



HIGHMARK
WESTERN NEW YORK

1-844-639-2441

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Benefit Summary for Group:
Niagara County Community College
Effective Date: 1/1/2023

	POS 200			
	Core	Plus	OON	Additional Information
General Information				
Provider Network	200 Network			
Deductible	N/A	N/A	\$250 single / \$500 family	
Deductible Administration Type	None	None	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Coinsurance	N/A	N/A	20% coinsurance after deductible	
Out of Pocket Maximum	\$6,350 single/\$12,700 family	\$6,350 single/\$12,700 family	\$2,000 single / \$4,000 family	
Out of Pocket Administration Type	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Benefit Administration Date	1/1			
Dependent Coverage				
Dependent Age	26/26			
Dependent Coverage Ends	End of birth month			
Domestic Partner and Children	Not covered			
Prescription Drug Coverage				
Prescription Drugs	\$7/\$15/\$30	\$7/\$15/\$30		
Mail Order	1 copay per 90 day supply	1 copay per 90 day supply	Not Covered	

Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York are trade names of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

	POS 200			
	Core	Plus	OON	Additional Information
Physician and Other Services				
Primary Office Visit	\$5 copayment	\$0 or \$5 copayment	20% coinsurance after deductible	
Specialist Office Visit	\$10 copayment	\$15 or \$10 copayment	20% coinsurance after deductible	
Telemedicine	\$5	\$0 or \$5	Not covered	Coverage only through specific telemedicine vendor. If not provided by the specific telemedicine vendor, please reference the "Office Visit" line.
Allergy Injections	\$5/\$10	\$0/\$15 or \$5/\$10	20% coinsurance after deductible	
Allergy Testing	\$5/\$10	\$0/\$15 or \$5/\$10	20% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	\$5/\$10	\$0/\$15 or \$5/\$10	20% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	Covered in Full	Covered in Full	20% coinsurance after deductible	
Specialist Copay/Coinsurance for Dependents up to age 19	\$10 copayment	\$15 or \$10 copayment	20% coinsurance after deductible	
Emergency and Urgent Care Services				
Emergency Room	\$35 copayment	\$35 copayment	Covered as in-network	Prudent layperson language applies. Emergency Room cost-share waived if admitted; inpatient benefits now apply.
Ambulance	Covered in full	Covered in full	Covered as in-network	
Urgent Care Center	\$5	\$0 or \$5	Covered as in-network	

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Preventive Services				
Bone mineral density measurement or test	Covered in full	Covered in full	20% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full	Covered in full	20% coinsurance after deductible	
Immunizations	Covered in full	Covered in full	20% coinsurance after deductible	
Mammogram	Covered in full	Covered in full	20% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	Covered in full	20% coinsurance after deductible	
Routine Physical Exam	Covered in full	Covered in full	Not covered	
Well Child Visits	Covered in full	Covered in full	20% coinsurance after deductible	
Hospital Services				
Inpatient Hospital	Covered in full	Covered in full	20% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	\$10	\$15 or \$10	20% coinsurance after deductible	
Skilled Nursing Facility	Covered in full	Covered in full	20% coinsurance after deductible	Unlimited Days
Diagnostic Testing Services				
Laboratory Tests	Covered in full	Covered in full	20% coinsurance after deductible	
Radiology	Covered in full	Covered in full	20% coinsurance after deductible	
Maternity Services				
Physician Services: Prenatal and Postnatal Care (initial visit)	\$5	\$0 or \$5	20% coinsurance after deductible	
Inpatient Maternity	Covered in full	Covered in full	20% coinsurance after deductible	
Mental Health and Substance Abuse				
Inpatient Mental Health	Covered in full	Covered in full	20% coinsurance after deductible	Unlimited visits: Subject to medical necessity
Outpatient Mental Health	Covered in full	Covered in full	20% coinsurance after deductible	..
Inpatient Substance Abuse - Rehab	Covered in full	Covered in full	20% coinsurance after deductible	..
Inpatient Substance Abuse - Detox	Covered in full	Covered in full	20% coinsurance after deductible	..
Outpatient Substance Abuse	Covered in full	Covered in full	20% coinsurance after deductible	..

	POS 200			
	Core	Plus	OON	Additional Information
Diabetic Supplies and Services				
Diabetic Equipment	\$5	\$0 or \$5	20% coinsurance after deductible	
Insulin and Other Oral Agents	\$5	\$0 or \$5	20% coinsurance after deductible	If administered by pharmacy vendor copay is lesser of Rx or office visit copay.
Diabetic Medical Supplies (Test strips, Syringes, etc)	\$5	\$0 or \$5	20% coinsurance after deductible	
Rehabilitation Services				
Chiropractic Care	\$5 copayment	\$5 copayment	20% coinsurance after deductible	
Physical - Occupational - Speech Therapies	\$10	\$15 or \$10	20% coinsurance after deductible	30 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	\$10	\$15 or \$10	20% coinsurance after deductible	
Additional Services				
Chemotherapy - Outpatient Facility	\$10	\$15 or \$10	20% coinsurance after deductible	
Durable Medical Equipment	20% coinsurance	20% coinsurance	50% coinsurance after deductible	
Home Health Care	\$10	\$15 or \$10	20% coinsurance after deductible	Unlimited Visits IN; 365 Visits OON. Any IN Visit counts toward the OON limit
Hospice	Covered in full	Covered in full	20% coinsurance after deductible	
Prosthetics and orthotics	20% coinsurance	20% coinsurance	Not covered	
Dialysis	Covered in full	Covered in full	20% coinsurance after deductible	
Wellness Card	Not covered	Not covered	Not covered	
Pediatric Vision Services				
Routine Exam	Covered in full	Covered in full	OON Services reimbursement by vendor. after deductible	1 every calendar year
Medical Eye Exam	\$10	\$15 or \$10	20% coinsurance after deductible	
Adult Vision Services				
Routine Exam	Covered in full	Covered in full	OON Services reimbursement by vendor. after deductible	1 every calendar year
Medical Eye Exam	\$10	\$15 or \$10	20% coinsurance after deductible	

*Cost share may vary based on place of service for services listed above.

**For a list of Medicare Part D creditable coverage prescription drug plans, please refer to our website.

***This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.