

# Health coverage on your terms.

Individual and  
family plans

For benefit period:  
January 1 to December 31, 2026

 **HIGHMARK**   
Because Life.™



# Say hello to a great health plan.

Shopping for your own health insurance? With Highmark, you get the coverage and benefits that matter most to you. This guide will help you find an affordable plan that checks all the boxes.

Looking for something in particular? Click on the headings below to jump to that section.

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# Why choose a Highmark health plan?

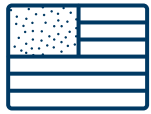
Here are a few big benefits  
right off the top of our heads.



1

## Expert care, close to home.

Highmark invests big in a patient-first approach to care, with easy access to high-quality, lower-cost health care services in your area.



2

## Coverage that travels with you.

All of our plans come with access to **BlueCard®**. It connects you to the largest physician and hospital networks in the U.S. with over 2 million providers, including 97% of all hospitals.\*

Your coverage extends to many top-rated, out-of-state facilities, like:

- University of Vermont Medical Center
- Massachusetts General Hospital
- Cooperman Barnabas Medical Center
- Memorial Hospital for Cancer and Allied Diseases
- Medical Center at UC San Francisco
- Brigham and Women's Hospital
- Sloan Kettering Cancer Center
- New York Presbyterian Hospital
- Southwestern Vermont Medical Center
- University Hospital SUNY Health

Keep in mind that BlueCard covers routine,\*\* emergency, and urgent care for most plans.

\* According to the Blue Cross Blue Shield Association.

\*\* Certain services may require you to work with your BlueCard-participating provider to obtain prior authorization.

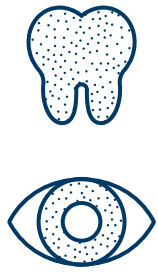


3

## No red tape.

See whichever in-network doctors you want to see — **no referral needed.** Call 1-888-BLUE-428, and we'll find a specialist for you. No hoops, no hoopla.



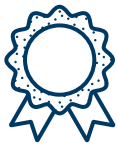


4

## All your care, all in one plan.

Healthy eyes and teeth are important parts of overall health, and regular checkups can help you stay ahead of potential problems down the road. It's especially important for kids, which is why all our plans come with pediatric dental and vision benefits.

**Our plans with “Adult Dental and Vision” in their name include these benefits. So if you want to keep things simple, this is a great option. That way you won’t need to purchase separate plans.**



5

## Easy access to top-performing specialists.

Only doctors who consistently deliver safe, effective treatments make the **Blue Distinction®** list. When you use our Find a Doctor tool, the Blue Distinction logo will appear by their names to help you choose a top-performing specialist for any care you need.



6

## Mental health care that’s exactly the right fit.

With Mental Well-Being powered by Spring Health, you get expanded, quicker access to mental health care. A personalized care plan will help guide you to the right resources based on your needs.



### THE HIGHMARK MEMBER APP AND WEBSITE

## Your entire plan at your fingertips.

No more searching for old files or waiting on snail mail. Your digital ID card, Find a Doctor tool, deductible progress, and claims status are all available on the **My Highmark app** or at **MyHighmark.com**.

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**And that’s just for starters.**

Turn the page for even more reasons to choose Highmark.

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**We make it easier  
for you to get the  
care you want.**



## VIRTUAL HEALTH

### Face-to-face with a doctor, 24/7.

Get a diagnosis, treatment plan, or prescription anytime, right from your phone or computer. Best of all, the virtual health services provided by Well360 Virtual Health are also available through many in-network providers.



## 24/7 NURSE LINE

### Answers from a health pro, 24/7.

Medical concerns during off hours? Just call 1-888-BLUE-428 to get support from a registered nurse or a health coach anytime and put your worries to bed.



### Your appointments, booked for you.

It's as simple as calling **1-888-BLUE-428**. We'll help you find the in-network doctor you need and reserve some space on their calendar. Which means less on-hold music for you.



## SAVE ON PRESCRIPTIONS

### SensibleRx Complete

This program makes it easy for you to save money on prescription drugs by selecting generic drugs over brand-name drugs.

Some details to keep in mind:

- If your provider prescribes and you select a brand-name drug when a generic alternative is available, your cost for that prescription will be higher than the brand-name copay.
- In addition to the brand-name drug copay, you'll also have a penalty equal to the difference in costs between the generic and the brand-name drugs.
- Only the brand-name copay will be applied to your total maximum out-of-pocket.

Here's an example of how SensibleRx Complete works:

|                                                              |         |
|--------------------------------------------------------------|---------|
| Brand-name drug copay                                        | \$25    |
| Penalty for brand-name drug                                  | \$15.98 |
| Your cost for selecting the brand-name drug over the generic | \$40.98 |
| Amount applied to your maximum OOP                           | \$25    |



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#### HEALTH SAVINGS ACCOUNT PLANS



## Helping you save for today and tomorrow.

Health savings accounts (HSAs) let you put money away for things like medical costs, prescriptions, and more. They're available for Bronze plans.

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#### VIRTUAL PHYSICAL CARE, POWERED BY SWORD

## Physical care from the comfort of home.

This personalized digital physical care program helps with back, joint, or muscle pain from the comfort of your own home.

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#### DIABETES MANAGEMENT

## Support to control diabetes.

We offer programs to help with diabetes management. Eligible members with type 1 or type 2 diabetes have access to management tools, coaching, and clinical support to help you take better control of your health.

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#### CHF AND COPD MANAGEMENT

## Health coaching for CHF and COPD made personal.

Through an easy-to-use app and website, this personalized health program offers support for managing congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

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#### KIDNEY CARE MANAGEMENT

## Coordinating kidney care between doctor visits.

This care coordination program works to provide early detection of kidney disease and help slow disease progression.

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**Need help with  
your health goals?**

**We've got you covered.**



#### \$250 WELLNESS CARD

## Redeemable for gym memberships.

Consider it a little something extra for the journey to good health.\*

\* Limited to one (1) \$250 wellness reward per contract.



#### WELLNESS

## Personalized support for health goals.

Looking to lose weight? Quit smoking? Be more active? You have access to experienced wellness coaches and tools that will help you make healthy choices based on your lifestyle. Once you're enrolled, visit **MyHighmark.com**.



#### BLUE365®

## Discounts to help you stay healthy and active.

With Blue365, you get exclusive discounts on travel, car rentals, and even clothing and footwear. Check out member-only deals at **blue365deals.com/bsneny**.



**Let's take a minute  
to cover the basics  
of Affordable Care  
Act (ACA) plans.**

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# Enrollment dates

There are two ways you can enroll in or change your ACA coverage. One is a fixed period that happens every year. The other is for special cases that can happen anytime.

## 1 Open Enrollment Period

### November 1, 2025 – January 31, 2026

If you sign up by December 15, 2025, your plan takes effect on January 1, 2026.

If you sign up between December 16, 2025 and January 15, 2026, your plan takes effect on February 1, 2026.

If you sign up between January 16, 2026 and January 31, 2026, your plan takes effect on March 1, 2026.

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## 2 Special Enrollment Period

### Can happen anytime throughout the year

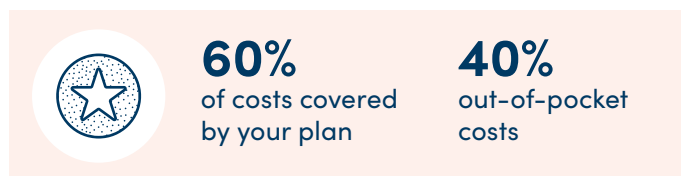
During a Special Enrollment Period, you can only get or change coverage if you have a qualifying life event. Examples include losing your existing coverage, a new addition to the family, getting married, or moving to a new area where you can't keep your current plan. Many Special Enrollment Periods only last 60 days from the qualifying life event.

If you think you're eligible for a Special Enrollment Period, you may be asked to submit documents to verify it. You can go to **[HighmarkCatalog2026.com/NENY](https://HighmarkCatalog2026.com/NENY)** for more information.

# Metal levels

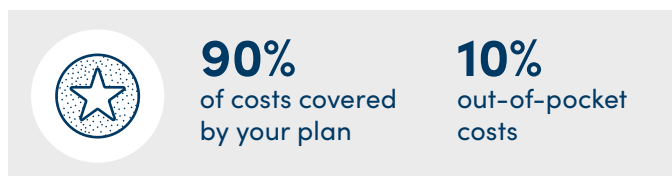
ACA plans are broken into five categories based on how you and your plan share the costs of your health care. Just so you know, metal levels reflect cost-sharing\* differences only — which means you get the same quality of care at any level.

## Bronze



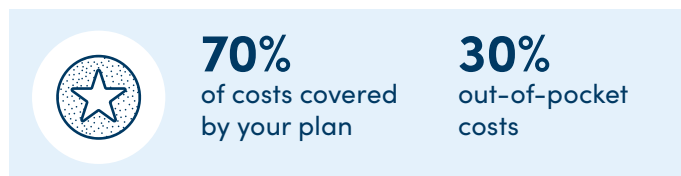
If you don't use a lot of health care services and/or want to keep a low premium (the amount you pay each month) a Bronze plan might be right for you.

## Platinum



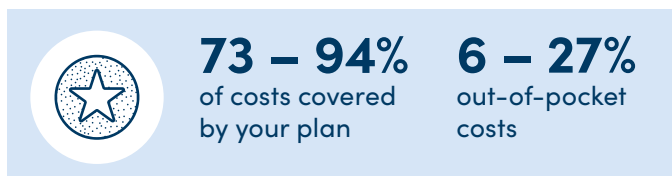
If you use health care services frequently and/or want to keep out-of-pocket costs low for all services, consider a Platinum plan.

## Silver



If you want to balance premiums with out-of-pocket costs, Silver plans might be the way to go.

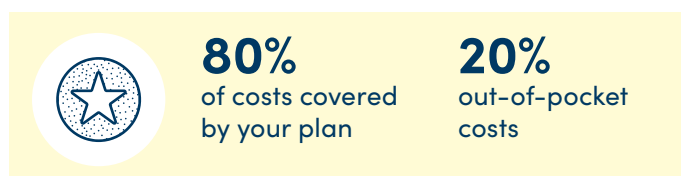
## Extra Savings Silver



If you're eligible for cost-sharing reductions (CSRs), Extra Savings Silver plans give you lower out-of-pocket costs. Eligibility for these plans is determined through **nystateofhealth.ny.gov**.

Please refer to page 18 for additional information on CSRs.

## Gold



If you use health care services somewhat frequently and/or want low out-of-pocket costs for most commonly used services, you might want to consider a Gold plan.

Financial help in the form of advance premium tax credits (APTCs) or cost-sharing reductions (CSRs) are available only on plans purchased through **nystateofhealth.ny.gov**.

\* The portion of health care services that you pay out-of-pocket. This generally includes deductibles, coinsurance, and copays.

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# Ways to save

**Good news:** There are two ways available to save for ACA members.

**Even better news:** Nearly 90% of our ACA members qualify to save.

## Advance premium tax credits (APTC)

APTCs\* may be applied — in advance — to lower what you pay each month for your premium on any plans through New York State of Health health plan marketplace except catastrophic.

## Cost-sharing reductions (CSR)

CSRs lower out-of-pocket costs that you may pay at the time of service for doctor visits, lab tests, drugs, and other covered services. CSR plans offer lower deductibles, copays, and coinsurance. You can only get these savings if you enroll in an Extra Savings Silver plan.

**You can qualify for both an APTC and a CSR.**

Premiums and advance premium tax credits (APTC) will vary by county. The APTC can lower the monthly premium.

\* Financial help in the form of advance premium tax credits (APTCs) or cost-sharing reductions (CSRs) are available only on plans purchased through [nystateofhealth.ny.gov](https://nystateofhealth.ny.gov).



# Financial help

To see if you're eligible for financial help, locate your qualifying income and household size on the chart below. Then refer to the Base or Extra Savings plans for your county to find the plans that meet your needs.

Even if you don't qualify for cost-sharing reductions, you may be eligible for APTCs. Please refer to the Base plan options for your county. The chart below is a guide. Final eligibility will be determined through [nystateofhealth.ny.gov](https://nystateofhealth.ny.gov).

## What is the income for those covered under your health plan?

| Who needs coverage? | Eligible for Medicaid                              | Eligible for CSRs and APTCs  |                       |                       |
|---------------------|----------------------------------------------------|------------------------------|-----------------------|-----------------------|
|                     | Medicaid Eligible Range<br>138% of the FPL or Less | Essential Plan<br>138 – 250% | CSR 87%<br>251 – 350% | CSR 73%<br>351 – 400% |
| Single              | Less than \$21,597                                 | \$21,598 – \$39,125          | \$39,126 – \$54,775   | \$54,776 – \$62,600   |
| Family of 2         | Less than \$29,187                                 | \$29,188 – \$52,875          | \$52,876 – \$74,025   | \$74,026 – \$84,600   |
| Family of 3         | Less than \$36,777                                 | \$36,778 – \$66,625          | \$66,626 – \$93,275   | \$93,276 – \$106,600  |
| Family of 4         | Less than \$44,367                                 | \$44,368 – \$80,375          | \$80,376 – \$112,525  | \$112,526 – \$128,600 |
| Family of 5         | Less than \$51,957                                 | \$51,958 – \$94,125          | \$94,126 – \$131,775  | \$131,776 – \$150,600 |
| Family of 6         | Less than \$59,547                                 | \$59,548 – \$107,875         | \$107,876 – \$151,025 | \$151,026 – \$172,600 |
| Family of 7         | Less than \$67,137                                 | \$67,138 – \$121,625         | \$121,626 – \$170,275 | \$170,276 – \$194,600 |
| Family of 8         | Less than \$74,727                                 | \$74,728 – \$135,375         | \$135,376 – \$189,525 | \$189,526 – \$216,600 |

Most individuals and families with household incomes 100% or more of the federal poverty limit (FPL) will qualify for premium tax credits. These credits help lower the cost of health insurance coverage and are based on the second-lowest-cost Silver plan available in your area on [nystateofhealth.ny.gov](https://nystateofhealth.ny.gov). The second-lowest-cost Silver plan is also known as the “benchmark plan.” Premium tax credits vary by income. Income below 138% FPL: If your income is below 138% FPL and your state has expanded Medicaid coverage, you qualify for Medicaid based only on your income.\*

American Indians and Alaska Natives who are members of federally recognized tribes are eligible for cost-sharing reductions at alternative dollar thresholds.

This chart is only applicable for coverage in 2026 and in the 48 contiguous states and the District of Columbia. For families/households with more than 8 persons, add \$5,500 for each additional person.

\* HHS Poverty Guidelines for 2025 (March 3, 2025). Retrieved from <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

**Check to see if you qualify for one or both types of help.**  
**Call 855-486-2096.**

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# Here's your Enrollment Checklist.

Now that you know more about Highmark and ACA plans, it's time to gather what you'll need to find the right plan for you and your family. You'll need this info for each person who will be covered on your plan.

- ☐ **Date of birth**
- ☐ **Social Security number**  
(or legal immigrant documents)
- ☐ **Income documentation for all household members, even if they won't be covered by the plan**  
(pay stubs, W-2 forms, or wage and tax statements)
- ☐ **Current health insurance policy numbers**  
(if applicable)
- ☐ **Info on any health insurance you or your family could get from your job**

**All set? Great. Let's move on to the essentials.**

# 2026 Highmark products and plans

Phew, that was a lot of good info. Now, let's take a look at the products and plans available in your area for 2026.

**A quick way to narrow down your options.**

Prefer to search online? Answer three simple questions on our website to get plan recommendations.

Visit [Highmark.com/ComparePlansNENY](https://Highmark.com/ComparePlansNENY).



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# You get all the essentials.

You get access to the 10 Essential Health Benefits —  
plus coverage for preexisting conditions.

They include:

- |                                                           |                                                                         |
|-----------------------------------------------------------|-------------------------------------------------------------------------|
| 1 Outpatient care                                         | 6 Prescription drugs                                                    |
| 2 Emergency services                                      | 7 Laboratory services                                                   |
| 3 Hospitalization<br>(like surgery and overnight stays)   | 8 Rehabilitative and<br>habilitative services<br>and devices            |
| 4 Pregnancy, maternity,<br>and newborn care               | 9 Preventive and wellness<br>services and chronic<br>disease management |
| 5 Mental health and<br>substance use<br>disorder services | 10 Pediatric services,<br>including dental and<br>vision care           |

# Our networks and products

No matter what plan you choose, you get in-network access to top-quality care, close to home. You can even see in-network specialists without a referral. Whatever your health care needs and budget, we have a plan for you. All you have to do is choose.

## my Blue Access EX

my Blue Access EX plans give you access to high-quality, cost-effective care throughout New York with Highmark’s largest network. And with the BlueCard program<sup>1</sup>, you get in-network access to providers outside New York for routine, emergency, and urgent care, too.<sup>2</sup>

| BlueCard Program coverage | Inside NY              |                |              | Outside NY                        |         |                                       |              |
|---------------------------|------------------------|----------------|--------------|-----------------------------------|---------|---------------------------------------|--------------|
|                           | In-Network             | Out-of-Network |              | In-Network (BlueCard PPO Network) |         | Out-of Network (BlueCard PPO Network) |              |
|                           | ER/Urgent Care/Routine | ER/Urgent Care | Routine Care | ER/Urgent Care                    | Routine | ER/Urgent Care                        | Routine Care |
| my Blue Access EX         | Yes                    | Yes            | No           | Yes                               | Yes     | Yes                                   | No           |

<sup>1</sup> The BlueCard program connects independent Blue Plans across the country. It gives Blue Plan members access to in-network coverage while outside their plan area. The level of coverage depends on your chosen plan.

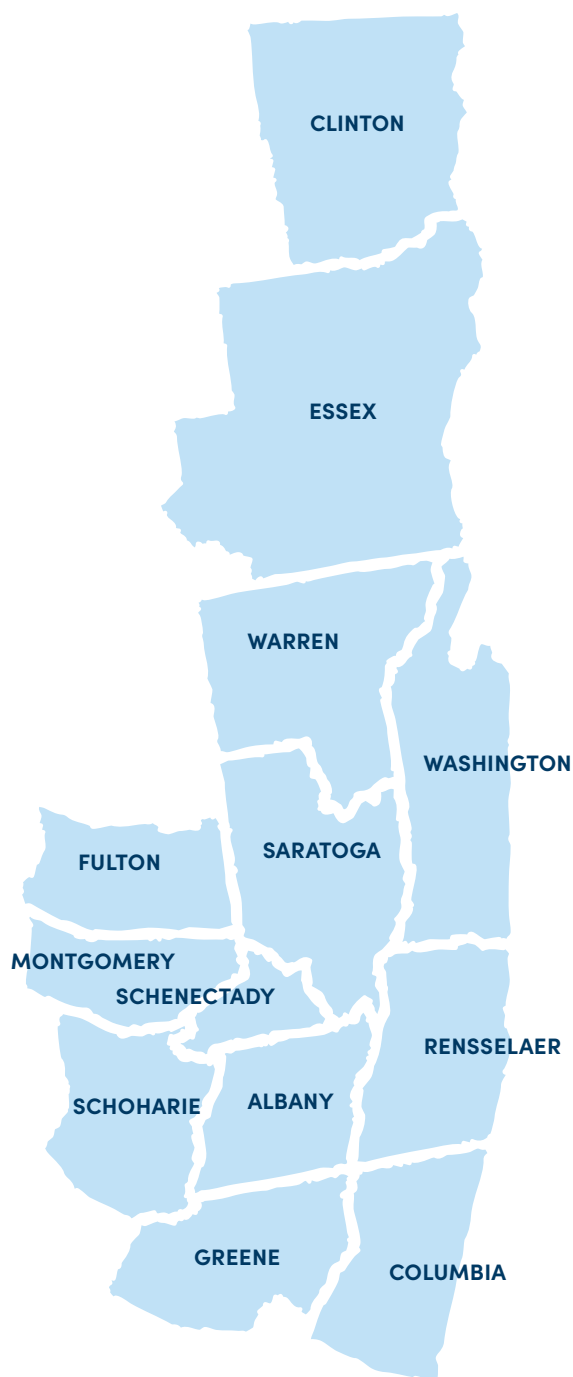
<sup>2</sup> Certain services may require you to work with your BlueCard-participating provider to obtain prior authorization.

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## Plans are available for residents of the counties highlighted below.



my Blue Access EX



To see if your provider is in network, visit [HighmarkCatalog2026.com/NENYPro](https://HighmarkCatalog2026.com/NENYPro).

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# Diabetes management

Diabetes puts you at a higher risk of several serious health conditions — including eye, heart, and kidney disease. However, managing your diabetes can help prevent or delay these conditions. Measuring your blood glucose, monitoring your diet, and taking your medications as prescribed are all key. Your Highmark plan comes with benefits and resources that make it easier.

## Diabetes tools and supplies\*

- ✔ Digital management programs for eligible members
- ✔ Coverage for common medications\*\*
  - Metformin Hcl
  - Mounjaro
  - Ozempic
  - Metformin Hcl Er
  - Jardiance
  - Basaglar Kwikpen U-100
  - Trulicity
  - Farxiga
  - Glimepiride
  - Glipizide Er
- ✔ Continuous glucose monitors
- ✔ Test strips
- ✔ Lancets

Specific medications and supplies may change throughout the coverage year. Always check your formulary at [highmarkacaformulary.com](https://highmarkacaformulary.com) to check under what tier your drugs and supplies are listed.

\* Out-of-pocket costs for these drugs and supplies will vary based upon the prescription coverage of the selected plan.

\*\* Preferred medications may change. Please check the formulary website ([highmarkacaformulary.com](https://highmarkacaformulary.com)) for the most up-to-date information.

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# Key terms



## COINSURANCE

The percentage of total cost of care you may owe for certain covered services provided by participating providers after reaching your deductible. For example, if your plan pays 80%, you pay 20%.



## COPAY

The set amount you pay for certain covered services. For example, it could be \$20 for a doctor visit or \$30 for a specialist visit. If you owe a copay, you must pay it when you check in for your visit.



## DEDUCTIBLE

The set amount you pay for covered health services or drug costs before your plan starts paying.



## EMERGENCY SERVICES

Care for a condition that you think needs immediate attention to avoid severe harm.



## FORMULARY

A list of drugs selected by the plan based on certain clinical factors. The list of medicines is sorted by tier. Lower tiers usually mean lower copays.



## OUT-OF-POCKET MAXIMUM

The most you'd pay for covered care provided by participating providers in a benefit period or year. If you reach this amount, your plan pays 100% after that.



## PRIMARY CARE PROVIDER (PCP)

The medical professional you see for most of your basic care, like yearly preventive visits and screenings.



## URGENT CARE CENTER

A walk-in center for when you have a condition that's serious enough to need care right away, but not serious enough for a trip to the emergency room.



## VIRTUAL VISIT

A real-time office visit with a doctor at a remote location, conducted via interactive audio and streaming video telecommunications.

# Looking for plan details?

**You're in the right place.**

**On the next page, there are a few questions to consider when looking for a plan. Your answers will help guide you to coverage that fits your needs and budget.**

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# Before selecting a plan, ask yourself:

- ☐ Are your doctors in network?
- ☐ Are your prescriptions covered?  
And how much do they cost?
- ☐ Are there any individual or family deductibles?
- ☐ If you want a health savings account (HSA), do the plans you're looking at include them?
- ☐ What does coverage look like when you travel?

You'll see plan summaries here. If you want any plan's full benefit list, visit **Highmarksbcs.com** or get a paper copy by calling **1-855-486-2096** (TTY/TDD: 711).

|                                                                | Coverage Level                                                             |                                                                                     |                                          |                                                     |
|----------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------|
|                                                                | Bronze Standard <sup>1</sup>                                               | Bronze Destination 65 <sup>1</sup>                                                  | Silver Standard                          | Silver Destination 65                               |
| Monthly Premium                                                |                                                                            |                                                                                     |                                          |                                                     |
| Individual                                                     | \$931.28                                                                   | \$913.37<br>+ Adult Dental & Vision<br>\$941.03                                     | \$1,260.86                               | \$1,236.60<br>+ Adult Dental & Vision<br>\$1,271.85 |
| Individual and Children                                        | \$1,583.18                                                                 | \$1,552.73<br>+ Adult Dental & Vision<br>\$1,599.75                                 | \$2,143.46                               | \$2,102.22<br>+ Adult Dental & Vision<br>\$2,162.15 |
| Individual and Spouse/<br>Domestic Partner                     | \$1,862.56                                                                 | \$1,826.74<br>+ Adult Dental & Vision<br>\$1,882.06                                 | \$2,521.72                               | \$2,473.20<br>+ Adult Dental & Vision<br>\$2,543.70 |
| Family                                                         | \$2,654.15                                                                 | \$2,603.10<br>+ Adult Dental & Vision<br>\$2,681.94                                 | \$3,593.45                               | \$3,524.31<br>+ Adult Dental & Vision<br>\$3,624.77 |
| Plan Availability                                              | my Blue Access EX<br>Bronze Standard <sup>1</sup>                          | my Blue Access EX<br>Bronze Destination 65 <sup>1</sup>                             | my Blue Access EX<br>Silver Standard     | my Blue Access EX<br>Silver Destination 65          |
| In-Network<br>Deductible                                       | Individual: \$4,125<br>Family: \$8,250                                     | Individual: \$3,800<br>Family: \$7,600                                              | Individual: \$2,450<br>Family: \$4,900   | Individual: \$0<br>Family: \$0                      |
| In-Network, Out-of-<br>Pocket Maximum                          | Individual: \$10,150<br>Family: \$20,300                                   | Individual: \$10,100<br>Family: \$20,200                                            | Individual: \$10,150<br>Family: \$20,300 | Individual: \$9,700<br>Family: \$19,400             |
| Primary Care Visit                                             | \$50 copay after deductible                                                | \$75 copay                                                                          | \$30 copay after deductible              | \$0 copay                                           |
| Specialist Visit                                               | \$75 copay after deductible                                                | \$75 copay                                                                          | \$65 copay after deductible              | \$50 copay                                          |
| Outpatient Mental<br>Health and Substance<br>Abuse Visits      | \$50 copay after deductible                                                | \$75 copay                                                                          | \$30 copay after deductible              | \$0 copay                                           |
| Physical and<br>Occupational Therapy <sup>2</sup>              | \$50 copay after deductible                                                | \$75 copay                                                                          | \$30 copay after deductible              | \$50 copay                                          |
| Chiropractic Care                                              | \$75 copay after deductible                                                | \$75 copay                                                                          | \$65 copay after deductible              | \$0 copay                                           |
| Diagnostic Test -<br>Lab Services                              | \$50 copay after deductible                                                | \$75 copay                                                                          | \$50 copay after deductible              | \$50 copay                                          |
| Diagnostic Test -<br>X-rays                                    | \$75 copay after deductible                                                | 50% after deductible                                                                | \$75 copay after deductible              | \$200 copay                                         |
| Urgent Care <sup>3</sup>                                       | \$75 copay after deductible                                                | \$100 copay                                                                         | \$70 copay after deductible              | \$100 copay                                         |
| Emergency Services                                             | \$500 copay after deductible                                               | 50% after deductible                                                                | \$500 copay after deductible             | \$1,000 copay                                       |
| Hospital Inpatient<br>(including facility<br>and professional) | \$1,500 copay after deductible                                             | 50% after deductible                                                                | \$1,500 copay after deductible           | \$2,000 copay                                       |
| Pharmacy Summary <sup>4</sup>                                  | \$10 after deductible/<br>\$35 after deductible/<br>\$70 after deductible/ | \$25 not subject<br>to deductible/<br>50% after deductible/<br>50% after deductible | \$15/\$40/\$75                           | \$15/50%/50%                                        |
| Integrated Adult Dental<br>and Vision Option <sup>5</sup>      | No                                                                         | Yes                                                                                 | No                                       | Yes                                                 |

<sup>1</sup> This plan is eligible for a health savings account (HSA).

<sup>2</sup> Limit of 30 combined physical and occupational therapy visits per benefit period. Limit does not apply to therapy services for the treatment of mental health or substance abuse.

|                                                                | Coverage Level                           |                                                     |                                        |                                                     |
|----------------------------------------------------------------|------------------------------------------|-----------------------------------------------------|----------------------------------------|-----------------------------------------------------|
|                                                                | Gold Standard                            | Gold Destination 65                                 | Platinum Standard                      | Platinum Destination 65                             |
| Monthly Premium                                                |                                          |                                                     |                                        |                                                     |
| Individual                                                     | \$1,628.51                               | \$1,597.18<br>+ Adult Dental & Vision<br>\$1,638.21 | \$1,986.55                             | \$1,948.32<br>+ Adult Dental & Vision<br>\$1,992.93 |
| Individual and Children                                        | \$2,768.47                               | \$2,715.21<br>+ Adult Dental & Vision<br>\$2,784.96 | \$3,377.14                             | \$3,312.14<br>+ Adult Dental & Vision<br>\$3,387.98 |
| Individual and Spouse/<br>Domestic Partner                     | \$3,257.02                               | \$3,194.36<br>+ Adult Dental & Vision<br>\$3,276.42 | \$3,973.10                             | \$3,896.64<br>+ Adult Dental & Vision<br>\$3,985.86 |
| Family                                                         | \$4,641.25                               | \$4,551.96<br>+ Adult Dental & Vision<br>\$4,668.90 | \$5,661.67                             | \$5,552.71<br>+ Adult Dental & Vision<br>\$5,679.85 |
| Plan Availability                                              | my Blue Access EX<br>Gold Standard       | my Blue Access EX<br>Gold Destination 65            | my Blue Access EX<br>Platinum Standard | my Blue Access<br>EX Platinum<br>Destination 65     |
| In-Network<br>Deductible                                       | Individual: \$775<br>Family: \$1,550     | Individual: \$0<br>Family: \$0                      | Individual: \$0<br>Family: \$0         | Individual: \$0<br>Family: \$0                      |
| In-Network, Out-of-<br>Pocket Maximum                          | Individual: \$10,150<br>Family: \$20,300 | Individual: \$7,900<br>Family: \$15,800             | Individual: \$2,000<br>Family: \$4,000 | Individual: \$5,000<br>Family: \$10,000             |
| Primary Care Visit                                             | \$25 copay after<br>deductible           | \$0 copay                                           | \$15 copay                             | \$0 copay                                           |
| Specialist Visit                                               | \$40 copay after<br>deductible           | \$30 copay                                          | \$35 copay                             | \$0 copay                                           |
| Outpatient Mental<br>Health and Substance<br>Abuse Visits      | \$25 copay after<br>deductible           | \$0 copay                                           | \$15 copay                             | \$0 copay                                           |
| Physical and<br>Occupational Therapy <sup>2</sup>              | \$30 copay after<br>deductible           | \$30 copay                                          | \$25 copay                             | \$0 copay                                           |
| Chiropractic Care                                              | \$40 copay after<br>deductible           | \$0 copay                                           | \$35 copay                             | \$0 copay                                           |
| Diagnostic Test -<br>Lab Services                              | \$40 copay after<br>deductible           | \$20 copay                                          | \$35 copay                             | \$0 copay                                           |
| Diagnostic Test -<br>X-rays                                    | \$40 copay after<br>deductible           | 50%                                                 | \$35 copay                             | 10%                                                 |
| Urgent Care <sup>3</sup>                                       | \$60 copay after<br>deductible           | \$60 copay                                          | \$55 copay                             | \$0 copay                                           |
| Emergency Services                                             | \$150 copay after<br>deductible          | \$400 copay                                         | \$100 copay                            | \$100 copay                                         |
| Hospital Inpatient<br>(including facility<br>and professional) | \$1,000 copay after<br>deductible        | \$725 copay                                         | \$500 copay                            | \$275 copay                                         |
| Pharmacy Summary <sup>4</sup>                                  | \$10/\$35/\$70                           | \$5/\$50/50%                                        | \$10/\$30/\$60                         | \$5/\$30/50%                                        |
| Integrated Adult Dental<br>and Vision Option <sup>5</sup>      | No                                       | Yes                                                 | No                                     | Yes                                                 |

<sup>3</sup> The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse.

<sup>4</sup> Visit [highmarkacaformulary.com](https://highmarkacaformulary.com) to view our Formulary and see if your drug is covered, and at which tier.

<sup>5</sup> See pages 34 – 38 for adult dental and vision benefit details.

|                                                          | Income Level                                                               |                                                         |                                                                            |
|----------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------|
|                                                          | 138 – 149% FPL                                                             |                                                         | 150 – 199% FPL                                                             |
|                                                          | Coverage Level                                                             |                                                         |                                                                            |
|                                                          | <b>Extra Savings Silver</b><br><b>94%</b><br>of costs covered by your plan | <b>6%</b><br>out-of-pocket costs                        | <b>Extra Savings Silver</b><br><b>87%</b><br>of costs covered by your plan |
|                                                          | Standard Extra Savings Silver C                                            | Destination 65 Extra Savings Silver C                   | Standard Extra Savings Silver Supreme                                      |
| Plan Availability                                        | my Blue Access EX Standard Extra Savings Silver C                          | my Blue Access EX Destination 65 Extra Savings Silver C | my Blue Access EX Standard Extra Savings Silver Supreme                    |
| In-Network Deductible                                    | Individual: \$0<br>Family: \$0                                             | Individual: \$0<br>Family: \$0                          | Individual: \$450<br>Family: \$900                                         |
| In-Network, Out-of-Pocket Maximum                        | Individual: \$1,275<br>Family: \$2,550                                     | Individual: \$900<br>Family: \$1,800                    | Individual: \$3,350<br>Family: \$6,700                                     |
| Primary Care Visit                                       | \$10 copay                                                                 | \$0 copay                                               | \$15 copay after deductible                                                |
| Specialist Visit                                         | \$20 copay                                                                 | \$0 copay                                               | \$35 copay after deductible                                                |
| Outpatient Mental Health and Substance Abuse Visits      | \$10 copay                                                                 | \$0 copay                                               | \$15 copay after deductible                                                |
| Physical and Occupational Therapy <sup>1</sup>           | \$15 copay                                                                 | \$0 copay                                               | \$25 copay after deductible                                                |
| Chiropractic Care                                        | \$20 copay                                                                 | \$0 copay                                               | \$35 copay after deductible                                                |
| Diagnostic Test - Lab Services                           | \$20 copay                                                                 | \$0 copay                                               | \$35 copay after deductible                                                |
| Diagnostic Test - X-rays                                 | \$20 copay                                                                 | \$0 copay                                               | \$35 copay after deductible                                                |
| Urgent Care <sup>2</sup>                                 | \$30 copay                                                                 | \$0 copay                                               | \$50 copay after deductible                                                |
| Emergency Services                                       | \$50 copay                                                                 | \$75 copay                                              | \$75 copay after deductible                                                |
| Hospital Inpatient (including facility and professional) | \$100 copay                                                                | \$175 copay                                             | \$250 copay after deductible                                               |
| Pharmacy Summary <sup>3</sup>                            | \$6/\$15/\$30                                                              | \$15/50%/50%                                            | \$9/\$20/\$40                                                              |
| Integrated Adult Dental and Vision Option <sup>4</sup>   | No                                                                         | Yes                                                     | No                                                                         |

|                                                          | Income Level                                                     |                            |                                                                  |                                                                   |                            |
|----------------------------------------------------------|------------------------------------------------------------------|----------------------------|------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------|
|                                                          | 150 – 199% FPL                                                   |                            | 200 – 249% FPL                                                   |                                                                   |                            |
|                                                          | Coverage Level                                                   |                            |                                                                  |                                                                   |                            |
|                                                          | Extra Savings Silver<br><br>87%<br>of costs covered by your plan | 13%<br>out-of-pocket costs | Extra Savings Silver<br><br>73%<br>of costs covered by your plan |                                                                   | 27%<br>out-of-pocket costs |
|                                                          | Destination 65 Extra Savings Silver Supreme                      |                            | Standard Extra Savings Silver Enhanced                           | Destination 65 Extra Savings Silver Enhanced                      |                            |
| Plan Availability                                        | my Blue Access EX<br>Destination 65 Extra Savings Silver Supreme |                            | my Blue Access EX<br>Standard Extra Savings Silver Enhanced      | my Blue Access EX<br>Destination 65 Extra Savings Silver Enhanced |                            |
| In-Network Deductible                                    | Individual: \$0<br>Family: \$0                                   |                            | Individual: \$2,160<br>Family: \$4,320                           | Individual: \$0<br>Family: \$0                                    |                            |
| In-Network, Out-of-Pocket Maximum                        | Individual: \$3,100<br>Family: \$6,200                           |                            | Individual: \$8,100<br>Family: \$16,200                          | Individual: \$8,100<br>Family: \$16,200                           |                            |
| Primary Care Visit                                       | \$0 copay                                                        |                            | \$30 copay after deductible                                      | \$0 copay                                                         |                            |
| Specialist Visit                                         | \$0 copay                                                        |                            | \$65 copay after deductible                                      | \$50 copay                                                        |                            |
| Outpatient Mental Health and Substance Abuse Visits      | \$0 copay                                                        |                            | \$30 copay after deductible                                      | \$0 copay                                                         |                            |
| Physical and Occupational Therapy¹                       | \$0 copay                                                        |                            | \$30 copay after deductible                                      | \$50 copay                                                        |                            |
| Chiropractic Care                                        | \$0 copay                                                        |                            | \$65 copay after deductible                                      | \$0 copay                                                         |                            |
| Diagnostic Test - Lab Services                           | \$0 copay                                                        |                            | \$50 copay after deductible                                      | \$50 copay                                                        |                            |
| Diagnostic Test - X-rays                                 | \$100 copay                                                      |                            | \$75 copay after deductible                                      | \$200 copay                                                       |                            |
| Urgent Care²                                             | \$0 copay                                                        |                            | \$70 copay after deductible                                      | \$100 copay                                                       |                            |
| Emergency Services                                       | \$500 copay                                                      |                            | \$275 copay after deductible                                     | \$1,000 copay                                                     |                            |
| Hospital Inpatient (including facility and professional) | \$450 copay                                                      |                            | \$1,500 copay after deductible                                   | \$2,000 copay                                                     |                            |
| Pharmacy Summary³                                        | \$15/50%/50%                                                     |                            | \$15/\$40/\$75                                                   | \$15/50%/50%                                                      |                            |
| Integrated Adult Dental and Vision Option⁴               | Yes                                                              |                            | No                                                               | Yes                                                               |                            |

<sup>1</sup> Limit of 30 combined physical and occupational therapy visits per benefit period. Limit does not apply to therapy services for the treatment of mental health or substance abuse.

<sup>2</sup> The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse.

<sup>3</sup> Visit [highmarkacaformulary.com](https://www.highmarkacaformulary.com) to view our Formulary and see if your drug is covered, and at which tier.

<sup>4</sup> See pages 34 – 38 for adult dental and vision benefit details.

# **Vision and dental benefits**

# Plans that include adult vision and dental

Highmark is making vision and dental care more accessible. At every metal level, we offer plans with the option to have adult dental and vision included. Pediatric dental and vision benefits are automatically included with every plan.

You can find adult dental and vision benefits on pages 36 – 38 and pediatric dental and vision benefits on pages 40 – 44.

## Vision coverage

Getting your eyes checked can help identify issues like diabetes early on when they’re easier to treat. One annual eye exam is covered at 100% with plans that include adult dental and vision benefits.

## Dental coverage

Seeing a dentist is the best way to take care of your oral health. Our adult dental includes 100% coverage on cleanings,\* X-rays, and sealants.

## It pays to have dental coverage

| Service                      | Average cost with dental coverage | Average cost without dental coverage (usual fee) |
|------------------------------|-----------------------------------|--------------------------------------------------|
| Exams, cleanings, and X-rays | \$0 – 37                          | Up to \$400 <sup>1</sup>                         |
| Composite filling            | \$71                              | \$170 <sup>2</sup>                               |
| Simple extraction            | \$33                              | \$163 <sup>3</sup>                               |
| Root canal                   | \$400                             | \$1,250 <sup>4</sup>                             |

\* Three cleanings per year.

<sup>1</sup> [https://www.dentaly.org/us/oral-hygiene/teeth-cleaning/#How\\_much\\_does\\_a\\_dental\\_cleaning\\_cost](https://www.dentaly.org/us/oral-hygiene/teeth-cleaning/#How_much_does_a_dental_cleaning_cost), last accessed May 8, 2025; <https://www.dentaly.org/us/panoramic-dental-xray/>, last accessed May 8, 2025

<sup>2</sup> [https://www.dentaly.org/us/tooth-filling/#How\\_much\\_do\\_fillings\\_cost](https://www.dentaly.org/us/tooth-filling/#How_much_do_fillings_cost), last accessed May 8, 2025

<sup>3</sup> [https://www.dentaly.org/us/tooth-extraction/#How\\_much\\_does\\_tooth\\_removal\\_cost\\_in\\_the\\_US](https://www.dentaly.org/us/tooth-extraction/#How_much_does_tooth_removal_cost_in_the_US), last accessed May 8, 2025

<sup>4</sup> <https://www.webmd.com/oral-health/guide/dental-root-canals>, last accessed May 8, 2025

# For all plans with adult dental and vision coverage — these are your vision benefits.

## In-network

| Vision benefits                                                    | Frequency - once every: |
|--------------------------------------------------------------------|-------------------------|
| Eye examination (including dilation when professionally indicated) | 12 months               |
| Spectacle lenses                                                   | 12 months               |
| Frame                                                              | 12 months               |
| Contact lenses (in lieu of eyeglass lenses)                        | 12 months               |

| Copayments                                           |                                                                                                                                                 |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| Eye examination                                      | \$0                                                                                                                                             |
| Spectacle lenses                                     | \$0                                                                                                                                             |
| Contact lens evaluation, fitting, and follow-up care | If a member chooses collection lenses, no copayment is required. If non-collection lenses are chosen, the member must pay all associated costs. |

| Eyeglass benefit - spectacle lenses                                                 | Average retail value | Member charges |
|-------------------------------------------------------------------------------------|----------------------|----------------|
| Clear plastic single-vision, lined bifocal, trifocal, or lenticular lenses (any Rx) | \$60 – \$120         | Included       |
| Oversize lenses                                                                     | \$20                 | Included       |
| Tinting of plastic lenses                                                           | \$20                 | \$11           |
| Scratch-resistant coating                                                           | \$25 – \$40          | Included       |
| Scratch protection plan single vision                                               | \$60 – \$120         | \$20           |
| Scratch protection plan multifocal                                                  | \$60 – \$120         | \$40           |
| Polycarbonate lenses <sup>1</sup>                                                   | \$60 – \$75          | \$0 or \$30    |
| Ultraviolet coating                                                                 | \$25 – \$30          | \$12           |
| Standard anti-reflective (AR) coating                                               | \$100 – \$175        | \$35           |
| Premium AR coating                                                                  | \$100 – \$175        | \$48           |
| Ultra AR coating                                                                    | \$100 – \$175        | \$60           |
| Standard progressive lenses                                                         | \$150 – \$195        | \$50           |
| Premium progressives (varilux®, etc.)                                               | \$195 – \$225        | \$90           |
| Ultra progressive lenses                                                            | \$225 – \$300        | \$140          |
| Blue light filtering                                                                | \$25                 | \$15           |
| High-index lenses (thinner and lighter)                                             | \$90 – \$150         | \$55/\$120     |
| Polarized lenses                                                                    | \$95 – \$110         | \$75           |
| Plastic photosensitive lenses                                                       | \$95 – \$150         | \$65           |

| Eyeglass benefit - frame                                              |                | Average retail value |             |
|-----------------------------------------------------------------------|----------------|----------------------|-------------|
| Non-collection frame allowance (retail):                              |                | Up to \$130          | Up to \$150 |
| Davis Vision Frame Collection <sup>2</sup><br>(in lieu of allowance): | Fashion level  | Up to \$125          | Included    |
|                                                                       | Designer level | Up to \$175          | Included    |
|                                                                       | Premier level  | Up to \$225          | Included    |

| Contact lens benefit (in lieu of eyeglasses)                                |                                                    |                 |
|-----------------------------------------------------------------------------|----------------------------------------------------|-----------------|
| Non-collection contact lenses: materials allowance                          |                                                    | Up to \$150     |
| Collection contact lenses <sup>2</sup><br>(in lieu of allowance): materials | Disposable                                         | Covered in full |
|                                                                             | Planned replacement                                | Covered in full |
|                                                                             | Evaluation, fitting, and follow-up care            | Included        |
| Medically necessary contact lenses (with prior approval)                    | Materials, evaluation, fitting, and follow-up care | Included        |

<sup>1</sup> Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

<sup>2</sup> Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

## One-year eyeglass breakage warranty included.

Adult vision benefits utilize the Davis Vision Network. There is no out-of-network coverage. Davis Vision is a separate company that administers Highmark vision benefits.

To find a provider in the Davis Vision Network, visit [HighmarkCatalog2026.com/NENY](https://HighmarkCatalog2026.com/NENY).

# For all plans with adult dental and vision coverage — these are your dental benefits.

| Dental Benefits                                                         |                                         |                    |
|-------------------------------------------------------------------------|-----------------------------------------|--------------------|
| Annual deductible per insured person                                    | \$50 per calendar year                  |                    |
| Annual deductible per insured family                                    | \$150 per calendar year                 |                    |
| Annual maximum per insured person                                       | \$1,500                                 |                    |
| Covered services:                                                       | Member pays                             | Elimination period |
|                                                                         | In network                              |                    |
| Oral Evaluations (exams)                                                | \$0 copayment not subject to deductible | None               |
| Consultations                                                           | \$0 copayment not subject to deductible | None               |
| Radiographs (all X-rays)                                                | \$0 copayment not subject to deductible | None               |
| Prophylaxis (cleanings — 3 per benefit period)                          | \$0 copayment not subject to deductible | None               |
| Palliative treatment (emergency)                                        | \$0 copayment not subject to deductible | None               |
| Sealants                                                                | \$0 copayment not subject to deductible | None               |
| Space maintainers                                                       | \$0 copayment not subject to deductible | None               |
| Repairs of crowns, inlays, onlays, fixed partial dentures, and dentures | 50% coinsurance after deductible        | 6 months           |
| Basic restorative (fillings, etc.)                                      | 20% coinsurance after deductible        | None               |
| Simple extractions                                                      | 20% coinsurance after deductible        | 6 months           |
| Surgical extractions                                                    | 50% coinsurance after deductible        | 6 months           |
| Complex oral surgery                                                    | 50% coinsurance after deductible        | 6 months           |
| Endodontics (root canals, etc.)                                         | 50% coinsurance after deductible        | 6 months           |
| General anesthesia and/or IV sedation                                   | 20% coinsurance after deductible        | 6 months           |
| Nonsurgical periodontics                                                | 50% coinsurance after deductible        | 6 months           |
| Periodontal maintenance                                                 | 50% coinsurance after deductible        | None               |
| Surgical periodontics                                                   | 50% coinsurance after deductible        | 6 months           |
| Crowns, inlays, onlays                                                  | 50% coinsurance after deductible        | 6 months           |
| Prosthetics (fixed partial dentures, dentures)                          | 50% coinsurance after deductible        | 6 months           |
| Adjustments and repairs of prosthetics                                  | 50% coinsurance after deductible        | None               |
| Implant services                                                        | Not covered                             | None               |
| Orthodontics                                                            | Not covered                             | None               |

Participating dentists accept the allowed amount as payment in full. Adult dental benefits utilize the Concordia Elite Prime Network. Members must use a United Concordia provider. United Concordia is a separate company administering dental benefits. There is no out-of-network coverage for this benefit.

All services listed may be subject to exclusions and limitations.

Our dental plan uses the Concordia Elite Prime network. To find in-network dentists, visit [HighmarkCatalog2026.com/NENY](https://HighmarkCatalog2026.com/NENY).

[illegible]

# All plans have pediatric vision coverage — these are your vision benefits.

## In-network

| Network benefit                                                              | Frequency - once every: | Members under 19 years of age |
|------------------------------------------------------------------------------|-------------------------|-------------------------------|
| Eye examination including dilation (when professionally indicated)           | 12 months               | \$0                           |
| Spectacle lenses                                                             | Unlimited               | \$0                           |
| Frame                                                                        | Unlimited               | \$0                           |
| Contact lens evaluation, fitting, and follow-up care (in lieu of eyeglasses) | Unlimited               | \$0                           |

## In-network (standard)

| Network benefit                                                              | Frequency - once every: | Members under 19 years of age                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Eye examination including dilation (when professionally indicated)           | 12 months               | Platinum Standard: \$15 copayment<br>Gold Standard: \$25 copayment after deductible<br>Silver Standard: \$30 copayment after deductible<br>Silver Standard Enhanced: \$30 copayment after deductible<br>Silver Standard Supreme: \$15 copayment after deductible<br>Silver Standard C: \$10 copayment<br>Bronze Standard: \$50 copay after deductible           |
| Spectacle lenses                                                             | 12 months               | Platinum Standard: 10% coinsurance<br>Gold Standard: 20% coinsurance after deductible<br>Silver Standard: 30% coinsurance after deductible<br>Silver Standard Enhanced: 25% coinsurance after deductible<br>Silver Standard Supreme: 10% coinsurance after deductible<br>Silver Standard C: 5% coinsurance<br>Bronze Standard: 50% coinsurance after deductible |
| Frame                                                                        | 12 months               | Platinum Standard: 10% coinsurance<br>Gold Standard: 20% coinsurance after deductible<br>Silver Standard: 30% coinsurance after deductible<br>Silver Standard Enhanced: 25% coinsurance after deductible<br>Silver Standard Supreme: 10% coinsurance after deductible<br>Silver Standard C: 5% coinsurance<br>Bronze Standard: 50% coinsurance after deductible |
| Contact lens evaluation, fitting, and follow-up care (in lieu of eyeglasses) | 12 months               | Platinum Standard: 10% coinsurance<br>Gold Standard: 20% coinsurance after deductible<br>Silver Standard: 30% coinsurance after deductible<br>Silver Standard Enhanced: 25% coinsurance after deductible<br>Silver Standard Supreme: 10% coinsurance after deductible<br>Silver Standard C: 5% coinsurance<br>Bronze Standard: 50% coinsurance after deductible |

# All plans have pediatric dental coverage — these are your dental benefits.

These plans will pay benefits for covered services shown below subject to exclusions and other Policy terms.

Payment is based on the plan allowance for the specific covered service.

There is no waiting period on covered services.

| Dental benefits                                                                 | Non-standard plans                                                           | Standard plans                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Contract year deductible per member                                             | N/A                                                                          | Follows in-network medical deductible                                                                                                                                                                                                                                                                                                              |
| Annual maximum per member                                                       | N/A                                                                          | N/A                                                                                                                                                                                                                                                                                                                                                |
| Out-of-pocket year maximum per member                                           | Follows in-network medical out-of-pocket maximum                             | Follows in-network medical out-of-pocket maximum                                                                                                                                                                                                                                                                                                   |
| Network                                                                         | Elite Prime                                                                  | Elite Prime                                                                                                                                                                                                                                                                                                                                        |
| Covered services                                                                | Member pays at participating dentists                                        |                                                                                                                                                                                                                                                                                                                                                    |
| Oral evaluations (exams)                                                        | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible | Platinum Standard:<br>\$15 copay<br>Gold Standard:<br>\$25 copay after deductible<br>Silver Standard:<br>\$30 copay after deductible<br>Silver Standard Enhanced:<br>\$30 copay after deductible<br>Silver Standard Supreme:<br>\$15 copay after deductible<br>Silver Standard C:<br>\$10 copay<br>Bronze Standard:<br>\$50 copay after deductible |
| Consultations                                                                   | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Radiographs (all X-rays)                                                        | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Prophylaxis (cleanings)                                                         | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Fluoride treatments                                                             | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Sealants                                                                        | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Space maintainers                                                               | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Crowns, crown repair, inlays, and onlays                                        | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Basic restorative (anterior composite, anterior amalgam, and posterior amalgam) | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Simple extractions                                                              | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Surgical extractions                                                            | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Oral surgery                                                                    | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Apicoectomy/periradicular surgery                                               | Platinum/Gold/Silver: \$25 copay<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |

| Dental benefits                                           | Non-standard plans                                                                | Standard plans                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Network                                                   | Elite Prime                                                                       | Elite Prime                                                                                                                                                                                                                                                                                                                                        |
| General anesthesia and/or IV sedation                     | Platinum/Gold/Silver: 50% coinsurance<br>Bronze: 50% coinsurance after deductible | Platinum Standard:<br>\$15 copay<br>Gold Standard:<br>\$25 copay after deductible<br>Silver Standard:<br>\$30 copay after deductible<br>Silver Standard Enhanced:<br>\$30 copay after deductible<br>Silver Standard Supreme:<br>\$15 copay after deductible<br>Silver Standard C:<br>\$10 copay<br>Bronze Standard:<br>\$50 copay after deductible |
| Palliative treatment (emergency)                          | Platinum/Gold/Silver: 50% coinsurance<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Endodontics (root canals, etc.)                           | Platinum/Gold/Silver: 50% coinsurance<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Surgical periodontics                                     | Platinum/Gold/Silver: 50% coinsurance<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Periodontal maintenance                                   | Platinum/Gold/Silver: 50% coinsurance<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Prosthodontics (fixed partial dentures)                   | Platinum/Gold/Silver: 50% coinsurance<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Prosthetics (complete dentures, adjustments, and repairs) | Platinum/Gold/Silver: 50% coinsurance<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Implant services                                          | Not covered                                                                       |                                                                                                                                                                                                                                                                                                                                                    |
| Maxillofacial prosthetics                                 | Platinum/Gold/Silver: 50% coinsurance<br>Bronze: 50% coinsurance after deductible | Platinum Standard:<br>\$15 copay<br>Gold Standard:<br>\$25 copay after deductible<br>Silver Standard:<br>\$30 copay after deductible<br>Silver Standard Enhanced:<br>\$30 copay after deductible<br>Silver Standard Supreme:<br>\$15 copay after deductible<br>Silver Standard C:<br>\$10 copay<br>Bronze Standard:<br>\$50 copay after deductible |
| Medically necessary orthodontics                          | Platinum/Gold/Silver: 50% coinsurance<br>Bronze: 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                    |
| Cosmetic orthodontic services                             | Not covered                                                                       |                                                                                                                                                                                                                                                                                                                                                    |

Participating dentists accept the allowed amount as payment in full. Pediatric dental benefits utilize the Concordia Elite Prime Network. Members must use a United Concordia provider. There is no out-of-network coverage for this benefit.

All services listed may be subject to exclusions and limitations.

These plans meet the minimum essential health benefit requirements for pediatric oral health as required under the federal Affordable Care Act.

These benefits are only available for children through the end of the benefit period that they turn 19 years old.

Our dental plan uses the Concordia Elite Prime network. To find in-network dentists, visit [HighmarkCatalog2026.com/NENY](https://www.highmarkcatalog2026.com/NENY).

# Pediatric dental benefits (continued)

## Medically necessary orthodontics coverage

In this section, “Medically Necessary” or “Medical Necessity” shall mean health care services that a physician or dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

1. In accordance with the generally accepted standards of medical/dental practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury, or disease; and
3. Not primarily for the convenience of the patient or physician/dentist, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

As used subpart 1, above, “generally accepted standards of medical/dental practice” means:

- Standards that are based on credible scientific evidence published in peer-reviewed, medical/dental literature generally recognized by the relevant professional community;
- Recognized Medical/Dental and Specialty Society recommendations;
- The views of physicians/dentists practicing in the relevant clinical area; and
- Any other relevant factors.

A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties, or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

## Coverage of medically necessary orthodontics

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
  - a) Preventing irreversible damage to the insured person’s teeth or their supporting structures and,
  - b) Restoring the insured person’s oral structure to health and function.
2. The insured person must have a fully erupted set of permanent teeth to be eligible for comprehensive, Medically Necessary orthodontic services for handicapping malocclusions of the adult dentition.
3. Other orthodontic covered services include: pre-orthodontic treatment visit for completion of HLD (NJ-Mod2) form, diagnostic photographs and panoramic radiographs; limited treatment for the primary, transitional, and adult dentition; interceptive treatment for the primary transitional dentition; minor treatment to control harmful habits; continuation of transfer cases or cases started prior to the insured person’s Effective Date; orthognathic surgical cases with comprehensive orthodontic treatment; placement and removal of orthodontic appliances; repairs to orthodontic appliances; replacement of lost or broken retainer; rebonding or recementing of brackets and/or bands; and removal of appliances by a provider that did not start the case when requested by report.
4. All Medically Necessary orthodontic services require prior approval and a written plan of care.

## Notes

[illegible]

# There's a whole lot of legalese around these plans.

## We put it all in one place for you.

### Important Benefit Details

**Non-Embedded Family Deductible:** For an agreement covering more than one (1) family member, the family deductible must be satisfied before the plan will begin to pay benefits for covered services for any covered family member. When the family deductible has been satisfied, the family deductible will be considered to have been satisfied for all family members, the plan will begin to pay benefits for covered services for all covered family members for the remainder of the benefit period (January 1, 2026 – December 31, 2026). The family deductible can be met by one family member or a combination of members.

**Aggregate/Embedded Family Deductible Plans:** For an Agreement covering more than one (1) family member, as each Member satisfies their individual Deductible, the Plan will begin to pay benefits for covered services for that Member for the remainder of the Benefit Period (January 1, 2026 – December 31, 2026), whether or not the entire family Deductible has been satisfied. When the family Deductible has been satisfied, the family Deductible will be considered to have been satisfied for all remaining covered family members. Not every individual member must meet the individual deductible for the family deductible to be met and no individual member may satisfy the entire family Deductible.

You are responsible for out-of-pocket costs each benefit period (January 1, 2026 – December 31, 2026) up to the maximum amount shown. Thereafter, the plan pays 100% of the Plan Allowance. During the remainder of the benefit period. This amount does not include amounts in excess of the plan allowance.

Diagnostic Lab services include Laboratory and Pathology. Diagnostic Lab services require one copay (or, for some plans, coinsurance after deductible) per date of service and type of service. The copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse.

Basic Diagnostic Services include Diagnostic X-ray, diagnostic medical and allergy testing. Basic diagnostic services require one copay (or, for some plans, coinsurance after deductible) per date of service and type of service. The copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse.

Advanced Imaging services include, but are not limited to, CAT scan, CTA, MRI, MRA, PET scan, and PET/CT Scan. Advanced Imaging services require one copay (or, for some plans, coinsurance after deductible) per date of service and type of service. The copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse.

Preventive care services include routine care like screenings and checkups that help keep you healthy. Refer to the Highmark Preventive Schedule for the list of preventive care services.

Essential Formulary prescription drug cost covers a 90-day (Mail Order) or 31-day (Retail) supply. All plans have a four-tier closed formulary prescription drug structure.

Qualified High Deductible Health Plans may be coupled with a Health Savings Account (HSA). However, certain cost-sharing reductions (CSR) or plan variations of this plan that are offered through the New York State of Health health plan marketplace are not intended to be used with an HSA. If you have questions, please check with your financial advisor.

The preventive vision exam is a routine eye examination, with refraction, that focuses on assessment, preventive eye care, and determination of the refractive state of the eye. A complete routine eye examination with refraction includes: case history, visual acuities (near and distance), external examination that includes pupils motilities, and color vision test, tonometry, refraction, binocular vision testing, slit lamp examination of the anterior segment (including the crystalline lens), fundus examination (including dilated fundus exam), assessment, and plans.

You should confirm the network status of a provider prior to receiving services. You can call 1-888-BLUE-428 to confirm if a doctor or facility will be in network in 2026.

If you purchase coverage through an agent or broker, that individual may receive a commission. Bonus or incentive compensation may also apply. For more details visit [Highmark.com](https://www.highmark.com) and enter your ZIP code. Select Plans followed by Shop Individual and Family Plans. Scroll to the bottom of the page and look for Highmark Individual Market Broker Compensation.

Please note that information regarding the Patient Protection and Affordable Care Act of 2010 (a.k.a. "PPACA", "Affordable Care Act", "ACA", and/or "Health Care Reform"), as amended, and/or any other law, does not constitute legal or tax advice and is subject to change based upon the issuance of new guidance and/or change in laws. This information is intended to provide general information only and does not attempt to give you advice that relates to your specific circumstances. The information regarding any health plan will be subject to the terms of the applicable health plan benefit agreement. Any review of materials, request for information, or application does not obligate you to enroll for coverage. Please request the Outline of Coverage for details on benefits, conditions, and exclusions. Providing your information is voluntary.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, visit <https://www.highmark.com/transparency-in-coverage>. For a paper copy of Claims Payment Policies & Other Information, call 1-855-873-4108 (TTY/TDD: 711).

### Additional Disclosures

Blue Distinction Centers (BDC) met overall quality measures for patient safety and outcomes, developed with input from the medical community. A Local Blue Plan may require additional criteria for providers located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable health care. Each provider's cost of care is evaluated using data from its Local Blue Plan. Providers in CA, ID, NY, PA, and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. Blue Distinction Total Care ("Total Care") providers have met national criteria based on provider commitment to deliver value-based care to a population of Blue members. Total Care+ providers also met a goal of delivering quality care at a lower total cost relative to other providers in their area. Program details and national criteria for BDC and BDC+ are displayed on [www.bcbs.com](http://www.bcbs.com). Individual outcomes may vary. For details on a provider's in-network status or your own policy's coverage, contact your Local Blue Plan and ask your provider before making an appointment. Neither Blue Cross Blue Shield Association nor any Blue Plans are responsible for noncovered charges or other losses or damages resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.

BlueCard coverage is available for emergency or urgent care for all plans when you are away from home. Routine care is also covered for some plans. Consult your plan documents for additional information.

Blue Distinction is a registered mark of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

BlueCard is a registered mark of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

Blue365 is a registered mark of the Blue Cross Blue Shield Association.

Mental Well-Being is offered by your health plan and powered by Spring Health. Spring Health is an independent company that provides mental health care services through its agents. Spring Health is solely responsible for their mental health care services.

Sword Health is an independent company that provides wellness services for your health plan. Sword Health Professionals provides its services through a group of independently owned professional practices consisting of Sword Health Care Providers, P.A., Sword Health Care Providers of NJ, P.C., and Sword Health Care Physical Therapy Providers of CA, P.C.

Well360 Virtual Health is offered by your health plan and powered by Amwell. Amwell is an independent company that provides telemedicine services and does not provide Blue Cross and/or Blue Shield products or services. Amwell is solely responsible for their telemedicine services.

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

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Highmark Blue Shield is a Qualified Health Plan insurer in the New York State of Health health insurance exchange. A Qualified Health Plan (QHP) is a plan that has been certified by the Health Insurance Marketplace and meets all ACA requirements. That includes providing the 10 Essential Health Benefits and staying inside the limits for deductibles, copays, and out-of-pocket maximums.

### Discrimination is Against the Law

The Claims Administrator/Insurer 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 Claims Administrator/Insurer 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 Claims Administrator/Insurer 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 Claims Administrator/Insurer 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 Claims Administrator/Insurer:

- 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 Claims Administrator/Insurer 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 of Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](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  
Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).

### Pennsylvania, Delaware, West Virginia, and New York: 1-833-521-1424 (TTY: 711)

ATTENTION: If you speak English, assistance services, free of charge, are available to you. Call the number provided for your state of residence.

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispizyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili.

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles.

ÀKÍYÈSÍ: Tí o bá nsò èdè Yorùbá, àwọn iṣẹ̀ ìtumọ̀ ati ògbufọ̀ èdè wà ní àròwọ̀tọ̀ lófẹ̀fẹ̀ fún ọ. Àwọn iṣẹ̀ ìtọ́jú ati ìrànłọ́wọ̀ tó yẹ (bíi titẹ́wé nla, gbígbo ohùn, ati iwé afọ́jú) lati pèsè iwífúnni ní àwọn ọ̀nà írááyè sí wà pẹ̀lu lófẹ̀fẹ̀.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויזוי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجاناً. تتوفر أيضاً الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقات يمكن الوصول إليها من دون أي تكلفة.

注意: 如果您说中文, 我们将为您提供免费的语言翻译和口译服务。此外, 我们还免费提供相应的辅助工具和服务 (如大字体、音频和盲文), 以便您获取无障碍格式的信息。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિ:શુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિ:શુલ્ક ઉપલબ્ધ છે.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई नि:शुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्ने उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि नि:शुल्क उपलब्ध छन्।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी नि:शुल्क उपलब्ध हैं।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용하실 수 있습니다. 도움!

# Ready to (en)roll?

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- By phone: 1-855-486-2096
- Online: [HighmarkCatalog2026.com/NENY](https://HighmarkCatalog2026.com/NENY)
- By contacting your agent or broker



Because Life.™