St. Bonaventure University PPO 6300 $2000/$4000 - 10647616, 20, 24

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). 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	June 1 2024	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $2,000 $4,000	 $5,000 $10,000
Deductible Accumulation (2)	Non-Embedded	Non-Embedded
Coinsurance - payment based on the plan allowance	0% after deductible	40% after deductible
Out-of-Pocket Maximum (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses). Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $5,000 $10,000	 $10,000 $20,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	$20 copay after deductible	40% after deductible
Specialist Office Visits & Virtual Visits	$20 copay after deductible	40% after deductible
Virtual Visit Provider Originating Site Fee	0% after deductible	40% after deductible
Urgent Care Center Visits	$35 copay after deductible	$35 copay after in-network deductible
Telemedicine Services (3)	0% after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 covered in full	 not covered
Adult Immunizations	covered in full	40% after deductible
Routine Gynecological Exams, including a Pap Test	covered in full	40% after deductible
Mammograms, Annual Routine	covered in full	40% after deductible
Diagnostic Services and Procedures	covered in full	40% after deductible
Routine Pediatric Physical Exams	 covered in full	 40% after deductible
Pediatric Immunizations	covered in full	40% after deductible
Diagnostic Services and Procedures	covered in full	40% after deductible
Emergency Services		
Emergency Room Services	$150 copay (waived if admitted) after deductible; $35 copay for freestanding urgent care facility after deductible	$150 copay (waived if admitted) after in-netwrok deductible; $35 copay for freestanding urgent care facility after in-network deductible
Ambulance - Emergency and Non-Emergency	$100 copay after deductible	$100 copay after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	$500 inpatient copay/admission after deductible	40% after deductible
Outpatient Surgery	$75 copay after deductible	40% after deductible
Maternity (non-preventive professional services) including dependent daughters	$20 copay after deductible (copay on initial visit only)	40% after deductible
Medical Care (including inpatient visits and consultations)	0% after deductible	40% after deductible
Therapy and Rehabilitation Services		
Physical Therapy	$20 copay after deductible limit: 30 visits/benefit period aggregate with occupational therapy and speech therapy	40% after deductible
Speech Therapy	$20 copay after deductible	40% after deductible

Benefit	In Network	Out of Network
	limit: 30 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	$20 copay after deductible	40% after deductible
	limit: 30 visits/benefit period aggregate with speech therapy and physical medicine	
Respiratory Therapy	$20 copay after deductible	40% after deductible
Spinal Manipulations	$20 copay after deductible	40% after deductible
Cardiac Rehabilitation Therapy	$20 copay after deductible	40% after deductible
Infusion Therapy	$20 copay after deductible; 0% after deductible for home dialysis	40% after deductible
Chemotherapy	$20 copay after deductible	40% after deductible
Radiation Therapy	$20 copay after deductible	40% after deductible
Dialysis	$20 copay after deductible; 0% after deductible for home dialysis	40% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	$500 inpatient copay/admission after deductible	40% after deductible
Inpatient Detoxification / Rehabilitation	$500 inpatient copay/admission after deductible	40% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	$20 copay after deductible	40% after deductible
Outpatient Substance Abuse Services	$20 copay after deductible	40% after deductible
Other Services		
Allergy Extracts	0% after deductible	40% after deductible
Allergy Injections	$20 copay after deductible	40% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	$20 copay after deductible	40% after deductible
Assisted Fertilization Procedures (GIFT & ZIFT excluded)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
	limit: 3 cycles/lifetime for in vitro fertilization	
Dental Services Related to Accidental Injury	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	$20 copay after deductible	40% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	$20 copay after deductible	40% after deductible
Mammograms, Medically Necessary	$20 copay after deductible	40% after deductible
Durable Medical Equipment and Supplies	0% after deductible; $20 copay after deductible for diabetic equipment and supplies	50% after deductible; 40% after deductible for diabetic equipment and supplies
Orthotics	20% after deductible	50% after deductible
Prosthetic Devices	0% after deductible for implantable prosthetics; 20% after deductible for external prosthetics	40% after deductible for implantable prosthetics; 50% after deductible for external prosthetics
Home Health Care	$20 copay after deductible	40% after deductible
	limit: 200 visits/benefit period aggregate with visiting nurse and home infusion therapy	
Hospice	$20 copay for outpatient services after deductible	40% after deductible
Infertility Counseling, Testing and Treatment	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	0% after deductible	40% after deductible
Transplant Services	0% after deductible	40% after deductible
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program (5) 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)** $10 / $20 / $30 Formulary generic copay $50 / $100 / $150 Non-Formulary generic copay $30 / $60 / $90 Formulary brand copay $50 / $100 / $150 Non-Formulary brand copay	

Benefit	In Network	Out of Network
	Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply **Select Specialty Drugs (31-day Supply)** $50 Non-Formulary copay $10 Formulary generic copay $30 Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $10 / $20 / $25 Formulary generic copay $50 / $100 / $125 Non-Formulary generic copay $30 / $60 / $75 Formulary brand copay $50 / $100 / $125 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply	

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 benefits summary.

Signature of Client Representative _____ Title _____ Date _____

(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 non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(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 NY Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).
(5) At a retail or mail-order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

Notice of Nondiscrimination

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. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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)
- 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, please call the customer service number on the back of your member ID card or 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, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US 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 US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

.פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee hane´é bíká'ígíí bich´j´dahodootnih.