non-Formulary Drugs: \$50 / \$100 / \$125 copayment Cost-sharing for Prescription Insulin Drugs will be \$0</p> <p><u>Preventive Prescription Drugs – NY Commercial List</u></p> <p>Retail Drugs (31-day Supply) Plan pays 100% (deductible does not apply)</p> <p>Maintenance Drugs through Mail Order (90-day Supply) Plan pays 100% (deductible does not apply)</p>	

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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- SILVER (72.25% 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.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.