	Coverage Level		
	BRONZE STANDARD HSAQ	**BRONZE POS 8000**	**SILVER STANDARD**
Plan Availability	POS	POS	POS
Monthly Premium			
Individual	$532.91	$474.37; With adult dental and vision: $505.36	$720.15
Individual and Children	$905.95	$806.43; With adult dental and vision: $859.11	$1,224.26
Individual and Spouse/ Domestic Partner	$1,065.82	$948.74; With adult dental and vision: $1,010.72	$1,440.30
Family	$1,518.79	$1,351.95; With adult dental and vision: $1,440.28	$2,052.43
In-Network Deductible	Individual: $6,100 Family: $12,200	Individual: $8,500 Family: $17,000	Individual: $2,100 Family: $4,200
In-Network, Out-of-Pocket Maximum	Individual: $7,150 Family: $14,300	Individual: $9,100 Family: $18,200	Individual: $9,450 Family: $18,900
Primary Care Visit	50% after deductible	50% after deductible	$30 after deductible One pre-deductible office visit*
Specialist Visit	50% after deductible	50% after deductible	$65 after deductible
Outpatient Mental Health and Substance Abuse Visits[1]	50% after deductible	50% after deductible	$30 after deductible
Speech, Physical, and Occupational Therapy and Chiropractic Care[2]	50% after deductible	50% after deductible	$30 after deductible
Diagnostic Test (Lab/X-ray)	50% after deductible	50% after deductible	$50/$75 after deductible
Urgent Care	50% after deductible	50% after deductible	$70 after deductible
Emergency Services	50% after deductible	50% after deductible	$500 after deductible
Hospital Inpatient (including facility and professional)[3]	50% after deductible	50% after deductible	$1,500 after deductible
Pharmacy Summary[4]	$10/$35/$70 after deductible	$15/50%/50% after deductible	$15/$40/$75
Includes Dental and Vision Option[5]	No	Yes	No

[1] Unlimited visits, 20 visits per plan year for family counseling.

[2] Inpatient: Limit of 60 combined physical and occupational therapy visits per benefit period for Standard plans. No visit limitations for non-Standard plans.
Outpatient: Limit of 60 combined speech, physical, and occupational visits per condition per plan year.

[3] For plans with a hospital inpatient copay, the copay includes all facility and professional charges. Please refer to the plan's contract for additional information.

[4] Visit **highmark.link/nyformulary** to view our Formulary and see if your drug is covered, and at which tier.

[5] See pages 28-32 for adult dental and vision benefit details.

*The pre-deductible office visit benefit is available once per plan year, per member, for one of the following office visits or services: primary, specialist, or chiropractic care; allergy testing and treatment; second opinions; physical, occupational, and speech therapy; applied behavior analysis (ABA) treatment; or outpatient mental health/substance use disorder (MH/SUD) treatment.

Additional annual benefit limits

- Home Health Care: 40 visits per plan year
- Hearing Aids: Single purchase every three years. Members must choose hearing aids from John R. Oishei Children's Hospital or Beckes Optical and Hearing Aids. Members are entitled to discounts through TruHearing
- Hospice: 210 days per plan year; five visits per plan year for family bereavement
- Skilled Nursing Facility: Unlimited for non-Standard plans; 200 days per year for Standard plans

	Coverage Level		
	SILVER POS 7000 HSAQ	SILVER DESTINATION 65	GOLD STANDARD
Plan Availability	POS	POS	POS
Monthly Premium			
Individual	$641.04	$681.31	$932.60
Individual and Children	$1,089.77	$1,158.23	$1,585.42
Individual and Spouse/Domestic Partner	$1,282.08	$1,362.62	$1,865.20
Family	$1,826.96	$1,941.73	$2,657.91
In-Network Deductible	Individual: $3,000 Family: $6,000	Individual: $2,500 Family: $5,000	Individual: $600 Family: $1,200
In-Network, Out-of-Pocket Maximum	Individual: $7,000 Family: $14,000	Individual: $9,450 Family: $18,900	Individual: $5,900 Family: $11,800
Primary Care Visit	$30 after deductible	$0 after deductible	$25 after deductible
Specialist Visit	$50 after deductible	$35 after deductible	$40 after deductible
Outpatient Mental Health and Substance Abuse Visits[1]	$30 after deductible	$0 after deductible	$25 after deductible
Speech, Physical, and Occupational Therapy and Chiropractic Care[2]	$30 after deductible	$0 after deductible	$30 after deductible
Diagnostic Test (Lab/X-ray)	$50 after deductible	$0/$125 after deductible	$40 after deductible
Urgent Care	$75 after deductible	$60 after deductible	$60 after deductible
Emergency Services	$300 after deductible	$300 after deductible	$150 after deductible
Hospital Inpatient (including facility and professional)[3]	$1,000 after deductible	$750 after deductible	$1,000 after deductible
Pharmacy Summary[4]	$5/$50/50% after deductible	$15/$50/50%	$10/$35/$70
Includes Dental and Vision Option[5]	No	No	No

[1] Unlimited visits, 20 visits per plan year for family counseling.

[2] Inpatient: Limit of 60 combined physical and occupational therapy visits per benefit period for Standard plans. No visit limitations for non-Standard plans.
Outpatient: Limit of 60 combined speech, physical, and occupational visits per condition per plan year.

[3] For plans with a hospital inpatient copay, the copay includes all facility and professional charges. Please refer to the plan's contract for additional information.

[4] Visit **highmark.link/nyformulary** to view our Formulary and see if your drug is covered, and at which tier.

[5] See pages 28-32 for adult dental and vision benefit details.

	Coverage Level			
	GOLD POS 200 HSAQ	GOLD DESTINATION 65	PLATINUM STANDARD	PLATINUM POS PLUS
Plan Availability	POS	POS	POS	POS
Monthly Premium				
Individual	$830.14	$882.30	$1,137.84	$1,012.84 With adult dental and vision: $1,055.80
Individual and Children	$1,411.24	$1,499.91	$1,934.33	$1,721.83 With adult dental and vision: $1,794.86
Individual and Spouse/Domestic Partner	$1,660.28	$1,764.60	$2,275.68	$2,025.68 With adult dental and vision: $2,111.60
Family	$2,365.90	$2,514.56	$3,242.84	$2,886.59; With adult dental and vision: $3,009.03
In-Network Deductible	Individual: $1,700 Family: $3,400	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $5,700 Family: $11,400	Individual: $9,450 Family: $18,900	Individual: $2,000 Family: $4,000	Individual: $6,500 Family: $13,000
Primary Care Visit	$20 after deductible	$0 copay	$15 copay	$10 copay
Specialist Visit	$40 after deductible	$30 copay	$35 copay	$30 copay
Outpatient Mental Health and Substance Abuse Visits[1]	$20 after deductible	$0 copay	$15 copay	$10 copay
Speech, Physical, and Occupational Therapy and Chiropractic Care[2]	$20 after deductible	$0 copay	$25 copay	$10 copay
Diagnostic Test (Lab/X-ray)	$40 after deductible	$0/$125 copay	$35 copay	$30 copay
Urgent Care	$50 after deductible	$60 copay	$55 copay	$40 copay
Emergency Services	$300 after deductible	$300 copay	$100 copay	$300 copay
Hospital Inpatient (including facility and professional)[3]	$750 after deductible	$750 copay	$500 copay	$500 copay
Pharmacy Summary[4]	$5/$40/50% after deductible	$5/$50/50%	$10/$30/$60	$5/$30/50%
Includes Dental and Vision Option[5]	No	No	No	Yes

Additional annual benefit limits

- Home Health Care: 40 visits per plan year
- Hearing Aids: Single purchase every three years. Members must choose hearing aids from John R. Oishei Children's Hospital or Beckes Optical and Hearing Aids. Members are entitled to discounts through TruHearing
- Hospice: 210 days per plan year; five visits per plan year for family bereavement
- Skilled Nursing Facility: Unlimited for non-Standard plans; 200 days per year for Standard plans